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Aims of Psychotherapy Research in the Nineties*

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abstract

Psychotherapy research aims at the scientific evaluation of existing practice and at the discovery of new fields of application. The early phases of psychotherapy research were marked by scientific justification and societal legitimation. These questions changed with extension of possible indications, with growing differentiation of treatment procedures and with the progressive implementation of psychotherapy within the health system. The early approach "does psychotherapy work at all" has been replaced by the questions "to whom is psychotherapy helpful" and "how does psychotherapy work".
As established part of the health system psychotherapy now is faced with the same urgent problems as other medical specialties: therapeutic goals and economic conditions have to be brought in balance. Thus the perspectives of psychotherapy research have to encompass the individual patient as well as the system of care.
These demands create new questions which enlarge the approaches of traditional psychotherapy research; new structural and logistic methodologies are asked for. .

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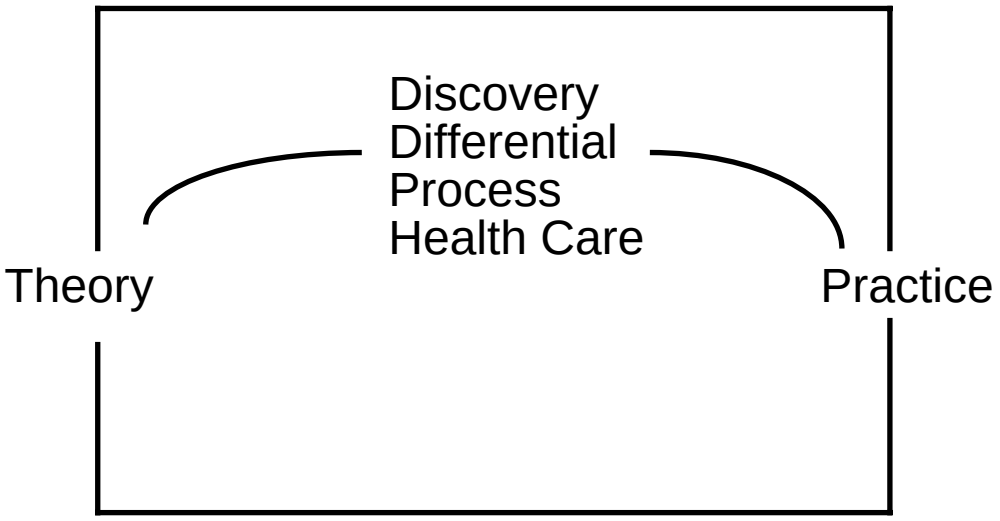
Psychotherapy research at any given time has multiple functions and tasks to perform; it aims at the scientific evaluation of existing practice and at the discovery of new fields of application
figure1



The early phases of psychotherapy research were marked by scientific justification and societal legitimation. These questions changed with extension of possible indications, with growing differentiation of treatment procedures and with the progressive implementation of psychotherapy within the health system. The early approach "does psychotherapy work at all" has been replaced by the questions "to whom is what kind of psychotherapy helpful" and "how does what kind of psychotherapy work".
Futhermore it has become obvious that the findings from systematic outcome research are directed at different audiences - e.g. at psychotherapists who conduct the treatment in question as well as to health professionals from related, often competitive disciplines. Research findings are addressed at those who benefit directly (e.g. patients or their relatives) as well as at those who fund the costs (e.g. insurance companies) or are responsible for adequate health policies (e.g. politicians, unions). The diverse groups may have totally different expectations (Strupp & Hadley 1977). Therefore outcome research has to provide a variety of information to satisfy the needs of the different interest groups.

Isolated in its scope, restricted outcome research has come to an (dead) end in the eighties. The findings of many investigations consistently support the conclusion that psychotherapeutic treatments rightly have become an integral part of the medical system. This success opens a view for raising new issues. The development of psychotherapy research in the nineties should be characterized by a growing diversification of research approaches. Process-outcome research, large scale multi-site studies on the treatment of specific diseases, and health care system research should become the leading paradigms of the decade.

a. Process research

We are now faced with the seeming paradox that, in spite of the overwhelming and certainly impressive evidence for the most frequently practiced forms of therapy, we are faced with many critical voices complaining that the many outcome studies have not contributed to a better understanding of therapeutic mechanisms. For example, Klaus Grawe,the author of an hotly debated review article (1992) wrote in 1988: "Only those who ignore the results of psychotherapy research can maintain with a certain subjective surety that they already know what is right for their patients." It is within this context that the very material of the therapeutic process is rediscovered and the detailed analysis of single cases once more achieves a prominent status (Dahl et al. 1988; Greenberg 1991; Greenberg & Pinsof 1986). This move entails increasingly focusing on details of the treatment process itself. This attention to specific details of treatment will require new assessment procedures and a better articulation of moment to moment events that significantly influence treatment outcome.

