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Efficacy of Psychotherapeutic Treatments: Research Based on Clinical Practice

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ABSTRACT. – This article examines the relationship between psychotherapy research and clinical practice. Despite research advances in the last twenty years, there are still numerous obstacles to overcome for the dissemination of this topic. For this purpose, we will highlight the differences between evidence-based research, aimed at determining which therapeutic treatment is more effective for different psychiatric disorders, and practice-based research, which intends to obtain results that are more similar to daily professional practice, by focusing on aspects such as the therapeutic relationship, patient and therapist characteristics and contextual factors. It is possible to create a clinical practice that is not disconnected from scientific evidence regarding various aspects of therapeutic work. Lastly, I will highlight how psychodynamic treatments have shown evidence of effectiveness that makes them comparable to other types of treatments, even though the complexity of studying the therapeutic relationship in such a setting needs more work in order to integrate quantitative and qualitative research.

Key words: Psychotherapy research; efficacy; outcome; therapeutic relationship; practice-based research. .

In a recent article published in the journal *American Psychologist*, Marvin Goldfried (2018) raises the question about how to promote the transition of psychotherapy towards a more mature scientific occupational statute, after more than one hundred years from its birth. According to Goldfried, there is still no general consensus on which are the basic principles that characterize its theory and operational practice. If, on the one hand, the theoretical fragmentation of therapeutic approaches continues to be an obstacle to finding an agreement on the principle aspects that characterize this therapeutic work (recently more than 500 schools of thought have been counted worldwide) (Prochaska & Norcross, 2018), there is still a problem in trying to reduce the

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distance between the world of research and that of professional practice. Not because a consensus on fundamental themes of psychotherapy must come from research results, but rather because no professional practice can exist without being linked to the results that research produces. The last 25 years have seen the establishment of an evidence-based research paradigm. In this perspective, research has the task of divulging its results, which are obtained via rigorous scientific methodologies, to the professional sphere, in order to improve the efficacy of interventions. Today we can affirm that this 'one-way' or 'top-down' strategy has obtained modest results and has had marginal impacts on the professional world. The therapist (or the person in charge of a health service) rarely uses research results to improve their way of working and provide more adequate answers to the needs of their patients. Therefore, the necessity to experiment with dissemination practices that follow two paths was born; from research to practice and from practice to research, rather than just one of these two (Goldfried, 2018). Practice-based research that acts as a complementary element to evidence-based research, should give value to the knowledge and competences of a clinician and researcher (Barkham, Stiles, Lambert, & Mellor-Clark, 2010). This integration is especially necessary in the psychodynamic or psychoanalytic therapy fields, which have historically paid the price for a conceptual detachment between practice and research. Therefore, there is a need to redirect the focus of clinical research towards practice-based research, that is, a research that answers pertinent and clinically significant questions posed by a clinician (Castonguay & Muran, 2015). Consequently, we must step out of this mutually discrediting perspective where the world of research is seen as an ivory tower with little connection to the real world, and where clinical practice is seen as a world of approximation lacking procedural and scientific rigor. Thus, what do clinical researchers really want? An in-depth survey conducted in Canada with more than one thousand psychotherapists (Tasca *et al*., 2015) has demonstrated that clinicians value the following themes as extremely important: understanding the mechanisms of change in psychotherapy, comprehending the components of the therapeutic relationship, learning the most efficacious methods to train therapists that can truly help treat patients. One can note therefore, that beyond the solely ideological picket fences and barriers, research and clinical practice can come together when one searches for concrete answers regarding the management of patients in therapy. Recently, in like manner, Nancy McWilliams (2017) asked herself which type of research would be truly useful to therapists that practice the profession, highlighting how the traditional question 'What works for whom?' (Roth & Fonagy, 2013) should translate into 'What works and with whom can we work best?', with a strong focus therefore on the study of the characteristics of the therapist and the interaction between the personality of the clinician and the relational world of the patient.

In this article, I will provide certain considerations concerning evidence-

based research in psychotherapy, with particular focus on psychodynamic therapy, in order to move towards research perspectives that are based on professional practice.

