

The Dodo Manifesto

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In this article I review the psychotherapy outcomes literature as it pertains to the Dodo hypothesis. This is the proposition that the effects of psychotherapy are due to common factors rather than specific techniques. A variety of sources provide substantial empirical support for the Dodo hypothesis. I conclude that CBT and medication do not appear to be any better than other methodologies for the treatment of psychological distress. I look at some of the criticisms of the Dodo hypothesis. I suggest that the major themes that emerge from the literature as it stands are conclusions that would be immediately obvious to most clinicians. Further, the utility of specific techniques has not been ruled out, due to some serious conceptual flaws in efficacy trials. I suggest that there are a number of ways for family therapists to survive in an evidence-based world. One is to point out to champions of evidence-based practice just how flimsy their claims are. Another would be to advocate for pluralism and to practise and conduct research under the aegis of a contextual philosophy.

There is currently a very strong move in healthcare toward 'outcomes', 'evidence-based practice' and 'standardised treatments'. This appears to be inspired by escalating costs. In such an environment, evidential (rhetorical?) lightweights like family therapy will struggle to compete with interventions such as CBT and medication. Do we have anything real to worry about?

The Dodo Hypothesis and Comparative Studies of Psychotherapy

The Dodo hypothesis originated with the psychologist Saul Rosenzweig in 1936. Rosenzweig published a paper about 'implicit common factors' in psychotherapy. He speculated that the efficacy of all forms of psychotherapy was similar, and that the success of psychotherapy was due to factors such as the therapeutic relationship and aspects of the patient's and therapist's personalities rather than specific techniques. Rosenzweig was reminded of an episode from *Alice's Adventures in Wonderland* where the somewhat

deranged Dodo bird organises a race in which the contestants start from different points on the course and at different times. After a while, the Dodo decides that the race is over. When asked who won the race the Dodo declares that 'everybody won, and all must have prizes'.

Some of the earliest empirical support for the Dodo hypothesis came in the late 1950s from the work of the psychiatrist Jerome Frank. Frank conducted research that compared weekly individual therapy, weekly group therapy and fortnightly supportive therapy (1/2 hour) for depressed patients. He found no difference between the conditions with regard to the relief of distress (Frank & Frank, 1993).

In 1975, Luborsky, Singer and Luborsky published an influential paper titled 'Comparative Studies of Psychotherapies: Is It True That Everyone Has Won and All Must Have Prizes?' These authors conducted a review of the available research literature and concluded that psychotherapy was an effective treatment, all psychotherapies were similarly efficacious, and medications were more efficacious than psychotherapy.

In 1977, Smith and Glass published the first meta-analysis of psychotherapy outcomes. This technique, pioneered by Glass, enabled the statistical coding and analysis of a host of relevant variables. The technique was a significant improvement on the subjective reviews of the past, and meta-analysis did much to establish the credibility of psychotherapy as a bona fide treatment for psychological distress (Wampold, 2001). Smith (1982) provided an overview of the original work and some subsequent refinements. The average effect size for psychotherapy was found to be 0.85, a large effect. This meant that the average person



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who received psychotherapy was better off than 80% of those who did not, assuming that the benefits of psychotherapy were normally distributed. This positive effect held across the spectrum of client variables and disorders. Smith found no significant differences between the various types of psychotherapy, and no significant differences between the efficacies of psychotherapy and medication. Furthermore, she discovered no correlation between therapist effectiveness and their qualifications and experience. These findings have been replicated in more recent meta-analyses (Wampold et al., 1997; Wampold, 2001; Elliott, 2002). Shadish et al. (1995) provided an overview of meta-analytic findings specific to marital and family therapy (MFT). Essentially the news is the same. MFT works. Only modest differences emerge between orientations with regard to outcomes. MFT does not appear to be any more effective than individual therapies.

The National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program compared the efficacy of cognitive behaviour therapy (CBT), interpersonal therapy (IPT), the tricyclic antidepressant Imipramine plus clinical management, and a placebo pill plus clinical management. Elkin (1994) reported on the general effectiveness of the treatments. Overall 24% of patients fully recovered from their depression by the end of the 16-week treatment period and stayed well throughout the 18-month follow-up period. The percentages of patients who recovered and stayed well in each of the conditions were CBT (30%), IPT (26%), placebo (20%), and Imipramine (19%).

The findings reported above are derived from efficacy studies — evaluations of psychotherapy in controlled (to varying degrees) conditions. Seligman (1995) reviewed and summarised the findings of the 'Consumer Reports' survey on psychotherapy. This was an effectiveness study; that is, an evaluation of the usefulness of psychotherapy as it is practised in the real world. The survey revealed that psychotherapy generally appeared to be very beneficial to its recipients, but no one treatment was more effective than any other. Other findings were that long-term therapy was more beneficial than short-term treatment; medication did not enhance the benefits of psychotherapy; psychologists, psychiatrists and social workers were equally effective practitioners of psychotherapy; while marriage counsellors and family GPs were not as effective as mental-health professionals. These results were recently replicated in Germany (Hartmann & Zepf, 2003).

