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Improving access to psychological therapies: For and against

Andrew Samuels–David Veale correspondence: October–December 2007

The following correspondence between Andrew Samuels, Professor of Psychoanalytic Studies at Essex University and Dr David Veale, Chairman of BABCP (British Association for Behavioural and Cognitive Psychotherapies) took place following a letter sent to *The Guardian* in October 2007 by Andrew Samuels. This letter was written the day after the Health Secretary, Alan Johnson, announced £170m government backing for a new NHS Improving Access to Psychological Therapies (IAPT) programme for people suffering from anxiety and depression. The IAPT programme, based largely on the National Institute for Clinical Excellence's (NICE) guidelines, included proposals for training a further 3600 therapists in high- and low-intensity therapeutic work based on cognitive-behavioural principles. This programme was debated by clinicians, policy-makers, commissioners and academics in the Savoy Conference in 2007.

We are grateful to both Professor Samuels and Dr Veale for permission to republish this correspondence in its original form.

Letter to *The Guardian*: October 12, 2007

Psychotherapists have failed effectively to communicate their considerable concern over the Government's plan to train 3500 Cognitive Behavioural Therapists. Partly this is because our leadership has thought something is better than nothing and that it would be irresponsible to let loose. Whatever the reason, we have allowed the proponents of CBT to caricature all other psychotherapies as delving unendingly into the patient's past and lacking any scientific validation as regards efficacy. Everyone knows the limitations of CBT – except, it would seem, the Government. The science is inadequate, the methods naive and manipulative, and the reluctance to engage with the key aspect of psychotherapy – the deep and complex relationship that develops between client and therapist – really very careless. Clients who enter CBT are approached in a mechanistic way, required to be passive and

45 obedient. Hence what is going to be on offer is a second class therapy for
citizens deemed to be second class.

Professor Andrew Samuels
Centre for Psychoanalytic Studies, University of Essex

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October 29, 2007

Dear Professor Samuels

55 I am writing on behalf of the British Association for Behavioural and
Cognitive Psychotherapies (BABCP). We have over 6000 members from
several disciplines, including psychology, nursing, psychiatry, counselling
and social work. We host our own annual conference and take part in
60 various international conferences. We provide opportunities for accredita-
tion and training. We publish an academic journal and our members
contribute to a number of international journals dedicated to CBT.

65 Many of our members read with disappointment and disbelief your
commentary in *The Guardian* about the NHS plans to increase access to
psychological therapies. It read as if the writer was angry and felt personally
attacked and slighted. The result was a letter that in our view was a
prejudiced and uninformed commentary on the nature of CBT.

70 I am sure that had you been the recipient yourself of such a
contemptuous attack you would have various ways of interpreting the
motives and reasons for it. Of course as individuals we are free to express
any views we wish but we are deeply concerned about these views by you
especially since you are a spokesperson for UKCP and that as an
organization we are still an institutional member. We ask you therefore to
75 consider the different roles you have because your views can only be divisive.
Moreover, we are concerned that when prominent individuals such as
yourself start contemptuous and ill-informed attacks in the media on CBT,
this can only be distressing and confusing for people receiving the therapy.

80 I would now like to address some of your main concerns in an open and
friendly manner and provide evidence against your suggestion that that CBT
is a 'second class therapy for citizens deemed to be second class'.

- 85 (1) It has been known for a long time that there are very high rates of
common mental health problems in our communities and that a vast
number of people who might benefit from psychological therapies
have no chance of access. The National Institute of Health and
Clinical Excellence (NICE) is an independent organization respon-
sible for providing national guidance on the promotion of good
health and the prevention and treatment of ill health. It

commissioned disorder-based consultant groups to examine the evidence for psychological therapies and medication in a range of mental disorders. It could have turned out that psychological therapies are not that effective but it didn't. On the contrary many national guideline groups have confirmed that there is now very good evidence, from many different types of study, that for many people psychological therapy is very helpful and in many cases as helpful as medication or sometimes better if combined with medication. In other words NICE has once and for all established some very fundamental principles: (a) people benefit from psychological therapies; (b) they can reduce relapse; and (c) people therefore need access to therapies that help them. This is huge move on from 30 years ago. 90 95 100