Efficacy in psychotherapy

What evidence does research produce regarding the efficacy of psychotherapeutic treatments? In the last few decades researchers have tried to answer this question within the logic of evidence-based research, with studies based on randomized control trial methodology (RCT) in which the therapeutic effects of different treatment conditions are confronted with the outcome of the patient. The epistemological premise of this type of research, based on the idea of verifying empirically-supported treatments (EST), is to identify specific treatments for specific disorders (Nathan & Gorman, 2015). In RCT experimental studies the comparison takes place via two different groups of subjects who are exposed to different conditions (for example, a group receives treatment and the control group does not). In order to establish how much a certain therapeutic intervention is effective in the treatment of a specific disorder, the RCT helps to answer the following research question: can we be sure that the improvements shown by patients are due to the therapy they have received? (Kazdin, 2008). The 'ideal' conditions to reach this objective are: i) selecting a sample of patients (of an adequate number) from the relevant clinical population; ii) assigning selected patients randomly to the treatment or control condition (the simplest situation being: patients in therapy *vs* patients without therapy); iii) patients from the experimental group receive therapeutic treatment, while patients in the control group do not receive treatment; iv) at the end of the treatment improvement outcome in the experimental group is verified as to whether it is significantly superior to patients in the control condition (Del Corno & Lo Coco, 2018). The principle advantage of this type of methodology and the reason why it is used in efficacy studies for psychological interventions is its high internal validity (one can establish that the improvement of the patient is caused by the treatment received), as with the use of a control group not undergoing treatment one can control the main threats that undermine the validity of the experiment. If, from a scientific point of view, this approach remains the 'gold standard', one cannot deny evident difficulties in its effective transferability to the psychotherapeutic world. Trivially though, can a clinician trust the results obtained from a highly controlled study, in which patients are rigidly selected? In normal clinical practice, a therapist faces progressively more diversified clinical diagnostic situations, and few would be a part of these rigid classifications taken from psychiatric diagnostic manuals.

Another example could be relative to the use of control groups in these trials. For instance, many studies have compared a specific treatment condition (*e.g*. a standardized CBT for anxiety disorders) with a clinical control condition, to verify if patient change was really linked to inherent technical aspects of CBT or 'aspecific' therapeutic factors which characterize any kind of psychological support: can one expect patients to report improvements only because they have been able to talk with a professional who listens, or because they finally feel relief that they can receive care from someone and overcome their demoralization? This condition can be compared to a placebo group in pharmacological trials (Wampold & Imel, 2015). In reality it is very difficult to talk about the placebo effect in psychotherapy research, especially because in therapy, differently from pharmacology, not all the people involved in the experiment (therapist, patient, researcher) can be kept 'blind' with regards to what treatment the patient is receiving. Despite the fact that RCTs still represent the gold standard to evaluate the efficacy of treatments, one can infer from these brief observations that there are various issues regarding the methodological relevance of these studies (Del Corno & Lo Coco, 2018). For instance, it is important to keep in mind that in every study concerning the efficacy of a treatment we will have patients who present substantial improvements after therapy, but also patients that do not improve or even report an overall worsening (Lambert & Ogles, 2013). Even if the variability range in the response of these patients is taken into consideration with statistical tests, the level of individual change is not adequately described or considered. The average improvement of a group of patients after a therapeutic intervention does not correspond to the significant benefit of the therapy for each individual patient (Kazdin, 2017). Therefore, the long-standing problem returns of how to integrate clinical research into a nomothetic approach (which analyses general rules) and an idiographic one (that is focalized on the characteristics of the single subject). Hereafter, we shall see how the shareable criticisms of RCT research that have been put forward by various authors in the last few years are helping to overcome a certain amount of rigidity, and are favouring the development of research themes whose results are more coherent with the challenges of professional practice.

Meta-analyses

In the perspective of evidence-based treatments, meta-analyses represent the supreme example of scientific evidence, as they can provide an estimate of the therapeutic effect of a certain treatment, based on all the results from published single studies on a topic (Wampold & Imel, 2015). Meta-analytical studies are usually divided up into a systematic review part and a met-

