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**The Effects of Psychotherapy:
A Review of Research Prepared for the Irish Council for
Psychotherapy**

by

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EXECUTIVE SUMMARY

One in four people suffer from mental health problems, so mental health problems are a major national and international challenge.

Psychotherapy is an effective intervention for a wide range of mental health problems in people of all ages. The average success rate for treated cases ranges from 65 to 72%.

Psychotherapy conducted within psychoanalytic, humanistic and integrative; cognitive-behavioural; constructivist; and systemic couple and family therapy traditions is effective. Recovery rates for different forms of psychotherapy are very similar.

The effects of psychotherapy are nearly double those of placebos and the overall magnitude of the effects of psychotherapy in alleviating psychological disorders is similar to the overall magnitude of the effect of medical procedures in treating a wide variety of medical conditions.

About 1 in 10 clients deteriorate as a result of psychotherapy.

Client recovery is dependent upon the delivery of a high quality psychotherapy service, which may be maintained through quality assurance systems. Therapists must be adequately trained, have regular supervision and carry reasonable caseloads.

Psychotherapy has a significant medical cost-offset. Those who participate in psychotherapy use fewer other medical services at primary, secondary and tertiary levels and are hospitalized less than those who do not receive psychotherapy.

Psychotherapy can reduce attendance at accident and emergency services in frequent users of such services with chronic psychological problems.

Clients who have more rapid access to psychotherapy (and who spend little time on waiting lists) are more likely to engage in therapy.

Certain common therapeutic processes or factors underpin all effective psychotherapies and these have a far greater impact than specific factors in determining whether or not clients benefit from psychotherapy.

Common factors include those associated with therapy process, therapists and clients.

The following client characteristics have been associated with therapeutic outcome: personal distress; symptom severity; functional Impairment; case complexity; readiness to change; early response to therapy; psychological mindedness; ego-strength; capacity to make and maintain relationships; the availability of social support, and socio-economic status (SES).

The following therapist characteristics have been associated with therapeutic improvement: personal adjustment; therapeutic competence; matching therapeutic style to clients' needs; credibility; problem-solving creativity; capacity to repair alliance ruptures; specific training; flexible use of therapy manuals; and feedback on client recovery.

There is a dose-effect relationship in psychotherapy. In adult outpatient psychotherapy 20-45 sessions are necessary for 50-75% of psychotherapy clients to recover.

The therapeutic relationship or alliance is the most important single common factor in psychotherapy. In a good therapeutic alliance the therapist is empathic and collaborative and the client is co-operative and committed to recovery.

Effective therapy involves the common procedures of problem exploration and reconceptualization; provision of a credible rationale for conducting therapy; generating hope and the expectation of improvement; and mobilizing clients to engage in problem resolution. This may be achieved by providing support and encouraging emotional expression; by facilitating new ways of viewing problems; and by helping clients to develop new ways of behaving adaptively.

For certain specific disorders such as schizophrenia, multimodal programmes in which psychotherapy and psychotropic medication are combined are more effective than either alone.

Psychotherapy alone or as an element in a multimodal programme is effective for the following specific problems of adulthood: depression; bipolar disorder; anxiety disorders; psychosomatic disorders; eating disorders; insomnia; alcohol and drug abuse; schizophrenia; personality disorders and related identity and self-esteem issues, and issues arising from childhood sexual, physical and emotional abuse; relationship problems; psychological problems associated with older adulthood; adjustment to physical illnesses; and coping with chronic pain and fatigue.

Psychotherapy alone or as one element of a multimodal programme is effective for the following specific problems of childhood and adolescence: sleep problems; enuresis; encopresis; attention deficit hyperactivity disorder; oppositional defiant disorder; conduct disorder; drug abuse; depression; anxiety disorders; eating disorders; paediatric pain problems; adjustment to chronic medical conditions; adjustment problems following major life transitions and stresses including parental separation, bereavement, and physical, sexual and emotional child abuse and neglect; and adjustment problems associated with developmental disabilities including intellectual disability and autistic spectrum disorder.

RECOMMENDATIONS

1. For mental health problems and psychological adjustment problems associated with physical illness and major life stresses, evidence-based approaches to psychotherapy, such as those reviewed in this report, should be provided by appropriately trained and supervised professional psychotherapists to children, adolescents and adults.
2. Psychotherapy alone or as an element in a multimodal programme delivered by a multidisciplinary team should be available for adults with the following specific problems: depression; bipolar disorder; anxiety disorders; psychosomatic disorders;

eating disorders; insomnia; alcohol and drug abuse; schizophrenia; personality disorders; relationship problems; psychological problems associated with older adulthood; adjustment to physical illnesses; and coping with chronic pain and fatigue. Evidence-based psychotherapeutic approaches should be used. These are detailed in the body of the report, and are consistent with international guidelines for best practice such as those produced by the National Institute of Clinical Excellence (NICE) in the UK.

3. Psychotherapy alone or as one element of a multimodal programme delivered by a multidisciplinary team should be available for the following specific problems of childhood and adolescence: sleep problems; enuresis; encopresis; attention deficit hyperactivity disorder; oppositional defiant disorder; conduct disorder; drug abuse; depression; anxiety disorders; eating disorders; paediatric pain problems; adjustment to chronic medical conditions; adjustment problems following major life transitions and stresses including parental separation, bereavement, and child abuse and neglect; and adjustment problems associated with developmental disabilities including intellectual disability and autistic spectrum disorder. Evidence-based psychotherapeutic approaches should be used. These are detailed in the body of the report, and are consistent with international guidelines for best practice such as those produced by the National Institute of Clinical Excellence (NICE) in the UK and the American Academy of Child and Adolescent Psychiatry.
4. Psychotherapy should be offered as rapidly as possible, with short waiting times. This is because clients who do not access services rapidly, are less likely to engage in therapy when it is offered, to deteriorate and later require more intensive services.
5. Psychotherapy should be offered in primary, secondary and tertiary care settings. This recommendation is consistent with the policy document– *A Vision for Change 2006*. In primary care settings, relatively brief psychotherapy may alleviate psychological difficulties before they become chronic intractable problems, requiring intensive services. In secondary and tertiary care, specialist psychotherapy may be offered,

often as part of multimodal intervention programmes, to address chronic, complex psychological difficulties.

6. Within the HSE and other health service organizations, service delivery structures should be developed to facilitate the development of psychotherapy services in primary, secondary and tertiary care. This recommendation is consistent with the policy document– *A Vision for Change 2006*
7. Because psychotherapy has the potential to cause significant harm in a small proportion of cases, it is recommended that psychotherapy only be offered by those appropriately trained and qualified, and that all qualified psychotherapists practice within the limits of their competence, and in accordance with a well-defined professional ethical code of practice.
8. Psychotherapists employed in the HSE and other organizations that offer psychotherapy services, should be registered with the Irish Council for Psychotherapy (and statutorily registered, when this option becomes available).
9. Psychotherapy training should be offered by programmes accredited by the Irish Council of Psychotherapy. These programme should involve partnerships between universities or other third level educational institutions on the one hand, and HSE or other clinical practice sites on the other. These programmes should meet the European Certificate of Psychotherapy standards set by the European Psychotherapy Association (which represents more than 100,000 psychotherapists across Europe). These standards include a commitment to the practice of evidence-based psychotherapy in an ethical manner, following training of sufficient depth and duration to allow the mastery of complex skills and the personal contribution of the psychotherapist's personality and preoccupations to the therapeutic endeavour .
10. Psychotherapists should engage in regular clinical supervision appropriate to the modality of psychotherapy being offered.

11. Within the HSE and other organizations where psychotherapy is practiced, reliable systems and structures for offering and receiving supervision should be developed.
12. Psychotherapists should engage in continuing professional development to keep up to date with developments in the field.
13. Within the HSE and other organizations where psychotherapy is practiced, reliable systems and structures for offering and receiving continuing professional development should be developed.
14. Psychotherapy services within the HSE and other organizations should be routinely evaluated to determine their effectiveness.
15. Partnerships between psychotherapy services within the HSE and other organizations on the one hand, and university departments with expertise in psychotherapy service evaluation on the other, should be developed to facilitate the evolution of psychotherapy services in Ireland, and to engage in research on the development of more effective forms of psychotherapy for vulnerable subgroups of clients who have difficulty benefiting from current approaches to psychotherapy.
16. Many of the recommendations listed above require considerable resources, and so the final recommendation is that a system for funding the development of psychotherapy services in Ireland be developed and implemented. Such a system would need to specify how psychotherapy services fit into the HSE and other organizations; what the work contracts, salaries and career structures for psychotherapists should be; how psychotherapy training, supervision, and continuing professional development will be managed and funded; and how psychotherapy research, especially research evaluating its effectiveness in an Irish context will be funded.

CHAPTER 1

INTRODUCTION

This chapter opens with cursory sketches of the origins and definition of psychotherapy. Then the various schools of psychotherapy are classified into the five main categories reflecting the divisions of the Irish Council for Psychotherapy: psychoanalytic psychotherapy; humanistic and integrative approaches; cognitive-behaviour therapy; constructivist psychotherapy; and systemic couple and family therapy. Finally, a hierarchy of types of evidence that bear on the effectiveness of psychotherapy from the least to the most persuasive is presented. The hierarchy includes case studies, single group outcome studies, controlled group outcome studies, narrative literature reviews and meta-analyses. In the remaining chapters of this report, greatest weight will be given to meta-analyses and narrative reviews of controlled group outcome studies in presenting scientific evidence for the effectiveness of psychotherapy.

ORIGINS OF PSYCHOTHERAPY

Modern psychotherapy has a long past and a short history. Its origins date back thousands of years, but psychotherapy as it is currently practiced is no more than 100 years old. In the western world, the idea that skilled dialogue can alleviate distress may be traced to Socrates (469-399 BC) and the classical Greek philosophers. Sigmund Freud (1856-1939) in Austria, founder of the psychoanalytic tradition, played a central role in the establishment of modern psychotherapy as a discipline and profession. The cognitive-behavioural; humanistic and integrative; constructivist; and systemic couple and family psychotherapy traditions developed in the wake of the trail blazed by psychoanalytic psychotherapy. John Watson in the USA (1878-1958) was a founding figure of the cognitive behaviour therapy tradition. Carl Rogers (1902-1987) in the USA developed client-centred therapy and established humanistic psychotherapy as the third force in modern psychotherapy. George Kelly (1905-1967) in the USA was the originator of constructivist psychotherapy. In the USA, the Englishman, Gregory Bateson (1904-1980), while not a clinician himself, inspired the development of systemic therapy and the family therapy movement.

The emergence of psychotherapy in Ireland. Psychotherapy flourished first in North America and later in the UK, other parts of Europe and elsewhere. Psychotherapy in

Ireland began in Monkstown, on the south side of Dublin. The Monkstown Analysts were established under the leadership of Jonathon Hanaghan (1886-1967) who was of Scottish and Irish ancestry. In 1942 he founded the Irish Psycho-Analytic Association. The cognitive-behavioural, humanistic, constructivist and family therapy approaches to psychotherapy in Ireland evolved in the 60s and 70s. In the 1980s and 90s a number of university and institute-based postgraduate programmes in these various forms of psychotherapy were developed. The first university-based psychotherapy programme was an inter-faculty masters course set up by University College Dublin in the early 1980s. It had three specialization options: family therapy (linked to the Mater Hospital), psychoanalytic psychotherapy (linked to St Vincent's University Hospital), and constructivist psychotherapy (linked to St James Hospital).

Irish Professional Psychotherapy Associations. The 1980s and 1990s also marked the foundation of many of the professional associations for the psychotherapy traditions that constitute the Irish Council for Psychotherapy (ICP). The Family Therapy Association of Ireland, the Irish Constructivist Psychotherapy Association, and the Irish Association for Humanistic and Integrative Psychotherapy were all established during this period and each of these forms a section of the ICP. Six separate organizations form the psychoanalytic section of ICP and most have been established in the last 25 years. These are the Irish Forum for Child and Adolescent Psychoanalytic Psychotherapy, the Irish Forum for Psychoanalytic Psychotherapy, the Irish Group Analytic Society, the Irish Analytical Psychology Association, the Northern Ireland Institute of Human relations, and the Irish Psycho-Analytic Association.

Milestones in Irish Psychotherapy. The Irish Standing Conference on Psychotherapy was set up in 1991 and this later evolved into the Irish Council for Psychotherapy. In 1993 Ed Boyne published *Psychotherapy in Ireland*, the first book of its kind to be published in the country introducing as it did, the lay reader to a variety of different approaches to psychotherapy. The volume was revised and republished on two occasions, most recently in 2003. All chapters in this edited book are written by leading Irish psychotherapists. The book contains chapters on psychoanalysis by Ross Skelton; child psychoanalytic psychotherapy by Michael Fitzgerald; Jungian analysis by Rita McCarthy and Patricia Skar; psychosynthesis by Miceal O'Regan; constructivist psychotherapy by Dorothy Gunne and Bernadette O'Sullivan; family therapy by Ed McHale; cognitive-behaviour therapy by Tony Bates; Gestalt therapy by Vincent

Humphreys; client-centred therapy by Rachel Graham; and humanistic and integrative psychotherapy by Patrick Nolan. In 1997 the ICP published the first edition of *A Guide to Psychotherapy* in Ireland. The third edition of this guide was published in 2000. The guide includes a national register and directory of psychotherapists in Ireland, along with a description of five broad psychotherapy traditions reflecting the five sections of the ICP, i.e. cognitive behavioural psychotherapy, family therapy, humanistic and integrative psychotherapy, constructivist psychotherapy, and psychoanalytic psychotherapy. In 2000 the ICP hosted the ninth European Association for Psychotherapy Congress at University College Dublin. What follows are some comments on the development of the approaches to psychotherapy represented by each of the five sections of the ICP within Ireland.

Psychoanalytic psychotherapy. The Irish Psycho-Analytic Association (IPAA) was formed in 1942 by Jonathan (Jonty) Hanaghan, who had been analysed in England by Douglas Bryan - a leading member of the original London Psychoanalytic Society. Hanaghan developed a radical Christian approach to psychoanalysis and practiced in Monkstown on the south side of Dublin. He developed a considerable following which continued up until his death in 1967. In 1999, the IPAA became incorporated and is now a member of the ICP's psychoanalytic section. In the early 1980s younger analysts from Monkstown together with other analysts who had trained abroad formed the Irish Forum for Psychoanalytic Psychotherapy (IFPP). In the 1990s those IFPP analysts specialising in working with children and adolescents established the Irish Forum for Child and Adolescent Psychoanalytic Psychotherapy (IFCAPP), whilst those involved in group psychoanalysis founded the Irish Group Analytic Society (IGAS). The IFPP became affiliated to the Irish Council for Psychotherapy (ICP). However, a number of analysts within the IFPP interested in the work of the French analyst Jacques Lacan formed the Association for Psychoanalysis and Psychotherapy in Ireland (APPI) in the 1990s and training for this form of analysis was conducted at the School of Psychotherapy at St Vincent's University Hospital. In 2005 the College of Psychoanalysts in Ireland (CPI) was founded. The preceding synopsis of the history of psychoanalysis in Ireland is from the CPI website (<http://www.psychoanalysis.ie/>).

Family therapy. The first Irish family therapy training programme was established at the Mater hospital in Dublin in 1980 (affiliated to UCD) and shortly afterwards another training programme was established at the Clanwilliam Institute in Dublin. The pioneers of family therapy in Ireland trained in a variety of North American Centres and returned to set

up the programmes at the Mater Hospital and the Clanwilliam Institute. In the early 1990s a doctorate in families and systemic therapy was established at University College Dublin. In 1989 The first world family therapy conference was held at Trinity College Dublin under the auspices of the International Family Therapy Association and the Family Therapy Association of Ireland which had been formed in the early 80s. A detailed account of the history of family therapy in Ireland is given in Phil Kearney's 2006 paper: Systemic Psychotherapy in Ireland, which was published in the UK family therapy newsletter, *Context*.

Humanistic and integrative psychotherapy. Humanistic and integrative therapies include person-centred therapy, Gestalt therapy, Reichian bodywork, primal therapy and other forms of regression therapy, psychosynthesis and other specific approaches to transpersonal experience. In the late 1980s and 1990s programmes in humanistic and integrative psychotherapy were established at a variety of centres in Ireland including the Dublin Counselling and Therapy Centre in Gardiner St.; the Creative Counselling Centre in Dun Laoghaire, the University of Limerick, University College Cork, and Dublin City University. The Irish Association for Humanistic and Integrative Psychotherapy was founded in 1992.

Cognitive Behavioural Psychotherapy. Courses in cognitive behavioural psychotherapy with adults were established in Trinity College Dublin and University College Cork in the mid-1990s. More recently a course on cognitive behaviour therapy with children and adolescents has been established at University College Dublin. In Ireland, most psychotherapists in this field are affiliated to the Irish branch of the British Association of Behavioural and Cognitive Therapists. In 1998 the annual conference of the European Association of Behavioural and Cognitive Therapists was held at University College Cork.

Constructivist Psychotherapy. In 1983 the first course in constructivist psychotherapy in Ireland was set up by University College Dublin with links to Garden Hill House at St James' Hospital Dublin, Mount Pleasant Day Hospital, and St Brendan's Hospital, all of which were within the Eastern Health Board. The course ran until the early 90s, but currently there is no constructivist psychotherapy training programme in Ireland, although a number of constructivist psychotherapists teach on other psychotherapy training programmes. The Irish Constructivist Psychotherapy Association was founded in 1989 and this is affiliated to the European Personal Construct Association.

Ideas which distinguish various psychotherapy traditions mentioned here will be outlined below. However, these different traditions share a number of common features, which allows a coherent definition of psychotherapy to be offered.

DEFINITION OF PSYCHOTHERAPY

Psychotherapy is a contractual process in which trained professionals with expert knowledge of their discipline interact with clients to help them resolve psychological problems and address mental health difficulties. Psychotherapy may be offered to children and adults on an individual, couple, family, or group basis. Psychotherapy has evolved as a way of addressing psychological problems and mental health difficulties. Common problems include depression, anxiety, conduct problems, drug and alcohol abuse, eating disorders, personality disorders, psychosis, somatic complaints of unclear origin, family conflict, psychosexual problems, and adjustment difficulties arising from physical illnesses, disabilities or life transitions.

Psychotherapy contract

The psychotherapy process is a contractual arrangement in which therapists and clients (or patients) agree, explicitly or implicitly, to fulfil certain roles.

Therapist's role. Therapists agree to offer clients a service in a professional and skilled manner and to adhere to ethical standards which safeguard clients' best interests.

Client's role. Clients agree to co-operate, to the best of their ability, with treatment procedures by, for example, attending regular meetings, talking about their concerns; exploring factors related to the origin, maintenance and resolution of their problems; taking steps to address factors that may lead to a resolution of their difficulties; and agreeing to address ambivalence about problem-resolution when this occurs, as it invariably does.

Fees. In private practice, the psychotherapy contract involves an agreed sessional fee. In public health services, the state covers this cost.

Psychotherapy training

To be able to offer a skilled and professional service to clients, psychotherapists typically have expert training in a particular approach to psychotherapy, and in addition, many have training in another health profession such as psychology, social work, nursing, medicine, or occupational therapy. Indeed, in the Irish health service much psychotherapy is offered

by professionals employed within these other health professions. However, under the 1990 Strasbourg Declaration on Psychotherapy, there is now a consensus within the European Association for Psychotherapy that psychotherapy is an independent scientific discipline and profession. The European Association for Psychotherapy (of which the Irish Council for Psychotherapy is a member) awards a European Certificate in Psychotherapy for training programmes that span at least 7 years and involve at least 3,200 hours of academic coursework, self-reflection and supervised clinical practice.

Coursework covers material on how to conceptualize psychological problems and mental health difficulties; how to interpret relevant scientific research findings; and technical skills for conducting one or more specific types of psychotherapy for one or more specific types of problems.

Self-reflection usually involves participation in personal psychotherapy to allow practitioners develop an experiential appreciation of the psychotherapeutic process from the client's perspective.

Supervised clinical practice involves working with clients under the guidance of a trained, skilled therapist for a specified number of hours and in some instances with a specified number and range of cases.

Continuing professional development is central to good psychotherapy practice. This often involves supervision of cases by more experienced therapists or peer supervision with other senior colleagues. It also involves reading professional journals and books; attending professional conferences and training events; and taking part in professional committees.

Ethics

To facilitate ethical practice, psychotherapists are members of a professional psychotherapy association and adhere to the code of ethics of that association. Codes of ethics specify that therapists should practice within the limits of their competence, observe client confidentiality, practice in a way that prevents clients from harming themselves or others, and not take advantage of their special relationship with their clients, by for example refraining from having sexual or financial transactions with them.

Statutory registration

In many jurisdictions there is statutory registration of psychotherapy, and therapists must

be licensed to practice their profession legally. Registration and licensing protects the public from charlatans by ensuring an adequate standard of training and adherence to a code of ethics. There is currently no statutory registration of psychotherapists in Ireland. In this respect, the public is not protected. However, the Irish Council for Psychotherapy has published a Psychotherapy Directory (<http://www.psychotherapy-ireland.com/index.cfm/loc/2/pt/6.htm>) which is effectively a non-statutory register of psychotherapists in Ireland. The directory includes psychotherapists from the five sections of the Irish Council for Psychotherapy, viz. (1) Cognitive Behavioural Therapy, (2) Constructivist Psychotherapy, (3) Couple, Family and Systemic Psychotherapies, (4) Humanistic and Integrative Psychotherapy, and (5) Psychoanalytic Psychotherapy. Six separate organizations form the psychoanalytic section of ICP, i.e., the Irish Forum for Child and Adolescent Psychoanalytic Psychotherapy, the Irish Forum for Psychoanalytic Psychotherapy, the Irish Group Analytic Society, the Irish Analytical Psychology Association, the Northern Ireland Institute of Human relations, and the Irish Psycho-Analytic Association.

Psychotherapy and counselling

Psychotherapy is sometimes distinguished from counselling. While both professions involve engaging clients with psychological problems in a therapeutic relationship with a view to problem resolution, distinctions may be made between these professions along a number of dimensions. Psychotherapists have more extensive training. It takes 7 years to train as a psychotherapist, and takes less to train as a counsellor. Counsellor training programmes often focus on specific problems or client groups, for example drug and alcohol abuse. In contrast, psychotherapy training programmes cover a broader range of problems and client groups, but usually focus on a specific therapeutic approach, for example systemic couple and family therapy; cognitive behaviour therapy; psychoanalytic therapy; or humanistic and integrative therapy. Some psychotherapies utilise unconscious as well as conscious processes to inform their therapeutic work e.g. individual and group psychoanalytic psychotherapies.

Psychotherapy, clinical psychology, social work, psychiatry and psychiatric nursing

Distinctions are made between the profession of psychotherapy on the one hand and clinical psychology, social work, psychiatry and psychiatric nursing on the other. In Ireland

the professions of clinical psychology, social work, psychiatry and psychiatric nursing have been established within the Irish health service for a number of decades, while psychotherapy posts are a recent innovation within the Irish Health Service. The basic professional training of clinical psychologists, social workers, psychiatrists and psychiatric nurses entails an element of psychotherapy training. Also, some members of these professions, complete psychotherapy training after they have finished their training in clinical psychology, social work, psychiatry and psychiatric nursing. Some members of clinical psychology, social work, psychiatry and psychiatric nursing currently offer psychotherapy to clients within the Irish health service.

Psychotherapy in multimodal treatment programmes

Psychotherapy is sometimes referred to as ‘talking therapy’ to distinguish it from the use of medication or physical treatment such as electro-convulsive-therapy (ECT) which are sometimes offered by medical practitioners, especially psychiatrists, as treatments for psychological problems. However, in certain contexts clients are offered psychotherapy as part of a multimodal programme which also includes medication, for example, a multidisciplinary mental health team may routinely offer a multimodal programme of psychotherapy and antidepressants for depression.

PSYCHOTHERAPY TRADITIONS

While the features of psychotherapy outlined in the previous section are common to all reputable approaches to psychotherapeutic practice, there are over 400 schools of psychotherapy and at least a dozen that are widely used in the English speaking world (Corsini & Wadding, 2004). However, available research evidence – the central concern of this report - is usefully conceptualized as falling into a small number of broad categories which correspond to the divisions of the Irish Council for Psychotherapy: psychoanalytic psychotherapy, humanistic and integrative psychotherapy; cognitive-behavioural therapy, constructivist psychotherapy and systemic couple and family therapy.

Psychoanalytic psychotherapy. Psychoanalytic psychotherapy is an approach to practice that has evolved from the seminal work of Sigmund Freud (Gabbard, 2004; Messer & Warren, 1998). A defining feature of this approach is the use of free association and interpretation to help clients become aware of how unconscious motivations and memories underpin their current difficulties. This empowers them to resolve conflicts and

find more adaptive solutions to the problems they currently face in their lives. In the UK, S. H. Foulkes was a founder of group analytic psychotherapy, in which the psychoanalytic approach was applied to small groups of clients, rather than on an individual basis. Melanie Klein and Donald Winnicott developed play-based techniques for engaging children in psychoanalysis.

Humanistic and integrative psychotherapy. Humanistic and integrative psychotherapy is an overarching term for a tradition that includes a variety of therapy models, for example, Carl Rogers' client-centred therapy, Fritz Perl's Gestalt therapy and various experiential therapies (Cain & Seeman, 2001). A defining feature of humanistic and integrative psychotherapy is the use of the relationship between the client and the therapist as a resource in addressing the client's problems.

Cognitive-behavioural therapy. Cognitive-behavioural therapy includes approaches that fall within the broad traditions of learning theory and cognitive science (Clark & Fairburn, 1997). A defining feature of cognitive behaviour therapy is the use of highly specific interventions for specific problems, such as cognitive interventions to change thinking patterns in depression or exposure to feared stimuli in treating anxiety disorders.

Constructivist psychotherapy. Constructivist psychotherapy is based on George Kelly's personal construct psychology (Winter & Viney, 2005). Personal construct psychology holds that people's problems are rooted in the way they construe or interpret the world. Consequently a defining feature of personal construct psychotherapy is the exploration and transformation of clients' construct and belief systems.

Systemic couple and family therapy. Systemic therapy includes approaches that involve working directly with couples, parents, families, and social networks (Carr, 2006). A defining feature of systemic therapy is the conjoint involvement of the client and members of their family or social system in understanding and addressing the presenting problems. Family therapy, parent training, couples therapy, sex therapy, and multisystemic therapy all fall into this category.

Scientific evidence and psychotherapy traditions

In a research report like this, it is important to acknowledge at the outset that scientific knowledge, such as that provided by randomized controlled trials and meta-analyses of such studies, has only recently begun to be valued by traditional psychoanalytic;

humanistic and integrative; and systemic couple and family psychotherapies, which have historically placed far greater value on self-reflective knowledge and case studies.

Most practicing psychotherapists in Ireland and abroad fall within the traditional psychoanalytic; humanistic and integrative; and systemic couple and family psychotherapy categories. This is not surprising, because traditional psychotherapies value self-reflection and include self-reflective personal therapy as a key element in training. Also, people who value self-reflection are attracted into this type of psychotherapy training.

Most of the scientific evidence-base for psychotherapy involves evaluations, not of traditional psychotherapies, but of cognitive behaviour therapy. This, too, is not surprising because cognitive behaviour therapy values scientifically identifying specific techniques that are effective in addressing specific problems, and the same value is not placed on this knowledge by traditional psychotherapies.

In light of this, one of the challenges facing all of us in the psychotherapy field when examining the scientific evidence is to be careful to avoid concluding that because a particular approach (cognitive behaviour therapy) has been more frequently evaluated than other approaches it is necessarily more effective. It is also important to acknowledge that all effective psychotherapies share certain common factors, an issue addressed in Chapter 3.

HIERARCHY OF EVIDENCE

The primary aim of this report is to present a summary of current scientific evidence for the effectiveness of psychotherapy in children and adults. In this context it is useful to organize categories of available scientific evidence into a hierarchy, from the least to the most persuasive. The hierarchy includes the following types of evidence:

- Narrative accounts and qualitative analyses of therapy with individual cases
- Single group outcome studies
- Controlled comparative group outcome studies and controlled single case design studies
- Narrative reviews of outcome studies
- Meta-analyses of controlled outcome studies.

Below a description of each category will be outlined. In the body of the report, evidence from higher levels in this hierarchy will be given priority. Highest priority will be given to

results of meta-analyses which quantitatively summarize results of many controlled trials involving the treatment of many hundreds of clients.

Case studies. In narrative accounts and qualitative analyses of therapy with individual cases, descriptions and explanations are given of the way therapy was conducted and the impact of therapy on the clients' problems or symptoms. Such studies offer important insights into the details of how specific types of psychotherapy may be conducted with specific cases. In all psychotherapy traditions pioneers began by reporting case studies. Some examples are sketched in Figure 1.1. Case studies are useful for teaching the subtle skills of psychotherapy (Wedding & Corsini, 2005). The main limitation of much case study evidence is that any observed improvements in clients' problems may be due to idiosyncratic responses of individual cases, biased observation by the psychotherapist, invalid or unreliable assessment of clients' problems, or to the passage of time.

