Efficacy or Effectiveness: Which Comes First, the Cure or the Treatment?

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The old adage asks, “which came first, the chicken or the egg?” In our discussions concerning the effectiveness or efficacy of hypnosis and psychotherapy, we often find ourselves wondering which should come first, effectiveness or efficacy. Should we seek to prove the cure (also known as efficacy), or should we treat the condition (also known as effectiveness)?

In today’s climate it is particularly important to be careful about what it is that we exactly say concerning our treatments’ effectiveness or efficacy. A few years back I was attending a workshop presented by the psychologist, Donald Meichenbaum. My comfort in challenging Dr. Meichenbaum during his presentation came, not so much from my supreme confidence and command of the material as it did from my friendship with him. I knew that if I were wrong, he would publicly humiliate me only with the utmost of kindness and affection. Those who know of his work (Meichenbaum, 1995, 2001), know that Dr. Meichenbaum is powerfully, and sometimes painfully, dedicated to evidence-based treatments—those for which the empirical literature has provided sufficient support. Dr. Meichenbaum invited me to role-play with him a case I had prepared for his program. Then he launched into his sermon on what the literature says and doesn’t say about the kind of work that I had just presented.

Then it was my turn. I questioned Dr. Meichenbaum as to what we, as clinicians who treat people with real collections of problems, are to do when our techniques have not been determined to be efficacious? Specifically, I asked how we should deal with individuals who had not first successfully passed through all the exclusion criteria required for study so that they can then be treated with a manualized technique. Perhaps, I suggested, we ought to professionally inform the patient that: “While I think I have a
tool that may help you with your problem, I cannot in good conscience offer it to you because it has not been proven in a clinical trial. It may be effective, but it is not as yet known if it is efficacious. Please come back to see me in three to five years because I might have an efficacious treatment for your problem by then.”

I was sure I had caught Dr. Meichenbaum at this point, but I had underestimated him. He replied that of course I should provide the probably effective treatment and hopefully observe the progress as I had previously seen in other patients. However, he continued, I should exercise caution when attempting to suggest that my technique, while helpful to a number of people, has yet to be proven effective. So, from this point of view, it could be construed that it is not so much what we do, but what we say about what we do. The two clinical cases that follow further illustrate this issue.

Clinical Case 1: Kevin

Kevin was a high school senior. He was a very bright, socially sensitive, and insightful young man whose complaint was that he could not swallow pills or capsules. This had become a problem because recently he had been diagnosed with Attention Deficit Disorder (ADD; American Psychiatric Association, 1994). He both needed and greatly benefited from Ritalin (methylphenidate). However, he could not swallow the pills, which he had been instructed to take three times a day. He was only able to manage swallowing a pill occasionally.

Kevin and his parents had tried a variety of ways to help him learn how to swallow pills, but none availed. When the pill reached an area from the back of his throat to as far as partway down his throat, he would gag, and the pill would come up. During our first meeting I inquired about any history that might somehow relate to this problem, such as an illness or allergic reaction in which his throat had closed, trauma to his throat, such as an injury or even a sexual assault, and all of these possibilities were denied.

Kevin wanted this problem resolved for several important reasons:

1) He planned to travel after graduation and was concerned that should he have an emergency away from home that required medication, he wouldn’t be able to take it since almost no adult medications come in liquid form.

2) The best method for his Ritalin (methylphenidate) dosing had been determined to be a once-daily dose of timed-release medication and not the three separate daily doses he was currently taking. His use of the three times a day routine was based on his poor track record of successful pill ingestion and the philosophy that if he were unable to take the time release medication on any given day, he would be completely without the medication he needed.

After consultation with several dentists who used hypnosis for gagging and related problems, I tried a number of techniques they had recommended as well as a few of my own. However, nothing was helpful.

When I find myself stuck, as I was with Kevin, I often go back over the patient’s history looking for something I might have missed the first time. I met again with Kevin and his parents in order to review the questions I had originally asked, and I received the same answers. Then I asked yet one more time whether Kevin had experienced any trauma to his mouth, neck, and/or his throat. Kevin and his father clearly answered “no.” However, Kevin’s mother was silent.
As all eyes turned to her, she said, “Well, not exactly ‘no’.” She then explained that when Kevin was born he apparently had, she thought, no gag reflex. The doctors and nurses had begun to work on Kevin. They inserted a tube into his throat for the purpose of stimulating the reflex. This maneuver eventually began to work, but upon removal of the tube, she reported, its small plastic end broke off in Kevin’s throat. This broken piece, shaped like a capsule, was retrieved with apparently little effort.

