A Science 86 Special Series on Psychotherapy

THERAPY UNDER ANALYSIS

SEYMOUR CHWAST

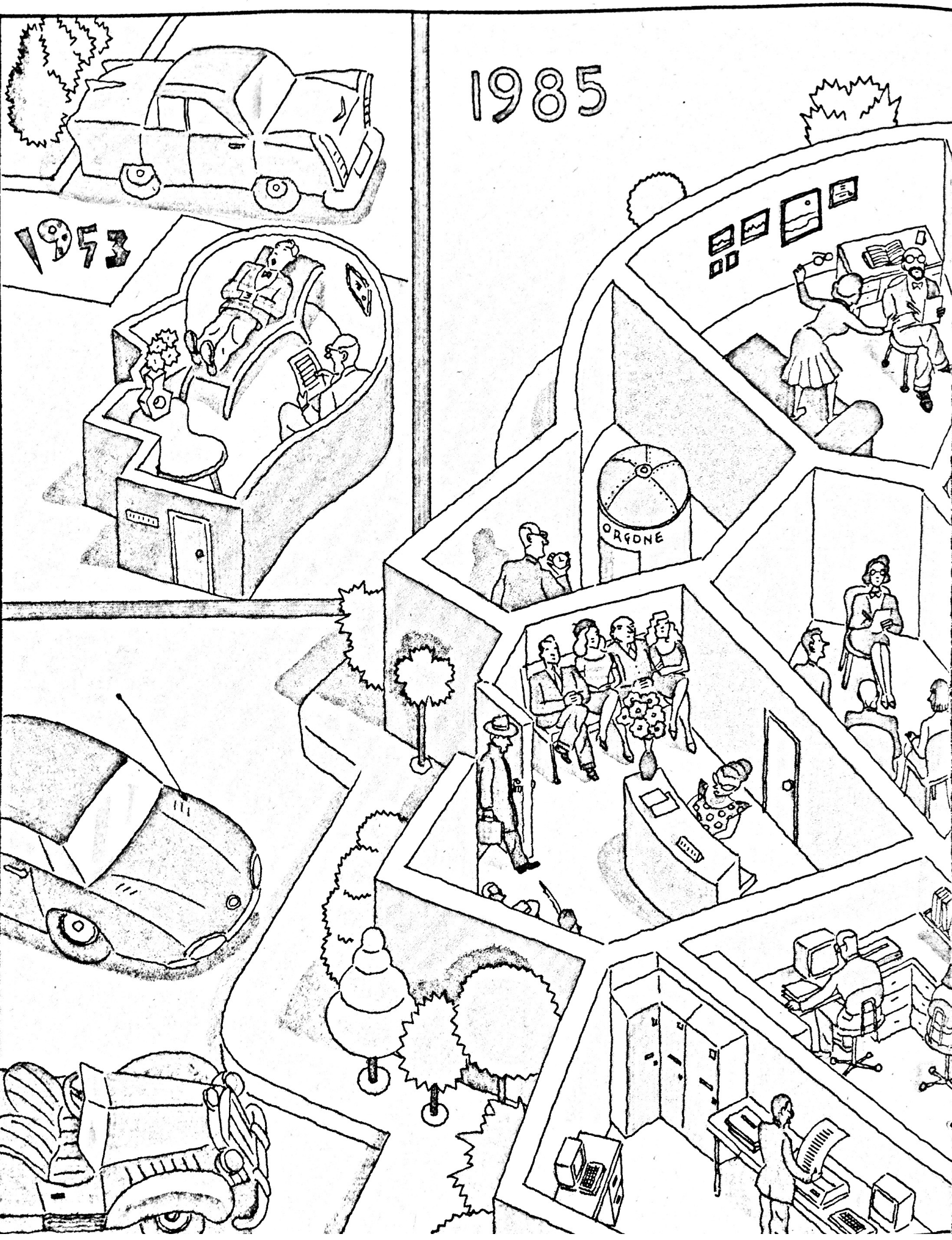
LIFE IS HARD, sometimes too hard to face alone. Every culture in the world recognizes this and includes a form of reprieve and comfort for its members' off days. In our culture one such refuge is psychotherapy, wherein a person seeks advice and help to overcome difficulties from someone unknown to him personally, someone trained to give it, usually in exchange for money.

The first experience with "the talking cure" often comes after a crisis. Let's say your mother died six months ago, and you've had a headache ever since. Last weekend you could not get yourself out of bed. You've never thought of seeking help from a therapist before, but you begin to think you're not getting enough from your wife, your friends.

