Psychotherapy in dissent

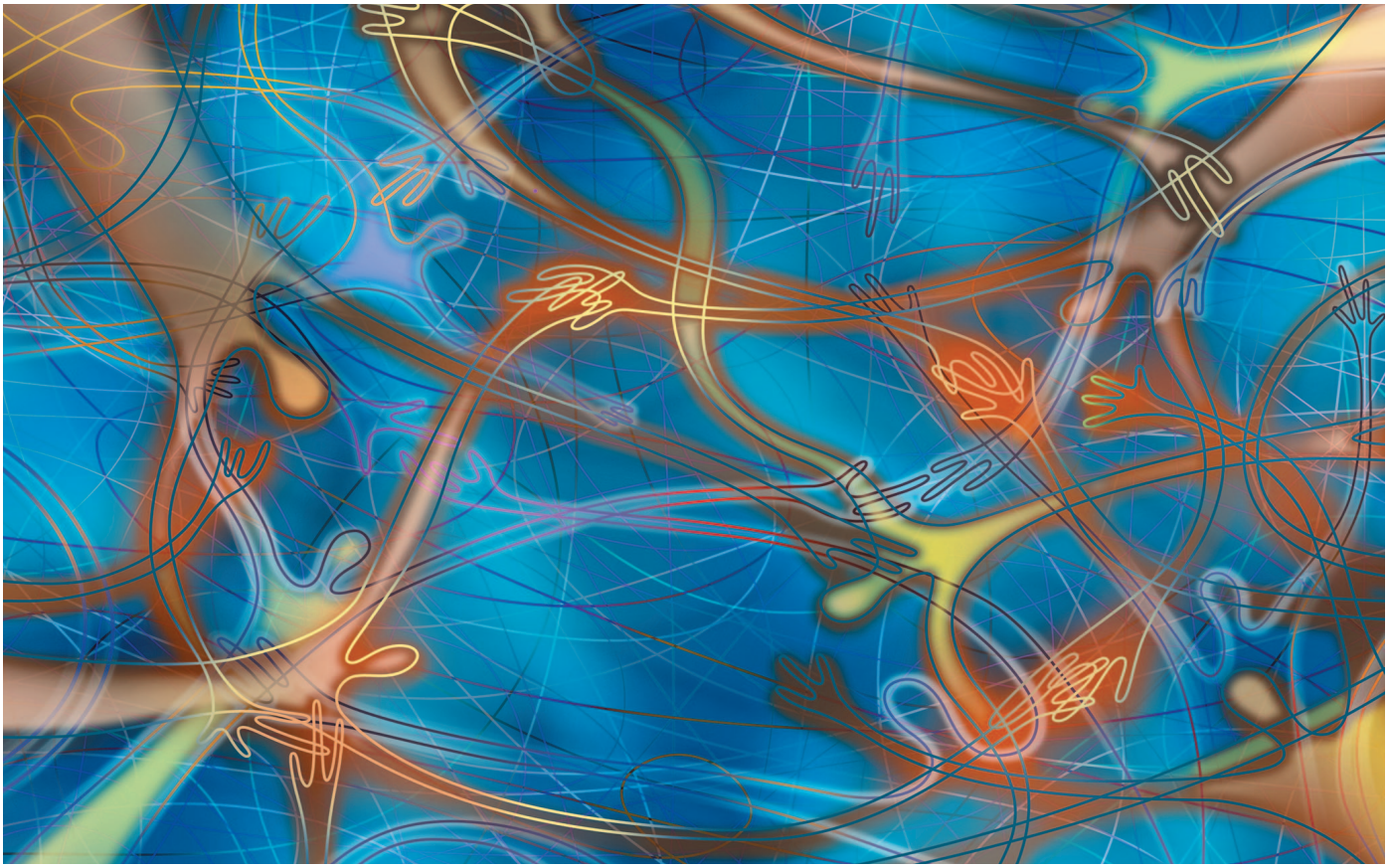
Some of the objections to the rise and rise of CBT are not based on fact. Equally, CBT itself is changing in line with research that advances our understanding of what needs to be integrated within its approach

by David Veale

I have borrowed the title of this article from the book *Psychiatry in Dissent* published in 1976 by Professor Anthony Clare, who sadly died last year. The book was very influential in helping me to decide to train as a psychiatrist. In it, Professor Clare came to the defence of the profession when it was under heavy criticism, and argued passionately for an evidence-based approach. I write in a similar vein to correct some of the myths and misunderstandings about cognitive-behavioural therapy (CBT) and the Increasing Access to Psychological Therapies programme (IAPT) which has been vilified in some quarters. I have tried to extract the common themes from the various articles and letters that have been published in *therapy today* and in the media, and respond.

