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Comparing apples and oranges: How do patient characteristics and treatment goals vary between different forms of psychotherapy?

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Objectives. The aim is to investigate whether different modalities and orientations of psychotherapy diverge with regard to patient characteristics and treatment goals, in a naturalistic setting for patients with substance use disorders.

Design. All psychotherapies ($N = 262$) during a year were surveyed at the Centre for Dependency Disorders, Stockholm County Council. Data were collected from the psychotherapists ($N = 38$).

Methods. A therapist questionnaire was used, covering the topics of interest. Data regarding problems and goals were categorized using a qualitative clustering method. Differences between therapy formats were analysed using statistical methods.

Results. The prevalence of psychological problems among the patients was high (88%). Patients in cognitive behaviour therapy (CBT) and family therapy (FT) had less severe psychological problems than patients in the other psychotherapy formats. With regard to treatment goals, FT focused on improved family relations, group therapies on relational improvements, psychodynamic therapies on insight and improved functioning, while CBT focused on behaviour change and improved motivation for change.

Conclusions. These findings suggest a shortcoming of the aim of the EST movement to consider reduction of target symptom as the only relevant treatment goal and to compare the efficacy of different treatments in this regard.

Psychotherapy research and politics of today are heavily influenced by the paradigm of Evidence-based medicine (EBM). EBM has been defined as an integration of relevant research, the clinical expertise that the clinician has developed with increasing experience and the patient's own choice (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). In 1993 division 12 (clinical psychology) of the American

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Psychological Association put together a task force to apply this paradigm to the field of psychotherapy. The Task Force on Promotion and Dissemination of Psychological Procedures (1995) established a set of rules for what should constitute empirically validated therapies (EVT; Chambless *et al.*, 1996), later re-named empirically supported therapies (EST; Chambless & Hollon, 1998). Randomized controlled trial (RCT) was placed at the top of their hierarchy of research methods. Thus, an EST was defined as psychotherapy for a specific disorder for which efficacy had been demonstrated in two well-performed RCTs conducted by two independent research groups. The main advantage of RCT is that the experimental design assures a strong internal validity, which enables causal inferences about the efficacy of the treatment in question (Mulder, Frampton, Joyce, & Porter, 2003).

However, the exclusive emphasis on RCT as the gold standard of evidence has led to much criticism. One criticism is that RCTs have low external validity (i.e. generalizability) due to the strict regulations of psychotherapy to fit the experimental research design. As Seligman (1995) pointed out: the use of randomization, rigorous control, treatment manuals, corrections of therapists who do not adhere to the manual, a fixed number of sessions, and a diagnostically homogenous patient group – these are all prerequisites that strongly differ from the conditions in the real clinical world. Due to the strict inclusion criteria regarding diagnosis and the lack of a demand of long-term follow-up, some psychotherapy methods have been declared as ESTs despite a quite poor record of recovered patients. As demonstrated in Westen and Morrisons' (2001) review of the research studies leading to EST status for certain psychotherapies for depression, generalized anxiety and panic disorders, an average of two-thirds of the patients screened for a study were excluded because of co-morbidity or subclinical pathology, 7% were dropouts, 13% did not improve, 5% relapsed, and only 10% remained improved at follow-up. The EST paradigm also misses the possibility that patients vary in suitability for one kind of treatment or another, based on variables other than psychiatric diagnosis. Research on aptitude by treatment interaction (ATI) supports the notion that patients have differential psychotherapy suitability contingent on resistance/reactance (Beutler, Moleiro, & Talebi, 2002), and functional impairment and coping style (Beutler, Harwood, Alimohamed, & Malik, 2002). Furthermore, the fundamental assumption behind EST that a certain set of psychotherapeutic techniques should be the most successful for a certain mental disorder has generally been contradicted by psychotherapy research findings. A recurring finding is that different forms of psychotherapy show equal efficacy when they are compared (Lambert & Ogles, 2004; Wampold, 2001) and that most of the patient improvement depends on non-specific factors such as patient and therapist characteristics, environmental factors, expectations, and the therapeutic relationship (Lambert, 1992; Norcross & Lambert, 2006; Wampold, 2001).