But Wait, There's More ...

Much of the empirical support for the Dodo hypothesis comes from comparative studies of psychotherapy, but data from client, process and component studies are also supportive. For example Sotsky et al. (1991) reviewed data from the NIMH Treatment of Depression Collaborative Research Program in order to determine which patients might benefit most from particular treatments. They found that the least cognitively impaired subjects appeared to respond most favourably to CBT. Ilardi and Craighead (1994) looked at process data and found that most of the improvement that occurs during the course of cognitive therapy for depression occurs before any cognitive restructuring has begun. And, closer to home, Walsh (2004) conducted a study that involved 100 families who underwent structural family therapy. He found that the type of intervention used was not related to outcome. Structural family therapy apparently does not change family structure. Ahn and Wampold (2001) conducted a meta-analysis of component studies. They found that the key components of various treatment packages appear to add virtually nothing to the effectiveness of therapy.

Further support for the Dodo hypothesis comes from studies of therapist effects vs. treatment effects. Kim (2003) reviewed the data produced by the NIMH Treatment of Depression Collaborative Research Program in order to evaluate therapist effects against treatment effects. Kim found that 12.4% of the outcome variance at termination between the CBT and IPT conditions was due to therapist effects. Treatment effects accounted for 0% of the variance. Huppert et al. (2001) also found that therapist effects were very significant vis-à-vis treatment effects in a study that looked at the treatment of panic disorder. Interestingly, both of these studies involved manualised treatments. It thus appears unlikely that psychotherapy can ever truly be standardised.

The Dodo hypothesis is also supported by studies in which the effectiveness of trained and untrained therapists is compared. Trained therapists would presumably have a better grasp of technique than untrained therapists, and if technique is truly important, be more effective than untrained therapists. The most infamous study in this area is that published by Strupp and Hadley in 1979. The study compared the psychotherapeutic potency of very experienced psychologists and psychiatrists (average length of experience, 23 years) to college professors without a relevant professional background but who appeared to be able to form understanding relationships. The subjects were male

college students who exhibited symptoms of mild depression and anxiety. On average, the subjects treated by the professors showed as much improvement as the subjects treated by the professionals. This study, however, raises some concerns. One problem was that the professionals were assigned harder cases. However, the general finding is far from unique. For example, Leonard Bickman's (1999) review concluded that the available evidence did not support the utility of experience or higher degree programs for psychotherapists. In a more recent review, Atkins and Christensen (2001) reached the same conclusion. One review by Stein and Lambert (1995) found a modest effect for training, but the evidence was indirectly derived from the reviewed studies, and the authors concluded their review with a comment about the overall paucity of supporting evidence for graduate training.

CBT Equals Supertherapy?

A key issue in the literature is the relatively large effect sizes often attributed to cognitive and behavioural therapies. Some researchers have attributed such findings to allegiance effects (Smith, 1982; Miller et al., 1997; Wampold, 2001). Others, such as Eysenck (1994), say that this is all nonsense and maintain that cognitive and behavioural treatments are actually much better than the rest. A known tendency toward bias occurs in comparative trials of psychotherapy. This is apparently in the direction of the theoretical orientation of the first senior author (Denman, 1993). Luborsky et al. (1999) assessed that 69% of the variance in outcomes in comparative studies of psychotherapy was due to allegiance effects.

It is hard, however, to prove bias objectively. Robert Matthews' (2004) article about parapsychology provides an interesting parallel. Matthews reported on a number of studies that showed strong evidence for ESP. He was not interested in exploring whether or not ESP existed, but rather looked at the fact that scientific data had little impact on the opinions of believers and non-believers alike. Believers felt that positive data confirmed the obvious — ESP was real. Nonbelievers felt that data must have been contaminated or fraudulently produced because ESP does not exist. Matthews suggested that empirical evidence does not carry as much weight as we often assume, because the data around effects are construed through philosophical frameworks that are inherently subjective.

In any case, one does not have to look hard to find studies that suggest that CBT is nothing special. For example, Parker, Roy & Eysers (2003) concluded in a recent review that the superiority of CBT to other psy-

chotherapies as a treatment for depression had not been proven. Shear et al. (1994) directly compared CBT to nonprescriptive counselling as a treatment for panic disorder. They found that both interventions were equivalently helpful. And, in a relatively rare instance of a specific finding in a comparative study of psychotherapies, McIntosh et al. (2005) found that nonspecific supportive clinical management was significantly superior to CBT and IPT as a treatment for anorexia nervosa. Another specific finding, very relevant to family therapists, came about through the London Depression Intervention Trial. This study compared systemic therapy, CBT and antidepressant medications for depression. Systemic therapy was clearly the most efficacious treatment (Jones & Asen, 2000).

Is Medication Better Than Psychotherapy?