Some people first seek counseling because they are intellectually curious, others because they think their lives might be made richer though they are not particularly troubled. Still others are driven to it when symptoms like chronic pain and insomnia crowd into their lives for reasons they can't even pinpoint.

People hope such things won't happen to them. Yet up to 20 percent of the U.S. population face a bout of serious depression in their lifetimes, and depression is only one of many mental illnesses that can leave people functional but in pain.

One hundred years ago Freud started the therapy business by opening his first office in Vienna. Today there are more than 160,000 professional therapists in the United States alone. Lots of customers come away satisfied, but only in the past three decades has science tried to figure out just what happened to them, or to those who weren't helped. In these pages *Science 86* presents an overview of the research into what psychotherapy can—and can't yet—accomplish. We follow this review with a consumer's guide to some of the most popular and highly regarded kinds of therapies, a discussion of the drug treatments that often accompany talking cures, and an insider's critique of the therapy industry.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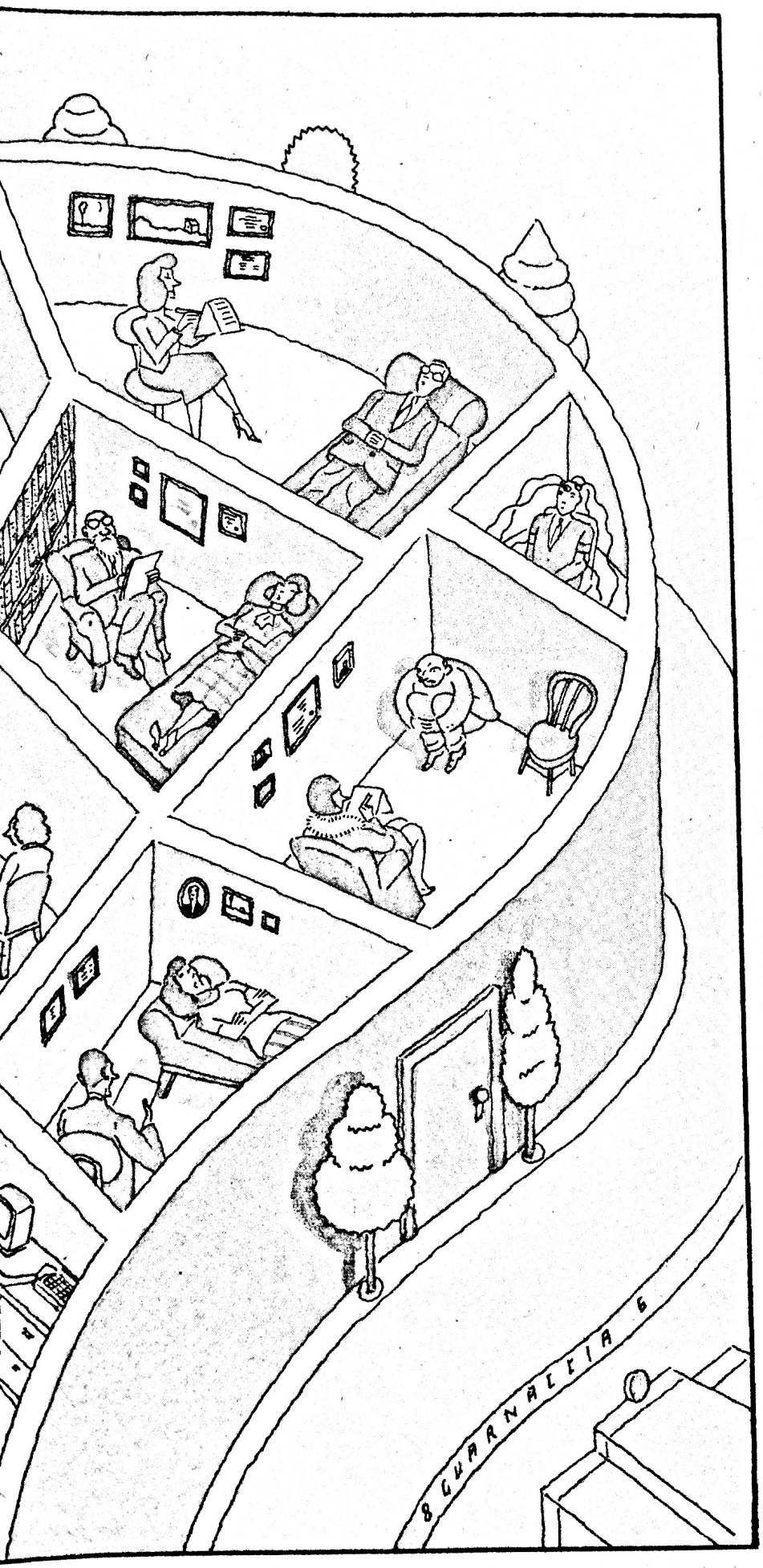


The demand for therapy has increased 400 percent in three decades. Does it work?