Like it or not, it is the many controlled trials and other studies conducted for CBT (and keep in mind that this is broad term for a range of approaches including Behavioural Activation, Dialectical Behaviour Therapy, Acceptance and Commitment Therapy, Mindfulness-based Cognitive Therapy, Schema-based Therapy, etc.) that have helped to get us to this position. Behaviour Therapy, family interventions and later CBT were fundamental to breaking down the closed doors to working with psychosis. If you look at the NICE guideline (long versions) you will see time and again, when exploring other therapies, the phrase 'insufficient evidence'. We find it extraordinary that you and others do not seem to understand this fundamental point; that CBT has helped put psychological therapies centre stage. Governments are recognizing the importance and value of psychological therapies. From here the issues becomes more complex such as who should have access, what type of therapy they should have, for how long and so forth. Again NICE makes clear that it can only guide the NHS on the basis of evidence and because CBT has been so focused on developing an evidence base in the past 30 years this is the therapy currently in focus. However, NICE also acknowledges that we need a massive injection of research monies. 105 110 115 120

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(2) It is not just the 'Government' who wants to increase access to psychological therapies for depression and anxiety disorders. The decision is based upon the various NICE guidelines and meta-analysis of hundreds of randomized controlled trials as well as widespread consultation with researchers, clinicians, professional and voluntary organizations and users. These studies have also been published in major international journals – are these journals also being naïve and hood-winked? You have had every opportunity to be part of this process through the stakeholder process within NICE. 125 130

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When given the choice, clients commonly prefer an effective psychological therapy to medication, yet many people who may

135 potentially benefit are either simply not referred, because of the long
waiting lists, or some opt for CBT in the private sector. The plans are
therefore an attempt to provide patient choice of evidence-based
140 psychological therapy by reconfiguring services so that they are more
consistent with the NICE guidelines. Increasing access also finds
favour with five leading mental health charities (Mental Health
Foundation, Mind, Rethink, The Sainsbury Centre for Mental
Health, and Young Minds) (Bird, 2006, *We need to talk: The case for
145 psychological therapy on the NHS*, Mental Health Foundation), from
cross-party political support and from approval by a wide range of
user groups such as OCD Action, Triumph Over Phobia and
National Phobics Society. Such injection of funding to implement
the NICE guidelines was called for by the sponsors of the Savoy
Conference (which include the British Psychoanalytical Council and
the Association for Psychoanalytic Psychotherapy in the NHS). Such
a broad spectrum of a support from other political parties, mental
health charities, user groups, psychotherapy associations is hardly
150 ‘the Government’.

- (3) Your letter implies that we are somehow agents of the state concerned
with the superficial manipulation of people’s minds in mechanistic
ways. I cannot tell you how distressing it is for someone in your
position to publicly present this view. Cognitive behaviour therapists
155 have the same motives and desire to help others, the same concerns
and fallibilities as anyone else. Indeed, it is often a keenness to be
helpful – not a cold mechanistic psychology that can cause problems.
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
160 efficient, compassionate and caring ways within a support relation-
ship. Professor David Richards who is pioneering a pathfinder
site at Doncaster for low-intensity workers has repeatedly spoken
of the importance of supervision and developing a safe, supportive
relationship – that obviously differs from those of psychodynamic
165 approaches but is not in anyway mechanistic. In fact I am
sure you will know that behavioural therapists are often rated as
amongst the warmest of therapists (Schaap, C., et al. (1993), *The
therapeutic relationship in behavioural psychotherapy*. Chichester:
Wiley).
- (4) You seem to lack awareness of current practice in CBT. As noted
above the therapeutic relationship is not ignored in CBT. For an up-
to-date reading about the therapeutic relationship in CBT, you
might want to look at Gilbert & Leahy (2007, *The therapeutic
170 relationship in the cognitive behavioural psychotherapies*, Routledge)
or Kohlenberg et al. (2004) on Functional analytic psychotherapy. In
S.C. Hayes, V.M. Follette, & M.M. Linehan (Eds.), *Mindfulness and*

acceptance: Expanding the cognitive-behavioral tradition (pp. 96–119). New York: Guilford).

Obviously the relationship that develops with more severe difficulties is different for milder problems – and CBT is well aware of these complexities. There are very rich and important developments on how CBT is using research from studies of social cognition, attentional processing, memory and imagery to inform their theory and practice – including the therapeutic relationship.

