

Simpson, A. (2010). What is the best treatment for Nancy in Aotearoa, New Zealand?
Australian Journal of Counselling Psychology, 10(2), 3-8.

What is the best treatment for Nancy in Aotearoa, New Zealand?

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Abstract

Depression is an increasing problem affecting New Zealand society with enormous social costs. Determining the best form of treatment for depressive symptoms is a complex issue located in an ongoing professional debate. This article asks what is best treatment for a hypothetical patient, Nancy residing in Aotearoa. It considers how we might know what is best for the patient. The medical model, with its disease perspective, sees cure in specific ingredients. Within this model Randomised Clinical Trials (RCTs) are viewed as the best research method to determine the most effective therapy modality. RCTs however do not establish effectiveness in the practice setting. Within the bicultural New Zealand context this suggests that our patient may not be helped by a practitioner following an intervention recommended by the findings of RCTs. The contextual model views the effectiveness of psychotherapy as related to the context of the psychotherapy process regardless of the modality used. A related research methodology is single participant case studies. It is suggested that recording and aggregating the findings of single participant-case studies might produce more realistic data, generalisable to both New Zealand's Pakeha and Maori populations.

Nancy is a 32 year-old female of mixed Pakeha and Maori ethnicity completing an MBA at an Aotearoa New Zealand University. She believes her marriage has left her “dissatisfied” with “no-self confidence at all” and unable to “trust herself or her decisions”. Describing her life as “a downward spiral of sadness”, Nancy is socially withdrawn and repeatedly cries. Although she is often fatigued, she has trouble sleeping at night. Worried and afraid, she frequently thinks of suicide as the only way to end her suffering.

While Nancy is a hypothetical patient, her symptoms indicating depression are real for large portions of Aotearoa New Zealand’s bicultural population. An estimated one in five women (19%) and one in ten males (10%) in Aotearoa New Zealand experience a depressive disorder at some stage in their lives (Wells, Bushnell, Hornblow, Joyce, & Oakley-Browne, 1989). Depression occurs cross culturally, throughout life, is typically recurrent, and twice as likely amongst women (Campbell, Robison, Skaer, & Sclar, 2000). Maori visiting a GP are three times more likely to have depressive symptoms than non-Maori, while 55% of Maori women visiting a GP express depressive symptoms compared with 19% of non-Maori women (MaGPIe Research Group., 2005). Depression is one of the world’s most common mental illnesses (Kennedy, Lam, Nutt, & Thase, 2004) and is increasing in Aotearoa New Zealand with each birth cohort, while onset age is decreasing (Wells et al., 1989).

Which psychotherapy modality would best treat Nancy’s depressive condition? Although psychologists have asked related questions for decades there is no clear-cut answer. The issue is related to research methodology and assessment. It is further associated with an even broader concept of competing psychotherapy meta-models; the *medical model* and the *contextual model*. Within the context of these two meta-models, this article considers the effectiveness and efficacy of two prominent outcome research methods – Randomised Clinical Trials (RCTs) and case studies – particularly as they relate to depression within

bicultural Aotearoa New Zealand. This discussion has significant implications for mental health practice in general, and for mental health practice in bicultural Aotearoa New Zealand in particular.

Evaluative criteria

Outcome assessment methods are a key to determining a client's improvement in psychotherapy. This raises the questions of how should improvement be rated and by whom, questions that have been addressed in various ways throughout the history of psychotherapy outcome research. Early outcomes evaluations were primarily based upon therapist impressions (Ogles, Lambert, & Masters, 1996) and even today some argue that the therapist is the best judge (Reed, 2007). The latter approach lacks an objective criterion. Therapist judgements risk subjective errors due to reliance on individual cognitive heuristic strategies compromised by motivated reasoning and affective biases stemming from emotional reactions. Standardised pre/post treatment rating scales attempted to overcome this shortcoming. Yet the continued possibility of therapist bias led to the development of patient self-report scales based on the argument that client satisfaction is the most appropriate effectiveness measure (Messer, 2007). Here too, there was concern for bias due to the client's limited perspective on treatment outcomes. In an attempt for greater objectivity, persons deemed impartial due to their being blind to the therapy modality being used and not having knowledge of early or late treatment status, were called in as independent outcome raters. Such trained independent observers would record their observations using a structured instrument and consensus would be achieved through inter-rater subjectivity

Are independent raters the best outcome judges in all situations however? Among the many stakeholders on psychotherapy effectiveness outcome assessment are the therapist, the independent raters, the client, the sponsor (when different from the client such as family members including significant other), the society (particularly in cases of mandated

treatment) and the funders of health care (Ogles et al., 1996). There are also different opinions on the desired and desirable outcomes of psychotherapy. These outcomes include symptom reduction, client satisfaction, independent functioning and adherence to norms of social behaviour within a particular cultural context. This involves consideration of the *content measured* (cognitive, affective, behavioural), *social level* (interpersonal, interpersonal, social role), *rater* (self, therapist, trained observer, relevant other), *technology* (global assessment, specific disorder, observation, status), and *time orientation* (sustained trait, momentary state) (Ogles et al., 1996).