analysis one. Systematic reviews are reviews of the evidence in literature that use systematic and explicit methods to identify, select, and critically evaluate relevant research published on a certain topic. They also collect and analyse data from studies that are included in the review. The term meta-analysis instead refers to a particular type of systematic review in which researchers use specific statistical techniques to quantitatively analyse and summarize the results of the included studies of the review. In a meta-analysis aimed at establishing the efficacy of a treatment, results are integrated from different RCTs that have been conducted separately, with the objective of obtaining an estimate of the effect of the intervention based on collected data from thousands of patients (Del Corno & Lo Coco, 2018). Traditionally, meta-analyses summarize data from RCTS where different conditions are compared, for example, between a specific treatment for an anxiety disorder and a control group; meta-analyses estimate the effect size of the therapy compared to the control conditions. The results of meta-analyses allow researchers to gather results from dozens of different studies and unite them into a single study. When meta-analyses are conducted rigorously and transparently, their results can provide clear evidence regarding key issues in healthcare interventions.

Despite their undoubtable advantages, one can raise doubts regarding meta-analyses and their usefulness in psychotherapy as they present weaknesses that can limit the reliability of the obtained results. For instance, the results of a meta-analysis cannot ever be better than the single studies that are included in the analysis: if these single studies present intrinsic methodological limits, the meta-analysis cannot correct these original defects. Furthermore, there seems to be a tendency to not publish RCTs that did not find significant results in scientific journals (*e.g.* no difference between the treatment and control groups), while generally published RCTs (included in meta-analyses) report significant data supporting a certain treatment compared to a control condition: there is therefore an elevated risk of overestimating efficacy results of an intervention in meta-analyses. There is already ample evidence of this distortion in the case of treatments for depressive disorders (Turner *et al*., 2008).

Generally, for over 30 years now, meta-analytic research has shown that psychotherapy favours a positive change in patients, compared to control groups made up of patients who are not undergoing therapy (Wampold, 2001). At an empirical level, the famous Dodo bird verdict ('Everybody has won and all must have prizes') seems to reflect the evidence that no one therapy has demonstrated to be significantly superior to others in the treatment of specific disorders (Wampold & Imel, 2015). This equivalence of therapeutic efficacy has been maintained even when '*bona fide*' therapies were confronted, which are characterized by clear indicators recognised by the academic and professional community. These

are interventions aimed at the treatment of patients with clinically relevant problems; that are based on a well-defined therapeutic approach; possibly even based on a treatment manual; with particular reference to defined and detailed psychological processes (Wampold, 2001). These results have substantially reduced the claims of absolute superiority of one treatment model compared to another. Simultaneously, we are asking ourselves if common aspecific factors are identifiable in various different forms of therapy that are responsible for the improvement of patients (Laska, Gurman & Wampold, 2014). While the evidence-based approach and ESTs have conveyed the idea that psychotherapeutic treatments contain specific techniques aimed at treating a specific mental disorder, the approach towards apsecific factors has mainly focused on the importance of the therapeutic relationship between clinician and patient involved in the psychotherapeutic process as a tool to overcome difficulties the patient may have (Wampold, 2001).

Lastly, it is interesting to note how psychodynamic therapies, which are generally resistant to evidence-based logic, which is perceived (rationally) as very distant from the method of analytic work, have in the last years gathered different evidences aimed at emphasizing its positive results (Levy, Ablon & Kachele, 2015; Leichsenring *et al*., 2015). Despite the strong resistance on behalf of clinicians to recognize the scientific value of these studies and, especially, the real impact of these results in daily clinical practice, different international psychodynamic research groups have produced important meta-analyses aimed at demonstrating the efficacy of these types of therapies for a variety of clinical disorders (Levy, Ablon & Kachele, 2015; Leichsenring *et al*., 2015). On the whole, these meta-analyses have provided proof of efficacy for specific forms of psychodynamic psychotherapy both in the short and long-term and for a wide range of mental disorders, that also include personality disorders (Abbass, Hancock, Henderson, & Kisely, 2006; Leichsenring & Rabung, 2008).

For example, a meta-analysis on psychodynamic therapy by Abbass *et al*. (2006) considered 23 RCTs for a total of 1431 patients, showing benefits on depressive symptoms reported by patients after a short psychodynamic therapy (less than 40 sessions). The benefits increased at the follow-up more than 9 months after the therapy, suggesting that psychodynamic treatment, more than the elimination of the symptom, initiated psychological processes that provoke a change even after the treatment was terminated, activating a positive cycle (Del Corno & Lo Coco, 2018). With regard to the treatment for anxiety disorders, the most extensive meta-analysis (with 14 RCTs and 1073 patients) showed that psychodynamic therapies promote benefits in patients with the following diagnoses: social anxiety, phobias, panic, and GAD, that were significantly superior to the control condition and comparable to those obtained with other types of accredited

treatments, mainly with a CBT orientation (Keefe, McCarthy, Dinger, Zilcha-Mano, & Barber, 2014).