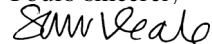
So I hope that if you spend time actually finding out about CBT – may be come to our next conference (see www.babcp.com) – you will see how multi-dimensional, broad minded, questioning, searching and evidence-based we are. At the end of the day we are a *psychological* therapy and CBT has long taken the view that we cannot be that or develop it unless we are well embedded in psychological research and understanding. So CBT is not ‘naïve and mechanistic’ and clients are not ‘passive and obedient’. CBT requires mutual guided discovery for therapist and patients. It needs collaboration and negotiation of goals and active change. It means clients participating in planning ways of testing out what has been learned between sessions. Formulation is a shared process that identifies the personal meanings people attach to external events or internal experiences. These meanings are not made up in the moment but obviously often fuse the past and the current context. CBT however does not ignore this but its first focus is on how helping people stand back from their feelings and thoughts and take a more objective and supportive stance. Some people come to see that they way they are coping with – their best efforts – for example avoidance, rituals, excessive appeasement or using alcohol and illicit drugs are actually making things worse for them. The idea that we are unconcerned with social or historic contexts is simply not true and this has been discussed on our website under ‘Myths of CBT’ for some years.

- (5) Where are the caricatures by cognitive behaviour therapists of other psychotherapies as delving unendingly into the patient’s past? We could present in the media many case histories of clients being made worse by years of ineffective therapy and then improving with CBT but we don’t since it lacks scientific validity and is disrespectful of other modalities. Of course, CBT has limitations. It is not a universal panacea and *cannot* offer a quick fix. However after about 30 years of research, CBT is doing reasonably well and is more cost effective than medication for many mental disorders in the long term. The effects, size and range of disorders it treats increases with every new generation of researchers, because CBT is constantly changing and growing. We are not against an empirical debate with data – for

example there is now evidence suggesting that CBT is superior to psychodynamic transference-based psychotherapy in borderline personality disorder (Giesen-Bloo et al., 2006. Outpatient psychotherapy for borderline personality disorder: A randomized trial of Schema-focused therapy versus transference-focused therapy, *Archives of General Psychiatry*, 63, 64–90). We have big debates between ourselves such as whether the focusing on the content of beliefs for treating depression are that necessary! (Dimidjian S., et al. (2006). Randomized trial of behavioural activation, cognitive therapy, and anti-depressant medication in the acute treatment of adults with major depression. *Journal of Consulting and Clinical Psychology*, 74, 658–670). There are important debates to have about process and outcome – but this must be science-based – as some of the new psychodynamic approaches such as mentalizing understand well. However, we have huge challenges ahead. It would be better if we pulled together than pulled apart and focused our energy on testing the theories and outcomes.

I do hope that your contributions in future will be based on evidence, that you will not further misrepresent CBT. I also hope that this letter will assist you to reflect and to act with compassion and understanding rather than with contempt.

Yours sincerely


Dr David Veale
President BABCP

November 5, 2007

Dear Dr Veale,

Thank you for your letter of October 29, 2007 and for your kind offer to forward this reply to the many people to whom you sent your letter. I am grateful for this offer as I do not have any of the relevant address lists. Please could you let me know when this has been done and if there are any expenses attached to it that you would like me to cover. I am relieved that you want a debate to take place.

Please use my consulting room address and e-mail for further correspondence (above).

I don't want to let you personalize this so I won't go there in this reply – but I am sorry I hurt your feelings and those of your members. I wrote passionately and not in my usual pluralistic vein because I am so concerned about what is happening. My reputation in the profession is, I

think, that of being an unusually tolerant and open-minded person with regard to the matter of diversity in psychotherapy and counselling. This has often brought me into conflict with my own analytical community.

I also wrote as an individual and not on behalf of UKCP although I can see that there could be a muddle if people at BABCP really want there to be one!

I'm going to reply to you in two stages. The first – this letter – is in global and political terms, and the second – in a couple of weeks' time – will address the science and professional issues. I should be grateful if the second letter could also be distributed to the same people as the first. In that second letter, I shall be listing existing peer-reviewed research that shows that CBT is not demonstrably more effective across the board than other therapies, that its positive effects are short-term, that longer-term therapies have, in due course, good results, that the methodology and information-seeking instruments of some of the research into CBT's effectiveness are skewed so as to favour CBT, that there is evidence of researcher bias in favour of their own preferred modality of psychotherapy, that NICE's approach is partial and limited, that RCTs and evidence-based approaches do not constitute a gold standard in medicine let alone with regard to therapy, that the positioning of 'science' with respect to psychotherapy in much of the research is tendentious (just to give a flavour of what is being written out there).