A would-be practitioner-researcher proposed the question in the title of this article, must consider how well an instrument measures the specific outcome dimensions they wish to evaluate to select the most appropriate instrument for their given criterion.

A Brief History of Psychotherapy Outcome Research

A limitation of the earliest studies evaluating psychotherapy outcomes was that the modality used required a term of treatment lasting many years (Ogles et al., 1996). This made it difficult to determine if client symptoms diminished on account of the psychotherapy process, the passage of time, or other extraneous factors. In a high impact study Eysenck (1952) claimed that people with mental illnesses who were not clients of psychotherapy had a similar “spontaneous remission rate” as the symptom reduction rate found in most psychotherapy clients. A wave of psychotherapy studies followed incorporating no-treatment “wait-list” groups and various psychotherapy modalities. The conclusion of numerous such studies is that psychotherapy is more efficacious than spontaneous remission in reducing the symptoms of mental illness (Smith & Glass, 1977).

The next question to become the focus of psychotherapy research concerned the most efficacious modality. Randomised Controlled Trials (RCTs) were conducted comparing two or more treatments such as cognitive behavioural therapy and psychodynamic therapy.

Many such studies into depression in particular (Elkin et al., 1989) and mental illness in general, concluded that therapy modalities are generally comparable in their results (Wampold, 2007a). This conclusion was famously proclaimed by Rosenzweig (1936) as the Dodo Bird verdict from *Alice in Wonderland*: “Everyone has won and so all must have prizes”. The Dodo bird verdict led to questioning about the specific causes of condition improvement in the psychotherapy process (Greenberg & Watson, 2007). Today debate about the cause of client improvement is drawn along the lines of two competing meta-models: the *medical model of psychotherapy*, and the *contextual model of psychotherapy* (Wampold, 2001).

The Medical-model of Psychotherapy

The medical meta-model psychotherapy is the dominant model in psychology today (Wampold, 2001). Its dominance is favoured by several factors. These include apparent scientific advantage over alternatives, historical roots spanning back to the theories of Freud, and economics of daily practice that are embedded in the health care delivery structure (Wampold, Ahn, & Coleman, 2001). The medical model in psychotherapy is similar to the medical model in medicine, the difference being that in medicine the theories, explanations, and techniques are physically and biochemically based, whereas in psychotherapy they are largely psychologically based. Language associated with the medical model that permeates psychotherapy practice includes terms such as symptoms, diagnosis, disorder, treatment, and active ingredients.

The basic components of the medical model involve (1) a client presenting a problem, disease or complaint; (2) a psychological explanation for the distress, which leads to (3) a change mechanism, and (4) therapeutic actions involving (5) specific therapeutic ingredients that are held to be effective against the particular disorder (Wampold, 2001; Wampold et al., 2001). To elaborate on these components, client symptoms are diagnosed as indicating a

disorder, often using the American Psychiatric Association's *Diagnostic Statistical Manual of Mental Disorders* (DSM-IV). A therapist provides a psychological explanation for the disorder. Such explanations are as many as there are varieties of psychological theories proposing the causes and cures of mental distress. Each theory proposes a change-inducing mechanism and promotes actions that constitute therapy. Finally, specific ingredients within therapy are held to be the agents of change. The general aim of therapy in the medical model is reduction of symptoms indicative of the problem, disease, or complaint.

Wampold (2001) points out that the central component to the medical model is *specificity*, which involves giving pre-eminence to specific ingredients rather than the common factors in the psychotherapy context. Based upon this premise there is the expectation that psychotherapy outcome variance is based upon the specific ingredients used. There is little evidence to support this view, however. The general conclusion of meta-analyses of psychotherapy studies is that all therapy classes are comparable in their results with zero difference between them once variation due to effects common to all psychotherapy is accounted for (Grencavage & Norcross, 1990; Wampold, 2007a; Wampold et al., 1997).

The Contextual-model of Psychotherapy

In contrast to the dominant medical model's view that clients of psychotherapy improve due to the specific ingredients of a treatment modality, the contextual model holds that the effectiveness of psychotherapy is due to the context of the therapy process. This context includes client characteristics (Bohart, 2007), therapist characteristics (Wampold, 2007b), the "Hawthorne effect" of receiving attention (Cone, 2002), theoretical allegiance (Luborsky & Barrett, 2007) and the therapeutic alliance (Norcross & Lambert, 2007).