Does medication represent a superior technology for the relief of psychological distress? I believe not. I will look briefly at two types of medication — antidepressants and neuroleptics.

As reported above, the NIMH Treatment of Depression Collaborative Research Program found that antidepressant medication worked no better than psychotherapy. The drug used in the NIMH study, Imipramine, is a tricyclic, but the newer drugs — selective serotonin re-uptake inhibitors (SSRIs) — are no more effective (Geddes et al., 1999). The typical finding is that therapy and medication produce similar results. For example, both types of intervention typically generate effect sizes of between 0.8 and 1.0 (Tillett, 1996). And Baker (2001) reported that in the treatment of depression, both technologies usually bring about a reduction in symptoms of around 50%.

As with psychotherapy, the utility of antidepressant medications has been attributed to the placebo effect. Kirsch et al. (2002) reviewed the efficacy data submitted to the US Food & Drug Administration for the six most widely prescribed antidepressants approved between 1987 and 1999. The pharmacological effects of the drugs in question appeared to be negligible. This finding does not seem to have been aggressively challenged, with most replies, such as that by Thase (2002), maintaining that a small effect was still useful. Moncrieff, Wessely and Hardy (2004) in the Cochrane review of antidepressants versus active (plausible) placebos, concluded that differences between the two were small (pooled effect for medications of 0.17). The authors recommended that research on the unblinding of subjects in drug trials needed to occur.

The SSRIs are supposed to counter depression by increasing the availability of serotonin at various sites in a patient's brain, the theory being that a lack of serotonin causes depression. However, this theory has a number of problems. Baker (2001) reported that lowering the serotonin levels of otherwise healthy volunteers does not result in these people suffering depression, though some changes in mood are noted. Reducing serotonin levels in already depressed people does not make depression worse. SSRIs immediately raise serotonin levels, but usually no mood changes occur for about three weeks. Further, these medications have no effect in about 30% of cases.

Ostensibly, antidepressant medications would appear to have an advantage over psychotherapy in terms of cost-effectiveness. This may not be the case. Antonuccio, Thomas and Danton (1997) looked at the relative cost-effectiveness of CBT and Prozac as treatments for depression. They looked at direct patient costs, direct costs to the community and indirect costs to society. They found the cost of Prozac treatment was 33% higher than CBT treatment. Vos et al. (2005) reported very similar results for CBT and SSRIs in general. Jones and Asen (2000) reported that in the London Depression Intervention Trial, drug therapy was no cheaper than systemic therapy overall and was probably a more expensive long-term treatment option.

Neuroleptic medications are the standard treatment for psychotic illnesses, but there is some good evidence that simply providing a benign social environment and conveying expectations of recovery can be an effective treatment for these illnesses. In the early 1970s, Loren Mosher, then the head of schizophrenia research at NIMHS in the United States, started the Soteria Project (Whitaker, 2002). Soteria involved mostly nonmedical treatment delivered in a homelike setting by nonprofessional staff. Staff members were required to convey an expectation of recovery and not to invalidate subjects' experience of psychosis. Subjects were recruited from emergency rooms in the San Francisco area. Subjects were young, unmarried, met the DSM criteria for schizophrenia and appeared to be unwell enough to warrant hospitalisation. Results were contrasted with treatment as usual — hospitalisation and medication as standard. In the initial six weeks of treatment, 14% of Soteria subjects received medication as opposed to 94% of subjects in the control condition. An equivalent reduction in psychotic symptoms occurred in both groups at six weeks. At a two year follow-up, there was a medium effect-size advantage to Soteria subjects

across composite outcome measures (Bolan & Mosher, 2003). The project results were replicated at another facility, Emanon (Mosher, 1999), with a replication in Switzerland (Ciompi et al., 1992; Ciompi et al., 1993) and other projects operating in Sweden and Finland (Whitaker, 2002).

Gottdiener and Haslam (2002) conducted a meta-analytic review of the evidence pertaining to the utility of individual psychotherapy for schizophrenia. They found that, contrary to popular opinion, individual psychotherapy appears to be as efficacious as medication. I am not aware of a similar review being conducted for family therapy but there certainly are successes with schizophrenia reported in the literature (see e.g. Haley & Schiff, 1993).

