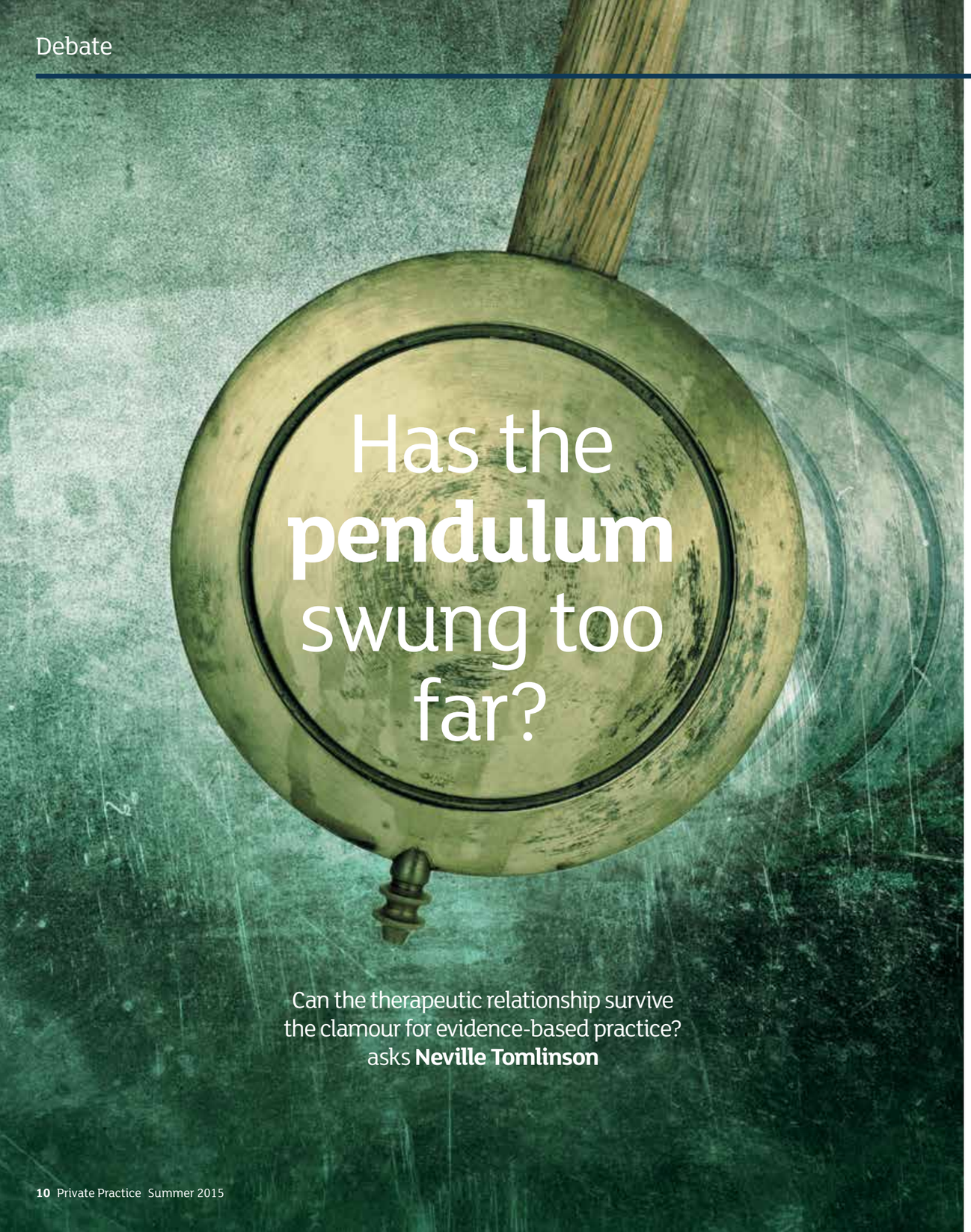

Has the **pendulum** swung too far?

Can the therapeutic relationship survive the clamour for evidence-based practice? asks **Neville Tomlinson**

On 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 naïve 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 Loewenthal[3] add emphasis to this point by quoting someone who they title the architect of the RCT, Austin Bradford Hill,[4] 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; 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.[5]

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.[3] The shortcomings of a reliance on the RCT to determine the efficacy of psychological therapies are extensive[3,6,7] and were succinctly encapsulated by Mollon's letter to *The Psychologist* in 2007[8] 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.'