Single group outcome studies. Single group outcome studies provide more convincing evidence of the effectiveness of psychotherapy. In such studies a group of cases with similar sorts of problems is assessed before and after treatment with a standard set of assessment instruments. Because data are collected on more than one case, single group outcome studies rule out the possibility that improvement is the idiosyncratic response of a single case. Where structured interviews are used to assess outcome, pre-therapy and post-therapy assessment interviews are conducted by different members of a research team, and usually interviewers are unaware of whether a client has been treated or not, to prevent interviewer bias from influencing results. Also, in these studies, well developed scientific measures of clients' problems or symptoms are made, so it may be said with confidence that any observed improvements have been validly and reliably assessed. In psychotherapy studies, self-report questionnaires and structured clinical interviews are the most commonly used assessment measures. Measures of a wide range of problems - for example, anxiety, depression, drug abuse, and psychotic symptoms - have been developed. Typically an instrument yields one or more diagnoses or problem scale scores. For these sorts of instruments to be considered scientifically valid, they must have been shown in instrument development studies to measure what they purport to measure. So a valid measure of depression has been shown in development studies to measure depression and not boredom or exhaustion. For assessment instruments to be considered reliable, they must yield the same score on two

consecutive assessment occasions within brief time period (for example 2 weeks.). This is referred to as test-retest reliability. For interviews to be considered reliable, two raters should provide similar ratings for the same client. This is referred to as inter-rater reliability. The main shortcoming with evidence based on single group outcome studies is they leave open the possibility that improvements in clients' functioning may be due to the passage of time.

Comparative group outcome studies. To out-rule the possibility that observed improvement in clients' problems following psychotherapy are due to the passage of time, gains made by treated cases are compared with gains made by untreated cases in a control group. In psychotherapy studies, clients in control groups usually do not receive any treatment, or receive routine clinical management of their problems, but not the form of psychotherapy being evaluated in the study. An example of results from a comparative group outcome studies is given in Figure 1.2. After therapy, the average score of the group that received couples therapy for chronic depression was lower than that before therapy, and this gain was maintained at follow-up a year later and overall this pattern of improvement was better than that for cases treated with antidepressants. In Figure 1.3, at 6 years follow-up a higher proportion of adolescents that received family therapy for anorexia were recovered compared with the control group who received individual therapy. In comparative group outcome studies the probability that differences in improvement shown by the treatment and control groups could have occurred due to chance is evaluated with statistical tests. In the psychotherapy outcome research literature, by convention a treatment is considered to be effective if the differences in improvement rates between treatment and control groups could only have occurred by chance in 5 cases out of 100. This probability level is referred to as $p < .05$. Thus, in a comparative group outcome study if the treatment group improved more than the control group and this difference was statistically significant, we may conclude that psychotherapy led to greater improvement than would have occurred due to the passage of time, and that the extent of this improvement was greater than could have occurred due to chance. There are many variations of the basic controlled treatment outcome study, but the 'gold standard' is the randomized controlled trial (RCT).

Randomized controlled trials. In RCTs, cases are randomly assigned to treatment and control groups, to out-rule the possibility that differences in improvement rates are due to responsive and unresponsive cases having been systematically assigned to treatment

and control groups. Where randomization is not possible, cases in treatment and control groups may be matched on important variables such as problem type, severity and chronicity; number of co-morbid problems; and demographic factors such as age, gender, socio-economic status, marital status and so forth. In some RCTs the effectiveness of a new treatment is compared with 'treatment as usual'; with a placebo treatment; or two novel treatments are compared. There is a tradition in medical RCTs, to use 'sugar pills' as placebos, so patients in the control group do not receive the medicine which is being evaluated, but believe that they are being helped since they are receiving what looks like an active treatment (the placebo sugar pill). In some psychotherapy treatment outcome studies, clients receive placebo therapy. This usually involves having as much contact with a therapist as those in the treatment group, but receiving some innocuous, though credible, placebo psychotherapy, for example engaging in 'intellectual discussions' about plausible topics. When placebo control groups are included in RCTs, they rule out the possibility that treatment gains were due simply to therapist-contact rather than psychotherapeutic techniques and processes.

Efficacy and effectiveness. A useful distinction is made between efficacy and effectiveness comparative group outcome studies (Cochrane, 1972). In efficacy studies clients with a specific type of problem (and no comorbid difficulties) are assigned to treatment and control groups. The treatment group receives a pure and potent form of a very specific type of psychotherapy from specialist psychotherapists in practice centres of excellence. Efficacy studies are typically conducted at university affiliated centres with carefully selected clients who meet stringent inclusion and exclusion criteria. For example, often patients with comorbid substance abuse and personality disorders or self-harming behaviour are excluded in efficacy studies of treatments for depression. Therapists are highly trained, intensively supervised, and the fidelity with which they offer treatment is scientifically checked by rating the degree to which recordings of therapy sessions conform to treatment protocols specified in therapy manuals. Effectiveness studies, in contrast, are conducted in routine clinical settings, rather than centres of excellence, with clients who are representative of typical referrals, and while therapy manuals and supervision are employed, there is often a greater degree of flexibility about their use than in efficacy studies. Efficacy studies tell us how well treatments work under ideal conditions. Information about the impact of treatments under routine conditions is provided by effectiveness studies. Effectiveness studies tell us how well manualized therapies work

when flexibly implemented by regular psychotherapists with a normal level of supervision, with clients who have a main presenting problem but other complex difficulties. It is useful to think of effectiveness and efficacy studies as representing the extremes of a continuum along which a variety of treatment outcome study designs fall.

Controlled single case designs. Just as the RCT is the 'gold standard' for group outcome studies of psychotherapy effectiveness, controlled single case studies are the 'gold standard' for case studies of psychotherapy effectiveness. Such designs have been extensively used in investigating the impact of specific treatments in cases of developmental disabilities. The multiple baseline across cases is a good example of such a design. In this type of study frequent reliable and valid measurements of a central problem are made with a small number of cases (usually 3 to 5) until all cases show a stable baseline. At this point the first case, but not the others, commences psychotherapy. Once the first case shows significant and sustained improvement, then the next case commences psychotherapy. The same pattern is followed in commencing treatment with other cases in the study. A graph of the results from such a study is given in Figure 1.4. From the graph it may be seen that at the start of the study all three cases had stable baselines and improvement in each case coincided with the onset of therapy. If only the first case had been treated, there would have been no way of knowing whether improvement was due to treatment or the passage of time. But the fact that the untreated cases showed no improvement until treatment began provides evidence for effectiveness of treatment.

Narrative reviews of outcome studies. While an individual treatment outcome study with positive results provides evidence that in one context, a specific form of psychotherapy was effective for a group of clients with a specific type of problem, a narrative review of outcome studies synthesizes the results of many outcome studies. In a narrative review of group outcome studies of psychotherapy with specific problems, systematic computer-based and manual literature searches are conducted to identify treatment outcome studies. The reviewer then summarizes key findings of these studies and draws conclusions about the effectiveness of specific forms of psychotherapy with specific types of problems. Narrative reviews of treatment outcome studies provide more convincing evidence than the results of a single outcome study because they provide evidence that positive results have or have not been replicated. However, the conclusions

drawn in narrative reviews of many treatment outcome studies are inevitably biased by the prejudices of the reviewer.

Meta-analyses of controlled outcome studies. Meta-analysis is a systematic and quantitative approach to reviewing evidence from multiple treatment outcome studies which aims to overcome the impact of reviewer bias on the review process. In meta-analysis of group outcome studies, effect sizes are calculated for each study and then averaged across all studies. Effect sizes express quantitatively the degree to which treated groups improved more than the control groups. A graphic explanation of the calculation of effect sizes is given in Figure 1.5 and a system for interpreting them is given in Figure 1.6. Effect sizes of .8 and above are considered large. Meta-analyses provide a quantitative index of the effectiveness of psychotherapy based on large numbers of controlled studies including large numbers of cases. In this report, wherever possible results of meta-analyses will be presented as evidence for the effectiveness of psychotherapy.

However, when interpreting the results of meta-analyses it is important to keep in mind that a number of methodological factors have been found to influence average effect-sizes. These include the methodological rigour of the studies included; the type of outcome measure used to calculate effect sizes; the use of weighting procedures in calculating average effect sizes; and researcher allegiance to specific forms of therapy. Each of these issues deserves comment.

In the first major meta-analysis of psychotherapy outcome studies Smith's team (Smith & Glass, 1977; Smith et al., 1980) found that the average effect size for high quality studies was .88 while that for moderate and low quality studies was .78. Thus, they concluded that the strongest evidence for the effectiveness of psychotherapy comes from meta-analysis of the most scientifically rigorous treatment outcome studies.

In routine clinical practice and in treatment outcome studies, psychotherapy leads to greater changes on 'reactive' measures of specific problems the therapy was designed to address, than on broad measures of overall adjustment. Therefore it is not surprising that the results of meta-analyses are affected by the types of outcome measures used to calculate effect sizes. For example, Shadish et al. (2000) in a meta-analysis of 90 studies found larger average effects sizes for measures of specific problems compared with measures of general adjustment.

Hedges and Olkin (1985) have argued that it is more valid to weight effect sizes for each study based on the number of participants, with greater weight being given to studies

involving more participants. When this statistical refinement is used to compute overall effect sizes in meta-analyses, smaller effect sizes are obtained. For example Shadish et al. (1997) in a re-analysis of data from a number of previous meta-analyses (including Smith et al's (1980) seminal study) found that effect sizes based on unweighted procedures were in the .7-.8 range whereas when weighting procedures were used effect sizes between .4 and .6 were obtained. It is important to keep this in mind, since prior to the mid-90s weighted effect sizes were rarely reported.

Smith et al. (1980) in their seminal meta-analysis found average effects of .95 and .66 for types of psychotherapies favoured and not favoured by researchers, respectively. The difference between these two effect sizes of .29 is a rough estimate of allegiance effects. Thus, therapy approaches favoured by researchers were evaluated more positively. Gaffan et al. (1995) in a meta-analysis of studies of cognitive therapy for depression found that allegiance effects have decreased from the 1970 to the 1990s. This is partly due to researchers giving non-favoured therapies a 'fair trial' by, for example, having such therapies delivered by skilled therapists following a well defined protocol for the alternative therapy.

CONCLUSIONS

Modern psychotherapy has developed over the past 100 years, and in Ireland the past 30 years have been the period of greatest growth. Psychotherapy is a contractual process in which trained professionals interact with clients to help them resolve psychological problems. Psychotherapy may be offered to children and adults on an individual, couple, family, or group basis. In addressing the scientific evidence-base for the effectiveness of psychotherapy it is useful to classify the various schools of psychotherapy into five categories reflecting the divisions of the Irish Council for Psychotherapy: psychoanalytic; humanistic and integrative; cognitive-behavioural; constructivist, and systemic couple and family. Evidence for the effectiveness of psychotherapy may be organized into a hierarchy from uncontrolled case studies which are the least persuasive to meta-analyses which are the most persuasive. In the following chapters of this report, greatest weight will be given to meta-analyses of controlled group outcome studies.

Figure 1.1. Case studies.

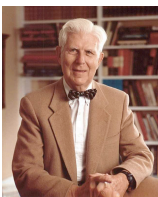
**Melanie Klein
Psychoanalysis**



Melanie Klein (1961) described session-by-session her analysis over 93 sessions of 10 year old Richard who presented with an anxiety disorder, school refusal and peer relationship problems. This work illustrates her analytic play therapy technique, in which she interpreted drawings, play, dreams and other verbal material to help the boy resolve the unconscious conflicts underlying his anxiety.

Klein, M. (1961). *Narrative of a Child Analysis. The Conduct of the Psycho-Analysis of Children as seen in the Treatment of a Ten Year old Boy*. New York: Free Press.

**Aaron T. Beck
Cognitive Therapy**



Beck (1958) described a series of cases in which he used cognitive therapy to treat depression and anxiety disorders. His approach involved helping people identify and challenge negative automatic thoughts which underpinned their negative mood states. Socratic dialogue, behavioural experiments and other techniques were used to facilitate this process.

Beck, A.T. (1976). *Cognitive Therapy and the Emotional Disorders*. New York: Meridian

**Carl Rogers
Client-Centred Therapy**



Rogers (1954) described how he treated Mrs Oak for complex family difficulties involving marital conflict and her daughter's psychosomatic complaints using client-centred therapy. This involved creating a therapeutic relationship characterized by warmth, empathy, and unconditional positive regard, and through non-directive listening empowered Mrs Oak to become aware of emotional experiences she was keeping from awareness. As she accepted these she was empowered to make important decisions about how to resolve her family difficulties.

Rogers, C. (1954). The case of Mrs Oak: A research analysis. In C. Rogers & R. Dymond (Eds.). *Psychotherapy and Personality Change* (pp. 259-348). Chicago: Chicago University Press.

**George Kelly
Personal Construct Therapy**



Kelly (1955) described how he used self characterization (writing and analysing a detailed description of the self from the perspective of another) and fixed role therapy (adopting a role defined by a new set of constructs) to help Ronald Barrett cope with social and vocational issues which were causing him distress.

Kelly, G. (1955). *The Psychology of Personal Constructs* (Volumes 1 and 2). London: Routledge.

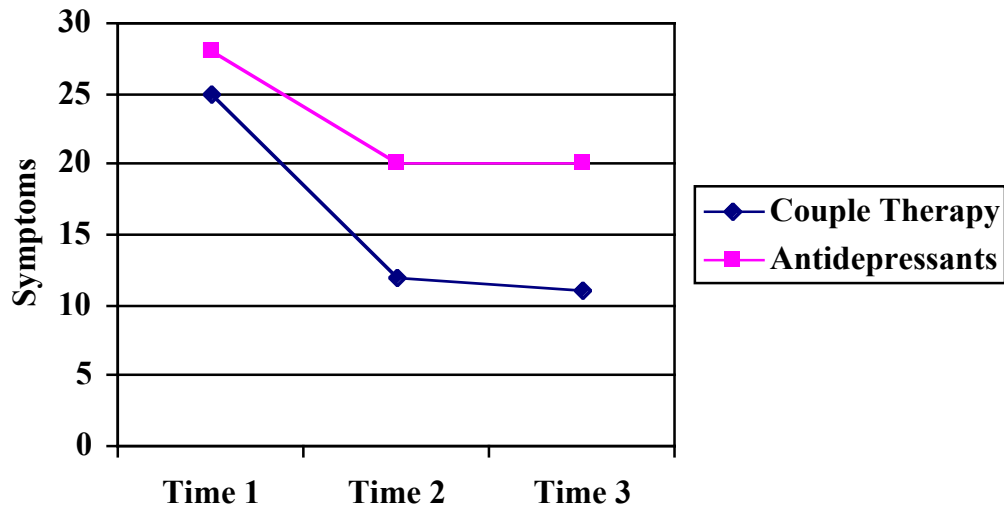
**Salvador Minuchin
Family Therapy**



Minuchin and his team (1978) described how they conceptualized anorexia as being maintained by a process of triangulation within the family. He showed how structural family therapy was used to help an adolescent girl break the cycle of self-starvation and empower the parents to help their daughter recover and maintain a normal eating pattern.

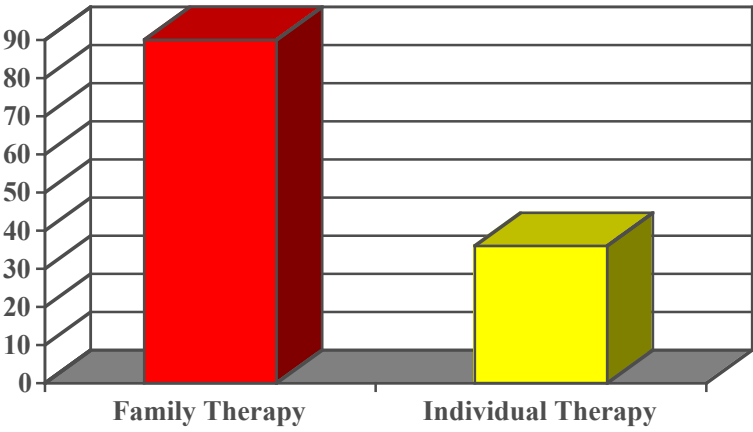
Minuchin, S. Rosman, B. and Baker, L. (1978). *Psychosomatic Families: Anorexia Nervosa in Context*. Cambridge, MA: Harvard University Press.

Figure 1.2. Improvement in mean symptom scores on the Beck Depression Inventory for adults with chronic depression receiving systemic couples therapy or antidepressants before treatment (Time 1), 1 year after treatment (Time 2) and at 2 years after treatment (Time 3).



Adapted from: Leff, J., Vearnals, S., Brewin, C., Wolff, G., Alexander, B. & Asen, E. *et al* (2000) The London Depression Intervention Trial. Randomised controlled trial of antidepressants versus couple therapy in the treatment and maintenance of people with depression living with a partner: clinical outcomes and costs. *British Journal of Psychiatry*, 177, 95–100.

Figure 1.3. Improvement rates at 6 years follow-up for adolescents with anorexia treatment who received family therapy or individual therapy



Adapted from: Eisler, I., Dare, C., Russell, G. F. M., Szumukler, G. I., Le Grange, D. and Dodge, E. (1997) Family and individual therapy in anorexia nervosa. A 5-year follow-up. *Archives of General Psychiatry*, 54: 1025–1030.

Figure 1.4. Graph of results of multiple baseline across cases psychotherapy outcome study.

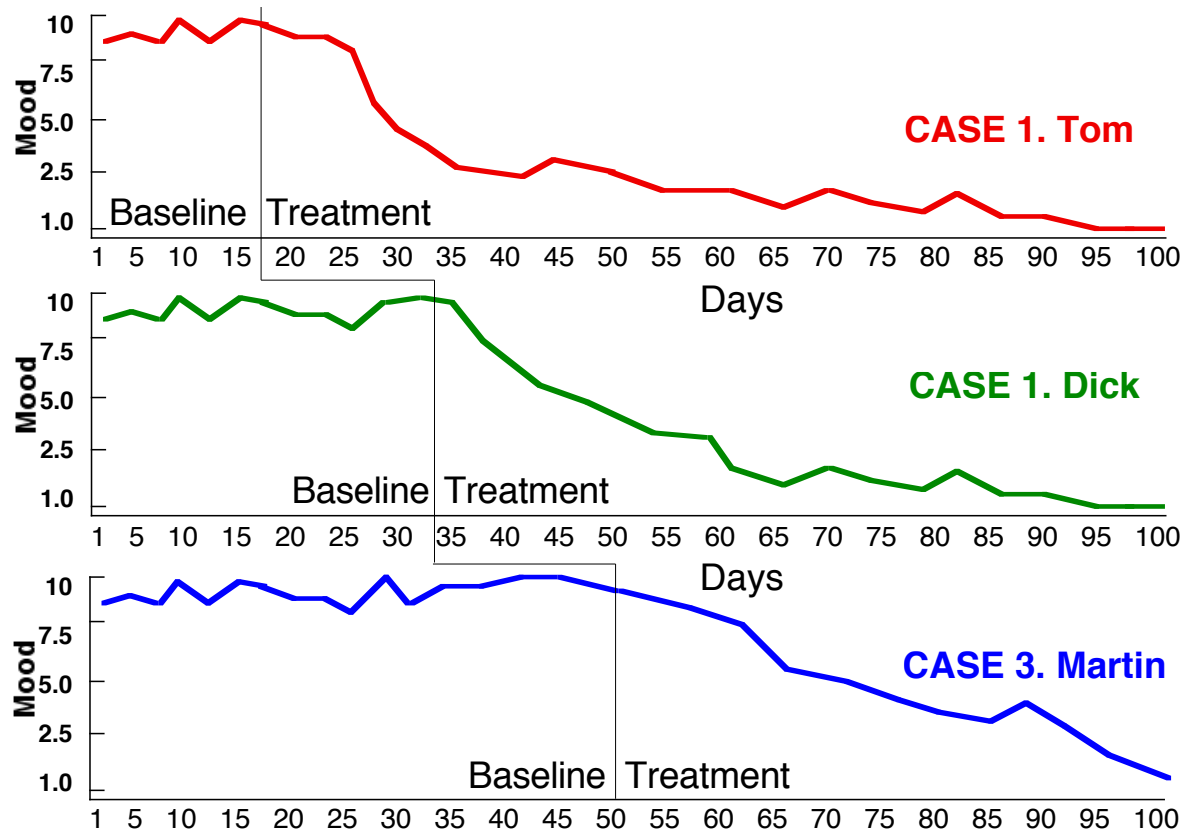
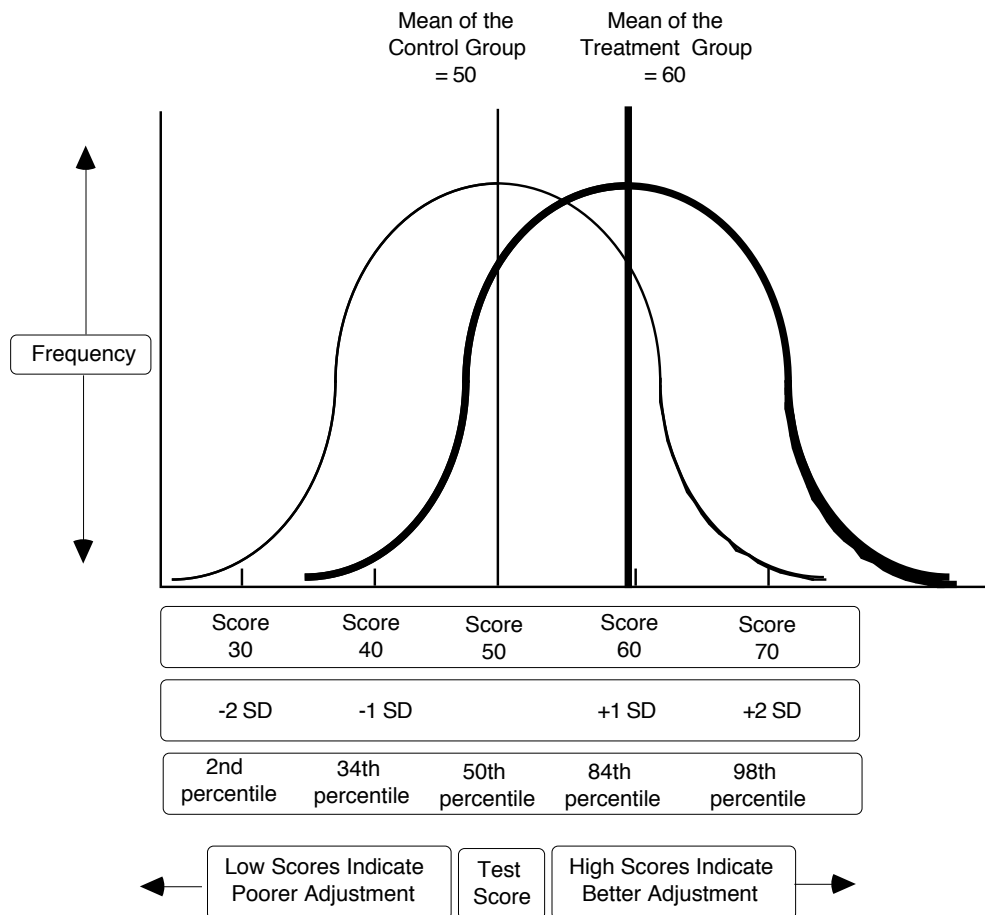


Figure 1.5. Graphic representation of an effect size of 1



$$d = \frac{\text{Mean of the treatment group} - \text{Mean of the control group}}{\text{Pooled standard deviation}} = \frac{60-50}{10} = 1$$

An effect size of 1 indicates that after treatment the average case in the treatment group is better adjusted than 84% of the control group.

Figure 1.6. Interpretation of effect sizes

Effect size d	Cohen's Designation ¹	Percentage of untreated cases that the average treated case fares better than ²	Success Rate for treated group ³	Success rate for untreated group ³	Percentage of outcome variance accounted for by treatment ⁴	Correlation With Outcome ⁵
1.0	Large	84	72	28	20	.44
.9		82	71	29	17	.41
.8		79	69	31	14	.37
.7		76	67	33	11	.33
.6	Medium	73	64	36	8	.29
.5		69	62	38	6	.24
.4		66	60	40	4	.20
.3		62	57	43	2	.15
.2	Small	58	55	45	1	.10
.1		54	53	47	0	.00

Note: This table is adapted from Wampold (2001, p. 53).

1. From Cohen (1988).

2. From Glass (1976).

3. From Rosenthal and Rubin (1982), assuming overall success rate of .5, success rate for treated cases is .5+correlation with outcome/2 and success rate for untreated cases is .5-correlation with outcome/2.

4. From Rosenthal (1994, p.239), percentage of variance = $d^2/(d^2+4)$.

5. From Wampold (2001, p.53), correlation = $\sqrt{d^2/(d^2+4)}$.

CHAPTER 2

THE OVERALL EFFECTIVENESS OF PSYCHOTHERAPY

Currently evidence for the effectiveness of psychotherapy is overwhelming. Major meta-analyses of hundreds of treatment outcome studies involving thousands of child, adolescent and adult clients with a wide range of problems show unequivocally that psychotherapy works. In this chapter some of this evidence will be reviewed.

QUESTIONS ABOUT THE EFFECTIVENESS OF PSYCHOTHERAPY

In a seminal paper in 1952, Hans Eysenck concluded from a review of 24 uncontrolled studies and data from untreated cases, that the evidence available at the time did not support the effectiveness of psychotherapy. However, he also remarked that the evidence-base was weak and recommended that well designed studies be conducted to rigorously evaluate the effectiveness of psychotherapy. Levitt published a similar paper in 1957 on the effectiveness of psychotherapy for children and adolescents in which he reached similar conclusions to those of Eysenck.

Since the 50s a central question addressed by many psychotherapy researchers has been 'Does psychotherapy work?' Broad-based treatment outcome studies of heterogeneous groups of clients receiving broadly defined therapy approaches and reviews of such studies have been conducted to answer this broad question.

More refined questions about the effectiveness of psychotherapy have also emerged, the most widely known of which is that posed by Gordon Paul "What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances?" (Paul, 1967, p. 111). This question has inspired narrower studies of the effects of specific treatment protocols on specific client groups with particular types of problems and careful reviews and meta-analyses of such treatment outcome studies. In chapters 4 and 5 this evidence will be addressed. However, in this chapter our main concern is with the broader question.

META-ANALYSIS AND OVERALL EFFECTIVENESS

Twenty five years after Eysenck's seminal paper Mary Smith and Gene Glass (1977) published the first major meta-analysis of psychotherapy outcome studies in the *American*

Psychologist and followed it up with a book on the topic in 1980 (Smith, Glass & Miller, 1980). The main contribution of Smith and Glass was to show that the results of many treatment outcome studies could be systematically quantitatively synthesised to reach a valid and useful conclusion. On the basis of their 1977 quantitative review of 375 controlled evaluations of psychotherapy they concluded that the typical therapy client is better off than 75% of untreated individuals. This conclusion rested on the observation that the average effect size was .68, and was interpreted using the system given in Figure 1.6.

Since 1977 many meta-analyses have been conducted which have confirmed the efficacy of psychotherapy (Lambert and Ogle, 2004; Wampold, 2001; Weisz, 2004). In a synthesis of 68 separate meta-analyses of psychotherapy with children, adolescents and adults with a wide range of different psychological problems, Grissom (1996) found an aggregate effect size of .75, indicating that the average treated case fared better than 77% of untreated controls.

CONSUMER REPORTS SURVEY OF EFFECTIVENESS OF PSYCHOTHERAPY

The results of a large USA Consumer Reports survey of 4,100 adult psychotherapy clients with a wide range of problems which has received much attention from psychotherapy researchers are consistent with the results of the meta-analyses cited above (Seligman, 1995). While consumer survey results have more limited scientific validity than the results of meta-analyses of controlled treatment outcome studies, the results of the Consumer Reports survey is of interest because of its scale, the fact that the results are consistent with the results of meta-analyses, because they have direct bearing on the funding of psychotherapy through managed care programmes in the USA, and because Martin Seligman, a past president of the American Psychological Association was a consultant to the survey and championed the presentation of the results to the scientific community. From the results of the survey Martin Seligman concluded that psychotherapy clients benefited very substantially from psychotherapy. He also concluded that those who received long-term treatment did considerably better than those who received short-term treatment and that less improvement occurred when managed care or the client's health insurance company constrained their choice of therapist and the duration of therapy. A number of factors had no significant impact on improvement following psychotherapy including the additional use of psychotropic medication such as antidepressants; the type of theoretical orientation of the psychotherapist; and the profession of the psychotherapist.