TESTING THE TALKING CURE

BY NIKKI MEREDITH

ILLUSTRATIONS BY STEVE GUARNACCIA

PSYCHOTHERAPY HAS BECOME such an established accessory to contemporary American life it's easy to forget that it was not always so. As recently as 1957 only 13 percent of the population had sought some kind of psychological counseling in their lifetimes. That number is now almost 30 percent—or 80 million people—at a cost of over $4 billion annually.

This increase signifies a substantial change in popular attitudes toward psychotherapy, once considered the exclusive province of the very rich and the very disturbed. The new class of mental health patients has been created in part by the well-documented *Sturm und Drang* of social change, such as the breakdown of families, and in part by a standard of living free enough from physical hardship to accommodate a quest for emotional fulfillment. Thus, the great majority of those seeing therapists these days are not afflicted with severe and intractable mental illness but are more likely to suffer from problems associated with "normal" living.

Nonetheless, most who find their way into a therapist's office are truly unhappy, beleaguered by depression, anxiety, phobias, or some other distress from the long list besetting the human race. The

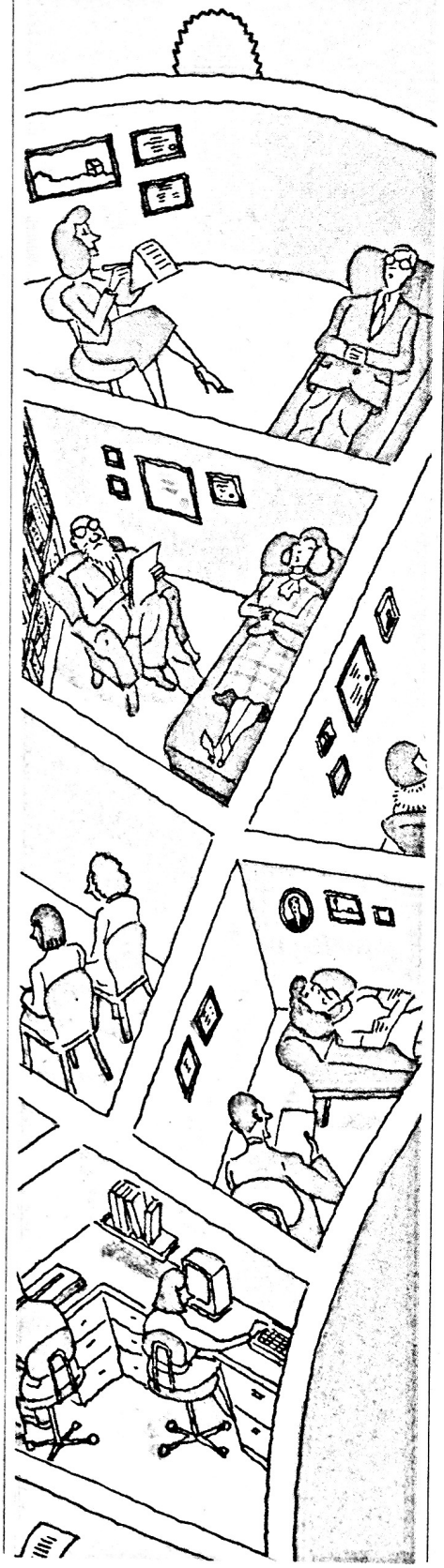
variety of people and maladies for which they seek relief has spawned a profusion of new treatment techniques. There are more than 250 brands of therapy now on the market, including not only offshoots of traditional individual, group, and family therapies but a multitude of others. The labels suggest that it is possible to convert almost any activity into therapy: work therapy, jogging therapy, breathing therapy, pleasant experiences therapy, soap opera therapy, and, for those not interested in such here-and-now pursuits, past-lives therapy.