Whitaker (2002) assembled a range of findings that challenge the widespread use of neuroleptics with psychosis. The two most significant were the World Health Organisation (WHO) study that looked at outcomes for schizophrenia in a range of countries, and some studies that suggested that neuroleptics had effects that might significantly impair the chances of a sufferer recovering from schizophrenia. Jablensky et al. (1992) reported on the WHO study. The study showed that people quite routinely recover from schizophrenia in developing countries (about two thirds recover) but they do not in developed countries (about one third recover). There was no obvious explanation for this finding. Whitaker suggested that the reason that the recovery rate in poorer countries is so high is because few people in these countries are maintained on neuroleptics. Whitaker reported on a number of studies that showed that the brains of schizophrenics who had been maintained on neuroleptics showed abnormally high concentrations of dopamine receptors, whereas the brains of schizophrenics who were 'neuroleptic-naive' did not (see also Warner, 1994, and Nordstroem et al., 1995). High levels of dopamine or abnormal sensitivity to dopamine have been offered as possible explanations for schizophrenia, and the utility of neuroleptics as a treatment for schizophrenia has been attributed to the effects that this class of drug have on dopamine pathways. Whitaker suggested that neuroleptics act as they are widely supposed to — they clamp down on dopamine pathways. An opponent process is then activated where the brain grows more receptors in order to restore equilibrium. The result is that the brain becomes hypersensitive to dopamine and thereby vulnerable to relapse. If Whitaker's suggestion is correct, it would not be an unprecedented situation. Tenner's (1996) review of the 'revenge effects' of technology revealed that while technological

advances often solve problems, they more often take acute problems and turn them into chronic problems.

What Are the Common Factors in Psychotherapy?

We don't really know. Empirically what has been established is that specific effects account for, at best, 8% of outcomes, general effects account for 70%, and the remaining 22% is unexplained but may have something to do with client characteristics (Wampold, 2001).

Frank & Frank (1993) suggested four factors common to all forms of psychotherapy. First, a relationship between the patient and the helper such that the patient had confidence in the helper's competence and desire to help. Second, the therapy took place in a setting designated by society as a place of healing. The setting also offered advantages such as safety and confidentiality. Third, a rationale was offered for the patient's distress that contained the possibility of resolution. Fourth, a task was prescribed by the therapist's rationale or theory that required some sacrifice or effort on the part of the patient. These factors invoked a placebo response. In essence, psychotherapy enhanced the patient's morale and this, in effect, could lead to snowballing changes in the patient's attitudes and behaviour.

Following the above model, it would appear that seeing a psychotherapist is little different to seeing a shaman in another culture. Perhaps you are feeling poorly. You go to see the Great Healer at her Sacred Tent. The healer tells you that you have offended the gods. She hands you a big stick and tells you that you need to take on a bear to make up for it. You narrowly survive your encounter with the bear and soon after start to feel better.

There is some empirical support for the view that psychotherapy is a placebo treatment. Baskin et al. (2003) conducted a meta-analysis of the structural equivalence of placebo controls in psychotherapy. They found that when placebo conditions are structurally equivalent to treatment conditions — that is, same number and duration of sessions, same format of therapy and equivalently trained therapists — the effects of active treatments above placebo appear to be negligible.

One of the most popular common-factor models was proposed by Miller, Duncan and Hubble (1997). These authors suggested that the effectiveness of psychotherapy was due to a set of factors — extratherapeutic (40% of any change that occurs), therapeutic relationship (30%), placebo effects (15%) and technique (15%). The percentages in this model obviously involve some guesswork, but the components have substantial empirical support. Extratherapeutic factors refer to

client characteristics and chance events. The therapeutic relationship is the most well-supported common factor (Lambert & Barley, 2001). As an aside, it is interesting to note that the therapeutic relationship appears to impact significantly on the efficacy of drug treatments as well (Krupnick et al., 1996). Placebo effects refer to hope and expectancy. Technique is important in the sense that it provides structure. Unstructured therapy is highly correlated with poor outcomes. This model seems to reflect the literature on common factors pretty well.

Sprenkle and Blow (2004) suggested that family therapists had largely ignored common-factors research. This was apparently due to the discipline's proud 'maverick' tradition. The authors also noted, importantly, that family therapy is uniquely complex in that we have to apply common factors to families rather than individuals. Thus, for example, family therapists need to build and maintain a number of therapeutic alliances at any one time.

On the Other Hand ...

Responses could be made to the Dodo hypothesis. The most salient would likely be that most of the research done tests psychotherapies against each other across broad heterogeneous groups. This means that average effect sizes may be quite meaningless. Parker et al. (2003) make this point in relation to research on CBT as a treatment for depression. Subjects are put into categories that are based on severity rather than aetiology. Treatments are assessed in terms of their universal impact. This means little chance of any specific effects being noted. The authors draw an analogy with oncology — cancers are not classified as belonging to groups such as major cancer, minor cancer or subclinical cancer and neither chemotherapy nor surgery is used as a universal treatment.

In addition to obfuscating potentially very important differences among clients, there is also the reliability problem with psychiatric diagnoses. Kutchins and Kirk (1998) cited an impressive array of evidence to the effect that this issue surfaces even when trained and experienced assessors are used. These authors reported that in DSM field trials, professionals were often unable to agree on the category of disorder from which a particular patient suffered, let alone a specific diagnosis. A number of diagnoses also have validity issues. Here is an example relevant to those of us who work with children and youth — 'conduct disorder'. Lambert et al. (2001) found that the diagnostic criteria for conduct disorder had only

slightly more internal consistency than symptoms chosen at random from the DSM-IV.