Another criticism of the EST concept concerns the exclusive focus on reduction of manifest target symptoms as the measure of therapeutic outcome. As a general guideline for measuring therapy outcome, Hill and Lambert (2004) suggest including measures regarding three domains: symptom distress, interpersonal problems, and social role functioning. Moreover, Blatt and Zuroff (2005) claim that an evaluation of therapeutic gain for depressed patients should include assessments of reduction of vulnerability to depression and development of resilience in terms of increased adaptive capacities for managing stressful life-events. A reasonable thought is that the definition of the outcome of a certain therapy should be related to the treatment goal. Many patients in therapy have other aims than symptom reduction, such as improved functioning, personal growth, enhanced quality of interpersonal relationships, etc. (cf. Dirmaier, Harfst, Koch,

& Schultz, 2006). Hill and Lambert (2004) point out that many patients have multiple problems, which are all addressed in therapy; hence, the proper assessment of outcome should ideally cover all relevant problem areas for the individual. One attempt at developing an individualized outcome measure based on diverging treatment goals is the goal attainment scaling (GAS; Kiresuk & Sherman, 1968), which requires that a number of mental health goals are formulated prior to treatment, and then operationalized into a scale of likely outcomes, in order to allow an independent observer to assess the outcome at a given time.

These critical arguments provide the background for comparing different psychotherapy methods in a naturalistic setting for patients with varying, and often multiple and complex, problems, to detect differences that might not be possible to address with a RCT design. The present study addresses the questions: Are different psychotherapy methods oriented towards patients with dissimilar problems and characteristics? Do various psychotherapy methods have different treatment goals?

Methods

Setting

The study took place at the Centre for Dependency Disorders, a large public addiction clinic within Stockholm County council with the assignment to provide specialized care for dependency disorders for the inhabitants of the major part of Stockholm County, Sweden. The clinic includes hospital wards for inpatient care, local out-patient units for general dependency care, specialized out-patient units for specific types of substance abuse, special units for adolescents with alcohol and drug problems, etc. In total, about 20,000 patients visit the clinic per year, although many of them make just one or two visits (e.g. one night at a ward for acute alcohol intoxication). There is one small-specialized team for group analytic therapy; otherwise psychotherapy within the clinic at the time of the study was organized through networks encompassing clinicians at various workplaces conducting psychotherapy as one clinical task among others. Referrals to psychotherapy were made within the clinic by the psychiatrists who were responsible for planning the patients' treatment. The referrals were sent directly to one of the psychotherapy networks, i.e. the networks for family therapy (FT), group therapy (GT), cognitive behaviour therapy (CBT) and individual therapy, i.e. psychodynamic (PDT), and cognitive therapy (CT). Subsequently, a therapist within the network saw the patient for psychotherapy assessment, before a decision could be made whether the patient should be offered psychotherapy – a decision mainly based on a judgment of the patient's motivation and suitability for the therapeutic method.

Definition of psychotherapy

For the present study, psychotherapy was defined as: a psychological treatment performed by a licensed psychotherapist, or someone with basic training in psychotherapy working under supervision, or a student in a psychotherapy training programme working under supervision. The treatment should be performed in accordance with a clearly defined and well-tried method (e.g. psychodynamic, cognitive, cognitive behaviour, group analytic, or FT). The treatment should aim at durable changes in the patient regarding thoughts, feeling, and/or behaviour, i.e. the treatment should have more extensive goals than supportive or psycho-educative

interventions. There should be an explicit agreement between the patient and the therapist that the treatment in question is psychotherapy.

Procedure

The study was performed from February to August, 2006, and concerned the psychotherapies that had taken place within the Centre for Dependency Disorders during the year 2005. All data was collected from therapists at the clinic. First, all licensed psychotherapists and therapists with basic training who worked at the clinic during 2005 were contacted by e-mail or telephone and asked if they had carried out any psychotherapy during the target year. Subsequently, appointments were scheduled with all therapists who had conducted therapy. A questionnaire was completed for every patient seen in therapy during 2005. The therapists completed the questionnaires with the author's assistance or provided questionnaire answers through interview, according to the therapist's preference. A few therapists completed the questionnaires without assistance, because we could not find time for an appointment. The therapists consulted casenotes while answering the questionnaire. Retrospective ratings of Global assessment of functioning (GAF; American Psychiatric Association, 1994) were made by the therapists reviewing casenotes.