b. multi-center studies

Detailed process research on multiple cases combined with sophisticated outcome measurement supports finding specific treatments for individual patients with particular disorders which is known as the question of differential indication. For many years substantial research on specific groups of patients remained rare as the psychosomatic institutions had to take care of a broad spectrum of patients, which only sometimes allowed for the

formation of groups homogeneous with respect to one disease. It took some time in psychosomatic medicine and psychotherapy to realize that this situation was not principally different from somatic medicine, where the development of multi-center studies led to progress because the desired homogeneity allowed better conclusions.
The multi-center study on the psychodynamic treatment of eating disorders that has been initiated by the Center for Psychotherapy Research in Stuttgart includes a wide range of inpatient and outpatient modalities all over Germany; it also works on the logistics of implementing the study in other European countries. As this multi-center study is heavily supported by non-university institutions and offers also clinical exchange programs we feel that this type of research commitment may well turn out to be a prototype for the new look in psychotherapy research (Kächele et al. 1992).

Especially in psychotherapy with patients suffering from severe somatic symptoms, the problem of outcome criteria is a very tricky one. What is the relationship of somatic and psychological criteria, in what way does one quantify the subjective and the objective dimensions?
Taking the improvement of the somatic status as the decisive criteria for the efficacy of the psychotherapeutic intervention.is very demanding, as our knowledge on the connections of psychological and somatic changes is quite limited. Basic research on the course of chronic psychosomatic disorders is practically absent

The deficits of outcome research for psychosomatic medicine have been also identified by the European Community, which issued an initiative (COST - Report 329/1991) to encourage formal research in this field.

Criterion-oriented research not only constitutes a problem for outcome research with psychosomatic disorders; there it becomes quite visible and leads to additional theoretical questions. In general, the discussion of criteria of outcome has been much neglected in outcome research. There are no standard criteria for the assessment of treatment success at all. Up to now individual research groups have been free to select their own criteria and to operationalize the measurement procedures. This is astonishing since the problems of standardization are well known.

Maybe it is not even desirable to find superficial compromises that are satisfying to no one. It could turn out to be more productive for the further development of psychosomatic medicine and psychotherapy if we continue to have an open discussion on goals, on criteria of success, and on the chances of reaching these.

c. Evaluation of economic aspects

The investigation of the relation between established therapeutic methods and outcomes is a highly current topic in many western health care systems. How much of which kind of therapy is adequate to guarantee a fair chance to the patient to reach the desired goals? Up to now we have no well established answers to this kind of question. Research on these topics is developing into two directions: (a) cost-benefit and cost-effectiveness analysis (CBA/CEA), and (b) dose-effect models.

Cost-benefit and cost-effectiveness analysis

Precipitously rising costs of medical activities led to the call for data providing a rational basis to build a health service system that guarantees affordable high quality treatment.

Cost-benefit and cost-effectiveness analysis (CBA/CEA) are rare and usually receive attention merely from the angle of health policy. Therapists perceive all these approaches as a substantial threat to their freedom to practice therapy as they see fit 'to do the best possible for their patients'--and probably they are right from a micro-perspective focusing on individual patients. However, from the macro-perspective of the clinical institution or the health care system as a whole, their practice might well be sub-optimal.

There is no doubt that all people involved wish maximally efficient psychotherapy, but clinicians as well as researchers hesitate to put this into monetary terms. This is not necessary at all: the point of interest in CBA/CEA is not just decreasing costs, but discovering how to employ scarce therapeutic resources to achieve a maximum of returns. An example of the latter would be a study designed to investigate how best to distribute sessions over treatments in order to support the processes of psychic development. In this respect CBA/CEA offers an opportunity for the application and

validation of theories of psychotherapy, and is complementary to the more familiar areas of psychotherapy research.

Thus in CBA/CEA different interests of different groups are to be distinguished; they do not have to be reconciled: patients and their relatives, insurance companies, employers. In spite of the enormous importance only few investigations are at hand (see (Newman & Howard 1986; Schlesinger et al. 1980; Yates & Newman 1980b)

Dose-effect models

I already referred to the possible linkage of micro-outcomes to macro-outcomes. To test this idea one has to investigate the relationship between the investment of therapeutic means and the outcome of therapy. There are qualitative and quantitative aspects to what constitutes 'therapeutic means'. Up to now only the quantitative aspects have been addressed explicitly (Howard et al. 1986)

Even if such investigations of the economic aspects of psychosomatic and psychotherapeutic care have no direct impact on the individual therapist's strategy to care for his patients, they are necessary to optimize patient care from the point of view of a macro-perspective on the health care system.

Investigations of these phenomena have far-reaching clinical implications because they correct the clinician's illusion (Vessey et al 1993) that he or she is treating an representative sample of patients. Epidemiological studies of the incidence and prevalence of psychosomatic or neurotic illnesses, of bodily dysfunctions or emotional disturbances, give an estimate of the need for services; the investigation of therapeutic practices yields an estimate of available resources to meet those needs; and, studies of the patterns of service utilization identify the constituencies served by the delivery system (Howard et al.1992).