A meta-analysis on the efficacy of long-term psychodynamic treatments (of at least 1 year) with patients with various complex mental disorders, such as borderline personality disorders, cluster C personality disorders, chronic depressive conditions, *etc*. (Leichsering & Rabung, 2011) analyzed 10 RCTs (971 patients in total) in which different long-term treatments were compared with therapies of lesser intensity and duration, such as CBT, DBT, or routine treatment conditions. The long-term therapies demonstrated a superior efficacy compared to short treatments: on average at the end of long-term treatment patients feel 70% better than patients in the control condition.

One of the most sophisticated meta-analyses (Kivlighan *et al*., 2015) on the maintenance in time of the obtained results of psychodynamic therapies examined studies where psychodynamic treatments were compared to non-psychodynamic ones; these were evaluated by a pool of clinicians and researchers as *bona fide* based on their stringent and shareable criteria. The authors found that psychodynamic therapies did not obtain significantly superior results at follow-up compared to non-psychodynamic ones, neither for principal symptomatology, nor for personality characteristics. On the other hand, a study with patients that presented a depressive disorder that was severe and long lasting, examined the difference between psychodynamic therapy and a control group undergoing CBT (Leuzinger-Bohleber *et al*., 2019); it showed that, three years after the start of the psychotherapy, the depressive symptomatology was reduced in both treatment conditions. However, the patients who underwent psychodynamic treatment showed major structural changes compared to patients undergoing CBT.

In summary, we can affirm that psychodynamic therapies obtain positive results, similar to or superior to other types of interventions for a wide variety of disorders; however the issue regarding the superiority of this treatment model compared to others in terms of maintenance of the obtained results in time remains open for debate (Wampold & Imel, 2015).

Can we go beyond the presumption of superiority of randomized controlled trials?

The limits of the evidence-based approach to psychotherapy, which is based solely on RCTs, has created an opportunity to expand research starting from an epistemological setting (and methodology) in which the effect of psychotherapy does not overlap with the efficacy of a medication. We can try to summarize this transformation as that of moving from evidence-

based therapy to practice-based therapy, a type of research that that starts from the importance of clinician's questions in order to improve the efficacy of their psychotherapeutic work (Tasca *et al*., 2015).

Historically, Westen, Novotny and Thompson-Brenner (2004) published an articulate study in which they highlighted the strong limitations of RCT studies in psychotherapy and the risk of conveying a generally reductionist and distorted idea regarding the efficacy of psychotherapy. Although the last 15 years have seen enormous progress, it is useful to note some of the methodological limitations emphasized by these authors. For instance, traditional RCTs describe a disembodied type of psychotherapy (without the therapist), as they aimed to show the efficacy of the *treatment*, minimizing the differences between different therapists by focusing on psychology manuals and adherence to protocols (thus hypothesizing that in this research different therapists act in the same way with their patients). (Fortunately) empirical research has instead shown that therapists tend to respond in different ways to different patients in therapy, based on their personal characteristics (Beutler *et al*., 2004; Steel, Macdonald, & Schroder, 2018). Even when therapists have been trained and supervised to offer a standardized treatment, variability in their therapeutic actions (and therefore of their response to patients in therapy) is unavoidable. Does it make any sense, therefore, to speak of treatment efficacy, for example of CBT or psychodynamic therapy, when its efficacy seems strongly influenced by the persona of the therapist? In the last few years, psychotherapy research has investigated the 'therapist effect' to determine how much the differences in outcome obtained by patients at the end of treatment are caused by differing therapist efficacy (Baldwin & Imel, 2013). We know, for example, that not all therapists obtain good results with their patients (Castonguay & Hill, 2017). Why is it that a therapist is able to treat patient A with more efficacy than patient B? In a study conducted by Barkham, Lutz, Lambert and Saxon (2017) on 362 therapists (and 14,254 patients) a big therapist effect was confirmed to influence patient outcome. These authors highlighted how this effect was even more pronounced for patients with more serious initial problems. The variability in the influence of the therapist is therefore to be kept in consideration, especially with more difficult patients. Some therapist variables that can influence the success of patient therapy have been described (Lingiardi *et al*., 2018). For example, attachment characteristics of the therapist and their reflexive function contribute to their ability to establish an empathic and supportive relationship with the patient (Cologon *et al*., 2017). Therapists with a secure attachment style (who tend to react less defensively and have less negative countertransference) show better results with more severe patients (Strauss & Petrowsky, 2017).