Clients who received medication and those that did not had similar outcomes. Clients treated with different types of therapy reported similar improvement rates. Similar improvement rates occurred regardless of whether clients were treated by therapists whose basic professional training was in psychology, psychiatry, or social work. While these results are those of a biased sample of undiagnosed consumers, involving outcome measures of unknown clinical reliability and validity, they are remarkably consistent with the results of meta-analyses reviewed in this and the next chapter.

EFFECTIVENESS OF PSYCHOTHERAPY WITH ADULTS

While Smith and Glass's meta-analyses included mainly studies of psychotherapy with adults, they also included many studies of therapy with children. With a view to determining the effects of psychotherapy for adults with psychological problems, Shapiro and Shapiro (1982) conducted a meta-analysis of 143 studies of psychotherapy exclusively involving adult populations. They found an overall effect size of 1.03, indicating that after treatment the average adult who participated in psychotherapy fared better than 84% of untreated control group cases. Two further meta-analyses deserve mention in this section because they offer support for the effectiveness of psychotherapy adults. Andrews and Harvery (1981) in a meta-analysis of 81 studies including only clinically distressed adults obtained an overall effect size of .72, indicating that the average treated case fared better than 77% of untreated controls. Landman and Dawes (1982) in a meta-analysis of 42 studies, marked by a high level of methodological rigour, obtained an overall effect size of .9, indicating that the average treated case fared better than 82% of untreated controls. The studies included in the meta-analyses by Andrews and Harvery (1981) and Landman and Dawes (1982) were subsets of those included in Smith and Glass's original 1977 meta-analysis. They are particularly important because they show that Smith and Glass's original meta-analytic findings were not an artefact of either including studies of unrepresentative, non-distressed clients or studies lacking in methodological rigour in their meta-analysis.

EFFECTIVENESS OF PSYCHOTHERAPY WITH CHILDREN

The results of four broad meta-analyses of studies involving children with a diverse range of psychological problems receiving a variety of different forms of psychotherapy provide evidence for the overall effectiveness of psychotherapy with children. These meta-

analyses include more than 350 treatment outcome studies. Casey and Berman (1985) in a meta-analysis of 75 studies conducted between 1952 and 1983 on psychotherapy with children under 13 obtained an overall effect size of .71, averaging across multiple outcome measures. This indicates that after treatment the average treated case fared better than 76% of untreated control group cases. Weisz et al. (1987) in a meta-analysis of 106 studies conducted between 1952 and 1983 of psychotherapy with 4-18 year old children and adolescents found an overall effect size of .79. This indicates that after treatment the average treated case fared better than 79% of untreated control group cases. Kazdin et al. (1990) in a meta-analysis of 223 studies conducted between 1970 and 1988 of psychotherapy with 4-18 year old children and adolescents found an overall effect size of .88 for treatment versus waiting list control comparisons. This indicates that after treatment the average treated case fared better than 81% of untreated control group cases. Kazdin et al (1990) obtained an effect size of .77 for treatment versus placebo comparisons, showing that after treatment the average treated case fared better than 78% of cases that received a placebo treatment. In this contexts, placebo treatments involved contact with a therapist and engagement in plausible, though theoretically ineffective, activities such as participation in discussion group or engagement in recreational activities with a therapist. Weisz et al. (1995) in a meta-analysis of 150 studies conducted between 1967 and 1993 of psychotherapy with 2-18 year old children and adolescents found an overall effect size of .71. This indicates that after treatment the average treated case fared better than 76% of untreated control group cases. In both of the analyses conducted by John Weisz's team, effect sizes following treatment and those obtained at about six months follow-up were very similar (Weisz et al, 1987, 1995). This indicates that not only is psychotherapy for children effective, but these effects are maintained up to six months after treatment has ended.

META-ANALYSES OF CLINICALLY REPRESENTATIVE THERAPY

It was noted earlier that one of the criticisms of broad meta-analyses is that many of the studies included in them involved clients who were not representative of those that attend typical services. That is, they contained many efficacy studies in which clients had less chronic or complex problems, were solicited by a researcher rather than referred for treatment, and the therapy was not conducted by routine therapists with normal case loads and working conditions. To address this criticism, meta-analyses have been conducted of

studies selected because they contained clients representative of those that attend regular outpatient clinics. Following in the tradition of Andrews and Harvey's (1981) meta-analysis of studies of clinically distressed clients mentioned earlier, William Shadish's group has conducted two important meta-analyses of the effectiveness of psychotherapy with clinically distressed clients who received therapy under clinically representative conditions. These analyses have included treatment outcome studies of children, adolescents and adults. In the first of these, Shadish et al. (1997) conducted a secondary analysis of 56 studies of clinically representative psychotherapy of children, adolescents and adults from 15 previous meta-analyses. The studies were conducted in non-university, community settings; included patients referred for treatment, not solicited by the researcher; and involved experienced professional therapists with normal case loads. The average effect size from these 56 clinically representative studies was .68 and was not significantly different from the average effect size from the 15 original meta-analyses which was .59. In the second meta-analysis, Shadish et al. (2000) included 90 studies varying in degree of clinical representativeness and found a weighted effect size of .41 which showed that therapy was effective across a range conditions of clinical representativeness. Taken together the results of the two meta-analyses reviewed in this section show that psychotherapy is effective when conducted under clinically representative conditions.

META-ANALYSES AND MAJOR REVIEWS OF STUDIES OF MAIN TYPES OF THERAPY

Within each of the five main psychotherapeutic traditions outlined in Chapter 1, corresponding to the divisions of the Irish Council for Psychotherapy, broad meta-analyses of controlled outcome studies have been conducted to determine the overall effectiveness of particular types of therapy with a range of psychological problems. What follows is a summary of such meta-analyses for the psychoanalytic; humanistic and integrative; cognitive-behavioural; constructivist; and systemic couple and family therapy traditions. Figure 2.1 contains details of meta-analyses summarized below. Figure 2.2. contains a graph of effect sizes from these meta-analyses.

Psychoanalytic psychotherapy

Within the psychoanalytic tradition, a distinction is made between short-term psychoanalytic psychotherapy and intensive long-term psychoanalysis. The former

involves weekly sessions for periods of 6-12 months, while the latter involves two or more sessions per week, usually for periods longer than a year. In both approaches, the focus is on the underlying, often unconscious, sources of an individual's psychological problems, and there is an assumption that much of our behaviour, thoughts and attitudes are regulated by the unconscious mind and are therefore not always within ordinary conscious control. Controlled studies and meta-analyses have been conducted for psychoanalytic psychotherapy but not psychoanalysis.

Three meta-analyses provide evidence for the effectiveness of psychoanalytic psychotherapy for a broad range of problems in adults, notably anxiety, mood and personality disorders (Crits-Christoph, 1992; Anderson & Lambert, 1995; Leichsenring, Rabung, Leibling, 2004). In the earliest of these, Crits-Christoph (1992) reviewed 11 well-controlled studies and found an overall success rate of 86% for brief psychoanalytic psychotherapy. This rate was greater than that of waiting list controls and about equal to those of other psychotherapies and medication. Anderson and Lambert (1995) in a later meta-analysis of 26 studies conducted between 1974 and 1994 found that short-term psychoanalytic psychotherapy had an effect size of .71 relative to no treatment and .34 relative to minimal treatments. The outcome for psychoanalytic psychotherapy and alternative treatments including cognitive behaviour therapy was similar. In a third meta-analysis of 17 studies conducted between 1970 and 2004, Leichsenring et al. (2004) found that short-term psychoanalytic psychotherapy yielded significant and large pretreatment-posttreatment effect sizes for target problems (1.39), general psychiatric symptoms (.9), and social functioning (.8). These effect sizes were stable and increased at follow-up to 1.57, .95, and 1.19 respectively. The between group effect size based on five studies that included waiting list or minimal treatment control groups was .7 for general psychiatric symptoms. This indicates that after treatment the average treated case fared better than 76% of controls. In this meta-analysis, the outcome for psychoanalytic psychotherapy did not differ from that of other forms of psychotherapy in the 14 studies where such comparisons were made. The results of these three meta-analyses clearly support the effectiveness of short-term psychoanalytic psychotherapy for common psychological problems in adults.

Unfortunately controlled studies of the outcome of long-term psychoanalysis have not been conducted. However, a number of important uncontrolled evaluations deserve mention because of the historical importance of psychoanalysis and the psychoanalytic

movement within Ireland and abroad. Fonagy et al. (2002) in an open door review which included a series of mainly retrospective outcome studies of long-term psychoanalysis involving over 300 cases found long term beneficial effects for a majority of children and adults with a wide range of difficulties including anxiety, depression and personality disorders. Also, more intensive therapy was more effective. Sandell et al. (1999) in a comparative study of 700 Swedish psychoanalysis and psychotherapy cases found that the majority of clients who participated in psychoanalysis showed improvement in symptoms, and social adjustment. Because these studies did not include untreated control group of cases with similar problems to treated cases, there is the possibility that the improvements observed could have been due to the passage of time. However, the Fonagy and Sandell's results are encouraging and show that controlled studies in this area would be worthwhile.

On behalf of the German Association for Psychodynamic Psychotherapy, Richter et al. (2002) and Loew et al. (2002) conducted a very thorough review of the evidence for the effectiveness of psychoanalytic psychotherapy with adults and children. Their reviews were conducted in response to a request from an agency of the German Government who required the evidence for health care policy development. Richter et al. (2002) identified 28 controlled diagnosis-specific studies which evaluated the effectiveness of psychoanalytic psychotherapy. These studies covered the following specific problems: mood disorders, anxiety disorders, stress disorders, dissociative, conversion and somatoform disorders, eating disorders, adjustment disorders, personality disorders, behavioural deviations, drug dependency and abuse, schizophrenia and psychotic disorders. They also reviewed 9 controlled studies covering a range of problem types. Loew et al (2002) reviewed 64 uncontrolled studies evaluating the effectiveness of psychoanalytic psychotherapy which were not included in Richter et al's (2002) review of controlled studies on psychoanalytic psychotherapy. Taken together the results of these reviews provided evidence for the effectiveness of psychoanalytic psychotherapy with a range of psychological problems in children and adults.

In the UK, Kennedy (2004) reviewed the evidence-base for the effectiveness of psychoanalytical psychotherapy with children and adolescents and identified 37 reports on 32 different studies. Collectively the results of these studies provided support for the overall effectiveness of child and adolescent psychoanalytic psychotherapy for a range of problems including depression, emotional disorders, disruptive behaviour disorders,

anorexia, poorly controlled diabetes, and problems arising from child abuse. The review also indicated that a number of factors influence the effectiveness of psychoanalytic psychotherapy. For young people, psychoanalytic psychotherapy is more effective with emotional disorders than conduct disorders; with children who have less (rather than more) severe problems; and with younger children (rather than with older children or adolescents). More intensive therapy is more effective than less intensive therapy, particularly for youngsters with severe problems. Concurrent intervention with parents enhances the effectiveness of individual psychoanalytic psychotherapy, particularly with younger children.

Humanistic and integrative psychotherapy

Elliott et al. (2004) conducted a thorough review of treatment outcome studies that fall broadly within the humanistic and integrative psychotherapy tradition. They included studies of client-centred therapy, experiential therapy, gestalt therapy and emotionally focused therapy in the review. The review included 112 uncontrolled studies in which pre-post treatment effect sizes were computed; 37 controlled studies in which effect sizes based on comparisons with waiting list controls were made; and 55 studies in which humanistic and integrative therapy was compared with other forms of treatment. Clients in these studies had a wide variety of psychological problems including anxiety disorders, mood disorders, eating disorders, personality disorders and relationship distress. Across all studies the average duration of treatment was 22 sessions. The average unweighted pre-post effect size was .99; the unweighted effect size based on comparison with untreated controls was .89. The more conservative weighted effect sizes were .86 for pre-post comparisons and .78 for treatment-control comparisons. These results indicate that the average treated case after therapy fared better than 80-84% of cases before therapy and 78-81% of untreated cases. The outcome for humanistic and integrative therapies and other forms of psychotherapy including cognitive behaviour therapy were similar. The results of this comprehensive review indicate that humanistic and integrative psychotherapy is a highly effective form of treatment for a range of common psychological problems in adulthood.

Cognitive behaviour therapy

In a review of 16 meta-analyses that included 332 studies of the effectiveness of cognitive behaviour therapy with 16 different disorders or populations, Bulter et al. (2006) obtained a large mean weighted effect size of .95 for depression and a range of anxiety disorders in children, adolescents and adults. Thus, the average treated case with anxiety and depression fared better than 83% of untreated controls. For bulimia the mean pre-post treatment effect size of 1.27 was also large, indicating that the average treated case fared better than 89% of untreated cases in control groups. For marital distress, anger control, and chronic pain in adults, and childhood somatic disorders effect sizes were moderate with a mean of .62. Thus, the average treated case with these problems fared better than 73% of untreated controls. For sexual offending the average effect size of .35 was relatively small. However, it was the most effective form of psychotherapy for reducing recidivism in this population. Thus, the average treated sex offender fared better than 64% of untreated controls. There was significant evidence for the long-term effectiveness of cognitive behaviour therapy for depression and anxiety disorders. Averaging across the four mean effect sizes at follow-up, the overall average effect size from this review of 16 meta-analyses was .79, indicating that the average treated case fared better than 79% of untreated controls six months or a year after therapy. Major narrative reviews of the extensive literature of the efficacy and effectiveness of behavioural and cognitive behavioural therapies with a wide range of child, adolescent and adult disorders are consistent with the findings of this review of 16 meta-analyses (Emmelkamp, 2004; Hollon & Beck, 2004).

Rational emotive therapy, developed by Albert Ellis, shares much in common with cognitive therapy and so is mentioned here. In rational emotive therapy, clients develop a facility for challenging irrational beliefs which underpin problematic emotional and behavioural patterns (Ellis & Greiger, 1986). In a meta-analysis of 70 rational-emotive therapy outcome studies Lyons and Woods (1991) found an effect-size of 1.02, which was related to therapist experience and to duration of the therapy. The average treated case fared better than 84% of untreated waiting list control group cases. Client who spent longer in therapy with more experienced therapists had better outcomes. In a meta-analysis of 19 studies of rational-motive therapy with children, Galloway et al. (2004) concluded that rational emotive therapy was effective in alleviating a range of problems in children and adolescents including anxiety, disruptive behaviours, irrationality, self-concept, and grade point average.

Acceptance and commitment therapy which has recently evolved within the cognitive behavioural tradition also deserves mention because of its growing importance within the field of psychotherapy (Hayes, Strosahl & Wilson, 2003). It includes the following core components: acceptance (rather than avoidance); changing relationship to negative thoughts (rather than their frequency or content); enhancing ongoing non-judgemental experience of the world; mindfulness exercises to foster a sense of self as context; choosing values; and engaging in committed action to achieve goals consistent with these values. In a meta-analysis of 21 controlled studies of acceptance and commitment therapy involving patients with a range of problems including depression, anxiety disorders, personality disorders, psychosis and other problems, Hayes et al. (2006) obtained a weighted effect size after treatment and at five months follow-up of .66. This indicates that the average participant in acceptance and commitment therapy fared better than 74% of those who received no treatment, or treatment as usual.

Taken together the results of these meta-analyses, reviews of meta-analyses, and narrative reviews offer strong support for the effectiveness of therapies that fall broadly within the cognitive behavioural tradition for a wide range of common psychological problems in children, adolescents and adults.

Constructivist psychotherapy

In a meta-analysis of 15 studies of personal construct psychotherapy with clients suffering from a wide range of psychological difficulties, Viney et al. (2005) found an effect size of .55 after treatment and .48 at 1-12 months follow-up. Thus the average treated case fared better after treatment than 71 % of untreated controls, and better than 68% at follow-up. These results were consistent with the conclusions of previous narrative reviews of the outcome literature (Winter, 2003). The 15 studies in the meta-analysis included evaluations of both individual and group therapy with adolescents, adults and older adults suffering from psychological disorders such as anxiety and depression and adjustment to physical illness. In a further meta-analysis of 8 studies in which personal construct therapy was compared with psychoanalytic, cognitive behavioural and humanistic therapies, Viney et al. (2005) found a effect size of .35. Thus, after treatment, the average constructivist psychotherapy case fared better than 64 % of cases treated in other forms of psychotherapy. There was no difference between the outcome of clients in personal construct psychotherapy and other forms of psychotherapy at 1-18 months follow-up. The

results of these meta-analyses support the effectiveness of constructivist psychotherapy. 'The effect size of 5.5 for constructivist psychotherapy, which is marginally though not significantly smaller than that of other forms of psychotherapy, may be due to the fact that constructivist psychotherapy has been subject to fewer evaluations than other forms of therapy.'

Systemic couple and family therapy

Shadish and Baldwin (2003) reviewed 20 meta-analyses of couple and family interventions for a wide range of child and adult focused problems. These included child and adolescent conduct and emotional disorders; drug and alcohol abuse in adolescents and adults; anxiety, depression and psychosis in adults; and marital distress. 16 of the 20 meta-analyses were of therapy studies and 4 included enrichment studies. Of the 17 therapy meta-analyses, 4 were of both couple and family therapy studies; 6 were of couple therapy studies; and 7 were of family therapy studies. For couple and family therapy the average effect-size across all therapy meta-analyses was .65 after therapy and .52 at follow-up 6 months to a year later. These results show that, overall, the average treated couple or family with clinically significant problems, fared better after treatment than 75 of untreated controls, and at follow-up fared better than about 71% of cases in control groups. After therapy the average effect of couple therapy was .84 and this was higher than that for family therapy where the effect size was .58. These results show that for cases with clinically significant problems, the average treated couple, fared better after treatment than about 80% of untreated controls, but the average treated family fared better than 72% of control group cases. For couple and family enrichment, the effect sizes after therapy and at follow-up were .48 and .32 respectively. These results show that, overall, the average treated couple or family without clinically significant problems, fared better after treatment than 68% of untreated controls, and at follow-up fared better than about 63% of cases in control groups. Shadish and Baldwin's synthesis of the results of 20 meta-analyses support the efficacy of systemic therapy for couples and families with a wide range of clinically significant problems and for couples and families without clinical problems but how want to develop family strengths such as communication and problem-solving skills and greater emotional cohesion.

EFFECTS OF PSYCHOTHERAPY AND MEDICAL PROCEDURES

To place the evidence on the overall effectiveness of psychotherapy in a broader context, it is useful to ask - Are the moderate effect sizes associated with psychotherapy very different from those associated with the treatment of medical conditions? In Figure 2.3 it may be seen that the overall effect size for psychotherapy and medical and surgical procedures are both in the moderate range between .5 and .8. The effect size for psychotherapy of .75 is from Grissom's (1996) synthesis of 68 meta-analyses mentioned earlier, and the effect size of .5 obtained for medical and surgical procedures is from Caspi's (2004) synthesis of 91 meta-analyses of various medical and surgical treatments for a range of medical conditions. From the data in Figure 2.3. it may be concluded that the moderate effect sizes associated with psychotherapy are similar to or slightly better than those associated with the treatment of medical conditions.

DETERIORATION AND DROP-OUT

Deterioration and dropping out of therapy have each been investigated as distinct problematic outcomes of psychotherapy. A consistent finding across the psychotherapy outcome literature is that up to 10% of clients deteriorate following psychotherapy (Lambert and Ogles, 2004). In a review of 46 studies on negative outcome in adult psychotherapy Mohr (1995) found that deterioration was associated with unique client, therapist and therapy characteristics. Deterioration was more common among clients with borderline personality disorder, obsessive-compulsive disorder, or severe interpersonal difficulties. Lack of motivation and the expectation of benefiting from psychotherapy without personal effort were also associated with deterioration. Deterioration was more common when unskilled therapists lacked empathy and did not collaborate with clients in pursuing agreed goals. Failure to appropriately manage countertransference and frequent transference interpretations were also associated with deterioration.

Dropping out of psychotherapy is a relatively common event. In a meta-analysis of 125 studies, Wierzbicki and Pekarik (1993) found a mean dropout rate of 47%. Dropout rates were higher for minority ethnic groups, less-educated clients, and those with lower incomes.

From this review it is clear that about 1 in 10 clients deteriorate following therapy and that marginalized clients with particularly troublesome disorders and negative attitudes to psychotherapy are vulnerable to dropping out of psychotherapy and deterioration. On

the other hand, adopting an empathic, collaborative and supportive approach to engaging these vulnerable clients in therapy may lessen the risk of dropout and deterioration.

QUALITY CONTROL IN PSYCHOTHERAPY

High quality psychotherapy is more effective than lower quality therapy. In this context high quality involves, a reasonable caseload, initial skills training in the specific model of therapy, ongoing regular supervision, and conducting psychotherapy according to the principles of practice specified for the model with sufficient flexibility to take account of each clients' unique characteristics. This conclusion has been borne out by the effectiveness of model programmes such as Scott Henggeler's Multisystemic therapy for adolescents with conduct disorder (Henggeler & Lee, 2003). Henggeler has developed a quality assurance system which includes manualized treatment and supervision and shown that client recovery is directly related to adherence to these protocols.

MEDICAL COST-OFFS

The evidence reviewed so far shows that psychotherapy is effective. However, an important concern is the financial implications of providing such a psychotherapy service. In this context, two questions are of interest. First - Do clients who avail of psychotherapy services, use fewer medical services and so incur reduced medical costs? This saving is referred to as medical cost-offset. The second question is – Is the medical cost-offset associated with psychotherapy greater than the cost of providing psychotherapy? If so, we can conclude that psychotherapy has a total cost offset. Findings of meta-analyses and narrative reviews of the cost-offset literature throws light on both of these questions.

In a meta-analysis of 91 studies conducted between 1967 and 1997, Chiles, Lambert, and Hatch (1999) found that psychotherapy or psychological interventions led to significant medical cost offsets. Participants in reviewed studies included surgery inpatients, high health-service users, and people with psychological and substance use disorders who received psychotherapy or psychological interventions alone or as part of a multimodal programme. Chiles and his team concluded that medical cost offsets occurred in 90% of studies and ranged from 20-30%. In 93% of studies where data were provided, cost-offsets exceeded the cost of providing psychotherapy. Greater cost offsets occurred for older inpatients who required surgery, oncology, and cardiac rehabilitation than for outpatients who required care for minor injuries and illnesses. Structured psychological

interventions, tailored to patient needs associated with their medical conditions led to greater medical cost offsets than traditional psychotherapy. In an earlier set of meta-analytic studies involving Blue Cross and Blue Shield US Federal Employees Plan claim files and 58 controlled studies, Mumford et al (1984) found that in 85% of studies medical cost offset for psychotherapy occurred. These were due to shorter periods of hospitalization for surgery, cancer, heart disease and diabetes, particularly in patients over 55.

In a review of psychological interventions for people with a variety of health-related difficulties, Groth-Marnat and Edkins (1996) found that medical cost-offsets occurred when such interventions targeted patients preparing for surgery and patients with difficulty adhering to medical regimens. Medical cost offset also occurred for smoking cessation programmes, rehabilitation programs, and programmes for patients with chronic pain disorders, cardiovascular disorders, and psychosomatic complaints.

Two other important reviews of the medical cost offset literature which focused largely on primary mental health problems in adults, rather than adjustment to physical illness deserve mention. In a review of 30 studies of psychotherapy for psychological disorders and drug and alcohol abuse, Jones and Vischi (1979) found that medical cost offsets occurred in most cases. In a review of 18 studies of psychotherapy for psychological disorders, Gabbard et al. (1997) found that in more than in 80% of studies, medical cost-offsets exceeded the cost of providing psychotherapy. Particularly significant cost-offsets occurred for complex problems, notably in studies of psychoeducational family therapy for schizophrenia and dialectical behaviour therapy for personality disorders, by reducing the need for inpatient care and improving occupational adjustment.

From the evidence reviewed here, it is clear that psychotherapeutic interventions have a significant medical cost-offset. Those who participate in psychotherapy use fewer other medical services at primary, secondary and tertiary levels and are hospitalized less than those who do not receive psychotherapy.

PSYCHOTHERAPY AND REDUCED USE OF EMERGENCY SERVICES

There is some evidence to indicate that in certain circumstances psychotherapy can lead to a reduction in the use of accident and emergency services, especially among frequent users of such services which chronic psychological difficulties. Studies of dialectical behaviour therapy with clients with borderline personality disorder, and a history of

frequent emergency psychiatric admissions associated with deliberate self-harm and suicidality, show that this form of psychotherapy reduces the frequency of visits to accident and emergency departments (Robins & Chapman, 2004). For example, Linehan et al. (2006) in randomized controlled trial involving a hundred clients with borderline personality disorder found that those who participated in a programme of dialectical behaviour made significantly less use of emergency services during a two year follow up period than a control group who received routine community-based treatment.

WAITING TIME AND ENGAGEMENT IN THERAPY

There is growing evidence that the amount of time clients spend on a waiting list has an impact on their willingness to engage in psychotherapy. Reitzel et al. (2006) in a study of over 300 adults referred for psychotherapy in the USA found that those who had spent longer on waiting lists were less likely to attend therapy, but no more likely to prematurely terminate therapy. Strang et al. (2005) in a randomised clinical trial of the effects of time on a waiting list on clinical outcomes in opiate addicts awaiting outpatient treatment in London, found that shorter waiting times were associated with more clients engaging in treatment. Bell and Newns (2004) in a study of 125 clients attending eating disorder programme found that waiting time (but not diagnosis, age or gender) was associated with attending a first appointment. Hicks & Hickman (1994) in a study of 60 couples referred for marital therapy in the UK found that longer waiting times (greater than 2 weeks) were associated with reduced likelihood of attending intake interviews.

SUMMARY AND CONCLUSION

A summary of the results of broad meta-analyses of psychotherapy outcome studies referred to in this chapter is given in Figure 2.1 and 2.2. The results of these meta-analyses collectively provide strong support for the effectiveness of psychotherapy. The effect sizes summarized in Figure 2.2 which range from .65 to 1.03 are medium to large according to Cohen's (1988) system for interpreting effect sizes. Collectively the summary data in Figure 2.2 indicate that the average child or adult case treated with psychoanalytic, humanistic and integrative; cognitive-behavioural; constructivist; or systemic couple and family therapy fared better than 74-84% of untreated cases. These effect sizes also indicate that the average success rate for treated cases ranged from 65 to 72%. In contrast, the average success rate for untreated control groups range from 28-35%.

The evidence reviewed in this chapter supports the following assertions:

- Psychotherapy is highly effective for a majority of cases with common psychological problems.
- Psychotherapy is effective for both adults and children.
- Psychotherapy conducted within psychoanalytic; humanistic and integrative; cognitive-behavioural; constructivist; and systemic couple and family therapy traditions is effective.
- The overall magnitude of the effects of psychotherapy in alleviating psychological disorders are similar to the overall magnitude of the effect of medical procedures in treating a wide variety of medical conditions.
- About 1 in 10 clients deteriorate as a result of psychotherapy.
- Client recovery is dependent upon the delivery of a high quality psychotherapy service, which may be maintained through quality assurance systems.
- Psychotherapy has a significant medical cost-offset.
- Psychotherapy can reduce attendance at accident and emergency services in frequent users of such services with chronic psychological problems.
- Clients who have more rapid access to psychotherapy (and who spend little time on waiting lists) are more likely to engage in therapy.

A striking feature of the evidence for the overall effectiveness of psychotherapy presented in this chapter is the remarkable similarity in positive outcome rates of diverse approaches with a range of populations and problems. It seems plausible to propose that certain common therapeutic processes or factors underpin all effective psychotherapies which are tailored to meet clients' specific therapeutic needs. A discussion of such common factors provides a point of departure for chapter 3.