Therapists

Data were collected from 38 therapists, whereof 31 (70%) women. They represented various professional backgrounds: psychologists (12), nurses (9), physicians (7), mental nursing assistants (7), social workers (3), or other (6). The mean age was 51, with a range from 33 to 68. The therapists had an average of 21 years' experience of work within dependency care and/or psychiatry, with a variation between 3 and 35 years. Fourteen (32%) were licensed psychotherapists, within the following therapy orientations: psychodynamic (6), cognitive (3), group analytic (3), and CBT (2). Five therapists underwent advanced psychotherapy training, oriented towards cognitive (2), cognitive behaviour (1), psychodynamic (1), and family (1) therapy. The remaining therapists had their basic training in family (8), cognitive behaviour (6), psychodynamic (6), and cognitive (3) therapy (one therapist had been in two different basic training programs).

Attrition

The initial effort by e-mail and telephone to trace all therapists active during 2005, revealed that 44 therapist had conducted psychotherapy during the target year. Data were collected from 38 of these therapists. It was too difficult to schedule an appointment with the remaining six clinicians who had ceased working at the clinic, had retired, or were on maternity or sick leave. It is unknown how many patients these six therapist had in psychotherapy during 2005.

Questionnaire

The questionnaire included questions about the patient's sex, age, substance of addiction (with indication of primary substance, if possible), other types of addictions (like gambling, sex, and food), type of psychological problems (psychiatric diagnosis, if present), abstinence at the start of therapy (yes/no) and duration of abstinence, GAF at

the start of therapy, date of therapy start, therapy format (individual/group/family), therapeutic method/orientation, frequency, therapy goals, somatic illness, termination of therapy during 2005 (yes/no), and date of therapy termination. The questions about psychological problems and therapy goals were open-ended and formulated in the following way:

- What type/s of psychological problem/s does the patient have? (Please mention psychiatric diagnosis, if such is at hand).
- Describe briefly the goals of the therapy.

Data analysis

The open-ended answers regarding psychological problems and treatment goals were categorized using a clustering method (Miles & Huberman, 1994). Most of the categories regarding psychological problems were organized in accordance to diagnostic categories in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994).

Differences between the psychotherapy methods with regard to the continuous variables (age, time of abstinence, and therapy length) were analyzed using one-way ANOVAs. The differences regarding GAF were not significance tested due to the high attrition in some of the cells (80% attrition for CBT, 68% attrition for FT).

Differences between the various psychotherapy methods with regard to the categorical variables were analyzed using cross-tables. With regard to the variables gender and abstinence at therapy start, each cell in the cross-tabulation was significance-tested to explore whether it occurred more or less frequently than could be expected by chance. For each cell, the expected and the observed frequency were compared using binomial tests. The procedure was carried out employing the statistical program EXACON (Bergman & El Khouri, 1987). With regard to the variables problem type and treatment goals, cross-tabulations were made for each category (occurrence: yes/no) and the distributions among psychotherapy methods were significance-tested using chi-square. Due to the high number of significance-tests, the alpha-level was set to .001 for each separate significance test, in order to decrease the risk for spurious significant results.

Results

Sample characteristics

According to the survey, 262 patients underwent psychotherapy at the Centre for Dependency Disorders in Stockholm during the year 2005. Data concerning gender, age, substance abuse at therapy start, length of abstinence prior to therapy start, and GAF at therapy start and therapy length are described in Table 1.

Several different substances occurred as primary substance of use, but alcohol ($N = 101$; 38.2%) was the most common (Table 2). The patients who did not have a substance use disorder ($N = 48$; 18.3%) were either in treatment for compulsive gambling or were grown-up children to parents with alcohol or drug problems.