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'.[8] However, Luborsky et al[9] emphasise that the researcher is probably unaware of his prejudices, and Leykin and DeRubeis[10] 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 leave your humanity behind when doing research.'[11] NICE treatment guidelines are approved by committees known as Guideline Development Groups (GDGs) which employ a combination of experts 'of all persuasions',[1] and some service users, to consider the evidence provided by RCTs as well as other evidence such as meta-analyses – an approach highlighting why some consider NICE to be the most diligent organisation in the world when it comes to assessing the available evidence.[1]

However, the reality of the expression 'of all persuasions' may not be the utopian scenario it suggests. Guy et al[3] 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 users/carers, and less than seven per cent were psychological therapists. Although a further seven per cent were categorised as clinical psychologists, Guy et al,[3] 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).[13] 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 Disorder*[14] 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

It is easy to forget that the research we are considering is gleaned from the life stories of our fellow humans

by these academics. Ultimately, the 2005 clinical guidelines recommended only two psychological therapies – trauma-focused CBT (TF-CBT) and eye movement desensitisation and reprocessing (EMDR). Ehlers currently works alongside David Clark at the Oxford Centre for Anxiety Disorders and Trauma based in the Department of Experimental Psychology at the University of Oxford. The Centre's website[15] declares that psychological treatments *'such as'* (italics added) TF-CBT can be effective in the treatment of PTSD. There is no mention of EMDR. Given it is the only other psychological treatment NICE currently recommends, it is conspicuous by its absence. Since 2005, several of the group have co-written papers on the treatment of PTSD (for example, Bisson et al),[16] and subsequently a guideline review in 2011 came to the conclusion that no amendments were required.

The evidence, one assumes, must be incontrovertible. However, Bisson et al's systematic review and meta-analysis of 38 RCTs discovered 'only limited evidence that TF-CBT and EMDR were superior to supportive/non directive treatments'.[16] TF-CBT beat the waiting list and 'usual care' (not defined) hands down and was ultimately recommended, alongside EMDR, as the psychological treatment that should be offered to *everyone* (italics added) with chronic PTSD. There is no suggestion of impropriety, but what I consider this does emphasise is the probability of an 'allegiance effect' within the GDG which leaves one pondering the 'chicken or egg' nature of the treatment recommendations made by the NICE clinical guidelines. Cooper[6] also suggests the prevalence of CBT-based evidence is because CBT is generally a short-term solution-focused therapy and thereby much easier to test and, as has been shown above, many of its proponents are based in educational establishments supportive of and committed to research.

The 'what' and the 'how'

Why does all this matter? There may be some academic jousting about the whys and wherefores about how a psychological treatment becomes recommended and whether the aetiology of mental and emotional distress can be pinpointed, but when all is said and done, successive governments, regardless of their political persuasion, have invested significant sums in talking therapies; something which would have been considered a pipe dream only a few years ago. And those who have championed the cause consider that, while there is still a great deal of work to be done, the investment, in the form of IAPT, has thus far proved successful overall.[1]

However, as always, there's a 'but' (actually there are several). As the reader may have noticed, this article has, to date, made no reference to the therapeutic relationship, let alone the client. It has mainly centred on the 'evidence' rather than the 'practice'. But the current trend and focus on an evidence-led approach generally implies that if you know 'what' to do, the 'how' can be engineered to ensure a successful outcome is more likely. And collating and poring over as many statistical data as you can get your hands on can determine both elements. The 'statistical data', in this instance, are clients, but as Lord Lipsey (Chair of the All Party Parliamentary Group on Statistics) asserts in a 2013 document promoting the varied uses of quantitative skills,[15] 'without numbers, most opinion is just that and much political debate vacuous'. An opinion you may or may not agree with.

In all seriousness, it is easy to forget that the research we are considering is gleaned from the life stories of our fellow humans; a point not lost on Healy,[18] who, although commenting on pharmaceutical treatments for mental health issues, highlights how the preoccupation with RCTs means that what he calls 'case vignettes', or case studies, are unlikely to be considered; a practice which he posits 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 (for example, Owens).[19]

It surprises me that this statement is generally applied to mankind as a whole, without consideration of the nuances of humans as the unique individuals we are; the by-product being the honing 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 Dallos[20] acknowledge within the opening pages of their book, *Formulation in Psychology and Psychotherapy,* that case formulation is, in essence, a '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.'[1] 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 relevant to current practice as it could be. But the references to 'a treatment' and its 'delivery' maintain the biomedical view of psychological therapies and place the therapist firmly in the role of expert. There are vague and brief references to Rogers' core conditions in Layard and Clark's book, *Thrive,*[1] but it seems clear they strongly advocate the standardised 'delivery' of psychotherapy.