While each treatment form has its champions, the therapies considered most credible by professionals are supported by well-developed theoretical formulations and have some sort of traditional pedigree. Freudian psychoanalysis, the antecedent of them all, is the best known but, in fact, one of the least practiced. The analyst and his couch, so often parodied in the media, is in reality accessible only to those sufficiently healthy to withstand the reliving and "working through" of early and often painful stages of their lives and sufficiently wealthy to pay for four or five sessions a week for the two to 15 years that it might take.

Most conventional therapies fall into two classes: psychodynamic—the most widely dispensed form of treatment—and behavioral. Psychodynamic therapies, though much less intense than psychoanalysis, are based on the same principles and therefore delve into such things as unconscious motivation. Behavioral therapies are derived from learning theory and focus on retraining behavior. Instead of looking for hidden causes, behaviorists guide their patients in changing their everyday actions and thoughts.

In recent years, abbreviated versions of the major therapies have gained in popularity. Brief therapy ranges from a single session to as many as 20, but generally the goal is to provide support, minimize weaknesses, and reinforce psychological defenses—with a minimum expenditure of time and money. (One of the first practitioners of brief therapy was Freud. Composer Gustav Mahler, suffering from impotence with his wife,

All 250 therapies treat the one syndrome shared by all patients: demoralization.



was treated successfully by Freud in a single four-hour session.)

The use of drugs has also increased in recent years, winning adherents among both psychodynamic and behavioral practitioners. There is mounting evidence that some drugs are useful in treating particular kinds of depression and anxieties and especially when used in conjunction with therapy.

As would be expected, the profusion of patients and therapies has been accompanied by a growth in the supply of mental health professionals—in 1975 there were 60,000 therapists in the United States; currently there are 160,000—and also an increase in the number of disciplines they represent. Psychiatrists, once the dominant force in the field, now must share clients with an ever-growing stock of psychologists, social workers, and a mix of other practitioners such as psychiatric nurses and clergymen. In fact, the largest portion of the nation's therapy is now practiced by nonpsychiatrists, who charge significantly less for their services: the median cost for psychiatric professionals in private practice is $90 a session; psychologists take in an average of $65; and the going rate for social workers, who outnumber psychiatrists by almost two to one, is $50.

The competition for patients and for insurance reimbursement has sparked fierce territorial disputes between professional organizations, each claiming its members have unique, superior attributes. In fact, varied as their training may be, the distinctions in actual practice are not as great as the acrimony would suggest. The differences in therapists' methods are determined more by their personalities and therapeutic ideologies than by their academic backgrounds. One bona fide difference is between those licensed to prescribe drugs—namely psychiatrists, who are physicians—and those who can't. Some nonmedical therapists circumvent this limitation by associating with a psychiatrist who will prescribe for their patients.

The unfettered growth of the psychotherapeutic enterprise faced its first serious challenge in the late 1970s when the Carter administration and Congress con-

A primer on the professionals

Your favorite confidante, Aunt Martha, has left town. You need someone to talk to and have decided that perhaps it would be best to see a professional. Which one should you choose? All the titles sound the same. But basically they fall into two categories: type of training and type of therapy used. The terms **therapist** and **psychotherapist** really don't tell you anything about qualifications or method of therapy. Psychiatrist, psychologist, clinical social worker, psychiatric nurse, and counselor are terms that explain how the person was trained and what their focus is. Psychoanalyst, behavioral therapist, group therapist, and any other kind of therapist are descriptive titles that tell what kind of therapy or approach will be used. Any professional can receive training in any type of therapy.

Psychiatrist is probably the term heard most often. A psychiatrist is a medical doctor who has done a residency (three or four years) in psychiatry. Different from psychology, psychiatry includes psychopharmacology (the mind and drugs), management of hospital patients, neurology, psychopathology, and psychotherapy. Because they are physicians, psychiatrists are the only mental health care providers allowed to prescribe drugs—an important difference if the patient has, for instance, manic-depression—but many other therapists work in conjunction with a psychiatrist who will prescribe for their patients. However, because most of their training is in hospitals, psychiatrists are familiar mainly with severe mental illness, not everyday problems such as mild anxiety and depression. Many psychiatrists, however, have gone on to receive additional training in psychotherapy.

Psychologists who specialize in psychotherapy and diagnosis are called clinical psychologists. They have Ph.D.'s in clinical psychology, which includes work in basic psychology, psychopathology, psychotherapy, and research. They have had at least a one-year internship in a mental health care setting and must pass a state examination. About 45,000 of the therapists practicing in the United States are psychologists. Says psychologist Sol Garfield, "Whereas psychiatrists, as physicians, are more inclined to view psychological disorders as diseases or illnesses, psychologists tend more to view them as learned patterns of behavior, or habit disorders."