A vast majority ($N = 230$; 88%) of the patients also had psychiatric/psychological problems concurrent with their substance use problems. The most common psychological problems were depression, anxiety, and personality disorders (Table 3).

Table 1. Patient and treatment characteristics for each therapy orientation and in the total sample

Therapy orientation	Females (%)	Age		No substance abuse at therapy start (%)	Abstinence prior to therapy start (months)		GAF at therapy start		Therapy length	
		M	*SD*		*MD*	Range	*M*	*SD*	*MD*	Range
Group therapy	58	41	8.9	96	8	0–132	60	7.3	11	2–116
Family therapy	47	33	14	52	0	0–24	66	10	6	0–30
Individual + Family therapy	64	18	1.5	21	0	0–3	61	8	36	Only one case
Psychodynamic therapy	49	36	14	74	1	0–276	54	11	23.5	1–53
Cognitive behavioural therapy	28	39	10	52	12	0–60	55	6.6	2	1–180
Cognitive therapy	58	38	12	96	12	0–84	54	12	12.5	2–45
Eclectic-integrative therapy	86	24	8.3	57	1	0–6	57	6.3	9	Only one case
Total sample	53	37	12	74	6	0–276	58	9	7	0–180

Table 2. Primary substance in the total sample and for each therapy orientation

Primary substance	Total sample (*N*)	Total sample (%)	GT (*N*)	FT (*N*)	I + FT (*N*)	PDT (*N*)	CBT (*N*)	CT (*N*)	EIT (*N*)
Alcohol	100	38.2	34	9	6	18	7	13	10
No substance abuse	48	18.3	26	1	0	2	19	0	0
Heroin	36	13.7	4	4	0	16	4	7	1
Mixed, two or more chief substances	35	13.4	9	2	4	11	2	6	1
Amphetamine	12	4.6	5	0	2	3	1	0	1
Cannabis	11	4.2	2	1	3	3	3	0	1
Benzodiazepines	8	3.1	1	0	0	2	2	2	0
Pain medication	8	3.1	4	1	0	0	1	2	0
Anabolic steroids	1	0.4	0	0	1	0	0	0	0
Cocaine	1	0.4	0	0	0	0	0	1	0
Solvent	1	0.4	0	1	0	0	0	0	0
Tobacco	1	0.4	0	0	0	0	1	0	0
Total	262	100	85	19	14	55	40	31	14

Note. GT, group therapy; FT, family therapy; I + FT, individual + family therapy; PDT, psychodynamic therapy; CBT, cognitive behavioural therapy; CT, cognitive therapy; EIT, eclectic-integrative therapy.

Table 3. Psychological problems in the total sample and for each therapy orientation

Problem type	Total sample (*N*)	Total sample (%)	GT (%)	FT (%)	I + FT (%)	PDT (%)	CBT (%)	CT (%)	EIT (%)
Depression/dysphoria	142	54	72	26	50	60	12	68	57
Anxiety (e.g. panic, phobias, obsessive-compulsive symptom)	97	37	44	26	57	24	30	52	29
Personality disorders	63	24	36	5	7	20	8	29	29
Suicidality/self destructiveness	45	17	15	21	57	14	0	23	29
Relational problems	34	13	14	42	7	16	0	10	7
Trauma	33	13	2	16	36	22	0	6	50
Aggressiveness/criminality	31	12	8	10	64	11	5	16	0
Psychosis/close to psychotic states	14	5	5	5	0	13	0	6	0
Eating disorders	13	5	5	5	14	6	2	0	14
Problems with family relations	8	3	1	10	21	0	2	3	0
Neuropsychiatric syndromes	7	3	1	10	7	2	2	3	0
Bipolar disorder	3	1	0	10	0	0	0	3	0
Other problems	50	19	18	10	29	27	2	23	36
Total	540								

Note. GT, group therapy; FT, family therapy; I + FT, individual + family therapy; PDT, psychodynamic therapy; CBT, cognitive behavioural therapy; CT, cognitive therapy; EIT, eclectic-integrative therapy.