And another problem. How many unique manoeuvres are there in psychotherapy? Miller et al. (1997) suggest a tendency for the proponents of the various schools of psychotherapy to highlight the differences among 'brands'. These authors use solution-focused brief therapy and Narrative therapy as an example. A number of therapeutic moves are common to both approaches but different language is used, and this suggests differences in content. In a study that has dire implications for comparative studies of psychotherapy, Ablon and Jones (2002) looked at data from the NIMH Treatment of Depression Collaborative Research Program. They had hypothesised that manualised psychotherapy regimens in controlled trials overlap considerably in process and technique. When they compared prototypical regimens for IPT and CBT with transcripts from the NIMH study's IPT and CBT conditions they found significant overlap, and indeed therapists in both conditions appeared to be doing CBT. Have we been comparing Coke to Pepsi and puzzling over findings that they both appear to be fizzy cola drinks?

Some authors have suggested that all forms of psychotherapy share effective technical components. Eysenck (1994) suggested that behavioural interventions (relaxation, modelling, suggestion, flooding with response prevention, and so on) were responsible for all of the benefit of psychotherapy, as well as spontaneous remission and placebo responses to psychotherapy. These techniques were sometimes inadvertently used by nonbehavioural therapists.

Gibney (2003) proposed that the essence of all psychotherapy was 'double description'. Gibney's idea was not a response to the Dodo hypothesis, but it is relevant. Double description is about drawing distinctions — comparing one version of events with other possibilities. The idea comes from Gregory Bateson's (1972) observation that the defining quality of mind is the ability to take multiple perspectives. Gibney suggested that the various schools of psychotherapy offered alternate, novel descriptions of the client's issues and thus established contexts in which new ways of thinking and behaving could develop. This is a poetic explanation that may contain some truth.

A third problem with the data that substantiates the Dodo hypothesis is that most of it comes from efficacy studies — subjects usually have one uncomplicated diagnosis, treatment regimens are manualised, supervision is intense and so on. This is, of course, exactly how psychotherapy is not usually practised in

the real world. So how relevant is the information from such studies?

Sexton, Ridley and Kleiner (2004) have been highly critical of the idea of grounding MFT practice and research in common factors. These authors made the point, probably correctly, that the so-called common factors are not clearly defined identities and are 'decontextualised' — they are not tied to the process of therapy. Sexton et al. suggested that a common-factors approach is old hat and somewhat primitive. They maintained that family therapists can now draw upon a variety of theoretically sound and well-validated models in the marketplace. Sexton is in fact a developer of one such product — Functional Family Therapy (see Sexton & Alexander, 2003).

What Does it All Mean?

The good thing about science is that it often reveals 'truths' that are not readily apparent. For example, the fact that matter and energy are the same thing is surprising. The fact that the book of life is written in an alphabet of only four letters is also surprising. However, to draw upon the 40-30-15-15 model described above, for example, it is not surprising to find that clients have lives outside of therapy that may impact very significantly on their well-being. It is not surprising that treating clients with sensitivity and respect is helpful. It is not surprising that hope is helpful. It is not surprising that taking a structured approach to solving client's problems is more helpful than just having a chat. Further to this list of not surprising revelations — it is not surprising that these factors would take precedence over the technical aspects of therapy. The utility of a supportive relationship and some hope to a distressed person is patently obvious. And because psychotherapy is conducted *with* intelligent, autonomous human beings rather than *on* inert mechanisms, factors such as the therapeutic relationship will determine the utility of any technical procedures because they will determine the participation of the client in therapy. So it would appear that after more than 40 years of research into psychotherapy, we have arrived at commonsense. And we cannot even say for sure that technical factors have no specific effects, because of significant flaws in the way the basic concepts have been operationalised in efficacy trials.

In my view, the current state of affairs reflects an obsession in Western culture that was originally inspired by Isaac Newton. Prior to Newton, most people had existed in a state of resigned bafflement about the apparently discontinuous vastness that was the universe.

Newton's genius was to unite a collection of previously disparate phenomena with a few simple 'laws'. Since that time, it has been on for young and old, with generations of thinkers trying to duplicate the great man's feat within their own fields of expertise. Sadly, those of us who work within the 'mind sciences' have been given the short end of the stick. We work with inordinately complex, invisible, indivisible and often inferred entities that elude simple quantification. As a result our 'science' often does not turn out very well. What it all means is this — the positivistic paradigm is not a good paradigm through which to legitimise the practice of family therapy, or any form of psychotherapy for that matter. It has obviously been very useful in other fields, but much less so here.