Another fundamental limitation of RCT research highlighted by Westen

and colleagues (2004) is the lack of importance assigned to the therapeutic alliance. Once we put aside the idea that psychotherapy is equivalent to medication, research focused on aspects of the relationship between therapist and patient that can facilitate the improvement of the latter in therapy. An exemplary work on this topic is that coordinated by J. Norcross in the last 20 years, summed up in the title of the volume '*Psychotherapy relationships that work*' (Norcross, 2002). This text, which has been regularly updated over the years, offers a way of disseminating elements of the therapeutic relationship that research has shown to be important in favouring positive therapy outcomes in a clinical setting. If we take the latest version of this text (Norcross & Wampold, 2019), the authors highlight how the main evidence-based relationship factors are: empathy, respect, collaboration, agreement on work objectives, authenticity, emotional expression, cultivating positive expectations, managing countertransference and the establishment of a genuine therapeutic alliance.

Regarding this last factor, a meta-analysis (including 295 studies and 30,000 patients) conducted by Flückiger *et al*. (2018) confirmed that this element is essential in predicting positive change in the patient at the end of therapy. This study underlines an important aspect for the work of the therapist: that relational aspects of therapy act simultaneously to treatment methods, based on the characteristics of the patient (Norcross & Wampold, 2018). The therapeutic process is therefore a complex aspect that must be analysed by keeping in mind the interaction between the characteristics of the patient, those of the therapist and their alliance, within a treatment setting.

Towards practice-based research

While evidence-based research has long claimed to examine if a treatment (*e.g*. psychodynamic, CBT, individual, group and family therapy) is effective in the treatment of a patient, contrarily practice-based research tries to comprehend if the specific therapeutic relationship, starting from therapist and patient characteristics and their meeting, can help to overcome problems presented by the patient. Norcross & Wampold (2019) have emphasized how research has confirmed what all common sense clinicians already know: no one treatment works for all patients, and what works with one, might not work with another. Matching between psychotherapy and mental disorder as proposed by ESTs seems therefore to be incomplete and often misleading. The therapist modifies his or her therapeutic approach based on the patient and it depends on the patient's needs. Consequently, 'effective' therapists implement various levels of therapeutic relationship in a responsive way depending on the patient being treated,

and also on the moment during therapy with the patient (Norcross & Wampold, 2019).

Namely, the idea that rather than just observing the impact of single therapeutic techniques on the patient, therapists must actually analyse the level of responsiveness they have to the patient (Stiles & Hovarth, 2017). At an empirical level, we have seen that in psychodynamic therapies we obtain better results with patients when the therapist does not follow a treatment model in a rigid way, but rather he or she uses adherence flexibility by working with the patient's characteristics (Owen & Hilsenroth, 2014). In psychodynamic therapies this flexibility, for instance, on the use of certain types of cognitive-behavioural interventions, seems to promote a better therapeutic alliance with the patient (Goldman *et al*., 2018). For example, the use of a selection of topics to discuss during psychotherapy sessions (which is typical of CBT interventions) with depressed patients who are undergoing psychodynamic therapy, seems to predict better results at the end of therapy (Katz & Hilsenroth, 2018).

Lastly, in a study based on the analysis of video recorded sessions of psychodynamic therapy for depression, the therapists that integrated a small quantity of CBT techniques in the first few sessions (*e.g*. starting by discussing certain topics; explaining reasons for using a particular technique during the session; discussing future patient life situations; providing information to the patient regarding symptoms and therapy) obtained better results at the end of treatment (Katz *et al*., 2019).