Clinical social workers and **psychiatric social workers** handle a growing segment of the mental health care market. The former travels to a variety of sites, while the latter works in a traditional office. For accreditation they have to have at least a master's in social work and two years' experience in a clinical setting. Most states require an examination. Social workers emphasize seeing the patient as a part of her environment.

Although all registered nurses can work in a psychiatric setting, some have continued their schooling and received a master's or doctorate in psychiatric nursing. These **psychiatric nurse specialists** can be certified by the American Nursing Association in either adult or child and adolescent psychiatric nursing. The only mental health specialists besides psychiatrists who have a medical background, their approach is to see body and mind as a whole.

Any of these professionals can be skilled in one or many of the few hundred therapies available.

The oldest type of psychotherapy is psychoanalysis. **Psychoanalysts** have been trained at one of many institutes throughout the United States and Europe. Although most are psychiatrists, psychoanalysts can be psychiatric nurse specialists, clinical social workers, or psychologists.

There are also marriage and family therapists (specialists solely in that therapy), mental health counselors, pastoral counselors, and others who have all been well trained, sometimes with the same course work. With more than 160,000 qualified therapists in the United States alone, there is fierce competition among the professionals. Since fees can vary by more than $50 a session, insurance coverage is the focus of the war over patients. Each type of therapist tries to get a state license or accreditation, often necessary for coverage. Qualification for licensing and accreditation differs from state to state, as does insurance coverage.

Everyone adds something different to the profession. As Daniel Goleman, psychologist and behavioral science writer for the *New York Times*, says, "All but the most adamant of psychotherapists will acknowledge that the competence of a given therapist depends more on his training, experience and innate ability than on his academic credentials or license."

Where to go from here? Call local mental health clinics, ask friends for recommendations, or call local professional associations. Relationships with therapists are intimate. If they are not willing to discuss their methods and fees in advance, call someone else. They should help, not confuse. Don't be afraid to ask questions. Aunt Martha would be proud.

—*Heléne Ross*

sidered instituting national health insurance and needed to decide what kinds of therapy to include. With Reagan's election, the prospect of national health insurance with or without psychiatric benefits faded along with the government's interest in regulation, but the continued rise in health costs has had its own regulatory effect.

Psychotherapy has been one of the fastest growing segments of total health costs, and therefore has been targeted for substantial cutbacks from the insurance industry. Many companies have limited expenditures by requiring practitioners to justify extended treatment to a panel of professionals and by putting arbitrary ceilings on benefits. Federal employees, for example, once had excellent Blue Cross mental health coverage that paid 80 percent of any sort of treatment up to $50,000. Now their best Blue Cross coverage pays 80 percent of only 50 visits a year.

There is an assumption that mental health services are more vulnerable to cutbacks than other medical services because there is less scientific evidence to support them. "People in science would like to believe evidence drives public policy, but it doesn't always," says Gerald Klerman, former administrator of the federal Alcohol, Drug Abuse, and Mental Health Administration. One example of this is the fate of prison therapy programs. Conventional wisdom has it that psychological rehabilitation efforts in some prisons were discontinued because they didn't work. However, it appears that no treatment program for adult offenders had been fairly tested, according to the National Academy of Sciences.

While science may not drive public policy, policy seems to be driving science. For as unwelcome as mental health cutbacks and the prospect of government regulation have been to practitioners, both have encouraged research. There are signs that the enormous gap between treatment and scientific study has begun to narrow. "We now have the method-

ology to conduct credible psychotherapy studies," says John Docherty, former director of research at the National Institute for Mental Health. "From a research standpoint, the field is the healthiest it's ever been."

The erratic history of systematic research got off to an explosive start in 1952 when British psychologist Hans J. Eysenck published a review comparing the improvement rates of a group of "untreated" neurotics with the improvement rates of groups that had been treated with psychoanalytic or eclectic (mixed treatment) psychotherapy. He reported that 72 percent of the "untreated" group improved, while only 64 percent of the group treated by eclectic therapy and 44 percent of the psychoanalytic patients got better.

At the time, psychoanalysts were quite popular and were cranking out reports of spectacular successes. Eysenck's study, though widely criticized, served to challenge this long-enjoyed complacency, and systematic research became a serious pursuit.