Almost half of the patients ($N = 116$; 44%) received pharmacological treatment for either their psychiatric disorder or their substance use disorder. The most common types of medication were antidepressants and anti-abuse medication (such as naltrexone, acamprosate, disulfiram, buprenorphine, and methadone), while other types of medication were rare.

The goals for therapies varied greatly. Usually, there were several goals for each patient in therapy. The treatment goals and their frequencies are described in Table 4.

Of the total sample of 262 patients, 122 started in psychotherapy during the target year, 2005. During the same year, 101 patients terminated their therapies. Therapy length for the terminated therapies varied between 0 and 180 months ($M = 18$, $MD = 7$, $SD = 28$).

The distribution between different therapy modalities are described in Table 5. All group therapies had a group analytic (i.e. psychodynamic) orientation. The family therapies most commonly had either an eclectic or a systemic orientation. The theoretical orientations of the individual therapies are described in Table 6.

Differences between therapy orientations

When describing differences between therapy orientations, three modalities were also considered as separate orientations: GT, FT, and combined individual and FT. This was done because each of these three modalities was rather homogenous with regard to theoretical orientation. Combined individual and GT was excluded from this description, because the sample was too small. Four of the five theoretical orientations found in individual therapy were included: psychodynamic, cognitive behavioural, cognitive, and eclectic–integrative. Systemic individual therapy was excluded, since, it only applied to one patient.

First, the different therapy orientations were compared with regard to gender distribution, age, abstinence, global functioning, and therapy length (for terminated therapies; Table 1). Significant differences between the therapy types were only found with regard to age ($F = 11.8$, $df = 7/254$, $p < .001$).

Alcohol was the most common primary substance in all therapy orientations but one. The exception was CBT, in which there was an overrepresentation of patients with no substance abuse (48%, $p < .001$). This was because about 60 percentage of the CBT treatments concerned patients with compulsive gambling (four-session Motivational Interviewing, MI). No other significant differences were found with regard to primary substance (Table 2).

The relative numbers of different patient problems varied significantly across the therapy types. The significant differences by problem type across therapies at the conservative .001 level were for depression/dysphoria ($\chi^2 = 47.7$, $df = 7$, $p < .001$), personality disorders ($\chi^2 = 25.8$, $df = 7$, $p < .001$), suicidality/self-destructiveness ($\chi^2 = 26.8, df = 7, p < .001$), relational problems ($\chi^2 = 25.7, df = 7, p < .001$), trauma ($\chi^2 = 41.6, df = 7, p < .001$), aggressiveness/criminality ($\chi^2 = 42.8, df = 7, p < .001$), and problems with family relations ($\chi^2 = 24.5$, $df = 7$, $p < .001$). The distribution of different psychological problems across therapy types are described in Table 3.

Furthermore, there were large differences between the psychotherapies with regard to treatment goals. The significant differences were for the goal categories relational improvements ($\chi^2 = 30.9$, $df = 7$, $p < .001$), behaviour change ($\chi^2 = 51.7$, $df = 7$, $p < .001$), termination/management of alcohol/drug use ($\chi^2 = 60.1, df = 7, p < .001$), self-esteem ($\chi^2 = 29.7$, $df = 7$, $p < .001$), insight/reflective functioning ($\chi^2 = 48.9$,

Table 4. Treatment goals, in the total sample and for each therapy orientation

Treatment goals	Total sample (*N*)	Total sample (%)	GT (%)	FT (%)	I + FT (%)	PDT (%)	CBT (%)	CT (%)	EIT (%)
Improved functioning (e.g. at work, in school, socially), autonomy	84	32	26	21	50	38	22	32	57
Relational improvements	79	30	49	5	21	29	12	16	36
Reduction/management of symptoms	62	24	19	10	50	18	28	39	21
Behaviour change	59	22	15	16	29	9	62	29	0
Termination/management of alcohol/drug use	57	22	9	32	86	27			57
Self-esteem, self-image, self-development	48	18	16	5	14	22	0	45	21
Affect management (e.g. regulating, identifying, or expressing feelings)	41	16	21	0	7	16	0	36	7
Insight, reflective functioning	37	14	5	5	0	38	0	29	14
Improved family relations	35	13	7	84	64	6	0	3	0
Processing (e.g. of trauma or crisis)	33	13	0	0	14	18	2	36	57
Improved motivation for change	23	9	0	0	0	0	58	0	0
Harmony, well-being, quality of life, sense of coherence	20	8	9	0	0	14	0	0	21
Ability to set limits	17	6	14	0	0	4	0	10	0
New cognitive patterns	10	4	0	0	0	4	0	23	0
Total	605								