Indeed Kevin, his father, and I were surprised to hear this new information. When Kevin asked why he had never been told of this incident, his mother explained that it had occurred during the first hour or two following his birth, that everything turned out fine, and that it had been a very long time ago.

It appeared that this story had some significance in relation to Kevin’s current problems. Hypnosis was used to help address this through the use of hypnotic age regression. I asked Kevin to go back in time to a time just before the incident his mother had described happened. Then I asked him to move forward in time through the incident until it was completely finished and resolved.

Of course, this should seem rather strange because we were dealing in trance with a time during Kevin’s first minutes of life. At least it seemed quite strange to me. In reviewing Kevin’s “recollections” of the event during the “replay” of the event, I asked “the baby” to express himself through 17-year-old Kevin. Interestingly, what “the baby” talked about wasn’t so much the event itself, but his more general experience of being restrained and having things done to him without any input. Still in hypnosis, the now 17-year-old Kevin spoke about people having decisions or events put upon them, without any consent or contribution. While this sounded most unusual, I reminded myself that I was dealing with a bright, socially sensitive adolescent.

Following our work on a few more minor issues, we concluded the hypnosis part of the therapy session. Kevin and I then discussed his experience, and I asked him how he felt all this rather extraordinary material might relate to his being able to swallow his medication. While Kevin saw a connection to the event, he still had a hard time seeing how it mattered today. Following a bit more discussion, I asked Kevin, who by then was usually able to take his three divided doses of Ritalin (methylphenidate), whom he actually thought was having a problem swallowing the pills, who needed that once daily dose. He said he wasn’t sure why, but he felt as if it were his mother who needed for him to take the time-release dose. Indeed, his mother was expending a great deal of effort monitoring Kevin’s compliance with his medication.

I then spoke with both Kevin and his parents. I assured everyone that Kevin could easily take his three pills per day, and that he did not need the single daily time-release pill right now. I indicated that the only role his mother should take in Kevin’s compliance was to refill the prescriptions. Kevin would do the rest. Furthermore, after his summer trip, later in the fall, when he was ready, Kevin would naturally ask to switch to the preferable once daily dose. Both Kevin and his mother were relieved.

*Thoughts about Kevin’s Treatment*

I found this experience both rewarding and very peculiar. I was glad that Kevin had been helped with his problem, but I couldn’t see how I could explain in detail to anyone what I did (I still haven’t explained it all). This is because I am certain there is nothing in the literature that supports what I did with Kevin, and there may even be
literature that argues against what I did. So my treatment of Kevin’s problem may have been “only” effective but not very efficacious. I am certain that Kevin doesn’t really care which came first, the cure or the treatment. In Kevin’s mind, as in those of most successfully treated patients, not having symptoms means that a cure has taken place.

Several years ago I was one of a few professionals interviewed for an article being written on hypnosis and medical care, especially pain treatment. The author had really done his homework and had also benefited from interviewing most of the others before he met with me. At the end of our discussion he asked me if I knew of the state-trait debate. After I commented on this topic, he asked me which state or trait. I told him that, when someone is suffering, comes to see a hypnotically informed clinician, and through some intervention on the clinician’s part experiences an abatement of the “pain”, he/she isn’t too interested in whether the clinician subscribes to the state theory or the trait theory.

Reductionism pushed medicine to a new level of scientific stature. This proved to be very helpful and important for both patients and medicine as evidenced by such phenomena as the eradication of certain illnesses from the planet and the vastly increased life span in Western culture. For a long time both medicine and psychology embraced the single cause/single cure perspective. The downside of such an orientation was that it also served to render our thinking rigid.

The contemporary reductionistic struggle reminds me of an exchange I had with my former physician. I had been experiencing some progression of a chronic condition and met with my doctor for help with some painful symptoms. The doctor examined me and reported (in perhaps too much detail) what was not the cause of my symptoms. Yet, he was not able to tell me what was causing my suffering, or what we should do about it (save that we should keep an eye on it). Of course, being a male clinician myself, I hadn’t sought help until the pain was interfering with my daily functioning. I had been watching the symptoms for nearly a year by the time I asked for help.