Despite the subsequent invalidation of Eysenck's work, many of the points for which he was criticized—issues of bias and methodology—have continued to weaken therapy research. He was accused of selecting only studies that would prove his point and of comparing studies in which the key variables were too disparate. For example, there was no way of determining if the illnesses of the treated and untreated groups were comparable in severity. Moreover, the studies Eysenck compared did not use a uniform definition of improvement. Critics also pointed out that many of the "untreated groups" were cared for by general practitioners and thus actually received some therapy, i.e., attention, reassurance, and suggestion. (To this day, the problem of setting up a placebo-free study baffles researchers.)

The pattern established by Eysenck and his critics continued for the next few decades. Every study was followed by an attack on the findings and research methodology, which was then followed by another study with different findings, which was also attacked, and so on. The result was a collection of studies whose findings canceled each other out.

The impasse was broken in 1980, when psychologists Mary Lee Smith, Gene Glass, and Thomas Miller published the results of an analysis of 475 studies revealing that the average patient who received therapy was better off at the end of treatment than were 80 to 85 percent of comparable patients who did not receive such treatment. Having considered only studies meeting minimum standards of controlled trial research—those including a control group—the researchers concluded: "Psychotherapy benefits people of all ages as reliably as schooling educates them, medicine cures them, or business turns a profit."

Although the Smith study is considered the most comprehensive and bias-free ever done, it created an impasse of its own. All the therapies examined, psychodynamic or behavioral, got comparable results for the treatment of all disorders. This despite dramatic differences in philosophy and procedure.

While upsetting the proponents of various therapies, the findings confirmed the ideas of those in the field who believe that it is the general rather than the specific aspects of therapy that produce change. Psychiatrist Jerome Frank, one of the most respected spokesmen for this point of view, says that all therapies share features that are effective at treating a syndrome shared by all patients: demoralization. Regardless of their complaints, he says, patients feel helpless, unable to cope, depressed, guilty, and worthless.

The elements contained in every therapy that are effective in treating this condition, says Frank, include a special relationship in which the therapist expresses concern and engenders trust; a special setting—the therapist's office—that is seen as a sanctuary; and a conceptual framework that, in addition to providing an explanation for the patient's behavior, offers hope that the treatment will relieve the suffering. And all therapies produce a degree of emotional arousal and an increase in patients' awareness of alternatives.

From all indications, most practitioners are not very flexible. Researchers have found that few therapists, regardless of their treatment philosophies, vary their techniques to meet the needs of individual patients. But it may be that specific treatments are crucial. "A major theme of research now is the development of specificity," says Docherty. "It is the increasing focus on specific factors that is leading to definitive answers."

The National Institute of Mental Health is now funding several projects that seek to compare specific treatments for specific disorders. Although the results are not yet available, one of the most ambitious is a rigorously controlled study on the treatment of depression. The study compares the success rates of cognitive therapy and interpersonal therapy, both of which have done quite well in preliminary trials in the treatment of depression, a malady that afflicts more than eight million adults annually. Cognitive therapy teaches patients to modify thoughts that produce feelings of unworthiness, frustration, and hopelessness. Interpersonal therapy, on the other hand, uses more traditional techniques and focuses on relationships and social functioning. The improvement rates of the two therapies will be compared to a group receiving antidepressant drugs.

Identical trials are being conducted at three research sites—University of Oklahoma, University of Pittsburgh, and George Washington University—thus getting a much larger sample of patients than is generally feasible and also providing simultaneous replication.

Researchers in this collaborative study have gone to great lengths to standardize treatment because in many earlier studies it has been almost impossible to define exactly what therapy was administered. Even among therapists within the

More than 250 brands of therapy are marketed today. Their names suggest that it is possible to convert almost any activity into therapy.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GESTALT
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PSYCHO ANALYSIS
PSYCHO ANALYSIS
PSYCHO ANALYSIS
SCREAM Longer Lasting
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JUNGIAN
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JUNGIAN
PRIMAL THERAPY
PRIMAL
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8 GUARNACCIA 6
BEHAVIORAL
SEX THERAPY
NIRVANA
Scream Longer Lasting

The case of the moody car salesman

You can't talk about a cure in psychotherapy until you've defined what the illness is. To make that process easier, the American Psychiatric Association publishes a field guide of sorts called *Diagnostic and Statistical Manual*, Third Edition. *DSM-III* attempts to describe every mental illness in terms so unequivocal, so objective, that any two therapists, regardless of which forms of treatment they dispense, will, after examining a given patient, arrive at exactly the same diagnosis. To get a feel for how a therapist might use the *DSM-III*, first consider this case history, from an APA teaching guide called *DSM-III Case Book*.