Figure 2.1. Summary of results of broad meta-analyses

Main Focus of Meta-Analysis	Author	Date	Number of studies	Population	Type of studies	Effect size for treatment vs waiting list control	% of untreated cases that the average treated case fares better than	% of outcome variance accounted for by treatment	% Successes for treated group	% Success for control group
Adults and Children	Grissom	1996	68 meta-analyses	Adults & Children	All meta-analyses	.75	77	12	68	32
	Smith & Glass	1977	375	Mainly adults	All published & unpublished studies up to mid 70s	.68	75	10	66	34
Adults	Smith et al.	1980	475	Mainly adults	All published & unpublished studies up to late 70s	.85	80	15	70	30
	Shapiro & Shapiro	1982	143	Adults	Studies of Adults up to 1979	1.03	84	20	72	28
	Andrews & Harvey	1981	81	Mainly adults	Studies of clinically distressed clients from Smith & Glass 1977	.72	77	11	67	33
	Landman & Dawes	1982	42	Mainly adults	Methodologically rigorous studies	.90	82	17	70	30
	Casey & Berman	1985	75	4-13 year olds	Studies conducted between 1952 and 1983	.71	76	10	66	34
Children	Weisz et al	1987	106	4-18 year olds	Studies conducted between 1952 and 1983	.79	79	13	67	33
	Kazdin et al.	1990	223	4-18 year olds	Studies conducted between 1970 and 1988	.88	81	12	69	31
	Weisz et al.	1995	150	2-18 year olds	Studies conducted between 1967 and 1993	.71	76	10	66	34

Clinically representative samples	Shadish et al.	1997	56	Adults & Children	Studies from other meta-analyses	.68	75	10	66	34
	Shadish et al.	2000	90	Adults & Children	Studies from other meta-analyses	.41	66	4	60	40
Psychoanalytic	Crits-Christoph	1992	11	Adults	Studies before 1992	86%				
	Anderson & Lambert	1995	26	Adults	Studies conducted between 1974 and 1994	.71	76	10	66	34
	Leichsenring et al.	2004	17 (5)*	Adults	Studies conducted between 1970 and 2004	.70	76	10	66	34
Humanistic and integrative	Elliott et al.	2004	222 (37)*	Adults	Studies conducted between 1970 and 2002	.89	82	17	70	30
Cognitive behavioural	Butler et al.	2006	16 meta-analyses	Adults & children	All large meta-analyses	.79	79	13	67	33
Rational emotive therapy	Lyons & Woods	1991	70	Adults		1.02	84	20	72	28
Acceptance and commitment therapy	Hayes	2006	21	Adults	All available studies	.66	74	9	65	35
Constructivist	Viney et al.	2005	15	Adults	All available studies	.55	71	7	63	37
Couple and family therapy	Shadish & Baldwin	2003	16 meta-analyses	Couples and families	All large meta-analyses	.65	74	9	65	35

* Only number in brackets studies were used to calculate the between group effect size

Figure 2.2. Mean effect sizes from meta-analyses of psychotherapy with adults and children, and therapy from different traditions.

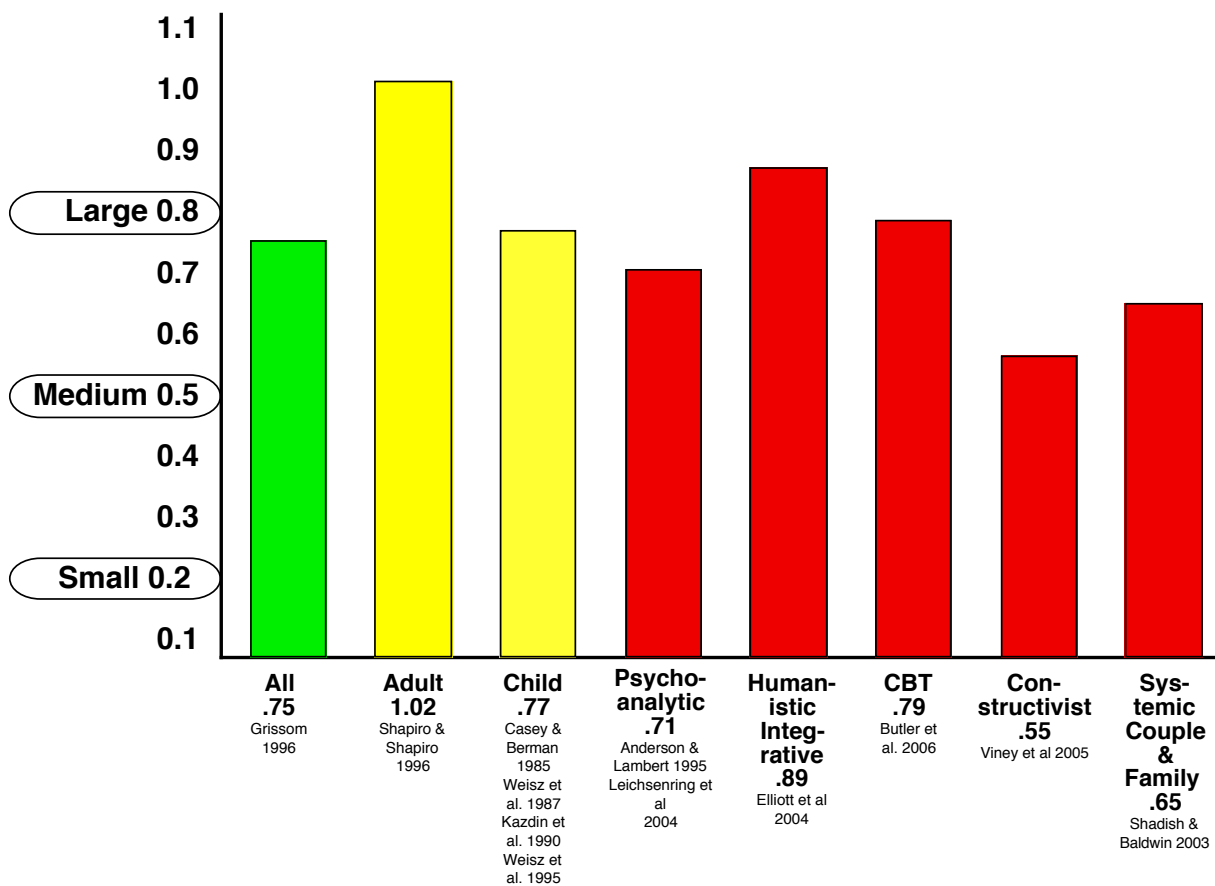
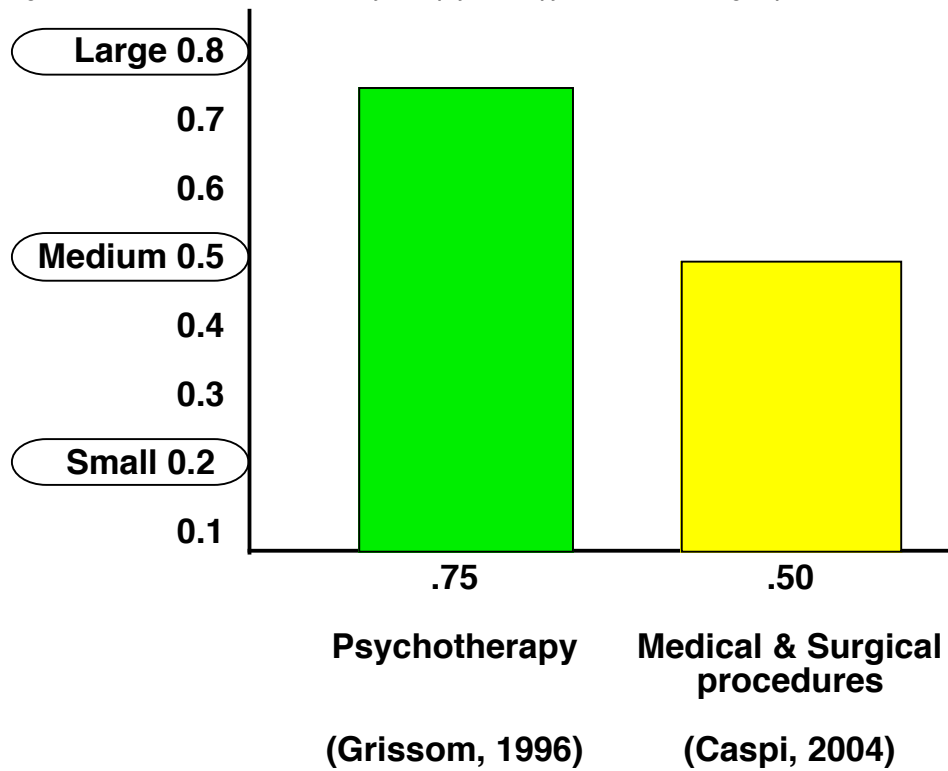


Figure 2.3. Mean effect sizes from meta-analyses of psychotherapy and medical and surgical procedures



CHAPTER 3

COMMON FACTORS IN PSYCHOTHERAPY

The evidence reviewed in chapter 2 indicates that psychotherapy is very effective in helping people overcome psychological problems. A question arising from this conclusion is what aspects of the wide variety of effective psychotherapies are responsible for the remarkable effectiveness of psychotherapy in helping people address psychological difficulties. In this chapter the role of factors common to all forms of psychotherapy is the central focus. In chapters 4 and 5, specific psychotherapy protocols that have been found to be particularly effective with particular problems will be considered.

COMMON FACTORS AND SPECIFIC PSYCHOTHERAPIES

A striking feature of the evidence reviewed in chapter 2 in support of the overall effectiveness of psychotherapy is the similarity in outcomes of diverse approaches with a range of populations and problems. All approaches to psychotherapy, when averaged across different populations, problems, and studies lead to moderate to large effect sizes and benefits for two thirds to three quarters of treated cases. While different approaches to psychotherapy may involve quite distinct procedures, and while different therapists and clients participated in different psychotherapy studies, the hypothesis that there are factors common to all effective psychotherapy has guided a large body of important research in the field.

One possibility is that psychotherapy is no more than a placebo, a psychological sugar-pill that gives clients hope and creates the expectation of improvement. It was mentioned in chapter 1 that to evaluate this hypothesis researchers have conducted studies in which a specific form of psychotherapy is compared with a psychological or pharmacological placebo condition. Common psychological placebo conditions involve engaging in intellectual discussion groups, recreational activities or receiving an inert procedure that is described as providing subliminal treatment. Pharmacological placebos involve clients receiving sugar pills. In a quantitative review of 46 meta-analyses of psychotherapy with children and adults involving hundreds of studies, Grissom (1996) compared the effects of groups receiving psychotherapy with placebos, and also conducted a number of other important comparisons. A summary of these, converted to average post-treatment, between groups effect sizes, is given in Figure 3.1. From the

graph it is clear that the effect size for psychotherapy compared with placebos was .58. Thus, the average treated case fared better than 72% of cases in control groups who received placebos. This shows that psychotherapy is not just a placebo that generates hope, but a set of procedures that actively influences the recovery process.

From Figure 3.1 it may also be seen that the effect size for therapy versus waiting list control groups (.75) is larger than the effect size of placebo versus waiting list control groups (.44). This shows that the effects of psychotherapy are nearly double those of placebos.

In Figure 3.1, a third important conclusion may be drawn from the small average effect size (.23) arising from the comparison of different psychotherapy protocols and approaches. This effect size indicates that recovery rates for different forms of psychotherapy are very similar, and that specific psychotherapeutic factors play a less important role in influencing recovery than common factors.

The results of two important analyses of the relative contribution of common and specific factors to psychotherapy outcome are summarized in Figure 3.2. In a non-quantitative narrative review of over 100 psychotherapy studies Michael Lambert (1992; Lambert & Barley, 2002) estimated that common factors were about twice as important as specific factors in contributing to the outcome of psychotherapy. From the left hand 'pie' in Figure 3.2, it may be seen that Lambert estimated that about 30% of psychotherapy outcome variance may be accounted for by common factors and 15% by specific factors. 15% of the remaining variance in outcome is due to placebo effects or creating the expectation of recovery. The remaining 40% of variance in outcome, Lambert estimated was accounted for by factors outside therapy such as social support from family and friends.

In contrast to Lambert's analysis, Bruce Wampold (2001) in a quantitative review of more than a dozen meta-analyses estimated that common factors are 9 times more influential than specific factors in determining the outcome of psychotherapy. He reviewed both broad meta-analyses in which studies of the effects of therapy for a wide variety of populations and problems were synthesized. He also reviewed meta-analyses in which the focus was on the effectiveness of different forms of psychotherapy for a specific problem such as depression or anxiety. He concluded that only 13% of the variance of outcome for psychotherapy clients is due to psychotherapy (including common, specific and other factors). This was based on his computation of an overall effect size for psychotherapy of

between .7 and .8 , and using the conversion system in Figure 1.6. The remaining 87% is due to extra-therapeutic factors. He also concluded that only 1% of the variability in outcome for psychotherapy patients was due to specific factors. This was based on the average between treatment effect size of .2, similar to that reported earlier in Figure 3.1, and converted to a variance estimate using the system in Figure 1.6. He estimated that 3% of the variance in outcome was due to unexplained therapy factors, probably client characteristics. The remaining 9% of the variance in outcome he concluded was accounted for by common factors.

Lambert's and Wampold's pies (as I have called them in Figure 3.2) represent extreme interpretations of the available data. However, they share one important conclusion. Common factors have a far greater impact than specific factors in determining whether or not clients benefit from psychotherapy. The major impact of common factors on the outcome of psychotherapy, provides a possible explanation for the similarity in outcome of different psychotherapies.

THE DODO-BIRD VERDICT

The hypothesis that different psychotherapies may lead to similar improvement rates, was first referred to as the 'Dodo bird verdict' by Saul Rosenzweig in 1936. The reference is to a quotation from Lewis Carroll's *Alice in Wonderland* - At last the Dodo said 'Everybody has won, and *all* must have prizes' – The Dodo's remark was made after a caucus race in which competitors started at different points and ran in different directions for half an hour. In a series of papers starting in 1975 Lester Luborsky and his team concluded that there was strong empirical evidence to support the Dodo bird verdict (Luborsky et al., 1975, 1993, 1999, 2002). For example, in a quantitative review of 17 meta-analyses of comparisons of a range of different treatments with each other, Luborsky, Rosenthal et al., (2002) found an average effect size .20, which is small and non-significant. When such differences were corrected for the therapeutic allegiance of the researchers involved in comparing the different psychotherapies, these differences tend to become even further reduced in size and significance (Luborsky et al., 1999). Researcher allegiance resulted in their preferred psychotherapies being delivered in a more sophisticated manner than non-preferred approaches.

However, not all reviewers agreed with Rosenzweig and Luborsky's position. They marshalled a body of evidence which casts doubt on the validity of the Dodo bird verdict

(Hunsley & DiGiulio, 2002). For example, Reid (1997) reviewed results of 42 focused meta-analyses of studies of specific treatments for specific problems such as depression, panic disorder, bulimia and so forth. He concluded that 74% of these meta-analyses showed evidence of differential treatment effects. Cognitive-behavioural treatments led to better outcomes for many problems. A similar conclusion has been drawn in major broad meta-analyses of both child and adult problems. Weisz et al. (1995) in the meta-analysis of 150 child and adolescent psychotherapy outcome studies mentioned earlier, found that the mean effect size on non-reactive measures for cognitive-behavioural treatments was .52, which was significantly greater than the mean effect size of .25 for client-centred and insight-oriented therapies. Shadish et al., (2000) in a meta-analysis of 90 studies in which clients, treatments, and therapists were representative of typical clinical settings found that treatment effect sizes were larger for cognitive-behavioural than traditional approaches to psychotherapy.

The conflicting findings of Luborsky et al., (2002) on the one hand and Reid (1997), Weisz et al. (1995) and Shadish et al. (2000) on the other have to some extent been reconciled by Walpold's (2001) analysis of the comparative psychotherapy outcome research mentioned in the last section. He agrees that in many instances, statistically significant post-treatment differences between different therapies occur, but the average effect size of these difference is about .2, whereas the average effect size for most therapies is about .8. Common factors are therefore far more important than specific factors. However, therapists must engage in specific forms of therapy for common factors to have a medium through which to operate. For example, in family therapy the process of convening family meetings, helping family members view individual problems as part of a pattern of family interaction, and exploring alternative interaction patterns creates a context within which therapists develops good working alliances with clients (which is one of the most important common factors).

CATEGORIES OF COMMON FACTORS

In considering common factors it is useful to distinguish between client factors; factors associated with the therapeutic context including the dose of therapy received, the quality of the therapeutic alliance, and therapeutic procedures; and therapist factors

Client factors

Clarkin and Levy (2004) conducted a comprehensive narrative review of more than 100 empirical studies and review papers on client characteristics that have been found to correlate with therapeutic outcome. They concluded that the following client characteristics have been associated with therapeutic outcome: personal distress; symptom severity; functional Impairment; case complexity; readiness to change; early response to therapy; psychological mindedness; ego-strength; capacity to make and maintain relationships; the availability of social support; and socio-economic status (SES). Clients with moderate to high personal distress were more motivated to engage and participate in therapy. When other factors were controlled for and taken into account in analyses, clients experiencing lower levels of personal distress made less therapeutic progress. Clients with severe symptoms and considerable functional impairment, involving difficulties carrying out their normal social and occupational roles, made less therapeutic progress than those with less severe symptoms and functional impairment. In complex cases, where clients had multiple, co-morbid chronic problems, particularly personality disorders, slower therapeutic progress was made than in less complex cases. A positive therapy outcome occurred where clients were not resistant to therapy and showed a readiness to change. Readiness to change in this context refers to status on Prochaska's stages of change: pre-contemplation, contemplation, preparation, action and maintenance (Prochaska & Norcross, 2002). Clients who were psychologically minded, and who had high ego-strength benefited more from therapy than those who lacked these attributes. Psychologically minded people understand their problems in intrapsychic terms, rather than blaming them on external factors. Ego strength is the capacity to tolerate conflict and distress while showing flexibility and persistence in pursuing valued goals. In the social domain, the capacity to make and maintain relationships, the availability of a social support network and high SES were all associated with a better therapeutic response than the absence of these features.

In a review of a series of psychotherapy outcome studies of adolescent and adult depression, bulimia and alcohol abuse, Lambert (2005) found that a sizeable minority of clients show a pronounced early response to psychotherapy and subsequently show a more rapid recovery. Incidentally, in pharmacological treatment studies, a 'premature response' to medication is predicative of a poor outcome, since it reflects a placebo effect rather than a pharmacological effect. However in psychotherapy, the common factors of engaging in treatment, forming a therapeutic alliance, and being offered a credible

rationale for therapy promotes recovery before specific factors such as those associated with cognitive behavioural, psychoanalytic or family therapy would be predicated to have taken effect.

From this review it is clear that clients with focal problems from well functioning families with low levels of life stress and high levels of social support respond well to therapy. Clients with multiple complex co-morbid problems from multiproblem families with high levels of life stress and low levels of social support respond less well to therapy. Clients who are psychologically minded, who are ready and motivated to engage in therapy, who actively participate in the therapy process, and show early improvement benefit more from therapy than those who do not have these attributes.

Therapy context factors: The dose-effect relationship

Within the therapeutic context, a particularly important factor to consider is the amount of therapy clients receive. Research on the psychotherapy dose-effect relationship aims to address this issue by asking the question: How many sessions of therapy are necessary for recovery? The seminal study in this area was conducted by Kenneth Howard et al. in 1986. In a probit analysis of 15 data sets from research studies spanning a 30 years involving over 2,400 psychotherapy clients, Howard and his team found that 14% improved before their first therapy session; 53% improved after 8 weekly sessions; 75% were improved by 26 sessions; and after 52 sessions, 83% had improved. Since Howard's study, more stringent criteria for improvement have been adopted in dose-effect studies, notably, Jacobson et al's (2004) criterion of clinically significant improvement. To show clinically significant improvement, cases must move from the clinical to the non-clinical range on a standardized scale by an amount that is statistically defined as reflecting reliable change. As a result of adopting this more conservative index of improvement, most studies that have been conducted since Howard's seminal paper, have found that more than 8 sessions are required for 50% of cases to show improvement (Hansen et al., 2002). A summary of these studies is given in Figure 3.3. From the figure it is clear that for acute and chronic symptoms up to 21 sessions of therapy are required for 50% of clients to recover. Figure 3.4. contains data from a large naturalistic study involving over 6,000 clients, in which Lambert et al (2001) showed that 21 sessions were required for clinically significant improvement in typical adult psychotherapy outpatients, but more than double this dose was required for 75% to achieve clinically significant improvement. In Hansen et

al.'s (2002) review paper, in addition to reviewing all naturalistic effectiveness studies in which clients received differing doses of therapy, they also provided an overview of the dose-effect relationship in a sample of 28 methodologically robust psychotherapy efficacy studies in which clients received predetermined fixed doses of therapy. These efficacy studies spanned a wide range of problem types and involved over 2000 clients. Hansen et al (2002) concluded that in these efficacy studies 58-67% of clients improved within about 13 sessions. This suggests that slightly lower doses of psychotherapy may be required for recovery in clinical trials. This may reflect differences in the types of cases, types of therapy, or types of measures used in psychotherapy efficacy studies, compared with naturalistic dose-effect relationship studies. That is, compared with naturalistic studies, in efficacy studies less complex cases, more structured manualized therapy, and more reactive measures may be used which collectively lead to clients requiring less therapy to be classified as showing clinically significant improvement. However, the overall pattern of results from naturalistic studies and efficacy studies supports the conclusion that up to about 20 sessions of therapy is necessary for 50% of adult clients to recover from acute and chronic symptoms of psychological distress.

The data summarized in Figure 3.3 also show that different amounts of therapy are necessary for recovery from different types of problems, with more chronic or pervasive problems requiring more therapy sessions. In a probit analysis of clinically significant recovery in 854 patients, Kopta et al (1994) found that symptoms of acute distress required 5 sessions; chronic symptoms required 14 sessions; and characterological symptoms required 104 sessions to achieve a 50% recovery rate. In a study of over 200 cases receiving 2, 8 or 16 sessions of either cognitive behavioural or psychoanalytic therapy, Barkham et al (1996) found that clinically significant recovery from interpersonal problems required higher doses of psychotherapy than did recovery from symptoms of depression or general distress. Only 40% showed recovery from interpersonal problems after 16 sessions. These results support the view that clients with pervasive characterological problems probably require more than 20 sessions of psychotherapy to make clinically significant progress.

Further support for the dose-effect relationship has come from major meta-analyses of outcome studies. For example, Shadish et al. (2000) in their meta-analysis of 90 studies of psychotherapy under clinically representative conditions found a correlation between

therapy dose and effect size. No well designed studies of the psychotherapy dose-effect relationship for children and adolescents have been conducted.

From this review it is clear that in adult psychotherapy there is a relationship between the dose of therapy received as indexed by the number of sessions, and the amount of improvement that occurs. More therapy leads to greater improvement although the incremental benefit of each additional session diminishes as therapy progresses. 50% of clients can make a clinically significant recovery within about 20 sessions (or about 6 months of weekly sessions). However, for 75% of clients to show clinically significant recovery the dose must be doubled to about 40-50 sessions. In practical terms this amounts to weekly sessions over a period of about a year. The amount of therapy required to get optimal benefit varies depending upon client characteristics and diagnosis. Chronic characterological problems like those associated with personality disorders require more sessions than acute problems like depression or anxiety for optimal benefit to be achieved.

Therapy context factors: The therapeutic alliance

Of all the common therapy context factors that contribute to the outcome of psychotherapy, the therapeutic alliance has received most attention. Research on this issue addresses the question: How important is the relationship between the therapist and the client, for client recovery? In a meta-analysis of 79 studies of a range of different types of psychotherapy with a variety of adult psychotherapy populations, Martin et al. (2000) found a correlation of .22 between the therapeutic alliance and outcome. Shirk and Karver (2003) found precisely the same alliance-outcome correlation in a meta-analytic review of 23 studies of a range of different types of psychotherapy with children presenting with a wide variety of psychological problems. Using the conversion system in Figure 1.6 in Chapter 1, this correlation of .22 is equivalent to a moderate effect size of .45. It also indicates that the therapeutic alliance accounts for about 5% of the variance in outcome for psychotherapy clients. This is a very large contribution to the variance, in light of Wampold's (2001) estimate that overall, psychotherapy accounts for 13% of the outcome for psychotherapy clients (as shown in Figure 3.2). When the effect of the alliance is expressed as a fraction of the overall effects of psychotherapy, it amounts to 5/13, or 38%. Thus 38% of the effects of psychotherapy are due to the therapeutic alliance. Clearly, the therapeutic alliance is a major factor contributing to the outcome of all forms psychotherapy, and the most

important common factor contributing to the effectiveness of psychotherapy.

The American Psychological Association Task Force on Empirically Supported Therapy Relationships under the leadership of John Norcross (2002) conducted extensive literature reviews on all researched aspects of therapeutic relationships and pinpointed ways in which strong therapeutic alliances may be fostered (Norcross, 2002). The Task Force's findings are remarkably consistent with those of David Olinsky et al. (2004) who conducted a systematic wide-ranging narrative review of thousands of research studies on psychotherapy process from 1950-2001. Both Norcross and Olinsky confirmed the centrality of the therapeutic alliance to effective psychotherapy. They also concluded that a strong therapeutic alliance involves more than just good feelings or polite banter between therapists and clients. Rather, therapists and clients each contribute important elements which synergistically foster therapeutic alliances. In effective therapy clients were found to engage in therapy in a co-operative way, initially availing of opportunities to prepare themselves for the client role, and then showing significant openness, expressiveness and commitment to the therapy process, while therapists empathically collaborated with clients working towards consensually agreed therapeutic goals in a supportive and credible manner. In group therapy, therapists fostered group cohesion. Within the therapy relationship effective therapists showed positive regard, genuineness, and provided clients with both relevant feedback and relevant self-disclosure information. Ruptures in the therapeutic alliance are common. These may be associated with client transference, therapist countertransference or a mismatch between clients' needs on the one hand, and the therapist's way of conducting therapy on the other. Both Norcross and Olinsky concluded that strong therapeutic alliances are maintained by managing such ruptures in the therapeutic alliance and customizing the therapeutic relationship to take account of client's needs.

Therapy context factors: Common procedures

While an adequate number of sessions (20-45) and a good working alliance are important for effective psychotherapy, there are a range of procedures common to most forms of therapy that contribute to client recovery. These common procedures have been conceptualized in a variety of different ways. What follows is a brief synthesis of a number of the most influential and coherent of these common factor frameworks (Frank, & Frank, 1991; Hubble et al., 1999; Karasu, 1986; Lambert & Ogles, 2004; Norcross &

Goldfried, 2003; Sprenkle & Blow, 2004; Wampold, 2001). Effective therapy involves problem exploration and reconceptualization; provision of a credible rationale for conducting therapy; generating hope and the expectation of improvement; and mobilizing clients to engage in problem resolution. This mobilization process may involve helping clients develop more adaptive behaviour patterns and belief systems; more effective ways of regulating their emotions; and more supportive emotional connections with themselves, their family members and their therapists. There is also a developmental sequence common to most forms of psychotherapy in which interventions that support clients (such as reassurance and facilitating catharsis and emotional expression) precede interventions that promote learning to see problems in new ways (such as reframing and interpretation) and these in turn precede interventions that promote new forms of behaviour such as facing fears, regulating behaviour, interpersonal risk taking, and practicing new skills.

Therapy context factors: Combining medication and therapy

For specific disorders, multimodal programmes in which psychotherapy and psychotropic medication are combined are more effective than either alone (Kazdin, 2004; Thase & Jindal, 2004). In children, the effectiveness of systemic therapy in ADHD which includes parent-management training, school intervention, and self-instructional training for the child can be greatly enhanced by combining this with stimulant therapy. In adults being treated with antipsychotic medication for schizophrenia, relapse rates may be reduced by offering psychoeducational family therapy to reduce family stress and cognitive behaviour therapy to improve symptom management. In adults being treated with mood stabilizing medication such as lithium for bipolar disorder, relapse rates can be reduced by offering cognitive behaviour therapy or psychoeducational family therapy. In adults the effectiveness of psychotherapy for depression, particularly severe depression, can be enhanced through the concurrent use of antidepressants. In both children and adults, the effectiveness of an exposure and response-prevention cognitive behaviour therapy protocol for obsessive compulsive disorder can be enhanced through the use of antidepressants. For alcohol abuse in adults, disulfiram enhances the effectiveness of psychotherapy, and psychotherapy improves the effectiveness of methadone maintenance for adult heroin addicts. A more detailed review of evidence supporting the effectiveness of these multimodal programmes is given in later chapters in this report. However, these research findings underline the value of combining psychotherapy and medication in specific

circumstances, to facilitate recovery.

Therapist factors

Bruce Wampold (2001) in a review of major meta-analyses and re-analyses of data from large controlled psychotherapy outcome studies, concluded that 6-9% of the outcome variance is due to therapist effects. This is a large contribution to the variance, in light of Wampold's (2001) estimate that overall, psychotherapy accounts for 13% of the outcome for psychotherapy clients (as shown in Figure 3.2). When the effect of the therapist is expressed as a fraction of the overall effects of psychotherapy, it amounts to $6/13 - 9/13$, or 46 - 69%. Thus 46 - 69% of the effects of psychotherapy are due to the therapist (including therapist training, capacity to form an alliance and specific therapeutic technique). Clearly, the person of the therapist is a central factor contributing to the outcome of psychotherapy.