I am not suggesting that we abandon research, but it may be more useful for family therapists to justify their practice with hard results rather than flashy rhetoric. I am sure that we can all cite very successful psychotherapeutic interventions with our clients. The psychologist Daniel Fishman (1999) has pointed out that while universal solutions do not appear to have adequately met many human problems, there are a plethora of smaller, local, contextual examples of successful interventions. Fishman suggested a pragmatic approach where psychotherapists and professionals in related fields direct their efforts toward addressing the specific concerns of clients by the most appropriate means available. Such interventions could be incorporated into a database of case studies through which future practice could be informed. (Given the concerns about bias in the outcomes literature, it may be appropriate for future efficacy trials to be run by neutral parties or perhaps teams of ideologically opposed researchers such as psychoanalysts and radical behaviourists.) Fishman's approach seems sensible in light of the Dodo hypothesis. Indeed, it was the approach followed by one of family therapy's folk-heroes — Milton Erickson. Erickson's approach was to have an approach for each client (Jackson, 2003). Beels (2002) suggested that Erickson was one of a long line of American pragmatists who provided as much impetus for the development of 'family therapy' as the original Bateson group. To practise pragmatically, we need pluralism in psychotherapy. Therapists would need to be able to draw upon as wide a range of ideas as possible. Family therapy is clearly a useful tool to have at one's disposal when working with children and young people or looking at client problems that have a systemic flavour.

There is a clear way forward here — (1) turn down the positivistic rhetoric, (2) adopt a sceptical attitude

to the claims of evidence-based practice proponents, and (3) offer solid pragmatic data in support of our discipline.

Conclusion

The evidence as it stands suggests that no one type of psychotherapy is generally superior to any other. CBT and medication do not appear to be superior technologies. Thus, we have numerous valid approaches through which to assist distressed persons. In the main, the positivistic paradigm in psychotherapy research has not produced many profound insights, but certain commonsense aspects of psychotherapy appear to be very important. Taking a pragmatic approach to therapy and research is a way forward for family therapists.

References

- Ablon, J. S., & Jones, E. E., 2002. Validity of Controlled Clinical Trials of Psychotherapy: Findings from the NIMH Treatment of Depression Collaborative Research Program, *American Journal of Psychiatry*, 159: 775–783.
- Ahn, H-N. & Wampold, B. E., 2001. Where Oh Where are the Specific Ingredients? A Meta-analysis of Component Studies in Counselling and Psychotherapy, *Journal of Counselling Psychology*, 48: 251–257.
- Antonuccio, D. O., Thomas, M. & Danton, W. G., 1997. A Cost-Effectiveness Analysis of Cognitive Behaviour Therapy and Fluoxetine (Prozac) in the Treatment of Depression, *Behaviour Therapy*, 28: 187–210.
- Atkins, D. C. & Christensen, A., 2001. Is Professional Training Worth the Bother? A Review of the Impact of Psychotherapy Training on Client Outcome, *Australian Psychologist*, 36: 122–130.
- Baker, R., 2001. *Fragile Science: The Reality behind the Headlines*, London, Pan.
- Baskin, T. W., Tierny, S. C., Minami, T. & Wampold, B. E., 2003. Establishing Specificity in Psychotherapy: A Meta-Analysis of Structural Equivalence of Placebo Controls, *Journal of Consulting and Clinical Psychology*, 71: 973–979.
- Bateson, G., 1972. *Steps to an Ecology of Mind*, San Francisco, CA, Chandler.
- Beels, C. C., 2002. Notes for a Cultural History of Family Therapy, *Family Process*, 41: 67–82.
- Bickman, L., 1999. Practice Makes Perfect and Other Myths about Mental Health Services, *American Psychologist*, 54: 965–978.
- Bolan, J. R. & Mosher, L. R., 2003. Treatment of Acute Psychosis Without Neuroleptics: Two Year Outcomes From the Soteria Project, *The Journal of Nervous and Mental Disease*, 191: 219–229.
- Ciampi, L., Dauwalder, H-P, Maier, C., Aebi, E., Truetsch, K., Kupper, Z. & Rutishauser, C., 1992. The Pilot