Desiderata

Much of ongoing formal outcome research focuses more on psychotherapy than on psychosomatic medicine for several reasons. This focus on psychotherapy is itself an answer to the fundamental conflict, that

is associated with the pair of ideas "psychotherapy vs. psychosomatic medicine". To be sure, the separation of psychotherapy and psychosomatic medicine is artificial since each is related to the other. However, it is obvious that they emphasize different perspectives. Psychotherapy, more than psychosomatic medicine, represents the technical aspects of treatment and is therefore properly assessed in terms of outcome results (e.g. success or failure rates). As the treatment of choice for certain illnesses and as one of several possible treatments for other illnesses, psychotherapy stands in competition with other medical treatment techniques. Therefore, psychotherapy is confronted with the same questions that are traditional in medicine. As part of the medical health service delivery system, psychotherapy no longer has a special place regarding questions of outcome; however, with regard to the content of possible answers there is considerable room to play: An alternative philosophical view, which psychosomatic medicine claims to be, can shape values and goals of treatment. Outcome criteria from a psychosomatic point of view will enrich outcome research considerably. However, there is still a major deficit to work out. From this point of view there are some promising goals for research, namely: to model the relationship between somatic and psychic developments, to model the psychosomatic view of the clinical course of illnesses and growth of well-being (even if it is at present only at a symptom level), and to formulate them in a way that makes empirical research possible.

However, there are also traditional fields of psychosomatic medicine and psychotherapeutic clinical practice which are scarcely ready for systematic empirical outcome research. One of the typical examples is "in-patient psychotherapy".

Inpatient psychotherapy:

Inpatient psychotherapy is more than just psychotherapy in a hospital. Its general goals are based on the assumption that a convenient composition of a variety of therapeutic factors in a suitable structured institutional setting will allow the treatment of those patients who when treated in an outpatient setting are said to have little chances of success. Dependent on

therapists´courage. clinical experience and creativity, and given environmental conditions, new treatments programs are developed for 'difficult' patients. This promotes local solutions and prevents standardization. The sheer amount and diversity of psychotherapeutic and psychosomatic hospitals to be found all over Germany as a well established part of the 'psycho' health care system may come as a surprise to the foreigner; however it is an established fact that in Germany nearby 40 % of all patients receive their psychotherapy as inpatient psychotherapy (Meyer et al 1991). Inpatient psychotherapy may be characterized as "psychotherapy round the clock in the form of various well organized, coordinated and respectively theoretically justifiable indicated and individually dosed (verbal and non-verbal) intervention techniques" (Schepank & Tress 1988).

This inherent complexity of inpatient psychotherapy challenges conventional empirical research. Researchers are slow to develop adequate methodological concepts and to raise probing questions. Inpatient psychotherapy still awaits an empirically based clinical theory which will allow justifiable decisions on the indication (admission to which kind of treatment) and on the spending of diverse therapeutic resources. These demands are not met yet by available empirical research.

Therefore, inpatient psychotherapy should be the target of more systematized research because it may turn out that we may learn new things about micro-socio-cultural embedding of diseases - their interactional staging - by studying those aspects of therapeutic communication that misleadingly are called non-verbal. As all disease processes are anchored in basic biological processes we have to recognize that we do not know much about the elementary signal exchange and the impact of artificially manipulated environments on the course of diseases. We have no adequate conceptions at hand for those processes of semiotization of symptoms that finally lead to full symbolization; the empirical studies on the role of diverse semiotic layerings shaping the psychotherapeutic discourse on the medical ward round point to the usefulness of complex linguistic and semiotic investigations (Bliesener & Köhle 1986).

Inpatient psychotherapy treatment settings also provide options for new concepts, new methods and findings. The so-called adjunct methods that are despised by the established schools may have touched truths that have escaped systematic research up to now. Taking into consideration that in the very most cases psychotherapy (i.e. individual or group psychotherapy) covers only a small portion of the probably active ingredients of an inpatient treatment program the relevance of such a systematic research gap for inpatient psychotherapy becomes obvious.

Besides discovering inpatient psychotherapy as a research option we may expand the notion of inpatient psychotherapy to the world of the hospital where all patients are inpatients in more or too often in less favorable supportive psychological surroundings. If we think of patients in a situation of a bone-marrow transplantation we might like to know more about the defenses and coping resources to better help them to adjust to the life threatening treatment method (Arnold et al.1992); thus we also have to ask

- what role do certain factors which are acknowledged as relevant in empirical research on in- and out-patient psychotherapy do play in the context of clinical medicine?

We strongly feel that psychotherapy process and outcome research should shape not only psychosomatic medicine but should support the "widening scope of psychosomatic medicine" to provide empirical support for the relevance of motives and thoughts in all human disease.
Outcome research as described here should thus link up with liaison and consultation work. One cannot but emphasize the substantial lack of evaluative research in that area of possible psychological impact on medicine though a beginning has been made. It is time to prepare this field for serious and adequately conceptualized outcome research (i.e. to formulate a research program, to develop classification systems, to create specific instruments etc) and to achieve consensus among the scientific community that these fields are worth the personal efforts needed.

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