Larry Beutler and his team (2004) conducted a comprehensive narrative review of more than 100 empirical studies of therapist characteristics that have been found to correlate with therapeutic outcome. They concluded that the following therapist characteristics have been associated with therapeutic improvement: personal adjustment; therapeutic competence; matching therapeutic style to clients' needs; credibility; and problem solving creativity. Effective therapists were well adjusted themselves. They were judged to be competent in offering therapy in a 'seamless' way. They matched their style to clients' expectations and preferences. There is evidence for the effectiveness of three types of matching. For reflective overcontrolled clients an insight oriented approach is particularly effective, whereas a symptom-focused skills-building approach is more effective with impulsive undercontrolled clients. For clients who are resistant to directives, a self-directive approach is most effective whereas a directive approach is effective with non-resistant clients. For clients with a history of gratifying early relationships, confrontative insight oriented approaches are effective, whereas supportive approaches are more effective with clients with histories of problematic early relationships. Beutler et al., (2004) also concluded that effective therapists creatively found new ways to formulate and reframe clients' problems, and offered clients credible rationales for learning and practicing new adaptive skills for resolving problems.

Therapist factors: Therapist training

A therapist factor of particular interest to psychotherapy trainers, is the impact of therapist experience and training on therapeutic outcome. In a meta-analysis of the effects of psychotherapy training, Stein and Lambert (1995) found that for therapists with more training, fewer clients dropped out of therapy and their clients reported greater symptomatic improvement and greater satisfaction with therapy. The effect sizes for symptomatic improvement and satisfaction with therapy were .3 and .27 respectively. Using the system in Figure 1.6 for conversion, these effect sizes indicate that therapist training accounts for about 2% of the variance in outcome for psychotherapy clients. This is a moderate contribution to the variance, in light of Wampold's (2001) estimate that overall, psychotherapy accounts for 13% of the outcome for psychotherapy clients (as shown in Figure 3.2). When the effect of therapist training is expressed as a fraction of the overall effects of psychotherapy, it amounts to $2/13$, or 15%. Thus 15% of the effects of psychotherapy are due to therapist training. Clearly, therapist training is an important factor contributing to the outcome of psychotherapy.

This finding of a relationship between training experience and outcome is increasingly supported by well conducted studies. For example, in a study conducted in a clinic for training therapists to use empirically validated treatments, Driscoll et al. (2003) found that client outcome was significantly related to therapists' experience level as indexed by their total number of client contact hours since starting training. In a study on the effectiveness of three approaches to training in cognitive behavioural psychotherapy, Shalomskas (2005) found that therapists who attended a seminar and received supervision of their casework in the implementation of a manualized treatment protocol, showed significantly better therapy skills as judged by independent observers, than therapists who only reviewed the manual or completed a web-based training programme. The results of these two studies are examples from the growing body of evidence on the beneficial impact of training and experience on psychotherapy effectiveness. This evidence is in stark contrast to conclusions drawn from early studies in the area which suggested that there were no differences between effectiveness of trained therapists and paraprofessionals with limited training (Atkins & Christensen, 2001).

Therapist factors: Supervision and personal therapy

Supervision and engagement in personal therapy has a beneficial impact of therapist effectiveness. Lambert and Ogles (1997) in an extensive review of the effectiveness of

psychotherapy supervision concluded that supervision has a beneficial impact on both alliance formation and the use of technical skills. Milne and James (2000) in a systematic review of effective cognitive behavioural supervision concluded that closely monitoring the supervisee, modelling competence, providing specific instructions, goal setting and providing contingent feedback on performance have positive effect on therapist performance. Norcross (2005) in a synthesis of 25 years of research on the effects of personal therapy of mental health professionals, concluded that it has a positive impact of the quality of service psychotherapists offer to clients.

Therapist factors: Flexible use of manuals

There is evidence that the flexible use of therapy manuals enhances therapy effectiveness for both children (Carr, 2000; Hibbs & Jensen, 2005; Kazdin & Weiss, 2003) and adults (Nathan & Gorman, 2002; Roth & Fonagy, 2005). This is not surprising, since therapy manuals contain the blueprints for psychotherapy protocols that have been shown to lead to client recovery in efficacy studies. This in turn provides clinicians with clarity, and confidence that they are offering clients helpful and focused interventions based on credible rationales. Furthermore, the flexible, rather than rigid use of manuals allows clinicians to match their therapy style to clients needs. Finally, manuals probably help therapists avoid countertherapeutic practices such as drifting through therapy without a credible therapeutic focus and acting out destructive countertransference reactions evoked by clients with complex problems. From the forgoing, it is clear that the use of therapy manuals allow therapists not only to use specific techniques that are helpful with particular problems, but also provide an avenue through which to offer their clients access to the 'common factors' characteristic of effective psychotherapy. Therapy manuals evolved within the efficacy research tradition as a method for standardizing the way multiple therapists in a single study provided a particular psychotherapy protocol to a specific homogeneous group of clients with designated problems. Good therapy manuals provide a credible research-based rationale for treatment, broad principles or guidelines for conducting therapy, and detailed examples (with brief segments of therapy transcripts where appropriate) of how to use these guidelines in practice. For some types of therapy, such as psychoanalytic or systemic couple and family therapy, this may be enough. For other types of therapy, for example cognitive behaviour therapy, detailed session plans may be provided. To become proficient in using therapy manuals therapist require ongoing

supervision, and periodic feedback on the extent to which they are adhering to the manualized therapy protocol. To facilitate this, good manuals include a briefing on supervision and integrity checklists for monitoring adherence. These contain a set of items used for rating therapy transcripts or tapes. The items specify what therapists who are using the manual accurately should and should not be doing in therapy sessions.

However, there is still much controversy over the widespread use of therapy manuals (Addis, 2002; Herschell et al., 2004). Those in favour of manuals point to their value in efficacy studies; positive instances where community based clinicians have learned to use manualized therapy effectively; and the potential manuals have for enhancing initial psychotherapy training and ongoing continuing professional development. Those who question the value of manuals construe them as an inconvenient or ineffective imposition on clinical autonomy and judgment. They point to studies that show in certain circumstances rigid adherence to manuals leads to worse therapy; in some efficacy studies there is little relationship between adherence to manualized protocols and client recovery; and in some instances manualized therapies lose their potency when moved from the university clinic to the community.

While the controversy continues, it is worth noting that there are numerous examples of manualized therapies that have been successfully moved from the university clinic to the community and which are highly acceptable to practicing psychotherapists. Scott Henggeler's (Henggeler et al., 1998) manual and related training and supervision system for multisystemic therapy for adolescent conduct problems and Marsha Linehan's (1993) manual and related training system for conducting dialectical behaviour therapy with adults who have borderline personality disorder are particularly good examples of therapy manuals that have built in flexibility and can be used by community based psychotherapists with these very difficult populations.

Therapist factors: Receiving feedback

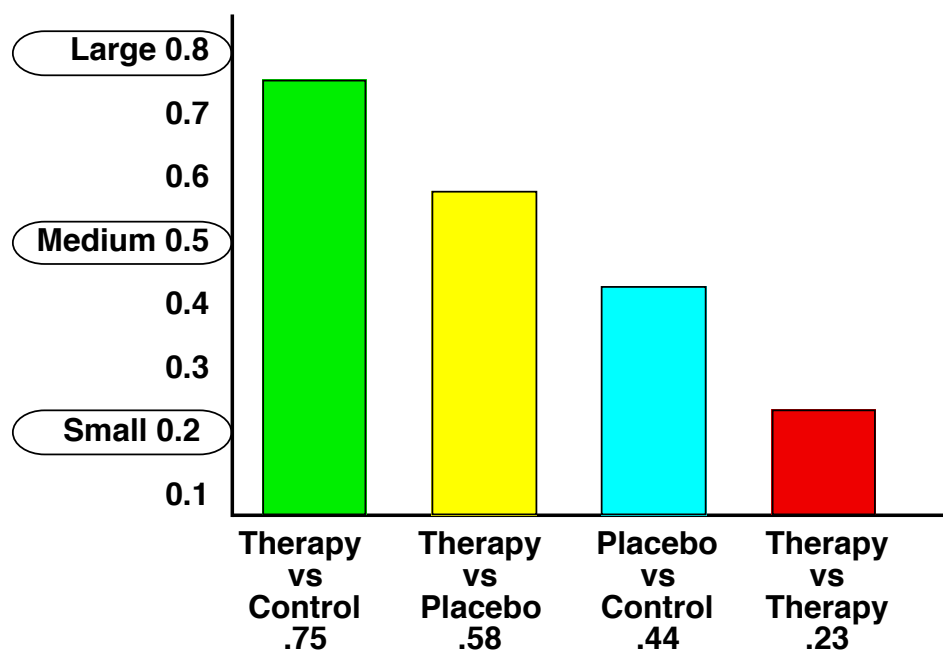
Providing therapists with feedback on client progress has been found to improve therapist effectiveness. In a meta-analytic review of three large scale studies involving over 2,600 clients and 100 therapists, Lambert et al (2003) found that formally monitoring client progress and giving this feedback to their therapists had a significant impact on clients who showed a poor initial response to treatment. This feedback system reduced deterioration by 8% and increased positive outcomes by 13%. In all three studies in the

meta-analysis, therapists were given clients scores on the Outcome Questionnaire 45 which gives an overall index of improvement as well as scores for personal distress, interpersonal functioning, social role functioning and quality of life (Muller et al., 1998).

SUMMARY

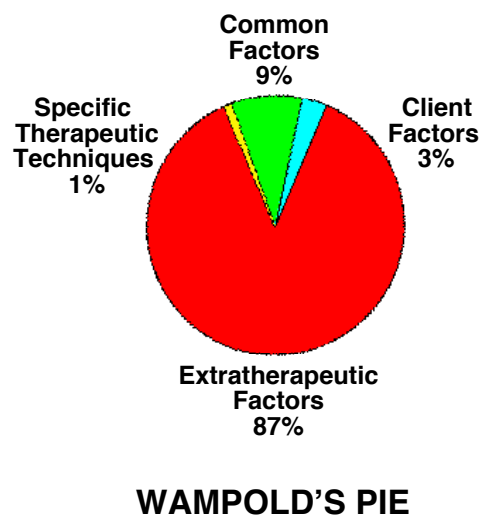
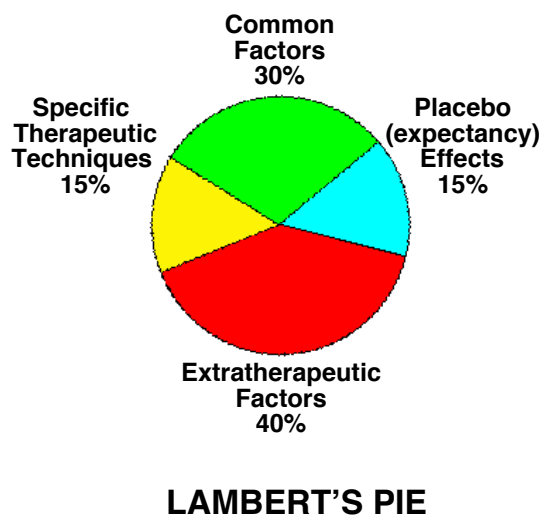
In this chapter the role of factors common to all forms of effective psychotherapy was considered. The effects of psychotherapy are nearly double those of placebos. Recovery rates for different forms of psychotherapy are very similar. Common factors have a far greater impact than specific factors in determining whether or not clients benefit from psychotherapy. Common factors include those associated with the therapy process, the therapist and the client. These are summarized in Figure 3.5. The following client characteristics have been associated with therapeutic outcome: personal distress; symptom severity; functional Impairment; case complexity; readiness to change; early response to therapy; psychological mindedness; ego-strength; capacity to make and maintain relationships; the availability of social support; and socio-economic status (SES). 20-45 sessions are necessary for 50-75% of psychotherapy clients to recover. The therapeutic relationship or alliance is the most important single common factor in psychotherapy. In a good therapeutic alliance the therapist is empathic and collaborative and the client is co-operative and committed to recovery. Effective therapy involves the common procedures of problem exploration and reconceptualization; provision of a credible rationale for conducting therapy; generating hope and the expectation of improvement; and mobilizing clients to engage in problem resolution. This may be achieved by providing support and encouraging emotional expression; by facilitating new ways of viewing problems; and by helping clients to develop new ways of behaving adaptively. For certain specific disorders such as schizophrenia, multimodal programmes in which psychotherapy and psychotropic medication are combined are more effective than either alone. The following therapist characteristics are associated with therapeutic improvement: personal adjustment; therapeutic competence; matching therapeutic style to clients' needs; credibility; problem-solving creativity; capacity to repair alliance ruptures; specific training; flexible use of therapy manuals; supervision and personal therapy; and feedback on client recovery.

Figure 3.1. The effects of psychotherapy compared with no-treatment control and placebo control groups.



Adapted from Grissom (1996).

Figure 3.2. Factors that affect the outcome of psychotherapy



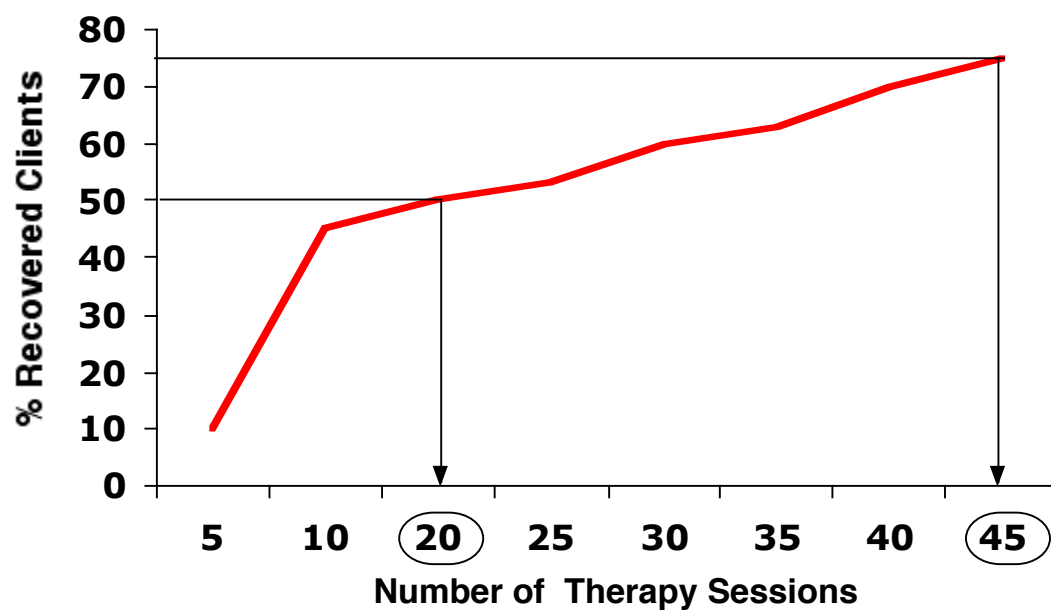
Adapted from Lambert and Barley (2002) and Wampold (2001)

Figure 3.3. Results of dose-response studies

Author	Date	Sample size	Number of sessions for 50% of sample to show clinically significant recovery		Number of sessions for 75% of sample to show some improvement
Howard et al	1986	2,431	--		26
Kopta et al.	1994	854	5	(acute symptoms)	--
			14	(chronic symptoms)	
			104	(characterological symptoms)	
Maling et al.	1995	307	10	(control problems)	--
			38	(social detachment problems)	
Barkham et al.	1996	212	8	(depressive symptoms)	--
			16+	(interpersonal problems)	
Kadera et al.	1996	64	16		--
Anderson & Lambert	2001	140	13		50
Lambert, Hansen & Finch	2001	6, 072	21		45
Hansen & Lambert	2003	4, 761	18		--

Adapted from Hansen, Lambert & Forman 2002. All samples include adult clients. Clinically significant recovery was evaluated using Jacobson et al.'s (2004) criterion.

Figure 3.4. Psychotherapy dose-effect relationship



Adapted from Lambert, Hansen and Finch (2001)

Figure 3.5. Therapy, client and therapist factors that affect positive psychotherapy outcome

Therapeutic Context Factors

Dose of 20-45 sessions
 Positive therapeutic alliance
 Empathy
 Collaboration and goal consensus
 Positive regard & genuineness
 Relevant feedback & relevant self-disclosure
 Repair alliance ruptures
 Manage transference & countertransference
 Common procedures
 Problem exploration
 Credible rationale
 Mobilizing client
 Support and catharsis
 Reconceptualizing problem
 Behavioural change
 Combining psychotherapy & medication for specific problems

Client Factors

High personal distress
 Low symptom severity
 Low functional Impairment
 Low problem Complexity / Chronicity / Co-morbidity
 Readiness to change & lack of resistance
 Early response to therapy
 Psychological mindedness
 Ego-strength
 Capacity to make and maintain relationships
 Social support
 High socio-economic status

Therapist Factors

Personal adjustment
 Therapeutic competence
 Matching style to patient
 Overcontrolled – insight
 Undercontrolled – symptom skills
 Positive past relationships – insight
 Negative past relationships - support
 Compliant clients – directive
 Resistant clients – self-directed
 Credibility of rationales
 Problem-solving creativity
 Specific training
 Flexible manual use
 Supervision and personal therapy
 Feedback on client recovery

CHAPTER 4

EFFECTIVENESS OF PSYCHOTHERAPY WITH SPECIFIC PROBLEMS IN ADULTHOOD

In this chapter, evidenced-based conclusions are presented about the effectiveness of specific forms of psychotherapy with specific psychological problems in adulthood. Traditional psychiatric categories (such as mood disorders, anxiety disorders, eating disorders etc.) have been used to organize evidence reviewed in this chapter. Such categories are described in the American Psychiatric Association's Diagnostic and Statistical Manual (DSM IV TR, APA, 2000c) and the World Health Organization's International Classification of Diseases (ICD 10, World Health Organization, 1992). This categorical approach, premised on a medical model of psychological difficulties, may be ideologically unacceptable to service users and psychotherapists who adopt systemic, constructivist, cognitive-behavioural, psychoanalytic, or humanistic and integrative frameworks. Many psychotherapists and service users view psychiatric diagnoses as being on a continuum with normal development and functioning, or as a reflection of systemic rather than individual shortcomings. However, the organization, administration and funding of clinical services and research programmes are framed predominantly in terms of the ICD and DSM systems and so diagnostic categories from these systems have been used to organize the material in chapters 4 and 5 of this report.

METHODOLOGY

To draw the evidence-based conclusions set out in this chapter, extensive computer and manual literature searches for relevant evidence were conducted. The terms used in these searches included names of disorders and problems that may be treated with psychotherapy, for example, anxiety, depression and so forth, along with terms reflecting the type of evidence being sought, such as meta-analysis, critical review, randomized controlled trial, treatment outcome study and so forth. A range of data bases such as PsycINFO and Medline were searched, along with the tables of contents of major academic journals in the fields of psychotherapy, counselling, psychology, psychiatry, social work, nursing and related fields. In addition, a search was conducted for key textbooks, or volumes of authoritative edited chapters in the area, for example Nathan and Gorman's (2002) *A Guide to Treatment's that Work*. These intensive literature searches

focused mainly on the 10 year period from 1996-2006. Earlier literature was searched less intensively. For each of the main problem areas, such as anxiety, depression and so forth, the most recent and most authoritative meta-analyses and narrative literature reviews were selected for review and inclusion in this report. Where meta-analyses and narrative literature reviews could not be found, controlled treatment outcome studies and randomized controlled trials were selection for inclusion. For each specific type of problem, results of selected meta-analyses, reviews and outcome studies were used as a basis for making evidence-based statements about key interventions, techniques, practices and protocols characteristic of effective psychotherapy with the problem in question. The literature search method is summarized in Figure 4.1.

PROBLEMS IN ADULTHOOD FOR WHICH PSYCHOTHERAPY IS EFFECTIVE

Psychotherapy alone or as an element in a multimodal programme is effective for the following specific adult problems

- Mood disorders, specifically major depression and bipolar disorder
- Anxiety disorders including generalized anxiety disorder, panic disorder, specific phobias, social phobia or social anxiety disorder, obsessive compulsive disorder (OCD), and posttraumatic stress disorder (PTSD)
- Adjustment to illness including preparation for surgery, adjustment to illnesses with high mortality rates such as cancer and heart disease, adjustment to chronic medical conditions involving adherence to complex regimes such as diabetes and asthma
- Facilitating coping with conditions involving pain and fatigue such as chronic pain, fibromyalgia, headaches, arthritis, irritable bowel syndrome, and chronic fatigue syndrome
- Psychosomatic disorders including somatoform disorder, hypochondriasis, and body dysmorphic disorder
- Eating disorders including obesity, bulimia and anorexia nervosa
- Insomnia
- Alcohol and drug abuse
- Schizophrenia

- Personality disorders; related identity and self-esteem issues; issues arising from childhood sexual, physical and emotional abuse; aggression; and sexual offending
- Relationship problems including marital distress, psychosexual problems and domestic violence
- Psychological problems associated with older adulthood including dementia, caregiver support, depression, anxiety and insomnia

In the remainder of this chapter evidence-based statements are given about particular psychotherapeutic interventions, procedures and protocols which have been shown through meta-analyses, narrative review and controlled treatment outcome studies to be effective for each of these sorts of problems. A complete bibliography of all cited papers is given at the end of the report. The problems for which psychotherapy is effective are summarized in Figure 4.2.

There is a danger that in summarizing a very large body of evidence within the constraints of a single chapter, the complexity of the psychotherapy process and the high level of skill required to facilitate this process may not be fully conveyed. For example, in the sections that follow reference is made to key elements of effective psychotherapy programmes such as psychoeducation, changing negative or maladaptive thinking styles, replacing maladaptive with adaptive coping strategies, changing daily routines, making lifestyle changes, social skills training, facilitating the development of supportive relationships with family and peers, developing better problem-solving skills, facilitating exposure to feared situations and so forth. There is a danger that such key elements may be misconstrued as simple procedures which could be offered by technicians. To pre-empt this, it is important in the first instance to emphasize the complexity of the process of psychotherapy. Clients with psychological disorders engage in a variety of maladaptive coping strategies, use a variety of subtle defence mechanisms, and engage in subtle counterproductive thinking patterns. Most of these maladaptive coping strategies, defence mechanisms, and thinking patterns occur outside clients' awareness. That is, these are often unconscious processes. Furthermore, many of these processes involve problematic relationships or interaction patterns, underpinned by problematic belief systems and narratives within the family, peer group, school or workplace. Helping clients become aware of these processes and relationship patterns; understand that they are counterproductive; evolve more adaptive coping strategies, defence mechanisms, thinking

styles and relationships is a highly skilled process. This is partly because of clients' resistance to change. It is one of the extraordinary paradoxes of psychotherapy, that clients come to therapy to resolve psychological problems by changing how they live their lives, and yet a significant portion of their time in therapy is spent dealing with their resistance to, and ambivalence about changing how they live their lives. Effective psychotherapy with individuals, couples, families and groups always involves addressing resistance. The complexity of psychotherapy is mentioned here, because the description of the key elements of effective evidence-based psychotherapy with specific disorders given below, often makes the process sound simple and uncomplicated. From the foregoing, it is clear that conducting psychotherapy is a highly skilled process.

MOOD DISORDERS IN ADULTS

Psychotherapy has an important evidence-based role in the management of mood disorders, especially major depression and bipolar disorder.

Depression

In adults, for major depression which is an episodic disorder, cognitive-behaviour therapy, interpersonal therapy, psychoanalytic psychotherapy, client-centred therapy and systemic couple therapy are effective treatments for helping clients recover from an episode of major depression (Beach, 2003; Craighead et al., 2002a; Gupta et al., 2003; Leff et al., 2000; Leichsenring, 2001; Wampold et al., 2002; Ward et al., 2000). These various forms of therapy help clients understand factors that have contributed to the development and maintenance of their depression; develop healthier, active daily routines; stop depressive thinking styles from dominating their mood; develop supportive relationships with family members and others, and address complex interpersonal and relationship issues. Psychotherapy is as effective as antidepressants (Casacalenda et al., 2002). However, initial treatment response to psychotherapy may be enhanced and the interval between episodes of depression can be lengthened if psychotherapy is offered as one element of a multimodal programme involving antidepressant medication and psychotherapy (Friedman et al., 2004; Hollon et al., 2006; Nemeroff, & Schatzberg, 2002; Otto et al., 2005). Despite its side-effects of memory problems, electro-convulsive therapy is the treatment of choice for severe depression that does not respond to antidepressants and psychotherapy (Carney et al., 2003). Mindfulness based cognitive therapy for people who have recovered

from three or more episodes of depression, has been shown to delay further relapses (Baer, 2003; Segal et al., 2002). This meditation-based therapy helps clients develop skills for breaking the link between depressive thinking styles and mood state. Group therapy is as effective as individual therapy in the treatment of depression (McDermut et al., 2001). Guided self-help using Peter Lewinsohn's *Coping with Depression* course is effective in helping people overcome depression in an stepped care model of service delivery (Cuijpers, 1998). International professional guidelines highlight the importance of including psychotherapy in the routine treatment of depression (APA, 2000a; NICE, 2004a).

Bipolar disorder

In adults with bipolar disorder a multimodal programme involving pharmacological treatment with mood stabilizing medication (e.g. lithium or carbamazepine) and structured psychotherapy is the treatment of choice, and leads to better medication adherence, lower relapse rates and better quality of life than medication alone (Geddes et al., 2004; Keck & McElroy, 2002; Otto et al., 2005). Cognitive behaviour therapy, psychoeducational therapy, couple or family therapy, and interpersonal therapy are particularly effective forms of psychotherapy in multimodal programmes for bipolar disorder (Craighead et al., 2002b; Gutierrez & Scott, 2004; Jones et al., 2005; Lam & Wong, 2005; Mansell et al., 2005; Sajatovic et al., 2004). These various forms of therapy help clients understand factors that contribute to the aetiology of bipolar disorder and the relapse process; identify and deal with prodromes when they occur; develop stable daily routines that involve adherence to medication regimes; stop manic or depressive thinking styles from dominating their mood states; and develop supportive relationships with family members and others. International professional guidelines highlight the importance of including psychotherapy in the routine treatment of bipolar disorder (APA, 2002; Goodwin, 2003; Grunze et al., 2002, 2003; NICE, 2006).

ANXIETY DISORDERS IN ADULTS

Psychotherapy is remarkably effective for anxiety disorders (Barlow & Allen, 2004; Deacon & Abramowitz, 2004; Marks & Dar, 2000). It also has more enduring effects than pharmacological treatments and does not involve the problems of dependence associated with some anxiolytics such as the benzodiazepines (Hollon et al., 2006; Otto et al., 2005). For these reasons, psychotherapy is usually the treatment of choice for anxiety disorders.

Effective psychotherapy involves a combination of some or all of the following specific techniques: developing relaxation and coping skills and supportive therapeutic and family relationships; using these skills and relationships to regulate anxiety when exposed to anxiety provoking situations or traumatic memories until habituation occurs; not engaging in maladaptive avoidant coping or using maladaptive defence mechanisms especially during the exposure process; and developing a more adaptive understanding of anxiety eliciting situations and the habituation process.

Generalized anxiety disorder

Effective psychotherapy for generalized anxiety disorder involves clients learning to reduce physiological arousal by practicing relaxation exercises, and developing skills to control the worrying process, which is usually perceived by people with generalized anxiety disorder to be out of control (Barlow et al, 2002; Mitte, 2005a; Westen & Morrison, 2001). For generalized anxiety disorder, psychotherapy is as effective as benzodiazepines and antidepressants (specific serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs)), in the short term but benzodiazepines are potentially addictive and the effects of psychotherapy are more enduring (Hollon et al., 2006; Otto et al., 2005; Roy-Byrne & Cowley, 2002).

Panic Disorder

Effective psychotherapy for panic disorder with and without agoraphobia involves clients developing relaxation and coping skills and supportive family relationships. These are then used to tolerate exposure to anxiety eliciting situations until habituation occurs (Barlow et al., 2002; Mitte, 2005b; Westen & Morrison, 2001). Anxiety eliciting stimuli include interoceptive cues that are misinterpreted as unrealistically dangerous and external situations associated with panic attacks. For distressed couples in which one partner has panic disorder with agoraphobia, a couples therapy approach to treatment in which the non-symptomatic partner supports the symptomatic partner in completing exposure tasks is particularly effective (Marcaurelle et al., 20003; Byrne et al, 2004). For panic disorder with and without agoraphobia, psychotherapy is as effective as benzodiazepines and antidepressants (SSRIs and TCAs) in the short term, but benzodiazepines are potentially addictive and the effects of psychotherapy are more enduring (Hollon et al., 2006; Otto et

al., 2005; Roy-Byrne & Cowley, 2002). These conclusions are consistent with international clinical guidelines (APA, 1998).

Specific phobias

Effective psychotherapy for specific phobias involves developing relaxation and coping skills which are then used to tolerate exposure to anxiety eliciting stimuli and situations until habituation occurs (Barlow et al., 2002). Exposure is conducted in vivo, in imagination or through simulation, for example using virtual reality technology to address flying phobia or fear of heights (Krijn et al., 2004; Rothbaum et al., 2002).