What has engaged my interest is that NICE and the CBT research community seeks to ignore all of this contrary research. I feel that there is something to question here in that many proponents of CBT refuse to admit of even the slightest doubt about the efficacy of what they do and the accuracy and appropriateness of the methods they use to seek to prove its efficacy. I will return to the theme of 'doubt' throughout this letter. Drs Roth and Turpin are to be commended for raising the risky possibility that CBT is being oversold.

I also felt a need to write because of something in the profession of psychotherapy that I mentioned in my letter to *The Guardian* but was cut out by their sub-editor. I wrote that psychotherapists had failed to communicate their concerns

partly because our leadership has thought something is better than nothing and that it would be irresponsible to let loose.

What I have heard as I go around is that the BACP, the UKCP and may be the BPC and the APP share many of the concerns I raised, but are terribly reluctant to go up against the Government. They are worried that might mean prejudicing the chances of their members in gaining some career and remuneration advantages when the IAPT schemes are fully rolled out, either directly or as the higher echelons in a hierarchical

programme of stepped care. Their critiques therefore remain muted or silent, and, above all, private. I have told whoever I can reach that this well-bred self-restraint is foolhardy, based on greed and *déformation professionnelle*. So at the very least be assured that I am even-handed in my criticism.

The rank and file of psychoanalytic, Jungian, psychodynamic, group, child, humanistic and integrative, systemic, and arts-based psychotherapists are basically utterly dismayed and appalled that the Government has, as they see it, made such a colossal misjudgement. Some of this may be ascribed to injured vanity and some to envy – but not all, by any means. You should read my postbag or the listservs used by psychotherapists. My language was pretty temperate by comparison.

Frankly, Dr Veale, you and your senior colleagues may have become completely insulated from all of this.

I have been surprised to hear from so many since I wrote my letter (and the one to *The Observer*) that they do not feel there has as yet really been a debate at a proper professional level about CBT and about IAPT. There is a sense in the psychotherapy world generally that the CBT community has won a battle, not because they offer a better kind of psychotherapy, but because they have bewitched and entranced the powerful with what looks like incontrovertible science. They have managed to render what often seem like the Central European or American ‘mysteries’ of psychotherapy acceptable to the English empirical mind.

Most of us doubt that the Savoy Conference will provide a platform for the debate that is needed. The mission statement leaves little room for manoeuvre in its circular clarion call:

We wish, in short, to foster a new, open and forward thinking dialogue around evidence based practice.

I have studied the programme and I hope that it will involve activity under the following three headings:

- (1) questioning the efficacy and general clinical approach of CBT;
- (2) questioning the appropriateness and objectivity of the typical methodologies and protocols used for psychotherapy outcome research of the kind employed by many CBT researchers;
- (3) questioning the level of understanding of the therapeutic process and the psyche that lies behind typical research done by CBT researchers.

During the next few weeks, in the run-up to the conference, I will be consulting with colleagues world-wide in order to assemble materials that address these problematics. I am not as ignorant as you think and have quite a good acquaintance with Mindfulness Based Cognitive Therapy.

Returning to my letter to *The Guardian*, you will agree that I was writing on the day after the Health Secretary made a statement in the Commons. Mr Johnson said:

I can announce today . . . that we will build a ground breaking psychological therapy service in England. Backed by new investment rising to £170 million by 2010/11, this will be capable of treating 900,000 additional patients suffering from depression and anxiety over the next three years. Around half are likely to be completely cured, with many fewer people with mental health problems having to depend on sick pay and benefits.

Elsewhere, I read that the therapeutic method to be utilized in the vast majority of these 900,000 treatments was to be CBT and that the additional 3500 therapists required would receive a relatively short training in CBT. On your own website, you discuss these 'feeder courses' at some length and with some degree of concern, do you not? I am sure I do not need to elaborate on this point and will just confine myself to saying that the notions of such a short training and such a short treatment shows what the Government and the Civil Service really think about therapy. We'll quickly sort out the wrong thinking that lies behind paralysing depression or crippling anxiety and get these patients who are a drain on the state back to productive work.

Anyway, put this together and you come up with something like this: the Government (not the mental health charities you list) announces that it is to put a huge amount of money into one kind of therapy that will cure half its recipients completely and very quickly of their depression and anxiety and will be delivered by people who have had a rather short training course. This will get nearly a million people off benefits and sick pay and back to work. When you consider that purview, Dr Veale, don't you suffer from a scintilla of doubt?