In my frustration, and with a return to my more holistic roots, I searched for a different kind of clinician to help me with this problem. I also took greater charge of my own health care. Happily, the new kind of healthcare worked. I experienced pain relief in the first visit and symptom resolution after 4-5 visits. I later returned to my doctor to report this as well as a number of other positive changes. He was pleased and then asked the question, “Of all those things you did to help yourself, what one really made the difference?” By now I had figured it out. No one thing helped. They all, in combination, helped.

Why should we assume that in healthcare there is one answer to the “cure” question. Our lives are multi-modal. Why shouldn’t our treatment also be multi-modal? Whenever we use the single-modal or reductionistic perspective, answers are either right or wrong, outcomes can be more easily measured, and the design of the research is much cleaner. I often wish my life were uni-modal. How much simpler it would be.

Clinical Case 2: George

George is a 50-ish computer systems manager for a local government entity who had fairly recently relocated to the Midwest from California. Throughout his life, since childhood, he had been a very active and competitive athlete. Well into his 30’s,
he competed, then coached, and then officiated in football. He was also the father to two grown, healthy, and well functioning children, and his wife had overcame a bout with cancer some ten years ago.

George presented with high blood pressure that was poorly controlled medically. He also had chronic bronchial asthma for the past eight years. George experienced frustration and stress at work, and he reported that he tended to hold in his frustrations. George had formerly used sports as an outlet, but could no longer do so because of his declining medical condition. Asthma and poorly controlled hypertension had completely sidelined him from his sports activities. George’s physician suggested that he talk with me about stress management.

I was very pleased that, after four visits, I had been able to help George begin to see improvement in all his areas of complaint. (Like all clinicians I do not have only success stories. I am using a second one here because it is so difficult to discuss effectiveness with cases that reflect failure). I do not believe that the interventions I used with George were particularly unique. Yet, I did something with George that others had overlooked.

George had played football for a semi-pro team associated with a National Football League team. He played during the time when that team won the Super Bowl. His team had also had a very winning season. Apparently George and the other players received a Super Bowl ring. I noticed the ring (it was hard to miss), and I observed that George came to his appointments wearing a warm-up suit. Sports were still very much a part of his identity—an identity that had been shattered by advancing years and illness. My interest in and attention to his sports identity quickly established a rapport that enhanced what I did clinically with George.

**Thoughts about George’s Treatment**

Most would agree that the kind of attentiveness and genuine interest that was present in my therapeutic relationship with George is a hard element to factor into research designs. Yet, the relationship cannot be left out of the research protocols that are attempting to discover what really works. Making no attempt to minimize or dismiss the importance of evidence based treatments in therapeutic outcomes, Norcross (2002) found that the patient-clinician relationship makes substantial and consistent contributions to treatment outcome—indeed independent of the specific type of treatment. He then suggested that efforts to advance practice guidelines or evidence-based lists of effective treatments that did not include the patient-clinician relationship are seriously incomplete and potentially misleading, both clinically and empirically. The treatment relationship acts in a collaborative manner with specific interventions, patient characteristics, and clinician qualities in determining treatment effectiveness. A comprehensive understanding of effective (and ineffective) treatment should consider all of these determinants and their optimal combinations. Practice and treatment guidelines need to explicitly address clinician behaviors and qualities that promote a facilitative treatment relationship.

Like others, Norcross (2002) reported that overlooking the relationship in favor of focusing on technique causes a significant amount of effort to be aimed at what typically constitutes, on a good day, about 15% of the outcome variance. If 15% of the outcome is attributable to technique and about 20% is attributable to “other factors”
this leaves approximately 65% of the outcome attributed to relationship-related factors. Why then the nearly exclusive focus on technique and treatment outcome? As with the reductionistic perspective, technique is the most explainable, the most easily defined, and the easiest measured of the three areas mentioned.