A 29-year-old car salesman was referred for evaluation by his current girl friend, a psychiatric nurse, who suspected he had a mood disorder, even though the patient was reluctant to admit that he was a "moody" person. Since the age of 14 he has experienced repeated alternating cycles that he terms "good times and bad times." During a "bad" period, usually lasting four to seven days, he sleeps 10 to 14 hours daily, lacks energy, confidence, and motivation—"just vegetating," as he puts it. Then he abruptly shifts, characteristically upon waking up in the morning, to a three- to four-day stretch of overconfidence, heightened social awareness, promiscuity, and sharpened thinking—"Things would flash in my mind." Occasionally the "good" periods last seven to 10 days, but culminate in irritable and hostile outbursts, which often herald the transition back to another period of "bad" days.

In school, A's and B's alternated with C's and D's. As a car salesman his performance has also been uneven; even on "good days" he is sometimes perilously argumentative with customers and loses sales that appeared sure. Although considered a charming man in many social circles, he alienates friends when he is hostile and irritable.

DSM-III-style diagnosis is largely a matter of excluding illnesses that don't apply and seeing what's left. So the therapist evaluating the car salesman would begin by asking himself, Does the patient suffer from some organic illness that could be causing these symptoms? If the answer were yes, the diagnosis might be primary degenerative dementia with depressive features (*DSM-III* diagnosis number 290.13) or organic affective syndrome (number 293.83). Since there's nothing in the history to indicate a physical illness, the therapist would go on to ask, Does he have any psychotic symptoms, like hallucinations? That might indicate schizophrenia with a superimposed atypical mood disorder. Because the salesman seems untroubled by visions or delusions, the therapist might next wonder if the problem is manic-depression. The trouble with that diagnosis, according to *DSM-III*, is that the patient must be seriously depressed or manic for at least two weeks, or manic enough to be hospitalized—ruling out the salesman. Well then, the therapist might ask himself, how long has this moodiness been going on? If it's less than two years, he could have adjustment disorder with depressed mood (number 309.00). But the salesman has been riding an emotional roller coaster for a good 15 years, which leaves two possible diagnoses. One is dysthymic disorder, a low-grade depression, but patients with that condition never experience the bursts of energy the salesman feels. So the diagnosis ends up number 301.13—cyclothymic disorder, the APA's terminology for chronic moodiness.

There's no question that the diagnoses in *DSM-III* sound wonderfully—sometimes comically—precise. But are they really objective? Like earlier editions, *DSM-III* never manages to escape accusations of ideological bias. For instance, the recent proposed addition of "self-defeating personality disorder," a diagnosis employed by Freud and his followers, rankled feminists, who feared that it was conceived with repeatedly battered women in mind—a "blame-the-victim" approach not justified by research on domestic violence.

Even if he harbors no such reservations, a therapist turning to *DSM-III* for help will only get so far: the book won't tell him what caused the problem or how to fix it. Though a precise diagnosis would seem to suggest an equally precise treatment, experienced therapists find that patients who are really motivated to change will often improve regardless of the form of treatment they receive. According to Robert Winer of the Washington Psychoanalytic Institute, "Patients well suited for the rigors of daily psychoanalysis can make better-than-average use of once-a-week therapy." And Dean Schuyler, a consultant at Sheppard and Enoch Pratt Hospital in Baltimore, says the best candidates for his brand of treatment—cognitive therapy—are those who would be considered well suited for psychoanalysis.

—Perry Turner

same school there is so much variability in the methods used that it is often said there are as many therapies as there are therapists. To overcome this, professional therapists hired for the project were trained to use the same methods—a process that is now more consistent because of the recent development of treatment manuals—and then monitored by supervisors. Further, each therapy session was recorded so it would be possible to analyze the extent to which the actual therapy conformed to the program.

Measuring outcome has been another dilemma. Many studies use very different measures of treatment success—ranging from the objective, such as rehospitalization, to the subjective, such as the patient's sense of well-being. The collaborative study uses a much more complex and sophisticated system. Multiple tests measuring a variety of factors such as symptoms and social functioning are completed at various junctures before, during, and after treatment. These evaluations are done by the patients themselves, "significant others," therapists, and independent evaluators who are blind to the type of therapy administered.