Now, let's go back to my letter to *The Guardian*. Therein, I stated that 'what is going to be on offer is a second class therapy for citizens deemed to be second class'. I don't think what I wrote was so 'off'. I didn't say CBT was second class, although I did say some other harsh things about it. If I have some CBT from you, Dr Veale, that would be one thing; but to have it from a former nurse who has done a course in CBT of a few months' duration and in a circumstance where I can only have a few sessions and with one particular goal – getting me back to work – that I may not have signed up for . . . Well, it's just an absurdly abstract question, isn't it? People with means and education, like you and me, or our families, are not going to get anywhere near IAPT-CBT, are we? That's what annoys me, and it is entirely consistent with everything I have written and said and campaigned for in the past 30 years about the social role and responsibility of psychotherapy and counselling for me to have finally gone public with my viewpoint.

I turn now to the question of 'contempt', as you put it. You ask where the caricature of psychotherapy other than CBT comes from and I am

surprised that you did not recognize these words from the much publicized summary of Lord Layard's Depression Report:

400 CBT and the new therapies are not endless nor backward looking treatment.
 And they are much better than what you would get from a GP counsellor – 'a little counselling'.

405 I am never surprised when people engaged in intense debate say quite cruel things. However, the thing I want to show you is that this business of 'contempt' works both ways. Why on earth take a swipe at GP counsellors? Or put down what I guess would be psychodynamic psychotherapy as endless and backward looking. The word 'backward' is loaded, don't you agree? Does it mean that you can't talk about your Mum and Dad in CBT? Or that it is backward of a patient to want to do so?

410 To be honest, if there are so many millions available for therapy, we should have greatly expanded the GP counsellor system, as well as providing more funding for counselling in schools, colleges, universities, and at the workplace itself. We should have tried harder to reach the target in the 1996 report on psychotherapy services in England of one consultant psychotherapist for ever 250,000 people. We might even have tried to create a situation
415 wherein the highly trained private sector psychotherapists could, individually or in consortia, come to deliver their services in the public sector. So many opportunities lost.

420 I am coming to the end now and there are some very delicate issues left hanging. First, I hope that Professor Parry's report at the Savoy Conference gives as full a picture as possible of what is happening in Newham and Doncaster and of how it is being researched. I also hope that issues of conflict of interest with respect to the management of the IAPT pilot project in Newham are managed better than they have been hitherto.

425 In my letter to *The Observer*, I urged that 'we spend this money on a full range of psychotherapies'. That remains my position. I would very much hope and expect CBT to be one of such a range.

430 To conclude: Professor Carl Gustav Jung, the analyst and teacher of Lord Layard's father, the great Jungian analyst John Layard, once said that 'behind every fanaticism lurks a secret doubt'. I have written my reply to you in the hope of eliciting some secret doubts.

Yours sincerely,

435 Andrew Samuels

440 PS: The last time I was told that it would distress patients in treatment if we were to discuss matters to do with psychotherapy in public was by the British Psychoanalytic Society in connection with media publicity

over discriminatory admission practices to their training. But I don't really see how we can avoid discussing things in public and this is bound to go to questions of efficacy and/or ethos. If the matter comes up in session, then I guess it can be worked with. If the patient is upset, but does not raise the matter, then, I agree, that presents a difficulty. Broadly speaking, I trust patients to cope with our public debates. The papers are full of articles on therapy, written from all angles. You will note that I haven't taken Lord Layard to task on the grounds of distressing patients over the contents of the Depression Report.

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November 20, 2007

Dear Dr Veale,

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This is the second part of my reply. I had hoped to have heard from you by now with regard to the first part. Rather than play cat and mouse, I will simply proceed in a transparent and clear manner.

I hope that our agreement that you would circulate my reply to the institutions and individuals to whom you circulated your letter still holds.

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What happened after your very wide circulation of your letter to me and the almost as wide circulation of my reply, was that many academics and researchers in the fields of psychotherapy and counselling started to send me abstracts and papers to add to my own resources. These addressed and occasionally went beyond the wide range of research questions that I laid out in my earlier letter:

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peer-reviewed research that shows that CBT is not demonstrably more effective across the board than other therapies, that its positive effects are short-term, that longer-term therapies have, in due course, good results, that the methodology and information-seeking instruments of some of the research into CBT's effectiveness are skewed so as to favour CBT, that there is evidence of researcher bias in favour of their own preferred modality of psychotherapy, that NICE's approach is partial and limited, that RCTs and evidence based approaches do not constitute a gold standard in medicine let alone with regard to therapy, that the positioning of 'science' with respect to psychotherapy in much of the research is tendentious.