'There should be greater patient choice between different types of therapies offered in the NHS'

The National Institute for Health and Clinical Excellence (NICE) is responsible for guiding the NHS. Its remit is to recommend treatments that



are cost effective and minimise the burden for the client. The guidelines it produces are based upon the current best evidence available – that is, a meta-analysis of hundreds of randomised controlled trials, cost-effectiveness studies and subsequent discussions with researchers, clinicians, and users. When there is evidence of cost effectiveness, then the guiding principle in the NHS is that of patient choice. When given the choice, clients commonly prefer an effective psychological therapy over medication, yet many people who may potentially benefit are either simply not referred because of the long waiting lists, or opt for the private sector. The IAPT programme aims to reconfigure services so that they are more consistent with the NICE guidelines and can provide patients with the choice of a psychological therapy for depression and anxiety disorders. At this point, evidence for the effectiveness of many psychological therapies other than CBT is lacking – which is not the same as evidence for the ineffectiveness of other psychological therapies. We all want good data that will help us adapt and improve the quality of life of our clients. People who are cynical of the process of NICE do not offer any alternative for making decisions about public policy or how they would improve the process and quality of life for the many people with common mental disorders.

Being empirically grounded is a core value for cognitive-behavioural therapists and they have put an enormous investment in research over the past 40 years. Note that being empirically grounded is not just about randomised controlled trials. What clients tell us is the source of inspiration in applying empirical questions. There are of course many different designs to answer different questions. They include:

- experimental designs that inform theory of why a symptom is maintained, which has led to specific models for different disorders;
- case series with multiple baselines or sequencing of interventions prior to a controlled trial;
- mediational studies to understand the processes involved in improvement;
- dissemination studies to determine whether a treatment manual in a specialist centre can be disseminated to primary care or real-life settings.

The process for finding evidence to disprove a theory is slow and tedious and requires a lot of investment over many years. Anecdotes and personal experience for a particular approach are for the media and not for making public policy decisions. The implications are that all future counsellors and psychotherapists should be trained as scientist practitioners so that they can collect and evaluate data, participate in peer review and be part of the scientific community. This has been a major cultural divide between CBT and other psychotherapies, but there are signs that this is now improving. Referring agencies, commissioning agencies, health insurance companies and clients will increasingly seek empirical data rather than anecdote. Of course, everyone supports greater patient choice. However, as far as the NHS (and most health insurance companies) is concerned, the choice will be between treatments that have a good evidence base and are cost effective in the long term.

It is worth stating that CBT as it is currently practised will not exist in the future. It constantly changes depending on new research. Being data led with testable models has a number of exciting consequences:

- It means no attachment to any specific model or technique. For example, in 1979, Beck first published his manual for depression. The emphasis was on challenging content of thoughts and 'control' of symptoms – more recent practice is investigating Behavioural Activation, which helps clients to not engage in processes like ruminating, and helping depressed patients to do the things they are avoiding. This approach is exciting, as it may have advantages to standard Beck cognitive therapy for severe depression[1,2].
- CBT encourages integration. The most important aspect of CBT is the formulation of the processes that maintain a disorder, and so whatever is the most effective way of breaking a cycle can be legitimately used. An example is the way that imagery techniques and rescripting for aversive memories, originally described in Gestalt, has been evaluated and incorporated into CBT, probably because these techniques offer a more powerful way of evoking emotion than verbal techniques do[3].
- Being data led informs service delivery. An example of the way data informs the delivery of therapy is provided at my own unit. Pilot data with post-traumatic stress disorder (PTSD) or obsessive compulsive disorder (OCD) suggests that providing intensive therapy over one week (15 hours) leads to outcomes equivalent to therapy once a week for 15 weeks. This is exciting because if it were to be confirmed in controlled trials then it would provide greater patient choice. Someone could take a week off work; overcome his or her problem and return to work without having to turn up to a hallowed hour once a week. Other researchers have looked into delivering CBT over the telephone[4] or via webcam. This emphasis on service delivery follows the values of placing the

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least burden on the client and securing maximum patient choice.

'It's the relationship that heals, not the technique'

Many people in CBT over many years have been working hard to try to focus on key agents of change so that these can be delivered in efficient, compassionate and caring ways within a supportive relationship. Most scientists are not convinced that a therapeutic relationship is a *sufficient* variable for change in most types of problems. It's up to psychotherapies to disprove this with a body of evidence to convince the scientific community that it is. There is, however, evidence that therapies which offer more than a good relationship do better for many problems. Equally, therapeutic relationships are not ignored in CBT – what usually matters is a 'good-enough' relationship. Cognitive-behavioural therapists are not mechanistic or cold – indeed, they are often rated as amongst the warmest of therapists[5]. Equally, issues of 'transference' and 'countertransference' are not ignored in complex problems, and Gilbert & Leahy[6] discuss the therapeutic relationship in CBT in more detail.

'All therapies are equal in effect'

Stiles et al[7] and many others suggest that all psychotherapies have an equal effect. These conclusions are drawn from large non-randomised (naturalistic) comparisons of patients receiving different therapies. The findings are very difficult to interpret because of the many selection biases[8]. They note that in Stiles et al[7] the sample is less than 38 per cent of the cases seen by the therapists who complete both pre and post outcome ratings and had been selected by the therapists. There are many different biases operating in those cases selected. In randomised controlled trials (RCTs), it is common for the last observation to be carried forward for people with missing data to estimate post-treatment scores. If this were done, it would drop the overall recovery rate from 58 per cent to 22 per cent. Equally significant in primary care is natural recovery, which may be anywhere between 40-60 per cent in depression, so the added benefit of a psychological therapy may be weak[8]. It is not surprising, therefore, that a therapist (of whatever persuasion) feels their approach works, as most of their clients are getting better naturally and not necessarily because of what they do.

