Debate

Can the therapeutic relationship survive the clamour for evidence-based practice?

asks Neville Tomlinson

Of all persuasions?

Another issue with an RCT, or any research (or article), is that it is prone to seek out evidence which supports the author’s views, what is known as the “research allegiance effect.” However, Luborsky et al12 emphasise that the researcher is probably unaware of his prejudices, and Leykin and DeRubeis6 have more recently suggested care must be taken when considering any allegiance bias, that a researcher’s therapeutic modality should not automatically infer bias towards it. Research and considerations of such issues will no doubt rumble on, but I imagine are never likely to get beyond the simple truth that, as Robson states: “You can’t lose your humanity behind when doing research.” NIC4 treatment guidelines are approved by committees known as Guideline Development Groups (GDGs) which employ a combination of experts ‘of all persuasions’; and some service users, to consider the evidence provided by RCTs as well as other evidence such as meta-analyses—a approach highlighting why some consider NICE to be the most diligent organisation in the world when it comes to assessing the available evidence. However, the reality of the expression ‘of all persuasions’ may not be the utopian scenario if suggests. Guy et al6 reviewed the composition of the GDGs that compiled the clinical guidelines for anxiety, depression and schizophrenia. Only, 11 per cent of the 75 so employed were classified as service user/carers, and less than seven per cent were psychological therapists. Although a further seven per cent were categorised as clinical psychologists, Guy et al6 citing Mollon,12 suggest that many British Psychological Society (BPS) members associated with the development of NICE guidelines are dedicated to research utilising CBT modalities. For a recent course assignment, I had reason to review the current NICE guidelines for the treatment of post traumatic stress disorder (PTSD). They were published in 2005 and, of the 17-strong GDG, eight were employees of the organisation commissioned to develop the clinical guidelines—the National Collaborating Centre for Mental Health (NCCMH)—two were classified as ‘sufferer representatives’, five were associated with eminent educational establishments across the UK, one was a consultant psychiatrist and one was the clinical director of a counselling service in Kent. One of the co-chairs of the GDG, Anke Ehlers, co-wrote A Cognitive Model of Posttraumatic Stress Disorder2 and key personnel involved in the drafting of the NICE guideline had previously written published works advocating the benefits of cognitive behavioural therapies. It would be difficult to imagine the remaining group members, in particular the sufferer representatives and counselling service director, having much influence on policy decisions given the plethora of evidence brought to the group.

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O

n the school run one morning last year, I was explaining to my daughter that I wouldn’t see much of her that evening because I had a client. My youngest son was sitting in the back of the car, apparently nonplussed by the news, and continued the far more important task of crashing one of his toy dinosaurs into some Lego. A few minutes later, a voice piped up from the back seat and declared: ‘Counselling is when you talk to someone about how things are’—Surprised and enthused by his interest in my work, I started to mentally prepare a reply that would add a few finer points to his somewhat naive statement (well, he is only six, bless him!). But I soon realised I couldn’t really improve on what he’d said. Fundamentally, ‘talking to people about how things are’ is exactly what we do— isn’t it?

In essence, I believe it is, but in these days of significant investment in psychological therapies from the public purse, there is far greater emphasis on the understandable need for clinicians to provide evidence that the talking they do with their clients is effective and produces a positive end result. However, how such evidence is established within counselling and psychotherapy is the source of a great deal of debate and scrutiny. The National Institute for Health and Care Excellence (NICE) is unequivocal: the gold standard of healthcare research is the randomised controlled trial (RCT).1

An alternative viewpoint, though, is that the appropriateness of a research design can only be judged by reference to the specifics of the question it addresses—and that it is a redundant argument to always infer that the RCT is superior.2 Guy, Thomas, Stephenson and Loewenthal3 add emphasis to this point by quoting someone who they title the architect of the RCT, Austin Bradford Hill, who, in 1965, wrote: ‘Any belief that the controlled trial is the only way would mean not that the pendulum had swung too far but that it had come right off the hook.’

However, in the current climate, without evidence of efficacy from such a trial, there can be no treatment recommendation from NICE. As such, talking therapies now find themselves rubbing shoulders with general medical care which, for the most part, includes diagnoses and courses of treatment. Those in the vanguard of current IAPT service provision, despite their protestations to the contrary, are apparently at ease with being embedded within the biomedical model, and even regard the term ‘talking therapies’ as inappropriate and at odds with the science which underpins current treatments.3

But many within counselling and psychotherapy, while acknowledging there will be biological consequences, firmly reject the notion that there are solely biological causes of mental and emotional health issues.4 ‘The shortcomings of a reliance on the RCT to determine the efficacy of psychological therapies are extensive6,7’ and were succinctly encapsulated by Mollon’s letter to The Psychologist in 20005 that included the following: ‘Therapies are recommended without regard for any understanding of the particular psychological nature of the target condition (or indeed of the therapy)—and thus there is no rationale offered to support the recommendation, other than that certain randomised studies have shown it to be helpful.’ Mollon went on to write: ‘This lack of psychological content seems to encourage an unfortunate tendency to perceive psychological therapies as analogous to pills that can be prescribed… the careful work of understanding the complexities of the individual, which are often somewhat remote from the presenting symptomatology, is lost.’