Grencavage and Norcross's (1990) meta-analysis found that the common factors in therapy involve (1) client characteristics, (2) therapist qualities, (3) change process, (3) treatment structures, (4) and relationship elements. Important client characteristics include

positive hope and expectation of improvement. Just seeking help will already make the client feel much improved, leading towards their recovery. Important therapist qualities include an inspiring personality that arouses hope and positive expectations in the client. The change process is the mechanism that provides opportunity for catharsis, ventilation, releasing tension, learning new skills, and receiving an explanation for their experiences in a low-risk environment. Even if the explanation is mythic, it can be beneficial if it provides a believable rationale for understanding the problem and prescribes a ritual for its resolution. The treatment structure involves the use of techniques and rituals, exploration of emotional issues, interaction, and a healing environment. Such structures have been said to provide a reason or excuse for the client to let go of their issues or symptoms. Finally, the therapeutic relationship or working alliance between the client and therapist provides an experience of relational closeness, encouraging the client to risk being vulnerable in relationships outside of the therapy setting. The aim of the relationship is to facilitate the client in feeling and functioning better by finding positive meaning in their experiences (Frank & Frank, 1991, as cited in Wampold, 2001).

Wampold (2001) draws a distinction between common factors theory and the contextual model. Although the factors listed above are common to all therapy, what is critical to the contextual model is the healing environment and meaning invested in it by the client and the therapist. A therapist adhering to the contextual model may focus on any of the psychotherapeutic domains - behavioural, verbal, or developmental, depending on their training and the unfolding relationship with the client. The modality, however, is viewed as a vehicle for the most important change agent – the client-therapist relationship.

Problems with RCTs

The medical model views RCTs as the “gold standard” evaluative psychotherapy outcomes research methodology. Use of RCTs is compatible with the perspective that cure is

induced by specific key ingredients. It is not at all compatible with the contextual model, which purports that particular ingredients are less significant than the curative process in the developing working alliance. Aside from this incompatibility, there are other problems associated with RCTs.

One of the most significant problems is that many therapists find the results from RCT research largely irrelevant to their practice (Duncan & Miller, 2007). Practitioners have been found to consume far less of the research literature than academics, relying more on their practical experience for learning about therapy than research (Morrow-Bradley & Elliott, 1986). Does this make practitioners the appliers of technical knowledge while making researchers the producers of such knowledge? Could it be that practitioners doing the job reflect on their practice and so also become producers of knowledge? Apparently not, most practitioners are not researchers, do not publish literature, do not participate in research, and often have negative attitudes towards research when compared with academic colleagues (Morrow-Bradley & Elliott, 1986). There are a number of reasons for this. One problem is data analyses of RCT studies reported in academic literature over emphasise group-based statistics and statistical significance (Morrow-Bradley & Elliott, 1986). This is associated with the *nomothetic* or general principle notion versus *idiographic* or the specifically-tailored-response quandary. This in turn raises the issue of the generalisability of research findings (Wampold, 2001; Westen, 2007). Researchers often fail to question their assumption that nomothetic or group-based outcomes are reliable and generalisable beyond a study sample. While such studies are important for providing findings to determine efficacy, they do not establish effectiveness with individual clients in practice settings where every effort is made to tailor the therapeutic intervention to the needs of the client.

The application of RCT research is further made difficult by the actuality that treatments, populations, and measures in research settings do not represent actual practice

(Morrow-Bradley & Elliott, 1986). “Therapists” in RCTs are often graduate students in training, while the client participants are frequently undergraduate college students (Kazdin, 1978). How can these college students be compared with actual clients representing a variety of conditions and the experienced therapists who treat them? Add to this the fact that the average difference between therapists is greater than the average difference found between treatment modalities (Wampold, 2007b). Another problem is that most RCTs do not include provisions to make their findings representative of ethnically diverse population groups (Sue & Zane, 2007). Psychotherapy is conducted in a historical and cultural context, while research is also conducted in a historical, cultural context, under the auspices of biomedicine.

These problems associated with evidence-based practice are particularly significant in New Zealand’s bicultural context considering that Maori and Pakeha have been found to have different phenomenological presentation profiles, diagnostic patterns, and treatment experiences (Tapsell & Mellsoy, 2007). Generally in psychotherapy there is a paucity of ethnic research due to difficulties in recruiting a sample that is representative of the ethnic population, devising culturally-valid measures, the costs involved, language proficiency issues, and questions about using intra-ethnic or inter-ethnic comparisons. For example, some researchers have expressed concern about the measurement of Maori wellbeing using the SF-36, an English language, Western-normed instrument constructed on non-Maori principles (Palmer, 2004). They further argue that failure to provide psychological measures appropriate to Maori is a breach of treaty obligations under Article Two of the Treaty of Waitangi, which grants Maori entitlement to participation in the Maori world. Issues associated with the generalisability of RCT findings to ethnic groups such as Maori relate to controlling for potential confounds of social, cultural, and ethnic variables. Further, Maori research can be controversial touching on sensitive topics such as disparity, inequity, prejudice, values, and

differential treatment, such that many researchers and the researched are uncomfortable with investigations into ethnic cultural variations (Durie, 2004).