Note. GT, group therapy; FT, family therapy; I + FT, individual + family therapy; PDT, psychodynamic therapy; CBT, cognitive behavioural therapy; CT, cognitive therapy; EIT, eclectic-integrative therapy.

Table 5. Therapy modalities, frequency and percentage

Therapy modality	*N*	%
Individual therapy	141	53.8
Group therapy	85	32.4
Family therapy (including couples therapy)	19	7.2
Individual and family therapy	14	5.3
Individual and group therapy	3	1.1

Table 6. Theoretical orientations among the individual therapies

Theoretical orientation	*N*	%
Psychodynamic	55	39.0
Cognitive behavioural	40	28.3
Cognitive	31	22.0
Eclectic, integrative	14	9.9
Systemic	1	0.7

$df = 7, p < .001$), improved family relations ($\chi^2 = 131.4, df = 7, p < .001$), processing ($\chi^2 = 60.8$, $df = 7$, $p < .001$), motivation for change ($\chi^2 = 140.0$, $df = 7$, $p < .001$), and new cognitive patterns ($\chi^2 = 36.1$, $df = 7$, $p < .001$). The distribution of various therapy goals across therapeutic orientations are described in Table 4.

Discussion

The results of the present study show that different psychotherapy methods are indeed oriented towards patients with dissimilar characteristics and that they have divergent treatment goals. Exceptionally severe problems were found among the patients who were in combined individual and FT. The patients in this treatment were younger than in the other therapeutic orientations. The typical patient would be a teenager abusing alcohol or a mixture of substances, having a severe combination of internalized problems, such as depression, anxiety, and suicidality/self-destructiveness, and externalized problems, such as aggressiveness/criminality. Such severe problems in young people need to be addressed with interventions involving both the individual and the family. Somewhat surprisingly, the least severe problems were found among the patients in CBT, in which almost half had no substance abuse and the prevalence of psychological problems was low. The explanation for this is that more than half of the CBT treatments were four-session MI for persons with compulsive gambling. The identified patients in FT had relational rather than psychiatric problems, not surprisingly. The patients in the remaining therapy methods had a high prevalence of psychiatric disorders, most frequently depression, anxiety, and personality disorders.

One notable finding with regard to treatment goals was that termination or management of alcohol or drug use only came in fifth place. One explanation for this is that most therapists at the clinic demand that a patient should have undertaken a successful treatment against alcohol or drug abuse and stayed abstinent for 6 months before being considered for psychotherapy. The psychotherapies are hence more directed towards the patient's co-morbid psychiatric and personal problems. More surprising is that reduction or

management of symptoms was only the third most frequent goal, surpassed by improved functioning and relational improvement. The various treatment goals were mostly congruent with each theoretical orientation. It seems quite natural that FTs were directed at improved family relations, GTs at relational improvements and PDTs at insight/reflective functioning and improved functioning. It is also no surprise that CBTs were mainly focused on behaviour change and improved motivation for change, when considering that most of these treatments were MI against compulsive gambling. The goals of the CTs were, however, less clear-cut in their theoretical foundation. The most common goal was not new cognitive patterns, as might be expected; instead improved self-esteem/self-image/self-development, reduction/management of symptoms, affect management, processing, and improved functioning dominated.

These findings regarding treatment goals suggest a shortcoming of the EST movement to consider reduction of target symptom as the only relevant aim of therapy and to compare the efficacy of different treatments in this regard. On the contrary, different psychotherapy methods seem to have clearly dissimilar goals. Therefore, it would seem adequate if different therapeutic orientations would use divergent primary outcome measures. Another alternative is individualized outcome measures, such as the GAS (Kiresuk & Sherman, 1968).