To demonstrate that all therapies are equal in effect, we need more randomised controlled trials with a waiting list comparison – we know that a number of approaches may improve mild to moderate depression in primary care but not for phobias, PTSD or OCD. Sometimes, therapists advocate 'deeper' therapy for more complex problems, but CBT was reported to do better than psychodynamic transference-based psychotherapy in borderline personality disorder[9].

Outcomes largely depend on the therapist'

If there is a significant variation in CBT delivered, then this is usually because of poor supervision and inconsistent adherence to a treatment protocol. It is important in CBT to audio or video-tape sessions – one copy is given to the patient to enhance learning and one copy is used by the therapist for quality control in supervision. Thus studies that demonstrate variance in therapist behaviour just mean that there was poor supervision and adherence to protocol. Controlled trials have an adherence measure whereby sessions are rated by an independent observer on a standardised scale, both to determine that the therapy being delivered is following the protocol and to assess the quality of the relationship. Quality in therapy is also improved by the therapists working in teams specialising in a particular disorder, or group of disorders for supervision.

'Clients need to discuss the root of the problem'

CBT ignores neither the context nor the history of how a problem developed. A developmental formulation takes into account known factors that have led to the current problems. Equally, there may be aspects of temperament or biology that are not known. However, endlessly searching for the root of the difficulties can encourage processes such as rumination that maintain the problem. Cognitive-behavioural therapists may use imagery techniques to try to understand past experiences, update their meaning and prevent avoidance of aversive memories and action to test out whether their beliefs are helpful in the here and now.

'CBT ignores social context'

CBT does not ignore the social context of mental disorder. Competent therapists are aware of the effects of, for example, poverty, continuing abuse or the lack of social support, which interfere with progress. They take care to facilitate the process by which the person becomes their own agent of change in a hostile environment, including interactions with relatives or friends who are critical or over-protective. Practitioners address these issues and work collaboratively on solutions that might be helpful in overcoming these obstacles.

'CBT is expert led, directive and makes people passive automatons'

Nothing could be further

from the truth. Effective CBT requires collaboration and negotiation. Clients have a shared formulation that identifies the meaning they attach to events or internal experiences and the avoidance behaviours that are maintaining their symptoms.

Once a client has a good psychological understanding of how s/he is maintaining his or her distress and handicap, then during therapy they have the responsibility to change.

They have agreed goals that include a return to their valued directions in life, such as employment or social roles. They participate in the setting of relevant homework between sessions, which is a crucial component of CBT. This might include testing out whether a belief is true, whether a cognitive process (eg ruminating or self-focused attention) is helpful or whether behaviour such as avoidance maintains their symptoms in the long term.

'CBT is just a "technical fix" or "sticking plaster"'
CBT is not a 'technical fix' or series of techniques. CBT is formulation driven and the model is derived from research into cognitive processes and behaviours.

As described above, a formulation is shared with a client. Once there is a road map, then various tasks may be used to get from 'A' to 'B'.

Some routes are shorter than others – therefore CBT tries to be a pragmatic approach to help individuals to return to their normal roles in life as quickly as possible.

Therapies that are longer need to demonstrate that they are more clinically or cost effective than CBT on quality of life measures.

'CBT is not able to help clients who cannot read or write or concentrate'
CBT can be adapted for people who cannot read or write and is used in child and learning disability services. As noted above, sessions should be routinely audio-recorded to be listened to again. Support material may be largely picture based and so on.

'CBT is too intellectual'
CBT done poorly may appear this way. However, the emphasis in CBT is for clients to act and to test out their beliefs or fears whilst experiencing emotion (so it's not done intellectually).

'The IAPT will be a cheap fix'
The Increasing Access to Psychological Therapies programme is not only about providing psychological therapy but also about improving the quality of therapy. This means that the therapists will be accredited as reaching a minimum standard for training. They will follow empirically driven protocols derived from randomised controlled trials. Protocols are not rigid and have to adapt to the context. Clients with more severe problems and co-morbidity can be routed to more experienced therapists. Staff would receive continuing professional development and attend workshops and conferences to maintain their accreditation. They would use standardised outcome scales and employment data that can be audited. If there is a high completion rate of the rating scales then the outcomes can be audited against those of a clinical trial. The IAPT centres will be a one-stop shop, so there will be access to employment advisers and help in overcoming the barriers to training and employment.

'CBT is being over-sold'
I am not sure who is over-selling it. Scientists are usually very cautious in discussing their results. CBT is not a universal panacea and cannot offer a quick fix. However, after about 40 years of research, it is doing reasonably well. The effect size and range of disorders it treats increases with every new generation of researchers and I predict it will continue to adapt and develop as new data is collected.

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