Social phobia

Effective psychotherapy for social phobia, which may be offered on an individual or group basis, involves developing coping skills, and using these to tolerate exposure to anxiety eliciting social situations (such as public speaking) until habituation occurs (Barlow et al., 2002; Rodebaugh et al., 2004). Using applied relaxation, social skills, and challenging negative automatic thoughts are three coping skills incorporated into many effective treatment protocols. Another important coping skill is tolerating anxiety and not using avoidance behaviour (or safety behaviours) routinely employed to lessen the impact of exposure to anxiety-provoking social situations. For social phobia, psychotherapy is as effective as antidepressants (monoamine oxidase inhibitors (MAOIs) and SSRIs) in the short term (Blanco et al., 2003; Roy-Byrne & Cowley, 2002), but the effects of psychotherapy are more enduring (Hollon et al., 2006).

Obsessive compulsive disorder

Effective psychotherapy for obsessive compulsive disorder involves exposure to cues (such as dirt) that elicit anxiety provoking obsessions (such as ideas about contamination), while not engaging in compulsive rituals (such as hand washing), until habituation occurs (Abramowitz et al., 2002; Eddy et al., 2004; Fisher & Wells, 2005; Franklin & Foa, 2002). This cognitive behavioural protocol is often referred to as exposure and response prevention. To help clients tolerate the anxiety associated with exposure, they may be trained in various coping skills including relaxation and challenging negative thoughts. For obsessive compulsive disorder, in the short term psychotherapy is as effective as antidepressants (clomipramine) (Dougherty et al., 2002). In cases that do not respond to

psychotherapy best practice guidelines recommend a multimodal programme involving psychotherapy and antidepressants (NICE, 2005a).

Post-traumatic stress disorder

Effective psychotherapy for post-traumatic stress disorder involves exposure to trauma related memories until habituation occurs. To help clients cope with exposure, psychotherapy may also include development of relaxation and coping skills (Bisson, 2005; Bradley et al., 2005). Eye Movement Desensitization and Reprocessing therapy (EMDR), which has enjoyed a good deal of popularity, while effective, is no more effective than other exposure therapies (Davidson & Parker, 2001). Despite its popularity, the weight of evidence shows that single session critical incident stress debriefing (CISD) following traumatic events is not effective in alleviating PTSD symptomatology (Bisson et al., 2003). In the short term, for post-traumatic stress disorder antidepressants (SSRIs, TCAs, MAOIs) are probably as effective as psychotherapy, but psychotherapy may be more effective in the long term (Yehuda et al., 2002). Best practice guidelines recommend psychotherapy alone as the initial treatment of choice and only introducing antidepressants if there is a failure to respond to psychotherapy (APA, 2004a; NICE, 2005b).

ADJUSTMENT TO ILLNESS

Psychotherapy has been shown to be effective for enhancing adjustment to surgery and illness, pain management and for the management of somatic symptoms of unknown or complex bio-psycho-social aetiology. A summary of key elements of protocols for which there is evidence of effectiveness is given below.

Preparation for surgery

Psychotherapeutic procedures may be used to help patients prepare for surgery and adjust to the aftermath of major surgical procedures (Block et al., 2003; Johnston & Vogele, 1993; Vogele, 2004). Psychological preparation for surgery has multiple benefits. It decreases pre-operative distress, post-operative pain, and post-operative complications. The use of pain medication before and after surgery is also reduced by pre-operative preparation. Pre-operative psychological preparation reduces the duration of post-operative hospitalization and related medical costs. Patients who participate in psychological preparation for surgery take more responsibility for their recovery and report

greater satisfaction with surgical services. Psychological preparation for surgery involves psychoeducation in which patients receive information about surgical procedures and typical sensory responses to these procedures; training in post-operative self-care skills which will speed recovery; and training in relaxation and cognitive coping skills to manage pre-operative anxiety and facilitate adjustment to post-operative pain and discomfort. Effective programmes involve a supportive therapeutic relationship, the provision of information using multimedia (oral, written, video-modelling), the involvement of family members in the programme; and opportunities to rehearse and practice coping skills.

Adjustment to life threatening illnesses

Psychotherapy is effective in alleviating illness-related distress and in facilitating adjustment to a range on major illnesses with high mortality rates (Schneiderman et al., 2001). It also enhances immune system functioning during recovery (Miller & Cohen, 2001). Psychotherapy has been shown to promote adjustment to cancer (Andersen, 2002; Barsevick et al., 2002; Edwards et al., 2004; Newell et al., 2002; Sheard & Maguire, 1999) and heart disease (Rees et al., 2004; Smith & Ruiz, 2002). Effective psychotherapy for enhancing psychological adjustment to serious medical conditions such as cancer and heart disease involves providing support, facilitation expression of illness related emotional reactions, psychoeducation about factors associated with psychological adjustment to illness, facilitating the development of stress management skills especially relaxation, meditation and cognitive coping skills, enhancing family support, and promoting healthier lifestyles. Effective psychotherapy may be offered within an individual, homogenous small group, marital or family context. These conclusion are consistent with those of best practice guidelines for palliative care for adults with cancer (NICE, 2004b).

Adjustment to chronic medical conditions

Psychotherapy facilitates adjustment to chronic illnesses requiring adherence to complex illness management regime such as asthma, Type 1 Diabetes and essential hypertension. Psychological interventions that improve asthma control and adherence to asthma medical regimes include psychoeducation; skills training in adherence; training in trigger avoidance and symptom monitoring using a peak flow meter; and relaxation and stress management training (Lehrer et al., 2002). For clients with Type 1 diabetes, psychosocial intervention programmes that improve illness management and psychological adjustment include

psychoeducation; skills training in adherence to diabetic medical regimes; and relaxation and stress management training (Gonder-Frederick et al., 2002). These conclusions are consistent with best practice guidelines for care of adults with Type 1 diabetes (NICE, 2004c). For hypertension effective psychotherapy involves a relaxation training and a lifestyle change programme that facilitates weight reduction, physical exercise, reduced sodium and alcohol intake, and potassium supplements (Blumenthal et al., 2002; Linden & Chambers, 2004).

COPING WITH PAIN AND FATIGUE

When psychotherapy is included as one element of a multimodal, multidisciplinary programme it is effective in helping adult clients manage chronic pain, fibromialgia, headaches, arthritis, irritable bowel syndrome, and chronic fatigue syndrome. Specific effective protocols are summarized below.

Chronic pain

Effective psychotherapy for chronic pain is offered as one element of an intensive multidisciplinary programme involving physiotherapy, occupational therapy and medical management, and is usually offered within a group therapy context (Guzmán et al., 2002; Morley et al., 1999; Ostelo et al., 2005; Turk, 2002). Effective psychotherapy involves psychoeducation; relaxation and coping skills training; graded exercise planning; reinforcement for engaging in adaptive behaviour inconsistent with the illness role; and building social support especially within the family.

Fibromialgia

Effective psychotherapy for fibromialgia is offered as part of a multidisciplinary programme involving medical pain management, physiotherapy, occupational therapy and graded exercise. Psychotherapy includes psychoeducation; relaxation, coping skills, assertiveness and sleep management training; usually in a group context with other fibromialgia clients (Adams & Sim, 2005; Busch, 2002; Hadhazy et al., 2000; Karjalainen et al., 2002; Rossy et al., 1999; Sim & Adams, 2002;)

Recurrent headaches

For both migraine and tension headaches effective psychotherapy involves psychoeducation and progressive muscle relaxation training (Haddock et al., 1997; Holroyd, 2002). The effectiveness of this can be enhanced with biofeedback and possibly with the addition of cognitive behavioural coping skills training. Electromyograph (muscle tension) biofeedback has been found to be effective for both tension and migraine headaches, and thermal biofeedback has shown some positive results in the treatment of migraine.

Arthritis

For pain management in rheumatoid and osteoarthritis effective psychotherapy involves psychoeducation, relaxation and coping skills training and involvement of marital partners or family members in therapy to enhance social support (Keefe et al., 2002).

Irritable bowel syndrome

A variety of psychotherapeutic interventions including psychoanalytic therapy, psychoeducational therapy, cognitive behaviour therapy, hypnotherapy and biofeedback are effective in the treatment of irritable bowel syndrome (Blanchard & Scharff, 2002; Lackner et al., 2004). All of these forms of therapy provide clients with a new and coherent way of understanding their condition within the context of a supportive psychotherapeutic relationship. Relaxation training, hypnotherapy, and biofeedback enhance clients' capacity to regulate physiological arousal and discomfort associated with their symptoms. Psychoanalytic therapy, and assertiveness training (which is included in some cognitive behavioural programmes) empower clients to break vicious cycles of social interaction through which symptoms are maintained. These forms of therapy also help clients develop more supportive social networks.

Chronic fatigue syndrome

Effective psychotherapy for chronic fatigue syndrome involves graded exercise and learning cognitive coping skills within the context of a supportive psychotherapeutic relationship (Edmonds, et al., 2004; NHS Centre for Reviews and Dissemination, 2002; Price & Couper 1998; Whiting et al., 2001).

PSYCHOSOMATIC DISORDERS IN ADULTS

Psychotherapy is effective in alleviating symptoms associated with somatoform disorder; health anxiety associated with hypochondriasis; and anxiety and dissatisfaction associated with body dysmorphic disorder.

Somatoform disorder

With somatoform disorder clients experience multiple unexplained physical symptoms. Effective psychotherapy for somatoform disorder involves co-ordination of patient care by a single designated professional, psychoeducation, relaxation and coping skills training, graded exercise and promotion of engagement in previously avoided routine activities of daily living, and regularization of care-giving and receiving family relationships (Allen et al., 2002; Kroenke & Swindle, 2000; Looper & Kirmayer, 2002; Simon, 2002). Co-ordination of care by a single professional helps clients manage uncertainty and anxiety associated with multiple conflicting messages from multiple professionals. Psychoeducation helps clients develop more adaptive understanding of the role of psychological and interpersonal factors in maintaining and potentially alleviating their symptoms. Relaxation and coping skills training empower clients to regulate physiological arousal and symptom related distress. Through graded exercise and engagement in activities of daily living, clients normalize their lives and overcome entrenched patterns of avoidance. Often couple or family therapy sessions are necessary to facilitate this process, since this may involve changes in symptom maintaining patterns of care giving and care receiving behaviour.

Hypochondriasis

Effective psychotherapy for hypochondriasis (or health anxiety) involves helping clients understand factors that contribute to the development and maintenance of anxiety about illness and death; engage in exposure to situations that elicit illness-related anxiety (including stopping habitual health checking routines) until they habituate to help them cope; gain control over illness-related worries, which are often experienced as being outside their control; and develop satisfying daily routines and long-term plans (Looper & Kirmayer, 2002).

Body dysmorphic disorder

With body dysmorphic disorder, there is a preoccupation with a perceived defect in appearance or an excessive concern over a slight physical abnormality. Effective

psychotherapy for body dysmorphic disorder involves helping clients enter situations in which they experience anxiety associated with others having opportunities to evaluate aspects of their bodies they mis-perceive as defective, until habituation occurs (Looper & Kirmayer, 2002; Williams et al., 2006). To facilitate habituation, patients do not conceal aspects of their bodies they mis-perceive as defective in these situations and refrain from frequent grooming mirror checking and reassurance seeking. Thus this is an exposure and response prevention therapy model. Effective psychotherapy also helps clients develop more adaptive beliefs about their bodies.

EATING DISORDERS

There is evidence for the effectiveness of psychotherapy with obesity, bulimia and anorexia nervosa in adults.

Obesity

Effective psychotherapy for obesity in adults involves goal setting and daily monitoring of eating, physical exercise and weight; a low calorie diet of 1000-1500 kcal per day which should produce weight loss of .5kg per week; about an hours daily physical exercise; organization of environmental cues, reinforcement, and significant relationships to support lifestyle changes in eating and exercise; and the development of coping skills to address beliefs and urges that interfere with lifestyle change and weight loss (Wadden et al., 2005). Effective programmes are of long duration with frequent sessions. Partner or group support for weight loss is provided by using couple or group therapy formats respectively. In the psychotherapy of obesity, early sessions focus on goal setting and contracting and later sessions address the development of relapse prevention skills. Because obesity is a chronic problem, infrequent follow-up sessions are required to maintain treatment gains. Multimodal treatment with psychotherapy and medication (orlistat or sibutramine) enhances treatment effectiveness (Avenell et al. 2004).

Bulimia nervosa

Both cognitive behaviour therapy and interpersonal therapy are effective treatments for bulimia nervosa in the short and longer term (Thompson-Brenner, et al., 2003; Wilson,

2005). In contrast, there is only evidence for the short-term efficacy of antidepressants for bulimia (Wilson & Fairburn, 2002). With cognitive behaviour therapy clients learn effective methods for symptom control by developing a regular and flexible pattern of eating that includes previously avoided foods; reducing concern with body shape and weight; and coping with high-risk situations for binge eating and purging to prevent relapse. With interpersonal therapy clients resolve interpersonal difficulties associated with their eating disorder, specifically those associated with loss, lifecycle transitions, role disputes and social skills deficits. Multimodal treatment programmes in which antidepressants and psychotherapy are combined may be helpful in some cases but there is no research on such programmes yet.

Anorexia nervosa

There is some evidence for the effectiveness of psychotherapy with anorexia nervosa in adulthood, but far less than is available for bulimia because of difficulties in researching this population (Fairburn, 2005; le Grange & Lock, 2005). Effective psychotherapy involves addressing developmental and interpersonal difficulties associated with self-starvation on the one hand, and helping clients develop and maintain regular and appropriate eating patterns on the other. For adults with anorexia, individual therapy is more effective than family therapy. Although with adolescents family therapy is the treatment of choice, as outlined in the next chapter. There is evidence for the effectiveness of individual therapy with adult anorexia conducted from psychoanalytic, cognitive-behavioural, and cognitive-analytic perspectives. Such psychotherapy is offered as part of a multimodal, multidisciplinary programme that involves weight restoration and management of medical complications of anorexia nervosa.

These evidence-based conclusions on psychotherapy for eating disorders are consistent with international guidelines for best practice (APA, 2000b; NICE, 2004d; RANZCP Clinical Practice Guidelines Team for Anorexia Nervosa, 2004).

INSOMNIA

Effective psychotherapy for insomnia involves psychoeducation, sleep restriction, stimulus control, relaxation training, and helping patients address unhelpful beliefs about the sleep-waking process (Edinger & Means, 2005; Espie, 2002; Manber & Harvery, 2005; Nowell et al., 2002; Pallesen et al., 1998; Smith et al., 2002). Psychotherapy for insomnia may have

more enduring effects than pharmacological therapy with benzodiazepines which are addictive. This type of psychotherapy is also effective for insomnia secondary to comorbid psychological disorders (e.g. depression) or medical conditions (e.g. chronic pain) (Smith et al., 2005).

ALCOHOL AND DRUG ABUSE

Evidence for the effectiveness of psychotherapy in the treatment of alcohol and drug abuse in adults comes from major narrative literature reviews such as Miller and Wilbourne's (2002) Mesa Grande review; Carroll & Oken's (2005) review, along with other review papers cited below. Two major multisite controlled trials of manualized brief interventions for alcohol abuse also deserve particular mention, because of their scale, the rigour with which they were conducted, and the support their findings provide for the effectiveness of psychotherapy for alcohol problems. The United Kingdom Alcohol Treatment Trial (UKATT) which involved 742 people showed that social behaviour and network therapy and motivational enhancement therapy led to significant reductions in alcohol consumption and alcohol-related problems (UKATT Research Team, 2005). Project MATCH which involved 1726 people in North America showed that motivational enhancement therapy, twelve-step facilitation, and cognitive-behavioural therapy were equally effective in ameliorating alcohol-related problems. Motivational enhancement therapy helps clients change their alcohol use behaviour by inducing cognitive dissonance and this is achieved by facilitating their evaluation of the pros and cons of continuing drinking (Miller et al., 1994). Social behavioural networking therapy helps clients address their alcohol problems by building a supportive social network and developing coping skills (Copello et al. 2002). It combines elements of community reinforcement (Sisson & Azrin, 1986) and relapse prevention (Marlatt & Gordon, 1985) approaches to addictions, both of which rest on strong evidence bases. In the MATCH project, the cognitive behaviour therapy programme for alcohol problems involved both of these elements also, with a strong emphasis on helping clients develop skills for coping with situations that put them at risk of relapse (Kadden et al., 1994). Twelve step facilitation, which was evaluated in the MATCH project, is a structured intervention to enhance engagement with alcoholics anonymously (Nowinski et al. 1994).

In light of these findings and other evidence cited below, a number of broad conclusions may be drawn on the effective use of psychotherapy in the treatment of

alcohol and substance use problems in adults. Effective psychotherapy for alcohol and drug abuse involves strategies for engaging clients in treatment (with a view to detoxification where appropriate), strategies for interrupting habitual patterns of abuse, and strategies for sustaining short-term treatment gains over the long-term (Amato et al., 2004a; Berglund, 2005; Corry et al., 2004; Finnelly & Moos, 2002; Griffith et al., 2000; Miller et al., 2003; O'Farrell & Fals-Stewart, 2003; Prendergast et al., 2002). Enlisting the co-operation of family members to help clients engage in treatment and the use of motivational interviewing with clients to help them evaluate the pros and cons of addressing their substance abuse problems are effective in engaging clients in therapy (Burke et al., 2003; Heetema et al., 2005; O'Farrell & Fals-Stewart, 2003; Stanton, 2004). For clients who have become physiologically dependent on drugs or alcohol, detoxification may be necessary. Effective psychopharmacological protocols for detoxification have been developed for a range of substances such as the use of benzodiazepines for withdrawal from alcohol and methadone for withdrawal from heroin (Amato et al., 2004; Mariani & Levin, 2004). Following detoxification (if it has been necessary) clients may be helped to develop skills for coping with situations where they are at risk of alcohol or substance abuse, including cocaine abuse, through cognitive behavioural skills training. This includes skills training for controlled drinking and cue exposure which focuses on learning skills to cope with situations that trigger drug abuse. Clients may be motivated to use these skills through making contingency contracts with their therapists and families and through their families participating in community based reinforcement of their attempts to avoid drug abuse. Effective treatment also focuses on strengthening social support. This may be achieved through couple or family therapy or involvement in 12 step programmes such as Alcoholics Anonymous or Narcotics Anonymous. (Miller et al., 2003; O'Farrell & Fals-Stewart, 2003). Relapse prevention training, and long-term infrequent individual, group or family review meetings or involvement in 12 step programmes are effective strategies for helping clients maintain treatment gains (Irvin et al., 1999; Miller et al., 2003). These are often combined in effective programmes with medication that either replaces the addictive drug (e.g., methadone or buprenorphine for heroin addiction) or makes the addictive drug less reinforcing (e.g. naltrexone) (O'Brien & McKay, 2002). There is some evidence that programmes that combine psychotherapeutic and pharmacological components are particularly effective for some substance use problems. For example, the combination of

psychotherapy and methadone maintenance has been shown to be more cost-effective than methadone maintenance alone in the treatment of heroin addiction (Kraft et al. 1997).

SCHIZOPHRENIA

Effective psychotherapy for adult schizophrenia is offered as one element of a multimodal programme in which clients are first helped to bring their psychotic symptoms under control through the use of antipsychotic medication (especially newer atypical antipsychotic medications such as olanzapine or risperidone which have fewer side effects compared with older antipsychotic drugs) (Bradford et al., 2002). Effective psychotherapy involves both family therapy and individual therapy (Gaudiano, 2005; Kopelowicz et al., 2002; Kuipers, 2006; McFarlane et al., 2003; Nose et al., 2003; Pilling et al. 2002a; Tarrier, 2005; Zygmunt et al., 2002). Family therapy includes psychoeducation, problem-solving and communication skills training to equip families with the skills to offer clients with schizophrenia a supportive, low-stress family environment in which to live. This type of therapy must be of at least six months duration to be effective and may be offered to either single families in a regular family therapy format or to small groups of families in a multiple family therapy format. This type of family therapy lengthens the interval between psychotic episodes, delays relapse, and allows clients to be maintained on lower doses of antipsychotic medication. Effective individual psychotherapy involves helping clients adhere to their antipsychotic medication regime and develop strategies for reducing the negative impact of delusions and hallucinations, not controlled by medication, on their quality of life. Although well researched, social skills training and cognitive rehabilitation have not been found to consistently improve social and cognitive functioning and reduce relapse rates in schizophrenia and so these interventions are not usefully included in the routine psychosocial care of clients with psychosis (Pilling et al., 2002b). The evidence-based practices outlined here are consistent with international best practice guidelines for the multimodal and multidisciplinary treatment of schizophrenia (APA, 2004b; NICE, 2003).

PERSONALITY DISORDERS AND RELATED PROBLEMS

Intensive psychotherapy programmes have been shown to be effective for personality disorders generally and for entrenched long-standing pervasive difficulties such as making and maintaining relationships, identity issues, and low self-esteem associated with many personality disorders; issues arising from childhood sexual, physical and emotional abuse;

self-harming associated with borderline personality disorder; aggression and anger management; and sexual offending (Bateman & Fonagy, 2000; Crits-Christoph & Barber, 2002; Leichsenring & Leibing, 2003; Perry et al., 1999). Such programmes have been developed within the psychoanalytic and cognitive behavioural traditions. Effective psychotherapy programmes for personality disorders hold certain features in common (Bateman & Fonagy, 2000). They are well structured. They include procedures for helping clients engage in treatment, maintain therapeutic contact and adhere to therapeutic regimes. They have a clear focus on key problems such as self-harm, aggression or problematic interpersonal relationships. They are theoretically coherent offering an explanation for problematic behaviours and interpersonal styles and for the role of psychotherapy in offering a solution to these problems. They foster a strong therapeutic alliance between therapists and clients, and usually the therapist is very active in maintaining the quality of this alliance, repairing alliance ruptures when they occur. Psychotherapy may include sequential or concurrent individual, group and family sessions, following a pre-established coherent pattern. Psychotherapy is conducted over a long period of time, usually extending beyond a year. Psychotherapists offering effective treatment programmes for personality disorders receive sustained intensive supervision, in which intense countertransference reactions elicited by psychotherapy with these clients is assessed. Effective psychotherapy programmes are well integrated into broader patient care programmes that involve clear policies and practices for inpatient care, use of medication, and crisis management where self-harming, aggression or other crises occur. Effective psychotherapy for clients with borderline personality disorder may be conducted on an outpatient basis, but inpatient care may be necessary where there is high risk of suicide, aggression, or chronic drug abuse. Psychopharmacological interventions for symptom management may be integrated into multimodal, multidisciplinary programmes (Koenigsberg et al., 2002). Antidepressants may be helpful for mood regulation and antipsychotic medication may be helpful in managing temporary psychotic features.

Borderline personality disorder

For borderline personality there is strongest evidence for the effectiveness of dialectical behaviour therapy which reduces self-harming and hospitalization (Robins & Chapman, 2004). This particular approach is manualized. It involves individual and group therapy, along with regular telephone consultations. Clients are helped to understand factors that

contribute to problematic entrenched behaviour patterns including self-harming and poor conflict management. They also develop more adaptive ways of dealing with interpersonal conflict and stress through using mindfulness, interpersonal effectiveness, distress tolerance and emotional regulation skills to help them cope, problem-solve and communicate more effectively.

Avoidant personality disorder

Effective psychotherapy for avoidant personality disorder involves social skills training and gradual exposure to anxiety provoking social situations until habituation occurs (Crits-Christoph & Barber, 2002). Antidepressants may also be effective with avoidant personality disorder (Koenigsberg et al., 2002).

Aggression

Effective psychotherapy for aggression and anger management involves psychoeducation and training in avoiding or pre-empting situations that trigger anger responses and training in relaxation and coping skills training for regulating angry responses in such situations (Beck & Fernandez, 1998; Del Vecchio & O'Leary, 2004; DiGiuseppe & Tafrate, 2003; Glancy & Saini, 2005). Effective psychotherapy is typically offered in a group context.

Sexual offending

Effective programmes for sexual offenders help clients accept responsibility for sexual offending and understand personal and situational factors that increase the risk of offending; modify justificatory cognitive distortions and develop victim empathy; develop social skills for forming intimate relationships; develop skills for coping with negative mood states; and formulate and rehearse a relapse prevention plan (Losel & Schmucker, 2005; Maletzky, 2002). Most effective psychotherapy programmes for sexual offending are structured and involve intensive group therapy over a period of about a year. In some instances they include adjunctive individual sessions and sessions with significant members of the offenders social network which are important for relapse prevention. Some effective programmes include conditioning procedures which specifically aim to reduce sexual arousal to deviant sexual stimuli and increase sexual arousal to non-deviant sexual stimuli. Hormonal treatments which reduce circulating testosterone levels (such as depo-Provera) may be included in multimodal treatment programmes for sex-offenders.

Hormonal treatments reduce sexual drive and sexual activity, but this effect is sustained only as long as clients receive the hormonal treatment (Maletzky, 2002).

RELATIONSHIP PROBLEMS

In addition to relationship problems associated with personality disorders such as making and maintaining relationships, identity issues, and low self-esteem (mentioned in a previous section), psychotherapy has been shown to be an effective intervention for marital distress, psychosexual problems and domestic violence.

Relationship distress

Effective couples therapy protocols for addressing relationship distress includes behavioural and cognitive approaches to couple therapy, emotionally focused couples therapy, insight oriented couple therapy, and self-control therapy (Byrne et al., 2004b; Gollan & Jacobson, 2002; Halford, 1998; Johnson, 2003; Shadish & Baldwin, 2003, 2005; Snyder et al., 2006). Behavioural couple therapy involves communication and problem solving skills training and the use of behavioural exchange procedures to facilitate greater fairness within relationships. Cognitive therapy helps couples challenge destructive beliefs and expectations which contribute to relationship distress and replace these with more benign alternatives. Integrative behavioural couples therapy, a recent refined version of behavioural couple therapy, includes a strong emphasis on building tolerance for partners' negative behaviours, acceptance of irresolvable differences and empathic joining around such problems. With insight oriented couple therapy and emotionally focused couple therapy, the aim of therapy is to help couples express feelings of vulnerability and unmet needs and to help clients understand how these feelings and needs underpin destructive transactions. Self-control therapy empowers partner to alter their personal contribution to destructive interaction patterns which underpin relationship distress.

Psychosexual problems

Psychotherapy can effectively address a range of psychosexual problems (Heiman, 2002; Segraves & Althof, 2002). For psychosexual problems associated with the occurrence and timing of orgasm, effective psychotherapy for both men and women involves

behavioural skills training aimed at helping clients develop control over the circumstances and timing of the orgasm and gradual exposure to anxiety provoking sexual situations until habituation occurs. For low sexual desire, couples therapy focusing on the reduction of relationship distress and enhancement of intimacy as described above is the current treatment of choice. For acquired male erectile dysfunction, Sildenafil (Viagra) is currently the most rapid and effective treatment (Burlis et al., 2001).

Domestic violence

Effective psychotherapy for domestic violence involves selection of cases that agree to a no-harm contract and intensive group-based multiple couple therapy aimed at helping couples identify and alter destructive relationship patterns. Stith et al. (2004) found that a multi-couple treatment programme was more effective than a single couple programme in reducing domestic violence and related marital distress. Male violence recidivism rates were 25% for the multi-couple group, 43% for the individual couple group. Key elements of treatment include the perpetrator taking responsibility for the violence; solution focused practices; challenging beliefs and cognitive distortions which justify violence; anger management training; communication and problem-solving skills training; and relapse prevention. Anger management training focuses on teaching couples to recognize anger cues; to take time out when such cues are recognized; to use relaxation and self-instructional methods to reduce anger related arousal; to resume interactions in a non-violent way; and to use communication and problem solving skills more effectively for conflict resolution. Ineffective treatments for domestic violence include group-based therapy for perpetrators which includes psychoeducation and cognitive behavioural skills training (Babcock et al., 2004).

PROBLEMS OF OLDER ADULTHOOD

Psychosocial interventions either alone or as part of multimodal intervention programmes have been shown to make a valuable contribution in the adjustment of older adults and their families in cases of dementia, depression, anxiety and insomnia (Woods & Roth, 2005).