Collaborative study researchers are also able to take advantage of a completely overhauled and more standardized diagnostic system, though new evidence suggests that other patient variables, such as personality type, may be more important than diagnosis in predicting the success of particular therapies. In preliminary research, Ann Simmons and George Murphy of Washington University in St. Louis used a test called the Rosenbaum Learned Resourcefulness Scale to measure patients' preferred methods of coping. They have had success in using the results to identify which patients will be responsive to cognitive therapy and which will be responsive to drugs.

Some researchers, however, believe that the clinical trial method—even when exhaustive attempts are made at specification and standardization—miss crucial information about the individual characteristics of each patient as well as the nature of the therapist-patient relationship.

John Curtis and George Silberschatz

Therapy offers the hope that we don't have to be crazy, and that may be invaluable.

are codirectors of another research project funded by NIMH designed to overcome the limitations of the clinical trial method. Their work, called process research, involves examining, in minute detail, what happens in each session during the course of a subject's therapy. "Going into the session and examining what happens in this detail is like basic cellular research in medicine, where people might spend years studying cells, the nature of cells, and the interaction of cells," says Silberschatz.

Curtis and Silberschatz are testing the effectiveness of a form of psychodynamic therapy based on a theory called control mastery. Oversimplified, control mastery means that the patient defines goals and is taught to invalidate beliefs that stop him or her from achieving those goals.

Four years into the five-year study Curtis and Silberschatz have found a high correlation between patient progress and the appropriateness of the therapists' interpretations. In tracking this, however, they have also witnessed enormous fluctuations in the behavior of therapists, all of whom are highly experienced. "Therapists will be on, then they'll be off, they'll be up and they'll be down," says Silberschatz. "We've seen bad therapies where the patient was not doing well and then, almost by accident, the therapist suddenly got on the right course and the patient got better. Then the therapist reverted to the old pattern and the patient got worse."

Silberschatz and Curtis are hopeful that the results of their study will help therapists become more consistent. "If we continue to show this high correlation over many, many cases," says Silberschatz, "it has enormous implications for training."

While none of the current research has yet resulted in major breakthroughs and there is still little hard evidence, the body of work is beginning to reveal nuggets of information that may one day lead to bigger answers. One of the questions remaining, however, is the extent to which these answers will be listened to by practitioners. In 1984, psychologists R. Bruce Sloane and Fred R. Staples

wrote, "There is little evidence that any findings of any outcome study have had much influence on the *practice* of psychotherapy. . . ."

Dianna Hartley, a researcher at the University of California Medical Center in San Francisco, believes that this inattention to research is in part due to the limited applicability of what findings there have been, even when they are positive. "If a study is published which says out of a sample of 100, 50 patients got analytic therapy, 50 got behavior therapy, and 70 percent of the patients got better, that doesn't really tell me much about the patient I'm seeing at three o'clock. The results haven't been broken down in a way that's useful to clinicians dealing with individual patients."

The work will eventually alter the practice of psychotherapy, Docherty argues. "There really has been a revolution in psychotherapeutic research," he says, "in its methods and its power to determine clinically relevant findings. But it takes a long time for findings to penetrate practice; that's true for medicine as well."

In the meantime, many of the people who are treated do not get better, and one of the criticisms leveled at psychotherapists is that they continue to dispense treatment in the absence of improvement. But historically, medicine has always had the problem of caring for people who have diseases for which there is no known cure.

And as it is most often used in this country, psychotherapy is a last resort. Contrary to myths, therapy is not the first choice of individuals in trouble but usually the last, after they have tried everything else. The average time lapse between the first symptoms of alcoholism and seeking help is five years; for those with panic attacks, 12 years. People suffer with anxiety and depression anywhere from six months to two years before seeking help. It is perhaps the way in which psychotherapy represents a last chance that is its most important contribution. To borrow Jerome Frank's concept, the very existence of therapy may play an important role in treating the demoralization of society. Perhaps we can never evaluate the symbolic role therapy plays, but the belief that we don't have to be depressed or anxious or crazy, the hope that there is always a way out, may be invaluable. In their summary of the contribution therapy makes to people's lives, researchers Smith, Glass, and Miller conclude: "Of the levers that can move society forward, psychotherapy is only one. It may not educate so well as schools; it may not produce goods and services so well as management science; it may not cure illnesses so well as medicine; but it reaches a part of life that nothing else touches so well." S

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