So up to what point is it useful to integrate different therapeutic techniques? In which conditions and for which patients is therapeutic flexibility fundamental? (Castonguay, Eubanks, Goldfried, Muran, & Lutz, 2015). How can one personalize therapy based on the needs of the patient? (Leichsenring *et al*., 2018). It is easily perceivable that to these complex questions there must be a complex approach to clinical research. For a few years now the *American Psychological Association* has supported an approach that is based on evidence-based practice, that foresees an integration between research results and therapist clinical experience, in the context of patient characteristics, patient preferences and cultural orientation (Norcross & Wampold, 2018). In this perspective, it is necessary to integrate an approach to research that is both quantitative and qualitative (Del Corno & Lo Coco, 2018). I will now describe an example of how this research with mixed methodologies can produce interesting results to help improve scientific knowledge and, at the same time, provide the clinician with insights that are pertinent to his or her professional practice. We have seen in this article how a key term in psychotherapy research is that of 'outcome', that is, the result of therapy. Outcome is a construct that was born from the world of research in order to evaluate the improvement of a patient, but is it useful in clinical practice? The work of De Smet *et al*.

(2019) offers some stimulating data with regards to this: in a RCT on the treatment of depressive disorders with psychodynamic and CBT therapy, the authors examined the outcome of patients both in statistical terms, that is, clinical significance, and with a qualitative in-depth analysis on the patient experience. Thus, the patients who were selected had all reported a clinically significant improvement (improved patients and cured patients) at the end of therapy, these were then asked to take part in an interview that was aimed at understanding their change experience in therapy. The objective of the study was to obtain a description of what is a 'good' therapeutic result from the patient prospective, as well as obtain the statistical significance of the reported change. The results showed that for patients a good result of therapy is a process of becoming, in which one must balance the achieved improvements with the difficulties that are still taking place. 'Cured' patients, *id est*, those that no longer presented depressive symptoms at the end of therapy, in some cases expressed how certain problematic aspects of their malaise were still present and that they had to continue 'to fight'. The more positive aspects of their healing experience focused on: i) having a superior sense of empowerment, that is, the strength to face problems in a new way, manage interpersonal relations, feel a certain maturity in their experience of self; ii) having improved their ability for insight and self-reflection.

It is interesting to note that these experience dimensions were for the most part common to all improved patients in both therapy formats, psychodynamic and CBT. Hence, the 'good' result of a therapeutic treatment is a complex personal experience and the integration of both a qualitative and quantitative evaluation of outcome; this can expand our knowledge of change regarding patient perspective.

Conclusions

In the last few decades we have tended to emphasize the distance between clinical practice and research. We have seen how, for a long time in the scientific community, a conviction of a top-down, rather than a bottom-up relationship direction between these two practices prevailed. The basic idea was that research produced scientific evidence that could then be transferred to clinicians in their treatment settings. From this perspective, the psychotherapist would carry out a more effective intervention with his or her patients if he or she followed the recommendations given by research, which could provide new understanding on the psychopathological characteristics of patients and on their possible therapeutic treatments. The clinician would be able to help his or her patients as long as they did not only base their work on their subjective experience, but they

had to refer to scientific evidence (Goldfried, 2018). We have highlighted how this process of knowledge transfer from research has not produced the desired effects since psychotherapists rarely turn to research results in moments of difficulty during the formation of a psychotherapeutic relationship with a specific patient (Castonguay, Barkham, Lutz, & McAleavy, 2013). The limits of research, which are often lamented by professionals, refer to data taken from generic samples of patients that rarely reflect the complexity of the real 'skin and bone' patients that come to psychotherapy sessions. Often there are statistical elements that are not easily comprehensible for the average psychotherapist and there are research topics that are only sometimes pertinent with the daily needs of a clinician (Tasca *et al*., 2015). Presently, it is surely more promising to have a strategy based on the integration of research and clinical practice that can build a bridge between the two realities that represent two sides of the same coin, that is, scientific professionalism and psychotherapy. This construction should be based on research that begins with clinical practice, and it must elaborate on ways of working that have more sense for the clinician (Levy, Ablon & Kachele, 2015). In summary, to go back to what Leichsenring *et al*. (2018) already stated, the future of psychotherapy is the plurality in recognizing that we need different forms of psychotherapy based on evidence, but that we must also keep in mind the irreducible complexity of our object of study.

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