Dementia

Reality orientation offered on a sessional and 24 hour basis is the main psychosocial intervention that has been shown to improve functioning in older adults with dementia (Spector et al., 2000). With reality orientation clients are repeatedly presented with orientation information about time, place and person to help them maintain an accurate understanding of their moment-to-moment situation. Cognitive stimulation therapy is a recently developed refinement of reality orientation. With this approach clients are helped through regular structured multisensory group exercises and through reminiscence exercises, matched to their level of cognitive functioning, to develop strategies for managing memory deficits. A recent randomized controlled trial showed that cognitive stimulation therapy was effective in the short and long-term in improving memory functioning in clients with dementia (Orrell et al., 2005; Spector et al., 2003). Cognitive stimulation therapy and reality orientation may be offered as elements of multimodal programmes which include multidisciplinary assessment of the older adult and family support network; home assessment and alterations; respite care of the older adult; carer support; and pharmacological treatment of dementia involving, for example, cholinesterase inhibitors such as tacrine with Alzheimer's disease (Tune, 2002; Woods & Roth, 2005). Evidence for the effectiveness of cognitive rehabilitation or reminiscence therapy for clients with dementia is inconclusive (Clare et al., 2003; Woods et al., 2005)

In older adults with challenging behaviour associated with dementia, psychosocial interventions are sometimes necessary because pharmacological interventions are not always effective in this area (Kindermann et al., 2002). Effective psychosocial interventions for challenging behaviour shown by older adults with dementia involve assessing the context and function of the challenging behaviour and then using one or more of the following components to modify it: avoiding situations that precipitate it; reinforcing alternative responses to challenging behaviour; providing pleasant sensory intervention (e.g., music, viewing visual multimedia stimuli or massage); arranging pleasant motor activities (e.g. walking, dancing); and facilitating pleasant social interaction with family friends or staff (Cohen-Mansfield, 2001).

Care-giver support

Certain psychosocial interventions are effective in reducing the burden on family members caring for relatives with dementia (Brodaty et al., 2003; Pusey & Richards, 2001; Schultz & Martire, 2004; Sorensen et al. 2002; Yin et al., 2002). Effective interventions for carers of

older adults with dementia include psychoeducation; provision of support; and provision or psychotherapy for depression following the guidelines outlined above for depression in adults. Effective psychosocial interventions for carers of older adults with dementia are most effectively offered as part of a multimodal package that includes clinical assessment and treatment of the older adult; home assessment and alterations; respite care of the older adult; and antidepressant medication for the carer if required.

Depression

In older adults, for major depression and dysthymia cognitive behaviour therapy, reminiscence therapy, psychoanalytic psychotherapy, and interpersonal therapy are effective treatments (Bohlmeijer et al., 2003; Karel & Hinrichsen, 2000; Scogin et al., 2005). These various forms of therapy help clients understand factors that have contributed to the development and maintenance of their depression; develop healthier, active daily routines; stop depressive thinking styles from dominating their mood; recollect pleasant and meaningful aspects of their lives and put their overall life story in a positive perspective; and develop supportive relationships with family members and others. These types of psychotherapy are as effective as antidepressants in older adults.

In older adults who have both dementia and depression carers are centrally involved in effective psychotherapy (Teri et al., 2005). With these clients, effective psychotherapy involves coaching carers in problem-solving skills and helping them use these to enhance the quality of care they offer to the depressed older adult by, for example, improving communication and scheduling regular pleasant events. Effective psychotherapy also involves scheduling regular daily opportunities for pleasant social interaction and pleasant sensory experiences and motor activities.

In older adults who present with depression either alone or with dementia, psychotherapy is optimally offered as one element of a multimodal programme that includes antidepressant medication.

Anxiety disorders in older adults

Effective psychotherapy for anxiety disorders in older adults involves clients learning to reduce physiological arousal by practicing relaxation exercises, developing cognitive skills to control the worrying process and then using these strategies to manage anxiety when

exposed to anxiety provoking situations until habituation occurs (Mohnman, 2004; Nordhus & Pallesen, 2003; Stanley & Beck, 2000).

Insomnia in older adults

Effective psychotherapy for insomnia in older adults involves psychoeducation, sleep restriction, stimulus control, relaxation training and helping patients address unhelpful beliefs about the sleep-waking process (Nau et al., 2005; Pallesen et al., 1998).

Psychotherapy for insomnia may have more enduring effects than pharmacological therapy with benzodiazepines which are addictive. This type of psychotherapy is also effective for insomnia secondary to comorbid psychological disorders (e.g. depression) or medical conditions (e.g. chronic pain). Psychotherapy for insomnia is as effective in the short term as the use of hypnotics and sedatives. It may be more effective in the long term. It does not carry the risk of dependence or rebound insomnia. The type of psychotherapy described here is also effective for insomnia secondary to hypnotic dependency (common in older adults) if combined with a tapered reduction in hypnotic use.

CO-MORBID PROBLEMS

Frequently family relationship problems involving siblings, partners and children; work-related stress; alcohol and drug abuse; personality disorders; and the adult sequelae of child sexual abuse occur as co-morbid problems along with a central presenting problem such as depression or anxiety. These comorbid problems make clients less responsive to treatment for their main disorder and so must be addressed if treatment of the main disorder is to be effective. For example, in a meta-analysis, depressed clients with personality disorders were found to have double the risk of a poor outcome compared with those who did not have co-morbid personality disorders (Newton-Howes et al, 2006). To help clients address family relationship difficulties secondary to any disorder, couple and family therapy are probably the most effective psychotherapeutic options (Snyder et al., 2006). For work-related stress, psychotherapy targeting work problems has been shown to be effective (Lehmer & Bentley, 1997). To help clients address drug or alcohol abuse problems secondary to any disorder, treatment specifically targeting drug and alcohol abuse, following the evidence-based guidelines above, may be required. For co-morbid borderline personality disorder, dialectical behaviour therapy or psychoanalytic

psychotherapy is appropriate. In adult survivors of child sexual abuse, evidence based guidelines outlined above for the management of PTSD may be followed.

CONCLUSION

Extensive computer and manual literature searches yielded a wealth of empirical evidence supporting the benefits of psychotherapy for a wide range of problems in adults and older adults. Specific practices and protocols detailed in this chapter may usefully be incorporated into routine psychotherapeutic practice with clients who present with the problems listed in this chapter.

Figure 4.1. Literature search method

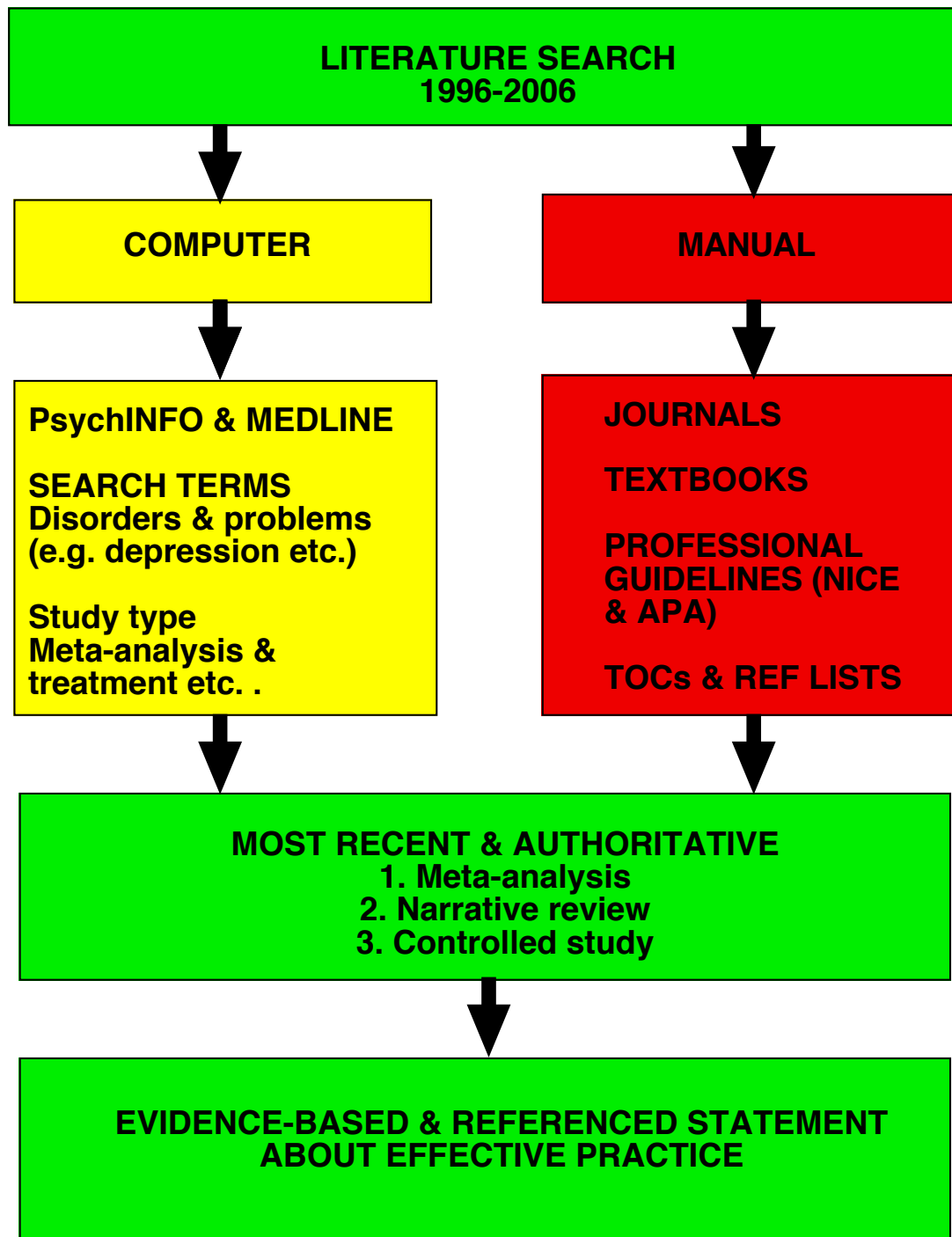


Figure 4.2. Problems in adulthood for which psychotherapy is effective

Mood disorders

Depression & bipolar disorder

Anxiety disorders

Generalized anxiety disorder, panic disorder, phobias, social phobias, OCD, PTSD

Adjustment to illness

Preparation for surgery, life threatening illness, chronic medical conditions

Coping with pain and fatigue

Chronic pain, fibromyalgia, headaches, arthritis, irritable bowel syndrome, chronic fatigue syndrome

Psychosomatic disorders

Somatoform disorder, hypochondriasis, body dysmorphic disorder)

Eating disorders

Bulimia, anorexia

Insomnia

Alcohol and drug abuse

Schizophrenia

Personality disorders & related problems

Borderline PD, Avoidant PD, aggression, sexual offending

Relationship problems

Marital distress, psychosexual problems, domestic violence

Psychological problems of older adulthood

Dementia, caregiver support, depression, anxiety, insomnia

Co-morbid problems

Family relationship problems involving siblings, partners and children; work-related stress; alcohol and drug abuse;

personality disorders; and the adult sequelae of child sexual abuse

CHAPTER 5

EFFECTIVENESS OF PSYCHOTHERAPY WITH PARTICULAR PROBLEMS OF CHILDREN, ADOLESCENTS AND PEOPLE WITH DEVELOPMENTAL DISABILITIES

For children and adolescents with psychological problems, there are evidence bases for the effectiveness of psychoanalytic therapy, family therapy and cognitive behaviour therapy. In this chapter, some preliminary comments on these will first be made. This will be followed by a consideration of specific evidenced-based psychotherapy protocols and practices for particular problems in childhood and adolescence.

Psychoanalytic therapy with children and adolescents

The aim of psychoanalytic psychotherapy with children is to understand and influence the client's internal world. The child's play and behaviour provide a window for the therapist into this inner world. One of the primary therapeutic tasks is attunement to the child in order to be receptive to the fine details of the child's emotional experience (Hunter, 2001). The transference relationship and the interpretation and containment of thoughts and feelings are used to enable integration and therapeutic change (Lanyado & Horne, 1999). However, external factors are also important and so are addressed within this therapeutic tradition. That is, while psychoanalytic psychotherapists focus on unconscious processes, analysing conflicts, removing repressions or reconstructing the past, they also enable processes and structures to develop to allow for the possibility of thought reflection and sustained emotional experience in the first place (Urwin, 2000). This approach differs from methods that focus exclusively on symptom relief (Barrows, 2001). Within the psychodynamic tradition, the psychotherapist's involvement with a young person may range from meeting for a few sessions as part of an assessment, which is considered a therapeutic intervention, to work over a longer time period. The involvement of parents and carers in both assessment and treatment phases is essential to the success of any intervention (Rustin, 1999). Psychotherapists within this tradition also conduct group work and interagency consultation. Rigorous training, personal analysis, and regular supervision are essential to the practice of psychoanalytic psychotherapy, and these ensure high standards of practice (Hunter, 2001, Lanyado & Horne, 1999).

The evidence-base for the effectiveness of psychoanalytic psychotherapy with children and adolescents has been extensively reviewed by Kennedy (2004). In a wide-

ranging computer and manual literature search 37 reports on 32 different studies were identified. These included 5 randomized controlled trials; 3 quasi-randomized controlled trials; 7 controlled outcome studies; 10 uncontrolled outcome studies; and a number of ongoing evaluation studies of various sorts. With two exceptions, all of the studies involved clinically referred samples, rather than samples recruited specifically for research purposes. Thus, results of the studies allow conclusions to be drawn about the effects of psychotherapy for routinely referred clinical cases. Collectively the results of this set of studies provided support for the overall effectiveness of child and adolescent psychoanalytic psychotherapy for a range of problems including depression, emotional disorders, disruptive behaviour disorders, anorexia, poorly controlled diabetes, and problems arising from child abuse. Psychoanalytic psychotherapy may lead to improvement in behaviour problems, symptoms associated with psychological disorders, peer and family relationships, and educational adjustment.

Kennedy's (2004) review provides evidence that a number of factors influence the effectiveness of psychoanalytic psychotherapy. For young people, psychoanalytic psychotherapy is more effective with emotional disorders than conduct disorders; with children who have less (rather than more) severe problems; and with younger children (rather than with older children or adolescents). More intensive therapy is more effective than less intensive therapy, particularly for youngsters with severe problems. Concurrent intervention with parents enhances the effectiveness of individual psychodynamic psychotherapy, particularly with younger children. Failure to offer concurrent intervention with parents may lead to a deterioration in family functioning compared with family therapy (Szapocznik et al., 1989).

Family therapy for child-focused problems

The aim of family therapy with child-focused problems is to harness family strengths to resolve children's problems. This involves understanding how current family behaviour patterns; family belief systems and narratives; and historical and contextual factors within the family have influenced problem formation and may potentially contribute to problem resolution (Carr, 2006). Conjoint meetings with parents and children are a central feature of family therapy, although separate sessions with children and parents may occur. The primacy of interpersonal and contextual factors, rather than intrapsychic factors in problem formation and resolution is a defining characteristic of this approach. A wide variety of

techniques are used to facilitate changing problematic family behaviour patterns, evolving more productive family narratives and belief systems, and addressing wider historical and contextual issues.

The evidence-base for the effectiveness of family therapy with children and adolescents has been extensively reviewed (Carr, 2006, chapter 18; Sprenkle, 2002). A large number of comparative outcome studies, and many narrative and met-analytic reviews support the effectiveness of family therapy for child-focused problems. Collectively the results of these studies provide support for the overall effectiveness of family therapy for child and adolescent disruptive behaviour disorders; substance abuse; anxiety and depressive disorders; anorexia; paediatric pain problems; adjustment to chronic physical illnesses; and adjustment problems following life transitions such as parental separation, bereavement and child abuse. There is a particularly strong and well-developed evidence-base for the effectiveness of family therapy with disruptive behaviour disorders, substance abuse and anorexia.

Cognitive-behaviour therapy with children and adolescents

The aim of cognitive behaviour therapy with children and adolescents is to help young people modify problematic behaviour patterns and related cognitive factors that constitute or underpin their presenting problems. Child-centred skills training in the areas of self-regulation, social problem-solving and communication; along with parent training in behavioural child management skills are key features of cognitive behaviour therapy for young people (Kendall, 2006).

The evidence-base for the effectiveness of cognitive behaviour therapy with children and adolescents has been extensively reviewed (Kazdin & Weisz, 2003; Spirito & Kazak, 2006). Numerous comparative outcome studies, and many narrative and met-analytic reviews support the effectiveness of cognitive-behaviour therapy for child-focused problems. Collectively the results of these studies provided support for the effectiveness of cognitive behaviour therapy for sleep problems; toileting problems; disruptive behaviour disorders; substance abuse; anxiety and depressive disorders; obesity; paediatric pain problems; adjustment to chronic physical illnesses; and adjustment of problems associated

with developmental disabilities including intellectual disability and autistic spectrum disorders.

PSYCHOTHERAPY WITH SPECIFIC PROBLEMS IN CHILDREN AND ADOLESCENTS

In the remainder chapter, evidenced-based conclusions are presented about the effectiveness of specific psychotherapy protocols and practices with specific psychological problems in childhood and adolescence. Traditional psychiatric categories (such as mood disorders, anxiety disorders, eating disorders etc.) have been used to organize evidence reviewed in this chapter. As was noted in the opening of chapter 4, these categories may be ideologically unacceptable to service users and psychotherapists, many of whom view psychiatric diagnoses as being on a continuum with normal development and functioning, or as a reflection of systemic rather than individual shortcomings. However, the organization, administration and funding of clinical services and research programmes are framed predominantly in terms of such categories, and so these have been used to organize the material in this chapter. To draw the conclusions set out below extensive computer and manual literature searches for relevant evidence were conducted using the same methodology as described in chapter 4 and summarized in Figure 4.1. The overarching conclusion that may be drawn from the evidence reviewed in this chapter is that psychotherapy alone or as one element of a multimodal programme is effective for the list of problems given in Figure 5.1. These include the following specific problems of childhood and adolescence:

- Sleep problems
- Toileting problems (enuresis and encopresis)
- Attention deficit hyperactivity disorder
- Pre-adolescent oppositional defiant disorder
- Adolescent conduct disorder
- Adolescent drug abuse
- Child and adolescent depression
- Child and adolescent anxiety disorders (phobias, selective mutism, separation anxiety and generalized anxiety; obsessive compulsive disorder; post-traumatic stress disorder)
- Eating disorders (feeding problems, anorexia, bulimia, obesity)

- Paediatric pain problems (headaches, recurrent abdominal pain, medical procedures)
- Adjustment to chronic medical conditions (asthma, diabetes)
- Adjustment problems following major life transitions and stresses (parental separation, bereavement, physical, sexual and emotional child abuse and neglect)
- Adjustment problems associated with developmental disabilities (intellectual disability and autistic spectrum disorder)

Effective psychotherapy approaches for disorders in this list have been developed within the cognitive-behaviour therapy family systems therapy and psychoanalytic therapy traditions (Carr, 2000; Kennedy, 2004). Within all of these traditions a central feature of effective intervention is offering psychotherapy in a manner that is sensitive to the developmental level of the child, taking account of the competencies and constraints associated with the child's stage of development.

SLEEP PROBLEMS

Effective treatment for settling and night waking problems in young children involves parental psychoeducation and support in behavioural management of sleep problems. In behavioural management programmes, parents are coached in reducing or eliminating children's day time naps, developing positive bedtime routines, gradually reducing parent-child contact at bedtime or during episodes of night waking; and introducing scheduled waking where children are awoken 15-60 minutes before the child's spontaneous waking time and then resettled (Mindell, 1999).

TOILETING PROBLEMS

For enuresis (wetting) and encopresis (soiling) in children highly structured forms of psychotherapy outlined below are effective interventions.

Enuresis

Effective psychotherapy for enuresis in children involves coaching the child and family to use an enuresis alarm, which alerts the child as soon as micturition begins (Evans, 2001; Houts, 2003; Mellon & McGrath, 2000; Mikkelsen, 2001; Murphy & Carr, 2000a). The effectiveness of enuresis alarm programmes can be improved by offering family psychoeducation; a reward programme often involving a star chart or token system, where

the child receives reinforcement for 'dry nights' or 'dry days'; rehearsal of toileting; retention control training; and overlearning.

Encopresis

Effective psychotherapy for encopresis is offered as part of a multimodal programme (McGrath et al. 2000; Mikkelsen, 2001; Murphy & Carr, 2000a). A balanced diet containing an appropriate level of roughage and regular laxative use are arranged. Effective psychotherapy involves psychoeducation about encopresis coupled with a reward programme to reinforce an appropriate daily toileting routine. Neither behavioural treatment alone nor dietary intervention and laxative alone are as effective as both together and the use biofeedback does not contribute to the effectiveness of this approach (Brazzelli & Griffiths, 2001). Ritterband et al. (2003) has recently shown that psychoeducation and coaching in behavioural management of encopresis provided on the internet enhances the effectiveness of routine treatment in primary care settings.

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

Effective psychotherapy for ADHD is offered as one element of a multimodal programme involving psychostimulant medication and psychosocial intervention, and within such programmes, psychostimulant medication makes the most significant contribution to helping children regulate their activity levels and attention (Anastopoulos et al., 2005; Friemoth, 2005; Greenhill & Ford, 2002; Hinshaw et al., 2002; Hinshaw, 2005; Jadad et al., 1999; Klassen et al., 1999; MTA Cooperative Group, 1999; Nolan & Carr, 2000; Purdie et al., 2002; Schachar et al., 2002). Methylphenidate is the most widely used stimulant (Conners, 2002). Effective psychosocial intervention has three principal elements: parent management training; school-based behavioural management; and child-focused therapy. Parent management training focuses on promoting rule-following at home while school-based intervention focuses on the management of school-based learning difficulties and conduct problems. Child-focused therapy aims to help children develop self-regulation skills. These conclusions are consistent with international practice guidelines (American Academy of Child and Adolescent Psychiatry, 1997a; American Academy of Paediatrics, 2001; Kutcher et al. 2004). A promising innovation in the treatment of ADHD is the use of computer based programmes to train children to enhance the functioning of working memory, which in turn has a positive impact on inattention, impulsivity and hyperactivity.

One controlled study has provided support for the effectiveness of this treatment approach (Klingberg et al., 2005).

OPPOSITIONAL DEFIANT DISORDER

Effective psychotherapy for preadolescent conduct problems includes parent management training alone or combined with child-based social problem-solving skills training in the case of primary school aged children (Behan & Carr, 2000; Burke et al., 2002; Kazdin, 2002; Nixon, 2002) or psychoanalytic psychotherapy in the case of youngsters with comorbid emotional disorders (Fonagy & Target, 1996). Parent management training includes psychoeducation, helping parents develop skills for monitoring antisocial and prosocial behavioural targets, and using behavioural skills to increase prosocial behaviour and reduce antisocial behaviour. Video-modelling and video feedback have both been used in effective parent management training programmes. With effective video-modelling based approaches to parent management training, parents learn child management skills through viewing video clips of actors illustrating successful and unsuccessful parenting skills. In Ireland there is now evidence for the effectiveness of John Sharry and Carol Fitzpatrick's *Parents Plus* video-modelling approach to parent training (Behan et al, 2000). This programme builds on the success of the *Incredible Years* video-modelling based programme developed in North America (Webster-Stratton & Reid, 2003). With effective video-feedback approaches to parent management training, parents learn child management skills by watching videotaped episodes of themselves using parenting skills with their own children (Brinkmeyer & Eyberg, 2003). Child-focused problem-solving skills training involves coaching children alone or in a group context to address conflict and complex interpersonal situations by breaking big unmanageable problems into smaller manageable problems; brainstorming solutions; evaluating the pros and cons of these; selecting the best option; implementing this; evaluating progress; modifying the solution if it is ineffective; and celebrating success (Kazdin, 2003).

In a retrospective study of 135 children with emotional disorders and 135 children with disruptive behaviour disorders, Fonagy and Target (1996) found that psychoanalytic psychotherapy was less effective with disruptive behaviour disorders than with emotional disorders, but that there were certain factors that enhanced its effectiveness with disruptive behaviour disorders. They found that with disruptive behaviour disorders, psychoanalytic psychotherapy was more effective if children were younger, had

oppositional defiant disorder rather than conduct disorder, had comorbid anxiety, had comorbid school-related problems, and engaged in more intensive treatment. The outcome of those with disruptive behaviour disorders who received intensive treatment over 3 years, were indistinguishable from youngsters with emotional disorders treated with psychoanalytic psychotherapy. However, a central problem in treating youngsters with disruptive behaviour disorders was the difficulty maintaining them in treatment and their high drop-out rate.

CONDUCT DISORDER

Effective psychosocial interventions for adolescent conduct disorder are family-based and vary in intensity from weekly family therapy to intensive treatment foster care (Kazdin, 2002; Nock, 2003; Woolfenden et al., 2002). It is therefore useful to conceptualize effective psychotherapy for conduct disorder in adolescence on a continuum of care which extends from functional family therapy, to more intensive multisystemic therapy, to very intensive treatment foster care (Brosnan & Carr, 2000). For less severe conduct problems, functional family therapy is effective (Sexton & Alexander, 2003). This combines parent management training with family-based communication and problem solving training. For adolescents with more severe conduct problems multisystemic therapy is appropriate (Borduin et al., 2004; Henggeler & Lee, 2003). This combines in a systematic way family therapy with individual skills training for the adolescent, and intervention in the wider school and interagency network. For adolescents who cannot be treated within their own families, effective psychotherapy is offered as part of a multimodal programme called treatment foster care that combines multisystemic therapy with specialist foster placement, in which foster parents use behavioural principles to help adolescents modify their conduct problems (Chamberlain & Smith, 2003, 2005). Where adolescents with conduct disorder have particular difficulties with aggression, a cognitive behavioural approach to anger management training is effective (Sukhodolsky et al., 2004). Adventure or wilderness therapy in which groups of delinquents are engaged in challenging adventure activities increase self-esteem but has little effect on antisocial behaviour (Bedard et al., 2003; Neill, 2003).

ADOLESCENT DRUG ABUSE

Effective psychotherapy for adolescent drug abuse is multidimensional and involves family therapy, as well as direct work with youngsters and other involved professionals (Cormack & Carr, 2000; Liddle, 2004; Liddle et al., 2005; Muck et al., 2001; Rowe & Liddle, 2003; Szapocznik & Williams, 2000; Tevyaw & Monti, 2004; Waldron & Kaminer, 2004; Williams & Chang, 2000). It involves distinct phases of engaging youngsters and their families in treatment, helping families organize for youngsters to become drug-free, helping families create a context for the youngster to maintain a drug free lifestyle, helping youngsters acquire skills to remain drug free, family re-organization, relapse prevention training for youngsters and their families and disengagement.

CHILD AND ADOLESCENT DEPRESSION

Effective psychotherapy for child and adolescent depression involves both individual and family components and includes cognitive-behavioural, interpersonal, psychoanalytic and family therapy approaches (Compton et al., 2004; Cottrell, 2003; Harrington et al., 1998; Lewinsohn & Clarke, 1999; Michael & Crowley, 2002; Reinecke et al., 1998; Rosenbaum-Asarnow et al., 2001; Sherrill & Kovacs, 2004). The family based component of effective psychotherapy for child and adolescent depression includes family psychoeducation, facilitating family support of the depressed youngster and home-school liaison to help the youngster re-establish normal school routines. The individual psychotherapy component involves facilitating self-monitoring, increased physical exercise and social activity, modification of depressive thinking styles, development and use of social problem-solving skills, and relapse prevention skills. The provision of insight into unconscious processes that may maintain depression, offering a containing environment to work through emotional processes are also significant features of effective psychotherapy for child and adolescent depression. Two trials provide evidence for the effectiveness of psychodynamic psychotherapy with children and adolescents with depression (Trowell et al. 2007; Muratori et al., 2003). In a randomized controlled study of 72 youngsters aged 9-15 assigned to psychodynamic or family therapy, Trowell et al. (2007) found that 100% of those who received psychodynamic therapy and 81% of those who received family therapy were fully recovered at 6 months follow-up. In a non-randomized controlled study of 58 children aged 6-10 years, most of whom had dysthymia, assigned to psychodynamic therapy or community-based treatment as usual, Muratori et al (2003) found that at two years follow-up, 66% of those who received psychodynamic psychotherapy were

recovered compared with 38% in the control group. In moderate or severe depression, psychotherapy may be offered as part of a multimodal intervention programme involving SSRI antidepressants and there is evidence from a multicentre trial that multimodal treatment is more effective than psychotherapy or medication alone (TADS team, 2004). However, due to the increased suicide risk associated with SSRIs, they are contraindicated now in adolescents (Healy, 2003). These conclusions are consistent with international best practice guidelines (American Academy of Child and Adolescent Psychiatry, 1998a; NICE, 2005c).

CHILD AND ADOLESCENT ANXIETY DISORDERS

In children and adolescents psychotherapy is an effective treatment, and the treatment of choice, for selective mutism, separation anxiety, simple phobias, social phobia, generalized anxiety disorder, obsessive compulsive disorder and post-traumatic stress disorder.