- Project 'Soteria Berne': Clinical Experiences and Results, *British Journal of Psychiatry*, 161: 145–153.
- Ciampi, L., Dauwalder, H-P., Maier, C. & Aebi, E., 1993. Pilot Project: 'Soteria Berne' for Treating Acute Schizophrenics: II. Results of a Prospective Study over 2 Years, *Nervenarzt*, 64: 440–450.
- Denman, C., 1993. The Essential Psychotherapies: Comment, *British Journal of Psychiatry*, 163: 406–407.
- Elkin, I., 1994. The NIMH Treatment of Depression Collaborative Research Program: Where We Began and Where We Are. In A. E. Bergin & S. Garfield (Eds), *Handbook of Psychotherapy and Behaviour Change*, 4th Edn, NY, Wiley.
- Elliott, R., 2002. The Effectiveness of Humanistic Therapies: A Meta-analysis. In D. J. Cain (Ed.), *Humanistic Psychotherapies: Handbook of Research and Practice*, Washington, DC, American Psychological Association.
- Eysenck, H. J., 1994. The Outcome Problem in Psychotherapy: What Have We Learned? *Behaviour Research and Therapy*, 5: 477–495.
- Fishman, D., 1999. *The Case for Pragmatic Psychology*, NY, New York University.
- Frank, J. & Frank, J., 1993. *Persuasion and Healing*, 3rd Edn, Baltimore, Johns Hopkins University.
- Geddes, J. R., Freemantle, N., Mason, J., Eccles, M. P. & Boynton, J., 1999. Selective Serotonin Reuptake Inhibitors (SSRIs) versus Other Antidepressants for Depression, *The Cochrane Database of Systematic Reviews*, 4.
- Gibney, P., 2003. *The Pragmatics of Therapeutic Practice*, Melbourne, Psychoz.
- Gottdiener, W. H. & Haslam, N. 2002. The Benefits of Individual Psychotherapy for People Diagnosed with Schizophrenia: A Meta-Analytic Review, *Ethical Human Sciences and Services*, 4: 163–187.
- Haley, J. & Schiff, N. P., 1993. A Model Therapy For Psychotic Young People, *Journal of Systemic Therapies*, 12: 74–87.
- Hartmann, S. & Zepf, S., 2003. Effectiveness of Psychotherapy in Germany: A Replication of the Consumer Report Study, *Psychotherapy Research*, 13: 235–242.
- Huppert, J. D., Gorman, J. M., Bufka, L. F., Barlow, D. H. & Shear, M. K., 2001. Therapists, Therapist Variables, and Cognitive-Behavioural Therapy Outcome in a Multicentre Trial for Panic Disorder, *Journal of Consulting and Clinical Psychology*, 5: 747–755.
- Ilardi, S. S. & Craighead, W. E., 1994. The Role of Non-Specific Factors in Cognitive-Behaviour Therapy for Depression, *Clinical Psychology Science and Practice*, 1: 138–156.
- Jablensky, A., Sartorius, N., Ernberg, G., Anker, M. et al., 1992. Schizophrenia: Manifestations, Incidence and Course in Different Cultures: A World Health Organisation Ten-Country Study, *Psychological Medicine, Supplement 20*: 1–95.
- Jackson, M. J., 2003. Techniques and Tales: Milton Erickson — The Man and His Influence, *Australian Journal of Clinical Hypnotherapy and Hypnosis*, 24: 23–34.
- Jones, E. & Asen, E., 2000. *Systemic Couple Therapy and Depression*, London, Karnac.
- Kim, D. M., 2003. Therapist Effects and Treatment Effects in Psychotherapy: Analysis of the National Institute of Mental Health Treatment of Depression Collaborative Research Program, *Dissertation Abstracts International*, 63: 5523.
- Kirsch, I., Moore, T. J., Scoboria, A. & Nicholls, S. S., 2002. The Emperor's New Drugs: An Analysis of Antidepressant Medication Data Submitted to the U.S. Food and Drug Administration, *Prevention & Treatment*, 5, 23.
- Krupnick, J. L., Sotsky, S. M., Simmens, S., Moyer, J. et al., 1996. The Role of the Therapeutic Alliance in Psychotherapy and Pharmacotherapy Outcome: Findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program, *Journal of Consulting and Clinical Psychology*, 64: 532–539.
- Kutchins, H. & Kirk, S., 1998. *Making Us Crazy*, NY, Free Press.
- Lambert, M. J. & Barley, D. E., 2001. Research Summary of the Therapeutic Relationship and Psychotherapy Outcome, *Psychotherapy: Theory, Research, Practice, Training*, 38: 357–361.
- Lambert, W. E., Wahler, R. G., Andrade, A. R. & Bickman, L., 2001. Looking for the Disorder in Conduct Disorder, *Journal of Abnormal Psychology*, 110: 110–123.
- Luborsky, L., Diguier, L., Seligman, D. A., Rosenthal, R., Krause, E. et al., 1999. The Researcher's Own Therapy Allegiances: A 'Wild Card' in Comparisons of Treatment Efficacy, *Clinical Psychology: Science & Practice*, 6: 95–106.
- Luborsky, L., Singer, B. & Luborsky, L., 1975. Comparative Studies of Psychotherapies: Is it True that Everyone has Won and All must have Prizes? *Archives of General Psychiatry*, 32: 995–1008.
- McIntosh, V. V. W., Jordan, J., Carter, F. A., Luty, S. E., McKenzie, J. M., Bulik, C. M., Frampton, C. M. A. & Royce, P. J., 2005. Three Psychotherapies for Anorexia Nervosa: A Randomised, Controlled Trial, *American Journal of Psychiatry*, 162: 741–747.
- Matthews, R., 2004. Opposites Detract, *New Scientist*, 13 March: 39–41.
- Miller, S., Duncan, B. & Hubble, M., 1997. *Escape from Babel: Toward a Unifying Language for Psychotherapy Practice*, NY, Norton.
- Moncreiff, J., Wessely, S. & Hardy, R., 2004. Active Placebos versus Antidepressants for Depression, *The Cochrane Library*, 3.
- Mosher, L. R., 1999. Soteria and Other Alternatives to Acute Psychiatric Hospitalisation: A Personal and Professional Review, *The Journal of Nervous and Mental Disease*, 187: 142–149.

