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CAN DR ORFORD'S PATIENT BE SAVED?

Doctor: Welcome to the university's psychotherapy clinic. I see that you've been referred by Dr Orford [1]. Let me see if I can help you, Mister . . . ?

Patient: Research, addiction treatment research, but you can call me A. T.

Doctor: Okay A. T. Tell me how you see your problem.

Patient: Me? You think its worth inquiring about a mere patient's perspective on the goals and nature of therapy [1]?

Doctor: I know it's irregular, but the research grant that funds my position runs out next week, so what the hell.

Patient: OK [sighs]. Well, I keep running short-term, randomized clinical trials of psychotherapies that I believe in my heart are profoundly different, but the results keep undermining that assumption and I end up learning nothing. And yet, I can't seem to stop, and it's got me worried. After all, isn't engaging in the same behavior over and over again despite negative consequences the perfect definition of addiction?

Doctor: Um . . . I'll ask Dr West when he comes in. In the meantime, let's begin with a functional assessment. What are the rewards of your behavior?

Patient: Enormous research grants, publications in top journals and the respect of my peers.

Doctor: Given that level of positive reinforcement, you should be happy, so behavioral analysis seems too simple to explain your addiction. Let me switch to a technique from motivational enhancement and existential therapies . . .

Patient: What's that sound?

Doctor: That's the research assistant behind the two-way mirror; she's screaming because I'm departing from the

manual, which is how psychotherapy is done in the real world [1]. I was going to ask you about your deepest values and goals in life.

Patient: I had hoped to advance scientific knowledge and to help suffering people at the same time.

Doctor: That's very admirable, A. T. Yet it says in Dr Orford's report that your search for knowledge has 'reached a dead end' (p. 882, [1]). I solicited a second opinion on your case from some other experts and they said much the same thing [2]. It must be hard to face the facts that you don't know much more than you did 20 years ago, and you haven't helped improve clinical practice much either.

Patient: Yes, it's crushing really, to have worked so hard yet made so little difference . . . [starts to sob].

Doctor: No intense affect please—it's hard for the raters to code.

Patient: Sorry [sniffles].

Doctor: Any other downsides to your behavior?

Patient: My addiction costs a lot of money. Do you know how many stereos I had to boost to pay for Project MATCH [3]? After spending so much money finding out that the matching hypothesis was wrong, I swore 'never again'. But then the UK Alcohol Treatment Trial (UKATT) came along and seemed so tempting that I thought things would be different this time around . . .

Doctor: Believe me, A. T., I understand: we've all been there. When did you start becoming aware of your addiction?

Patient: Practicing psychotherapists have been telling me for years that I was on the wrong track [4]. But it was easy to ignore you all because, you know, I never really liked or respected front-line clinicians very much to begin with.

Doctor: The feeling is mutual.

Patient: I knew it!

Doctor: Why is your denial breaking down now?

Patient: Because people I've known and trusted for years, people who are respected for their judgement, are much harder to ignore. They say it in different ways, but they agree I have a problem and I need to change [1,5,6]. But I'm scared.

Doctor: Of?

Patient: My reputation will suffer because I put so much time into things that didn't work. And I run with a conservative crowd. If I start doing my work differently than all my friends, governments and universities may decide

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that there's something wrong with me and that I don't deserve any resources.

Doctor: It sounds like you see some risks if you change, so it might help motivate you if you envisioned what you had to gain.

Patient: Like what?

Doctor: Let's look at what Dr Orford and other people who know and love you have said: you would learn much more about common processes of change in addictive behaviors, not just across psychotherapies but outside of treatment altogether [1,6]. You would provide therapists with information they could actually use, like how to know in real-time when treatment isn't working [5] and how to change to a different therapy in response [2]. And you would gain the methodological flexibility to pick research approaches in light of what you were studying, instead of letting the methodological tail wag the substantive dog [1,6]. All of these things seem in line with what you said your fundamental values were.

Patient: All of that sounds wonderful, but change is so much harder than pretending that nothing is wrong.

Doctor: A. T., a rocky, steep road is a better choice than a smooth and level one if it goes to where you want to end up.

Patient: That's a beautiful sentiment.

Doctor: Thanks. I read it in the treatment manual.

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IMPROVING RESEARCH TO EVALUATE THE EFFECTS OF PSYCHOLOGICAL TREATMENTS FOR ADDICTION

Jim Orford proposes a shift in research on psychological treatments for addiction [1]. Indeed, evaluating the effectiveness of treatments for addiction has posed a challenge to researchers; however, this challenge is no different from that faced when evaluating almost any health-care intervention. Disappointment over the poor evidence on effects of psychological treatments for addiction is not an isolated case. The problems are not specific either to addiction or to psychological interventions. Indeed, both points are issues for the broader scientific community.

Taking *BMJ Clinical Evidence* [2], for example, which summarizes the current state of knowledge and uncertainty about interventions used to prevent and treat important clinical conditions, we find that about half the treatments considered have unknown effects because of insufficient data or data of inadequate quality. Only 14% of interventions are clearly beneficial and 23% likely to be beneficial [2]. This is similar to the finding that a third of addiction interventions are beneficial (Cochrane Review Group on Drugs and Alcohol [3]). It would therefore be wrong to assume that uncertainty over the effects of treatments is specific to those studying drug and alcohol addiction.

Criticisms have been levelled at the quality of trials of effectiveness of psychological interventions. For example, most of the systematic reviews published in the Cochrane Library in a variety of fields of health care highlight major problems in the quality of these trials in terms of sample size, heterogeneity of interventions evaluated, duration of studies and outcome measure instruments used [4–10]. However, these criticisms can also be levelled at pharmacological interventions. For example, more than 70% of trials included in the Cochrane Systematic Reviews of interventions for addiction problems do not specify the method of allocation concealment, which is needed to protect against selection bias [11]. Of the total number of trials conducted to evaluate the effects of interventions for opioid addiction, only 10% are psychological interventions.

The need to test scientifically all plausible treatment options—including psychological interventions—is not