Other Issues of Consequence

There is another most significant problem with our thinking. How can we “prove” to third-party payers or to medical and psychological colleagues that hypnotherapy works—is more than effective—when we cannot agree on what hypnosis is? One result of our disagreements on this matter is that we study and measure the smallest, but best defined, aspect of the treatment. Yet, the factors influencing treatment are many. For example, Norcross’ (2002) review of empirical evidence concerning the psychotherapy relationship yields a number of salient factors. According to Norcross (2002):

**Demonstrably Effective** features include:
- the therapeutic alliance
- cohesion in group therapy
- empathy
- goal consensus
- collaboration

**Promising and Probably Effective** features include
- positive regard
- congruence/genuineness
- feedback
- repair of alliance ruptures
- self-disclosure
- management of counter-transference
- and the quality of relational interpretations.

Additionally, adapting or tailoring the therapy relationship to specific patient needs and characteristics (in addition to diagnosis) enhances the effectiveness of treatment.

The following list was derived based on empirical evidence in *Customizing the Therapy Relationship to Individual Patients* (Norcross, 2002) on the basis of patient behaviors or qualities. For example, patients presenting with high resistance have been found to respond better to self-control methods and minimal therapist directness, whereas patients with low resistance experience improved outcomes with therapist directness and explicit guidance.

**Demonstrably Effective as a Means of Customizing Therapy** includes:
- resistance
functional impairment.

**Promising and Probably Effective as a Means of Customizing Therapy** includes

- coping style
- stages of change
- anaclitic/sociotropic and introjective/autonomous styles
- expectations
- assimilation of problematic experiences.

Current research on certain patient characteristics is insufficient for a clear judgment to be made on whether customizing the therapy relationship to these characteristics improves treatment outcomes. Those features include attachment style, gender, ethnicity, religion and spirituality, preferences, and personality disorders.

Lynn, Kirsch, Barabasz, Cardena, and Patterson (2000) recommended several ways of enhancing research. These include a clear definition of the population being studied, descriptions of the procedures used that are given in sufficient detail so that the study could be replicated, and testing and reporting on the subjects’ hypnotizability. The authors further discuss the importance of defining hypnosis. However, this involves more than creating a simple definition. One problem we face is that hypnosis appears to be anything the researcher or clinician says it is. This, I believe, has serious implications concerning how, or if, hypnotically delivered treatments are accepted in medical or psychological treatment settings.

Norcross’ (2002) work emphasizes the significance of the therapeutic relationship as a factor affecting outcome. By now there is a great body of research supporting the patient-clinician relationship. However, Lynn et al. (2000) tell us that, at the time of their writing, there were no measures of this very important variable.

Liossi and White (2001) have gone a long way toward enhancing the credibility and acceptance of their hypnotic work following the Lynn et al. (2000) recommendations. These authors state the following: “The hypnosis intervention consisted of induction, suggestions for symptom management and ego-strengthening, and post-hypnotic suggestions for comfort and maintenance of the therapeutic benefits during the following week” (p. 148). In the next sentences the authors describe the techniques they used and the targets of their direct suggestions. These descriptions are not scripts, but are quite sufficient that the experienced clinician could utilize their model. The authors, however, go beyond a mere description of what they did. They indicate that a treatment manual was developed which had detailed descriptions of the interventions and that the reader can obtain a copy of the manual. By adding this one piece, Liossi and White (2001) will ensure their work’s acceptance in areas where hypnosis has had a difficulty gaining both acceptance and a positive reputation.

Hammond (1998) has provided a very stimulating and colorful rendition of the shortcomings of typical academic based research. While the focus of his editorial is on research, the clinicians do not escape unscathed, at least by implication. Hammond (1998) seems to say that if researchers and academics wish to influence clinical practice, they need to come outside and work in collaboration with experienced practicing clinicians. This will bring utility to their research and significant credibility to the
clinicians’ practice. Similarly, if the clinicians wish greater acceptance of their work, they too must collaborate with their researcher colleagues such that “we” will be able to demonstrate to both medical and psychological fields what we know and not just what we believe. Not knowing really is not a bad thing and actually is the basis of scientific inquiry. Dorsey (2003) reminds us that saying, “we don’t know how it works is not a sign of weakness in [medical] research, but an indicator of scientific integrity” (p. 39). I often try to help students and clients appreciate that there is much that we do not know but that should not interfere with our being effective in our work. The answer our patients seek is not “the” answer but “an” answer. We all need to keep open minds, but not so open that our brains fall out.

References