It is easy to forget that the research we are considering is gleaned from the life stories of our fellow humans. Has the pendulum swung too far?
the treatment of PTSD (for example, Bisson et al), and EMDR. Given it is the only other psychological treatment psychological treatments ’

An opinion you may or may not agree with.

The ‘what’ and the ‘how’

Why does all this matter? There may be some academic jargon about ‘reliability’ and ‘validity’ but what we are being told is that a psychological treatment becomes recommended and whether the aetiology of mental and emotional distress can be proportionately reduced, governments, regardless of their political persuasion, have invested significant sums in talking therapies; something governments, regardless of their political persuasion, have

Debate

The therapeutic relationship

Where does this leave the therapeutic relationship – and is relationship really that important? After all, therapists who cultivate warm relationships with their clients may have better outcomes, but doesn’t that merely put them on a par with, politicians, salespeople and prostitutes? (It is necessarily unsurprising, those with a more positive opinion of the potential benefits of psychological therapies give the question a far more consideration. Kochs13, for example, declares when asked whether it is the treatment or relationship that has greatest impact on the client, that the answer must be ‘both’, and that ‘what one does and how one does it are complementary and inseparable. To remove the interpersonal component from the instrumental may be acceptable in research, but it is a fatal flaw when the aim is to extrapolate research results to clinical practice.’)

The consequences of the latter are highlighted in McEvoy et al’s findings from a telephone survey conducted with people who presented with common mental health problems and who engaged with an IAPT service in the north west of England.16

The study highlighted that current clinical outcome measures are weighted towards predetermined socio-economic benefits that throw little light on the service user’s personal needs and experience of their ‘recovery’. The researchers conclude: ‘More emphasis may need to be placed on enabling service users to identify and pursue their goals’ this could potentially aid the process of recovery by counteracting the destructive tendency that there is for practitioners to think that they know best.’ Thus, as Johnstone and Dallos17 acknowledge, theclinician faces a demanding challenge: how to maintain the delicate balance between the formulations their-theoretical allegiances steer them towards while ensuring they truly listen to their clients’ stories and experiences. With his experience as a supervisor of clinical graduate students, Meichenbaum20 considers what he would witness if, among others, Foa (prolonged exposure therapy), Shapiro (EMDR) and Linehan (dialectical behaviour therapy) were conducting sessions in clinical interview rooms he which he has been in existence for centuries, from as far back as Hippocrates. If the current relevance of a Greek physician seems dubious, it should not be forgotten that a generally accepted tenet of cognitive therapy (CT) is the assertion of Epictetus that individuals are not disturbed by events, but by the view they take of them. (italics added) with chronic PTSD. There is no suggestion of human beings as the unique individuals we are; the key piece being the ‘notability of standardised approaches which can be applied when psychiatric or psychological formulations have been determined. Such processes again add an air of certainty, which they rarely merit. As an example, Johnstone and Dallos18 acknowledge within the opening pages of their book, ‘Formulation in Psychology and Psychotherapy, that case formulation is, in essence, ‘best guess’, a point underlined by the different formulations representing a range of therapeutic modalities developed by guest contributors to the book. But perhaps the latter merely adds weight to the argument that, once you have established the efficacy of evidence-based therapies for specific presenting issues, it is the ‘how’ that needs special attention.

The solution is therefore straightforward: what are needed are properly trained therapists. As Layard and Clark acknowledge, ‘Psychological therapies are complex. For them to be effective, they need to be delivered properly. Unless therapists are carefully trained, there will be considerable variability in the competence with which a treatment is delivered.’ ‘There can be no argument against the principle of this statement. Many would acknowledge that the training of counsellors and psychotherapists across the country is not always as stringent or thorough as it could be. But the references to ‘a treatment’ and its ‘delivery’ maintain the biomedical view of psychological and social work and place the therapist firmly in the role of expert and authority. Therefore, when Merikangas19 and brief references to Rogers’ core conditions in Layard and Clark’s book. ‘But it seems clear they strongly advocate the standardised ‘delivery of psychological therapy.’

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As the reader may have noticed, this article has, done, the investment, in the form of IAPT, has thus far

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Never has this rung more true for me than the week I started to counselling young people to feel secure, learn to manage their emotions and accept themselves, it is too important a goal to be used as an empty campaign tool.

Reference

About the author
Claire Thomas is a person-centred psychotherapist who began in private practice with face-to-face and online clients.
clairethomascounselling@gmail.com www.clairethomascounselling.co.uk

About the author
Neville Tilmonton is a counsellor currently working as a consultant with the University of Chester Psychological Therapies in Primary Care (CPTCC), a department of the University of Chester based in Shrewsbury. He has previously worked as a non-custodial offender as a Prisoner Education Counsellor, and at a local Mind association as Deputy Manager, where he had previously held the position of Counselling Co-ordinator. He is currently studying at the University of Chester for a Master of Psychological Trauma and has a small private practice in Nottingham.

Private Practice Summer 2015


About the author
Claire Thomas is a person-centred psychotherapist who began in private practice with face-to-face and online clients.
clairethomascounselling@gmail.com www.clairethomascounselling.co.uk

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19. Williams film], and I might be nice to people, mindful today of my mother tongue ‘play’ will become familiar
20. Brand raised