- Nordstroem, A-L., Farde, L., Eriksson, L. & Halldin, C., 1995. No Elevated D-sub-2 Dopamine Receptors in Neuroleptic-naïve Schizophrenic Patients Revealed by Positron Emission Tomography and [-2-2C]N-methylspiperone, *Psychiatry Research: Neuroimaging*, 61: 6783.
- Parker, G., Roy, K. & Eysers, K., 2003. Cognitive Behaviour Therapy for Depression? Choose Horses for Courses, *American Journal of Psychiatry*, 160: 825–834.
- Rosenzweig, S., 1936. Some Implicit Common Factors in Diverse Methods of Psychotherapy: 'At Last the Dodo Said, "Everybody has won and all must have prizes"', *American Journal of Orthopsychiatry*, 6: 412–415.
- Seligman, M. E. P., 1995. The Effectiveness of Psychotherapy: The *Consumer Reports* Study, *American Psychologist*, 50: 965–974.
- Sexton, T. L. & Alexander, J. F., 2003. Functional Family Therapy: A Mature Clinical Model for Working with At-Risk Adolescents and Their Families. In T. L. Sexton, G. R. Weeks & M. S. Robbins (Eds). *Handbook of Family Therapy: The Science and Practice of Working with Families and Couples*, NY, Brunner-Routledge.
- Sexton, T. L., Ridley, C. R. & Kleiner, A. J., 2004. Beyond Common Factors: Multilevel-Process Models of Therapeutic Change in Marriage and Family Therapy, *Journal of Marital and Family Therapy*, 30: 131–149.
- Shadish, W. R., Ragsdale, K., Glaser, R. R. & Montgomery, L. M., 1995. The Efficacy and Effectiveness of Marital and Family Therapy: A Perspective from Meta-analysis, *Journal of Marital and Family Therapy*, 21: 345–447.
- Shear, M. K., Pilkonis, P. A., Cloutre, M. & Leon, A. C., 1994. Cognitive Behavioural Treatment Compared With Nonprescriptive Treatment of Panic Disorder, *Archives of General Psychiatry*, 51: 395–401.
- Smith, M. L., 1982. What Research Says About the Effectiveness of Psychotherapy, *Hospital & Community Psychiatry*, 33: 457–461.
- Smith, M. L. & Glass, G. V., 1977. Meta-Analysis of Psychotherapy Outcome Studies, *American Psychologist*, 32: 752–760.
- Sotsky, S. M., Glass, D. R., Shea, M. T., Pilkonis, P. A., Collins, J. F. et al., 1991. Patient Predictors of Response to Psychotherapy and Pharmacotherapy: Findings in the NIMH Treatment of Depression Collaborative Research Program, *American Journal of Psychiatry*, 148: 997–1008.
- Sprenkle, D. H. & Blow, A. J. 2004. Common Factors and Our Sacred Models, *Journal of Marital and Family Therapy*, 30: 113–129.
- Stein, D. M. & Lambert, M. J., 1995. Graduate Training in Psychotherapy: Are Therapy Outcomes Enhanced? *Journal of Consulting and Clinical Psychology*, 63: 182–196.
- Strupp, H. H. & Hadley, S. W., 1979. Specific versus Non-specific Factors in Psychotherapy: A Controlled Study of Outcome, *Archives of General Psychiatry*, 36: 1125–1136.
- Tenner, E., 1996. *Why Things Bite Back: Predicting the Problems of Progress*, London, Fourth Estate.
- Thase, M. E., 2002. Antidepressant Effects: The Suit May Be Small, but the Fabric is Real, *Prevention & Treatment*, 5, 32.
- Tillet, R., 1996. Psychotherapy Assessment and Treatment Selection, *British Journal of Psychiatry*, 168: 10–15.
- Vos, T., Corry, J., Haby, M. M., Carter, R. & Andrews, G., 2005. Cost-Effectiveness of Cognitive-Behavioural Therapy and Drug Interventions for Major Depression, *Australian and New Zealand Journal of Psychiatry*, 39: 683–692.
- Walsh, J. E., 2004. Does Structural Family Therapy Really Change the Family Structure? An Examination of Process Variables, *Dissertation Abstracts International*, 64: 6317.
- Wampold, B. E., 2001. *The Great Psychotherapy Debate: Models, Methods, and Findings*, Hillsdale, NJ, Lawrence Erlbaum.
- Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K. & Ahn, H., 1997. A Meta-Analysis of Outcome Studies Comparing Bona Fide Psychotherapies: Empirically, 'All Must Have Prizes', *Psychological Bulletin*, 122: 203–215.
- Warner, R. 1994. *Recovery from Schizophrenia: Psychiatry and Political Economy*, London, Routledge.
- Whitaker, R., 2002. *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*, Cambridge, MA, Perseus. .