Case Studies

Better connecting of psychotherapy research outcomes to practice has been achieved through another psychotherapy research methodology called qualitative research. This approach chooses holistic emphasis and meaning as a criterion (rather than frequency). Qualitative research is conducted in naturalistic settings through observation, and values data collection through engagement with human beings to supplement the over-reliance on impersonal 'objective' administered tests and surveys (Hill, 2007). Case studies, consisting of ongoing client observations, is one of the best illustrations of the qualitative method (Ogles et al., 1996). The appeal of case studies is their ability to provide rich descriptions of psychotherapy process (Fonagy & Moran, 1993). Their weaknesses are a lack of internal and external validity as well as reporter/researcher subjectivity. There are many approaches to conducting a case study. It generally begins with recording observations either as hand written notes, audio, or video recordings. The information is then analysed using hermeneutic analysis including thematic and content analysis. Finally, the significant outcome measure is client satisfaction as opposed to mere symptom reduction.

Unfortunately, psychotherapy's short history includes many exaggerated claims 'supported' by case studies (Spence, 1993). Campbell and Stanley (1963, as cited by Ogley et al., 1996) provide a model involving three categories for discerning good and poor case study research. In pre-experimental case study research there is no scope for determining causality. Freud's case studies were of this nature. In quasi-experimental case study research, there is limited control over threats to internal validity. No established baseline and limited measurements makes it difficult to assess change. Finally, in true experimental case study research control is maximised.

True experimental case studies, otherwise known as single-participant design research, involves standardised measures in areas where change is expected, establishment of baselines, measuring at different time intervals, and predictions of treatment/non-treatment progress schedules and change (Hurst & Nelson-Gray, 2007). Data collection is meticulous at each process stage to be answerable to public scrutiny. Notes and recordings are kept along with records of the reasoning for decisions made as the case progresses. Further, aggregate data collected from many such individual case studies offers additional external validity over a singular case (Stiles, 2007). Unfortunately, such a research approach involving aggregated case history data is uncommon.

Experimental case studies or single-participant research is a valuable methodology that can bridge the gap between research and practice (Stiles, 2007). Clinicians need to apply the findings of evidence-based practice while making research a part of their psychotherapy practice. They need to cooperate by measuring and reporting each therapy session as part of a systematic case study. The collection and sharing of case studies as a part of regular practice would see the collection of many case studies that could be aggregated and evaluated in terms of the disorder or problem addressed, proscribed intervention, client satisfaction and symptom reduction percentages, and failures (Hurst & Nelson-Gray, 2007). Reporting of failures is just as important as the reporting of successes, for as much can be learnt failures and null hypothesis as can be learnt from success. An example of this from quantitative research is the insight gained from the Dodo bird verdict that arose from numerous attempts to demonstrate the efficacy and effectiveness of one or more therapeutic approaches over others. This approach to evidence-based practice is sensitive to the context of the therapeutic relationship. Further, it is particularly relevant to the New Zealand bicultural context where findings from Maori and Pakeha clients could be assessed separately and aggregated as they relate to these divergent cultural-ethnic groups.

Conclusion

Cases of depression such as Nancy's are an increasing problem affecting Aotearoa New Zealand society with enormous social costs. Outcome research measures for determining the best form of treatment for depressive symptoms is a complex issue. The medical model, with its disease perspective, seeks cure in the specificity of psychological treatment, and engages RCTs as the best research method to determine the most effective therapy modality. RCT findings do provide important information on the efficacy of psychotherapy but the mechanisms of change are not clearly elucidated, while successful therapeutic work in the practice setting does not provide evidence in support of the claims that practitioners make for the validity of their theory. This has significant implications for relevance of psychotherapy research findings in Aotearoa New Zealand.

Relevant research data, particularly for Maori, is likely to come from contextual model congruent experimental single participant-case studies that view the effectiveness of psychotherapy as related to the context of the psychotherapy process regardless of the modality used. Such an approach would certainly have greater relevance to individuals such as Nancy, for the implications of delivering culturally-appropriate psychological help is opened up by this line of inquiry. Through the careful and painstaking recording of cases of Maori and Pakeha clients the promise is that a more realistic data set is produced, generalisable both to Aotearoa New Zealand's Pakeha and Maori populations.

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