Various psychotherapy methods seem to be oriented towards different patient groups. In a naturalistic setting such as an addiction clinic, conscious efforts are made to match each patient to a suitable therapy method, based on the type of problems, personality features, and preferences. In some cases, various psychotherapy methods might be useful at different stages of an illness career. Patients with severe behavioural problems might initially need a treatment with a behavioural approach to terminate or manage the problematic behaviour, sometimes combined with pharmacological treatment. However, some of these patients also have complex personality and interpersonal problems, sometimes constituting the diathesis for the behavioural problems. These patients might need to continue in a more elaborate therapy aiming at more extensive changes. FT might be useful in all phases of the illness career – in the acute phase to create a family environment that supports the termination of a problematic behaviour, and later to address prolonged family problems.

Generally speaking, the goals and the patient characteristics of different psychotherapy methods stand out as so dissimilar that it seems like comparing apples and oranges. It is a difficult task for psychotherapy research to take these differences into consideration in a productive way. RCTs do not appear as the one and only solution for this. RCT was designed as an excellent tool for studying the efficacy of pharmacological treatments. However, psychotherapy is not like a medication in which a certain active substance is delivered in an exact dose. Psychotherapy is instead a complex dynamic process of two people or more (in FT and GT) interacting with each other over time, a series of overt/behavioural and covert/mental events. Each psychotherapy session, as well as the therapy as a whole, is more or less co-created by the patient and the therapist (probably even in highly structured forms of therapy). Such treatment cannot be put under total experimental control.

An alternative approach is proposed by Leichsenring (2004) who suggests that effectiveness studies of psychotherapy should be regarded as providing equally strong evidence as RCTs, if they are conducted as prospective quasi-experimental naturalistic studies with comparison groups and meet a number of additional criteria of strict methodology. Tucker and Roth (2006) are even more radical when discussing research on treatments for substance use disorders. They suggest that RCT should be placed only

as number two in the research method hierarchy, surpassed by multivariate longitudinal research using random samples and appropriate experimental control. The fundamental goals of such studies are to model the multiple influences on health and behaviour, including interventions, and to make valid inferences that apply to larger populations. The APA Presidential Task Force on Evidence-Based Practice (2006) re-connects to the original definition of EBM and states that Evidence-Based Practice in Psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences. When discussing what constitutes the best available research evidence, the Task force states that research needs to balance between internal and external validity. Multiple research designs contribute to evidence-based practice and different research designs are better suited to address different types of questions.

The present study has the limitation of only capturing a 'snapshot' of psychotherapies, i.e. data was only collected regarding patient and treatment characteristics at one given point of time and the study does not follow the longitudinal outcome. A further limitation is that data for economical reasons were only collected from therapists. Generalizations are restricted due to the limitations of the patient group, i.e. patients at an addiction clinic, and the over-sampling of patients in long therapies. However, this group is especially interesting for studying diversity of patient characteristics and treatment goals, because many patients have multiple problems – substance abuse, psychiatric symptoms, and personality disorders. This is the clinical reality. These are the persons that mental health professionals should treat in an optimal way.

Future research and politics regarding psychotherapy will hopefully be in line with the recently formulated paradigm of EBPP (APA Presidential Task Force on Evidence-Based Practice (2006)). As proclaimed by this paradigm, a multitude of research designs are needed to gain knowledge about what works in psychotherapy: RCT design to study the efficacy of treatment packages and dismantling designs for the efficacy of specific interventions, for selected patient populations under optimal laboratory conditions; naturalistic or quasi-experimental designs for examining the effectiveness of various psychotherapies for ordinary patients in real clinical settings; psychotherapy process research and correlation approaches for identifying variables contributing to differences in outcome; aptitude by treatment interaction (ATI) designs for investigating which patients benefit from what kind of therapy; qualitative research for exploring patients' own experiences of helpful change processes. Psychotherapy is a highly complex scientific area as it involves the mental life and interpersonal communication of human beings, and calls for multiplicity of sophisticated research approaches.

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