Phobias, selective mutism, separation anxiety and generalized anxiety disorder

For specific phobias (Davis & Ollendick 2004; Ollendick et al., 2004), social phobia (Beidel & Roberson-Nay, 2005), selective mutism (Freeman et al., 2004; Standart & Le Couteur, 2003), school refusal associated with separation anxiety (Elliott et al., 1999; Heyne & King, 2004; King & Bernstein, 2001; King et al., 2000) and generalized anxiety disorder, effective psychotherapy in children is family-based and involves psychoeducation, helping children and families monitor anxiety and avoidance behaviour, facilitating the development of relaxation, coping and social skills and the use of these skills during gradual exposure to feared stimuli and situations (Cartwright-Hatton et al., 2004; Compton et al., 2002, 2004; Dadds & Barrett, 2001; Kendall et al., 2005; Moore & Carr, 2001; Ollendick & King, 1998). Parents are helped to implement reward programmes to reinforce successful completion of exposure exercises and to avoid inadvertent reinforcement of avoidant behaviour (Barmish & Kendall, 2005; Barrett & Shortt, 2003). In cases of separation anxiety and selective-mutism, home-school liaison is also required (Elliott et al., 1999; Freeman et al., 2004; Heyne & King, 2004; King & Bernstein, 2001; King et al., 2000; Standart & Le Couteur, 2003). These conclusions are consistent with international best practice guidelines (American Academy of Child and Adolescent Psychiatry, 1997b).

Child and adolescent obsessive compulsive disorder (OCD)

Effective psychotherapy for OCD in children involves exposure and response prevention conducted in an individual, group or family therapy context, coupled with family therapy focusing on psychoeducation, externalizing the problem, monitoring symptoms, and helping parents and siblings support and reward the child for completing exposure and response prevention homework exercises (Abramowitz et al., 2005; Barrett et al., 2004; March et al., 2005; Rapoport & Inoff-Germain, 2000). Family therapy also helps parents and siblings avoid inadvertent reinforcement of children's compulsive rituals. With exposure and response prevention children are exposed to cues (such as dirt) that elicit anxiety provoking obsessions (such as ideas about contamination), while not engaging in compulsive rituals (such as hand washing), until habituation occurs. For obsessive compulsive disorder, psychotherapy is more effective than antidepressants (SSRIs) and a case may be made of multimodal treatment in which psychotherapy and antidepressants are combined in the treatment of OCD in children and adolescents, although controlled studies of combined treatments have not been conducted (Geller et al., 2003). Also, due to the growing evidence for increased suicide risk associated with SSRIs, they are contraindicated in adolescents (Healy, 2003). These conclusions are consistent with international best practice guidelines (American Academy of Child and Adolescent Psychiatry, 1997c; March et al., 1997; NICE, 2005a).

Child and adolescent post-traumatic stress disorder (PTSD)

Effective psychotherapy for PTSD in children involves exposure to trauma-related memories until habituation occurs and this may be conducted as part of a broader systemic intervention programme conducted on a family or group therapy basis, that maximizes family, school and peer group support (Carr, 2004; Enright & Carr, 2002; Saigh et al., 2004; Taylor Chemtob, 2004). Within such programmes families are offered psychoeducation, invited to monitor symptoms, and regularize the child's daily routines. To help clients cope with exposure to traumatic memories, psychotherapy may also include helping youngsters develop relaxation and coping skills. Where children have been sexually abused or assaulted, treatment may also involve training in self-protective skills (Cohen et al., 2004). These conclusions are consistent with international best practice guidelines (American Academy of Child and Adolescent Psychiatry, 1998b; NICE, 2005b).

CHILD AND ADOLESCENT EATING DISORDERS

Psychotherapy can be effective in addressing infant feeding problems, child and adolescent anorexia and bulimia nervosa, and obesity in children and adolescents.

Infant feeding problems

For children who are failing to thrive and who display severe feeding problems, effective psychotherapy focuses on facilitating productive feeding time routines between mothers and their infants (Kerwin, 1999). Mothers are coached in how to shape and reinforce appropriate feeding responses and ignore inappropriate responses.

Child and adolescent anorexia and bulimia nervosa

There is strong evidence for the effectiveness of family therapy and some evidence for the effectiveness of individual psychoanalytic psychotherapy in the treatment of anorexia in adolescents. Family therapy involves helping the parents work together to refeed the youngster or refeeding the youngster as an inpatient (Eisler, 2005; le Grange & Lock, 2005; Mitchell & Carr, 2000). This is followed by helping the family support the youngster in developing an autonomous healthy eating pattern and an age appropriate lifestyle. More than 75% of young people benefit from this form of therapy. Robin et al. (1999) found that both psychoanalytic psychotherapy with parallel parent intervention and family therapy led to significant improvement, but family therapy led to more rapid weight gain.

Controlled studies of the effectiveness of psychotherapy for bulimia in adolescents have not been conducted. However, older adolescents have been included in samples of young adults who have participated in bulimia treatment trials. For this reason, it may be assumed until better evidence becomes available that treatments shown to be effective with young adults with bulimia are appropriate for adolescents. Both cognitive behaviour therapy and interpersonal are effective treatments for bulimia nervosa in the short and longer term (Thompson-Brenner, et al., 2003; Wilson, 2005 Wilson & Fairburn, 2002). With cognitive behaviour therapy clients learn effective methods for symptom control by developing a regular and flexible pattern of eating that includes previously avoided foods; reducing concern with body shape and weight; and coping with high-risk situations for binge eating and purging to prevent relapse. With interpersonal therapy clients resolve

interpersonal difficulties associated with their eating disorder, specifically those associated with loss, lifecycle transitions, role disputes and social skills deficits.

These conclusions on psychotherapy for anorexia and bulimia nervosa in children and adolescents are consistent with international best practice guidelines (APA, 2000; NICE, 2004d; RANZCP Clinical Practice Guidelines Team for Anorexia Nervosa, 2004).

Child and adolescent obesity

Effective psychotherapy for obesity in children is family-based and involves helping parents and children to monitor dietary habits, physical exercise and weight and to make small permanent reductions in caloric intake and increases in activity level (Betty et al., 2004; Epstein, 2003; Jelalian & Saelens, 1999; Zimetkin et al., 2004;). Weight loss of a pound per month is a reasonable medium term goal and the long term goal should be to achieve a target weight below the 85th percentile. The short term goal of psychotherapy for obesity however, is healthy eating and increased activity. For children to achieve these goals, parents are coached in using prompting and reward programmes in the home setting to promote changes in diet and exercise. Cues and opportunities for eating outside set meal times within the home are reduced. Effective programmes are of long duration with frequent sessions. Early sessions focus on goal setting and contracting. Later sessions involve developing relapse prevention skills for managing high risk situations. Because obesity is a chronic problem, infrequent follow-up sessions are required to maintain treatment gains. Where appropriate, interventions to address peer teasing and poor body image may be incorporated into treatment. These conclusions are consistent with international guidelines for best practice (Barlow & Dietz, 1998).

PAEDIATRIC PAIN PROBLEMS

For children with persistent tension or migraine headaches; recurrent abdominal pain; or distress associated with painful medical procedures, psychotherapy is effective in reducing pain and distress (Murphy & Carr, 2000b).

Headaches in children

For both tension and migraine headaches relaxation training is the central component of effective psychotherapy (Connelly, 2003; Eccleston et al., 2002; Holden et al., 1999; Holroyd, 2002). For migraine, additional thermal biofeedback coupled with training in

cognitive coping strategies enhances the impact of relaxation training (Hermann & Blanchard, 2002).

Recurrent abdominal pain in children

Effective psychotherapy for recurrent abdominal pain is family-based and involves family psychoeducation, relaxation and coping skills training to help children manage pain, and contingency management implemented by parents to motivate children to engage in normal daily routines (Blanchard & Scharff, 2002; Eccleston et al., 2002; Janicke & Finney, 1999; Weydert et al., 2003).

Pain and anxiety associated with challenging medical procedures

Psychotherapy is effective in helping children manage pain and anxiety associated with challenging medical procedures such as injections, bone marrow aspirations or surgery (Kuppenheimer & Brown, 2002; Murphy & Carr, 2000; Powers, 1999). Effective psychotherapy involves both preparing children for these procedures and supporting them during the procedures. Preparatory psychotherapy includes psychoeducation, observing a model coping with the procedure, relaxation skills training, cognitive coping skills training, behavioural rehearsal, play therapy and providing incentives to cope with the painful procedures. During painful procedures effective psychotherapy involves distraction with pleasant stimuli or imagery-based distraction enhanced through hypnosis.

ADJUSTMENT OF CHILDREN TO CHRONIC MEDICAL CONDITIONS

In children and adolescents with chronic medical conditions where non-adherence to complex medical regimes seriously compromises physical health and leads to frequent hospitalization, psychotherapy improves illness management (Kibby et al., 1998; Lemanek et al., 2001).

Adjustment of children and adolescents to asthma

Psychotherapy which improves asthma control and adherence to medical regimes in children is family based and involves psychoeducation, skills training in adherence, symptom monitoring using a peak flow meter, trigger avoidance, relaxation and coping skills training to reduce physiological arousal, and family therapy to empower family

members to work together to manage asthma effectively (Brinkley et al., 2002; Guevara et al., 2003; McQuaid & Nassau, 1999).

Adjustment of children and adolescents to type 1 diabetes

For children and adolescents, psychotherapy which improves diabetes control, adherence to medical regimes and mood is family based and involves family psychoeducation, communication and problem-solving skills training, skills training in adherence to diabetic medical regimes, relaxation training and coping skills training, and contingency management programmes implemented by parents all of which aim to enhance adherence and promote self-regulation of negative mood states (Farrell et al., 2002; Hampson et al., 2000; McQuaid & Nassau, 1999). With poorly controlled diabetes, Moran, Fonagy et al. (1991; Fonagy & Moran, 1990) found that psychoanalytic psychotherapy with parallel parent intervention led to a significant improvement in diabetic control on behavioural and physiological measures. These conclusions on psychotherapy for children and adolescents with type 1 diabetes are consistent with international best practice guidelines (NICE, 2004e).

ADJUSTMENT PROBLEMS FOLLOWING MAJOR LIFE STRESSES

Psychotherapy is effective in helping children and families adjust to major life stresses and transitions including parental separation, death of a parent and child abuse and neglect.

Adjustment problems following parental separation

Psychotherapy is effective in helping children and adolescents cope with the sequelae of parental separation and divorce. Such psychotherapy may be conducted on a group basis and include catharsis, psychoeducation, problem-solving and stress management training to help children grieve the loss of an intact family structure and develop skills required to manage the psychological and social challenges they face as a result of their parents separation (O'Halloran & Carr, 2000). The effectiveness of such child-focused programmes may be enhanced by including a parallel parent training module which includes psychoeducation and support.

Adjustment problems following parental bereavement

Effective psychotherapy for youngsters with complicated or traumatic grief following parental bereavement requires both family and individually oriented interventions (Cohen et al., 2002; Cohen & Mannarino, 2004; Kissane & Bloch, 2002; Sandler et al., 2003). The family therapy aspect involves engaging families in treatment, facilitating family grieving, facilitating family support and decreasing parent-child conflict for the child experiencing traumatic grief, and helping the family to reorganize so as to cope with the demands of daily living and move on in the absence of the deceased parent. The individual component of treatment involves exposure of the child to traumatic grief-related memories and images until a degree of habituation occurs, in a manner similar to the treatment of post traumatic stress disorder. This may be facilitated by viewing photos, audio and video recordings of the deceased, developing a coherent narrative with the child about their past life with the deceased, and a way to preserve a positive relationship with the memory of the deceased parent in the present.

Adjustment problems following abuse and neglect

Psychotherapy is effective in alleviating adjustment problems associated with physical, sexual and emotional abuse and neglect. For looked after children who had been placed in care after removal from adverse family circumstances, Boston and Lush (1994; Lush, 1991) found that at two years follow-up significantly more looked-after children (who were in care or adopted) who received psychoanalytic psychotherapy with parallel intervention with carers showed improvement in social and psychological adjustment compared with an untreated control group.

Physical abuse and neglect. For physical child abuse either alone or accompanied by neglect, effective psychotherapy is family-based and addresses specific problems in relevant subsystems including children's posttraumatic adjustment problems; parenting skills deficits; and the overall supportiveness of the family and social network (Chaffin & Friedrich, 2004; Edgeworth & Carr, 2000; MacLeod & Nelson, 2000; Skowron & Reinemann, 2005; Tolan et al., 2005). Where parents have very poorly developed self-regulation and child-management skills, the child may initially be placed in a residential unit or therapeutic day care centre, which provides the child with a protective, supportive and intellectually stimulating context within which positive parent-child interaction may be fostered. Effective parent-focused interventions for physical abuse and neglect include

behavioural parent training which equips parents with child management skills and individual therapy which helps parents develop the skills required for regulating negative emotional states notably anger, anxiety and depression. Effective interventions for the family and wider system within which physical child abuse and neglect occurs entails co-ordinated intervention with problematic subsystems based on a clear assessment of interaction patterns that may contribute to abuse or neglect. The aim of such intervention is to restructure relationships within the child's social system so that interaction patterns that may contribute to abuse or neglect will not recur. Here therapy may focus on enhancing the quality of the marital relationship; the supportiveness of the extended family; and co-ordination of other inputs to the family from educational, social and health services.

Child sexual abuse. For child sexual abuse, effective treatment involves concurrent treatment of abused children and their non-abusing parents, in group or individual sessions, with periodic conjoint parent-child sessions (Cohen et al., 2005; Putnam, 2003; Ramchandani & Jones, 2003; Reeker et al., 1997). Where intrafamilial sexual abuse has occurred, it is essential that the offender live separately from the victim until they have completed a treatment programme and been assessed as being at low risk for re-offending. Effective child-focused therapy involves catharsis and identification of multiple complex emotions associated with abusive experiences. Through repeated exposure to abuse-related memories by recounting their experiences children process and habituate to intense negative feelings evoked by traumatic memories. Effective treatment for sexually abused children also includes relaxation and coping skills training; learning assertiveness and safety skills; and addressing victimization, sexual development and identity issues. It also involves developing insight into unconscious processes and containment and working through of traumatic material. For sexually abused girls, Trowell et al. (2002) in a randomized controlled trial, found that psychoanalytic psychotherapy was more effective than psychoeducational group therapy in the treatment of PTSD. In both treatments concurrent parent support was provided. Concurrent and conjoint work with non-abusing parents and abused children focuses on helping parents develop supportive and protective relationships with their children, and develop support networks for themselves.

DEVELOPMENTAL DISABILITIES

Highly structured psychosocial interventions are effective in treating adjustment problems and mental health difficulties of children, adolescents and adults with developmental disabilities including intellectual disability and autism spectrum disorders.

Intellectual disability

For children, adolescents and adults with intellectual disability, behavioural and cognitive-behavioural psychotherapy tailored to the ability level of clients may lead to improved functioning where the presenting problems include interpersonal problems and challenging behaviour (Carr et al., 1999; Didden et al., 1997; Kennedy & Carr, 2002; Prout & Nowak-Drabik, 2003; Whitaker, 2001). For interpersonal problems associated with difficulty regulating anger, anger management is effective for clients with a level of intellectual ability sufficient to learn anger management skills. This type of training involves psychoeducation about anger, self-monitoring, relaxation and problem solving skills training (Whitaker, 2001). Behavioural interventions are effective in modifying challenging behaviour such as self-injury, aggression, temper tantrums and property destruction. These interventions may be proactive or suppressive and to be effective must be based on a detailed functional analysis of the challenging behaviour they are designed to modify. Proactive interventions include functional communication training, negative reinforcement, neutralizing routines and instructional manipulation. Suppressive interventions include overcorrection and restraint.

Autism spectrum disorder

For children with autistic spectrum disorder, highly structured intensive interventions conducted for 20 or more hours per week over time periods spanning up to two years can lead to improvement in functioning. Applied behavioural analysis, structured teaching and speech and language focused programmes hold greatest promise in this area (Finnegan & Carr, 2002; Lord & National Research Council, 2001; Smith, 1999).

CONCLUSION

Extensive computer and manual literature searches yielded a wealth of empirical evidence supporting the benefits of psychotherapy for a wide range of problems in children and people with developmental disabilities. Specific practices and protocols detailed in this

chapter may usefully be incorporated into routine psychotherapeutic practice with clients who present with the problems listed in this chapter.

Figure 5.1. Problems in childhood and adolescence for which psychotherapy is effective

Sleep problems

Toileting problems

Enuresis & encopresis

Attention deficit hyperactivity disorder

Pre-adolescent oppositional defiant disorder

Adolescent conduct disorder

Adolescent drug abuse

Child and adolescent depression

Child and adolescent anxiety disorders

Phobias, selective mutism, separation anxiety and generalized anxiety, obsessive compulsive disorder, post- traumatic stress disorder

Eating disorders

Feeding problems, anorexia, bulimia, obesity

Paediatric pain problems

Headaches, recurrent abdominal pain, medical procedures

Adjustment to chronic medical conditions

Asthma & diabetes

Adjustment problems following major life transitions and stresses

Parental separation, bereavement & physical, sexual and emotional child abuse and neglect

Adjustment problems associated with developmental disabilities

Intellectual disability and autistic spectrum disorder

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

Mental health problems constitute a major national and international problem. This well documented on the World Health Organization's website (http://www.who.int/mental_health/en/index.html) and in the *Report of the Expert Group on Mental Health Policy- A Vision for Change* published in 2006. In Ireland and elsewhere around the world one in four people have significant mental health problems. 450 million people worldwide are affected by psychological disorders. Mental health problems rank second in global burden of disease, following infectious disease. Psychological disorders entail staggering economic and social costs. People with psychological disorders have a poor quality of life and increased mortality. Worldwide about 873,000 people die by suicide every year. Within the EU the economic costs of psychological disorders constitute 3-4% of the annual GNP. Much of these costs are due to decreased productivity, absenteeism and unemployment, and the remainder are due to service costs.

There is a growing consensus that mental health problems are best addressed through professionally delivered evidence-based practices, offered within the context of a tiered health service system, with distinctions made between primary, secondary and tertiary levels of care. Within such systems, psychotherapy has an important role to play as an evidenced-based intervention that may be offered alone or as one element of a multimodal programme for a wide range of mental health problems.

In Ireland, the policy document– *A Vision for Change 2006* – endorses this view. However, a key requirement in developing psychotherapy services is clarity about the evidence base for the effectiveness of psychotherapy. The present report has provided unequivocal evidence for the effectiveness of psychotherapy. Below are some of the main conclusions that may be drawn from the literature review contained in this document.

Overall effectiveness of psychotherapy

Psychotherapy is an effective intervention for a wide range of mental health problems in children and adults. Overall, the average treated person fares better after psychotherapy than 74-84% of untreated people. These effect sizes also indicate that the average success rate for treated cases ranged from 65 to 72%. In contrast, the average success

rate for untreated control groups range from 28 to 35%. Taken at the most sceptical level, if we subtract the outcome for control groups from those of treatment groups, then psychotherapies account for 37 – 44% of improvement, indicating a high level of response to psychotherapeutic interventions. The evidence reviewed in chapter 2 supports the following assertions:

- Psychotherapy is very effective for a majority of cases with common psychological problems.
- Psychotherapy is effective for both adults and children.
- Psychotherapy conducted within psychoanalytic; humanistic and integrative; cognitive-behavioural; constructivist; and systemic couple and family therapy traditions is effective. Recovery rates for different forms of psychotherapy are very similar.
- The effects of psychotherapy are nearly double those of placebos.
- The overall magnitude of the effects of psychotherapy in alleviating psychological disorders is similar to the overall magnitude of the effect of medical procedures in treating a wide variety of medical conditions.
- About 1 in 10 clients deteriorate as a result of psychotherapy.
- Client recovery is dependent upon the delivery of a high quality psychotherapy service, which may be maintained through quality assurance systems. Therapists must be adequately trained, have regular supervision and carry reasonable caseloads.
- Psychotherapy has a significant medical cost-offset. Those who participate in psychotherapy use less other medical services at primary, secondary and tertiary levels and are hospitalized less than those who do not receive psychotherapy.
- Psychotherapy can reduce attendance at accident and emergency services in frequent users of such services with chronic psychological problems.
- Clients who have more rapid access to psychotherapy (and who spend little time on waiting lists) are more likely to engage in therapy.

Common factors in effective psychotherapy

Certain common therapeutic processes or factors underpin all effective psychotherapies. The evidence reviewed in chapter 3 allows the following conclusions to be drawn about common factors:

- Common factors have a far greater impact than specific factors in determining whether or not clients benefit from psychotherapy.
- Common factors included those associated with therapy process, the therapist and the client.
- The following client characteristics are associated with therapeutic outcome:
 - personal distress
 - symptom severity
 - functional Impairment
 - case complexity
 - readiness to change
 - early response to therapy
 - psychological mindedness
 - ego-strength
 - capacity to make and maintain relationships
 - the availability of social support and
 - socio-economic status (SES).
- The following therapist characteristics are associated with therapeutic improvement:
 - personal adjustment
 - therapeutic competence
 - matching therapeutic style to clients' needs
 - credibility
 - problem solving creativity
 - capacity to repair alliance ruptures
 - specific training
 - flexible use of therapy manuals (for some therapy approaches) and
 - feedback on client recovery.
- There is a dose-effect relationship in psychotherapy. 20-45 sessions are necessary for 50-75% of psychotherapy clients to recover.
- The therapeutic relationship or alliance is the most important single common factor in psychotherapy. In a good therapeutic alliance the therapist is empathic and collaborative and the client is co-operative and committed to recovery.
- Effective therapy involves the common procedures of
 - problem exploration and reconceptualization

- provision of a credible rationale for conducting therapy
 - generating hope and the expectation of improvement, and
 - mobilizing clients to engage in problem resolution by providing support and encouraging emotional expression; by facilitating new ways of viewing problems; and by helping clients to develop new ways of behaving adaptively.
- For certain specific disorders such as schizophrenia, multimodal programmes in which psychotherapy and psychotropic medication are combined are more effective than either alone.

Psychotherapy for problems in adulthood and older adulthood

Psychotherapy alone or as an element in a multimodal programme is effective for the following specific problems of adulthood and older adulthood:

- Mood disorders, specifically major depression and bipolar disorder
- Anxiety disorders including generalized anxiety disorder, panic disorder, specific phobias, social phobia or social anxiety disorder, obsessive compulsive disorder (OCD), and posttraumatic stress disorder (PTSD)
- Adjustment to illness including preparation for surgery, adjustment to illnesses with high mortality rates such as cancer and heart disease, adjustment to chronic medical conditions involving adherence to complex regimes such as diabetes and asthma
- Facilitating coping with conditions involving pain and fatigue such as chronic pain, fibromyalgia, headaches, arthritis, irritable bowel syndrome, and chronic fatigue syndrome
- Psychosomatic disorders including somatoform disorder, hypochondriasis, and body dysmorphic disorder
- Eating disorders including obesity, bulimia and anorexia nervosa
- Insomnia
- Alcohol and drug abuse
- Schizophrenia
- Personality disorders; related identity and self-esteem issues; issues arising from childhood sexual, physical and emotional abuse; aggression; and sexual offending

- Relationship problems including marital distress, psychosexual problems and domestic violence
- Psychological problems associated with older adulthood including dementia, caregiver support, depression, anxiety and insomnia

Psychotherapy for problems of childhood and adolescence

Psychotherapy alone or as one element of a multimodal programme is effective for the following specific problems of childhood and adolescence

- Sleep problems
- Toileting problems including enuresis and encopresis
- Attention deficit hyperactivity disorder
- Pre-adolescent oppositional defiant disorder
- Adolescent conduct disorder
- Adolescent drug abuse
- Child and adolescent depression
- Child and adolescent anxiety disorders including phobias, selective mutism, separation anxiety and generalized anxiety; obsessive compulsive disorder; and post-traumatic stress disorder
- Eating disorders including feeding problems, anorexia, bulimia, and obesity
- Paediatric pain problems including headaches, recurrent abdominal pain, and painful medical procedures
- Adjustment to chronic medical conditions such as asthma and diabetes
- Adjustment problems following major life transitions and stresses including parental separation, bereavement, and physical, sexual and emotional child abuse and neglect
- Adjustment problems associated with developmental disabilities including intellectual disability and autistic spectrum disorder.

RECOMMENDATIONS

1. For mental health problems and psychological adjustment problems associated with physical illness and major life stresses, evidence-based approaches to psychotherapy, such as those reviewed in this report, should be provided by

appropriately trained and supervised professional psychotherapists to children, adolescents and adults.

2. Psychotherapy alone or as an element in a multimodal programme delivered by a multidisciplinary team should be available for adults with the following specific problems: depression; bipolar disorder; anxiety disorders; psychosomatic disorders; eating disorders; insomnia; alcohol and drug abuse; schizophrenia; personality disorders; relationship problems; psychological problems associated with older adulthood; adjustment to physical illnesses; and coping with chronic pain and fatigue. Evidence-based psychotherapeutic approaches should be used. These are detailed in the body of the report, and are consistent with international guidelines for best practice such as those produced by the National Institute of Clinical Excellence (NICE) in the UK.
3. Psychotherapy alone or as one element of a multimodal programme delivered by a multidisciplinary team should be available for the following specific problems of childhood and adolescence: sleep problems; enuresis; encopresis; attention deficit hyperactivity disorder; oppositional defiant disorder; conduct disorder; drug abuse; depression; anxiety disorders; eating disorders; paediatric pain problems; adjustment to chronic medical conditions; adjustment problems following major life transitions and stresses including parental separation, bereavement, and child abuse and neglect; and adjustment problems associated with developmental disabilities including intellectual disability and autistic spectrum disorder. Evidence-based psychotherapeutic approaches should be used. These are detailed in the body of the report, and are consistent with international guidelines for best practice such as those produced by the National Institute of Clinical Excellence (NICE) in the UK and the American Academy of Child and Adolescent Psychiatry.
4. Psychotherapy should be offered as rapidly as possible, with short waiting times. This is because clients who do not access services rapidly, are less likely to engage in therapy when it is offered, to deteriorate and later require more intensive services.

5. Psychotherapy should be offered in primary, secondary and tertiary care settings. This recommendation is consistent with the policy document– *A Vision for Change 2006*. In primary care settings, relatively brief psychotherapy may alleviate psychological difficulties before they become chronic intractable problems, requiring intensive services. In secondary and tertiary care, specialist psychotherapy may be offered, often as part of multimodal intervention programmes, to address chronic, complex psychological difficulties.
6. Within the HSE and other health service organizations, service delivery structures should be developed to facilitate the development of psychotherapy services in primary, secondary and tertiary care. This recommendation is consistent with the policy document– *A Vision for Change 2006*
7. Because psychotherapy has the potential to cause significant harm in a small proportion of cases, it is recommended that psychotherapy only be offered by those appropriately trained and qualified, and that all qualified psychotherapists practice within the limits of their competence, and in accordance with a well-defined professional ethical code of practice.
8. Psychotherapists employed in the HSE and other organizations that offer psychotherapy services, should be registered with the Irish Council for Psychotherapy (and statutorily registered, when this option becomes available).
9. Psychotherapy training should be offered by programmes accredited by the Irish Council of Psychotherapy. These programme should involve partnerships between universities or other third level educational institutions on the one hand, and HSE or other clinical practice sites on the other. These programmes should meet the European Certificate of Psychotherapy standards set by the European Psychotherapy Association (which represents more than 100,000 psychotherapists across Europe). These standards include a commitment to the practice of evidence-based psychotherapy in an ethical manner, following training of sufficient depth and duration to allow the mastery of complex skills and the personal contribution of the psychotherapist's personality and preoccupations to the therapeutic endeavour.

10. Psychotherapists should engage in regular clinical supervision appropriate to the modality of psychotherapy being offered.
11. Within the HSE and other organizations where psychotherapy is practiced, reliable systems and structures for offering and receiving supervision should be developed.
12. Psychotherapists should engage in continuing professional development to keep up to date with developments in the field.
13. Within the HSE and other organizations where psychotherapy is practiced, reliable systems and structures for offering and receiving continuing professional development should be developed.
14. Psychotherapy services within the HSE and other organizations should be routinely evaluated to determine their effectiveness.
15. Partnerships between psychotherapy services within the HSE and other organizations on the one hand, and university departments with expertise in psychotherapy service evaluation on the other, should be developed to facilitate the evolution of psychotherapy services in Ireland, and to engage in research on the development of more effective forms of psychotherapy for vulnerable subgroups of clients who have difficulty benefiting from current approaches to psychotherapy.
16. Many of the recommendations listed above require considerable resources, and so the final recommendation is that a system for funding the development of psychotherapy services in Ireland be developed and implemented. Such a system would need to specify how psychotherapy services fit into the HSE and other organizations; what the work contracts, salaries and career structures for psychotherapists should be; how psychotherapy training, supervision, and continuing professional development will be managed and funded; and how psychotherapy research, especially research evaluating its effectiveness in an Irish context will be funded.

These recommendation are consistent with the main recommendations of the *Report of the Expert Group on Mental Health Policy- A Vision for Change* published in 2006 and the *Report of the Working Group on the Role of Psychotherapy within the Health Service - The Role, Value and Effectiveness of Psychological Therapies: Benefits for the Irish Health Service* published in 2005. I refer here to the recommendation that psychotherapy be made available in the Irish public health service to people with mental health problems and psychological difficulties.

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