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The therapeutic relationship

Where does this leave the therapeutic relationship – and is the 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'.[21] Ouch! Perhaps unsurprisingly, those with a more positive opinion of the potential benefits of psychological therapies give the question a tad more consideration. Norcross,[22] 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 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 had engaged with an IAPT service in the north west of England.[23] 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 Dallos[20] highlight, the clinician 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, Meichenbaum[24] considers what he would witness if, among others, Foa (prolonged exposure therapy), Shapiro (EMDR) and Linehan (dialectical behavioural therapy) were conducting sessions in clinical interview rooms he could observe through a two-way mirror. Regardless of what he terms the 'acronym therapy' utilised, he suggests he would see professionals establishing, monitoring and maintaining the therapeutic alliance while developing and adapting the treatment process ethically, professionally and collaboratively. Just as our clients and their experiences are unique, so too are we as practitioners, and no doubt from day to day and from session to session.

Rogers[25] promoted 'a way of being', something I personally can only aspire to. My personal view is that sessions with our clients are a unique cocktail of circumstances and emotions and if we simply try to 'be' a therapist we can become detached from the interpersonal relationship we strive to develop. In my first placement session, I must admit that, for the first five minutes, I was mentally marking my responses to the client, and wasn't scoring myself particularly highly. Then, bingo, a pure reflection and I was on my way – for about half a second. My client looked at me with some consternation and asked what the hell he was supposed to say to that (only he didn't say 'hell'!). From that point forwards, I vowed never to try and 'do' counselling again.

The message implied by Layard and Clark[1] is that therapists should adopt more uniform methods. What form could this take? And is it already seeping into service delivery? Earlier this year, I was talking to a psychological wellbeing practitioner (PWP). Her role in an IAPT service included the completion of client assessments. During her observed training, she had to use the phrase 'that must be really difficult for you' at least three times, otherwise she would fail. Is this – what Layard and Clark possibly mean by 'enough empathy'[1] – really the way forward?

At an event in Birmingham late last year to celebrate the 25th anniversary of PCCS books, the distinguished panel (including Richard Bentall, Mick Cooper, Stephen Joseph and Jacqui Dillon) were asked closing questions about the need for practitioners to engage with evidence-based research, with some in the audience questioning the whole process and rationale. I thought Bentall and Cooper, in particular, while sympathetic, encouraged attendees to embrace research, albeit critically where necessary. Without it, they said, alternatives to current trends were unlikely to be funded. But it was the comments of a Danish psychotherapist, Lisbeth Sommerbeck, that stood out for me. Her initial response seemed to me to be quite positive – counselling and psychotherapy would maintain their role within future mental health service provision. But, she concluded, somewhat chillingly in my opinion, the therapies so delivered may not take a form we currently recognise as counselling and psychotherapy.

To conclude

I hope it is clear that my views regarding our profession's ever increasing reliance on 'evidence' is sceptical rather than dismissive. I believe we must remain vigilant about the nature, source and interpretation of the evidence and not become seduced by it. For, regardless of our therapeutic 'faith', we will never truly be certain of the causes of our clients' mental distress, nor can we wield an emotional scalpel to rid them of it. Ultimately only one person, the client, can determine their personal healing process and its success and sustainability.

Never has this rung more true for me than the week I started to write this article; a week that included the sad death of Robin Williams – a death that impacted so strongly on many people, myself included. Surprisingly for me, one of the most poignant and moving essays written about this tragic and untimely death was penned by Russell Brand in the *Guardian*.[26] Brand raised heartfelt questions of how this could happen to someone so gifted and loved, who was able to offer his love and joy so freely outwards but who, it appears, found it so difficult to turn it inwards. He concluded: 'What I might do is watch [a Robin Williams film], and I might be nice to people, mindful today how fragile we all are, how delicate we are, even when fizzing with divine madness that seems like it will never expire.'

There is no 'us and them' in mental health.[27] We all have it and slide back and forth along its spectrum. Sometimes, we are able to overcome its darker forces alone, sometimes we will seek help to do so, and sometimes we maintain the mask and muddle through as best we can. There is no panacea. As therapists, I still consider our greatest gifts to our clients are to truly listen, to build trust and rapport, to demonstrate accurate empathy, and to collaborate with them to achieve their goals.[28] If we can achieve this, then I believe we will have fulfilled a subliminal prerequisite of our clients.

I have found no academic author who can describe it more accurately or eloquently than Brian Keenan.[29] In describing how his relationship with his co-hostage, John McCarthy, tentatively developed, he writes: 'It needs a commitment to the courage of another person in order to approach them, be honest with them and know that you will not be shunned or rejected by them.' Therefore, with regard to the ongoing 'how' or 'what' debate, my answer will always be (with deference to The Killers and Hunter S Thompson) – are we human or are we counsellor?

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