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Thanks to the kind help of Denis Postle of the Independent Practitioners' Network and his website eIpnosis, <http://ipnosis.org> there now exists an archive of the research materials that were sent in. This is the link: <http://www.iapt-cbt.info/>

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It is now possible for you and your members, and any other interested parties, to ascertain that there is a significant debate in train and that many of your assertions about CBT invite interrogation. Let us hope that this debate forms a part, at least, of the 'Savoy' Conference.

What I suggest happens now is that you review this archive and comment on it. After that, we will then have our initial exchange of letters, the archive, and your comments on it to consider as a ‘core bundle’ and could then begin to think about a professional level debate based on the questions therein.

490- Please do not be offended if I point out that you have not, as yet, replied to my earlier letter even though your e-mail suggested you would try to do so.

I look forward to hearing from you. Please do let me know by return that this has reached you safely.

495 Yours sincerely,

Andrew Samuels

500 **December 20, 2007**

Dear Professor Samuels,

Thank you for your letter and for helping us to understand the context of your criticisms.

505 I accept that what colleagues in other psychotherapy organizations say publicly may be muted and that I am not privy to the internal conversations and various email lists.

I haven’t responded to all the points in your letter but I have tried to respond to the more important ones.

510 I want to expand on one aspect of this debate, which is about our values, and the directions in which we act. Being empirically grounded is a core value in behavioural and cognitive therapies over the past 40 years. It has kept us in good stead and the only reason why the NHS plans to expand the delivery of CBT. Being empirically grounded guides us in
515 deciding which approach will help our clients function and return to their roles as a parent, partner, worker, and full member of the community. When I say empirically grounded, it’s not just about randomized controlled trials (RCTs). There are of course many different designs to answer different questions – for example:

- 520 (a) Experimental designs that inform theory of why symptom is maintained and led to specific models and treatment manuals for different disorders. Thus a model for panic is very different to that of an eating disorder.
- 525 (b) Case series with a multiple baseline randomization that are often a preliminary to an RCT and can be done in everyday practice.
- (c) Audits of routine monitoring of cases for quality control and detecting promising treatments.

- (d) Mediation studies – to understand processes that mediate improvement in function which enables the testing of models. 530
- (e) Dissemination studies – to determine if a treatment manual developed in an Ivory tower be disseminated to therapists in primary care.
- (f) Cost effectiveness studies to determine the costs and savings of delivering a therapy. In this regard, the NHS will only expand psychological therapies that it has evidence of cost effectiveness and a NICE guideline is merely a snapshot for the best available evidence at that time. They are regularly updated as new evidence appears. It is the vehicle for recommending which therapies for the NHS to support. I have myself been a member of a NICE working group (on OCD and BDD) with a variety of professions and users and carers. I found it to be a very fair and transparent process in the way that studies are selected from the literature and meta-analysed. It is easy to criticize the failings but it is to others to argue for an alternative paradigm for determining clinical and cost effectiveness and how the data should be analysed or collected in the future. 535
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It is clear that if a therapeutic approach does not become empirically grounded then it will become increasingly on the fringe and not part of the NHS. When a psychotherapy is flexible and data led, there are number of implications: 550

- (1) It means no attachment to any specific theory or techniques. For example in 1979, Beck first published his manual for depression. The emphasis was on thought records and content – more recent practice focus on cognitive processes such as ruminating and helping depressed patients to act according to what they are avoiding in life. 555
- (2) It integrates approaches. An example is the way that imagery rescripting for aversive past memories which were originally described in Gestalt has now been evaluated in several case series and incorporated as a strategy in a number of treatment manuals for CBT in PTSD, social phobia and now BPD because they are a more powerful way of evoking emotion compared to verbal techniques. We all want to see the evidence from mediation studies, case series and RCTs for any approach that will help to reduce suffering and to help people act in their valued directions so that we can learn to apply to it to our own clients. 560
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- (3) It informs patient choice to determine which approach is the most effective for the least burden – if I have single episode of mild to moderate depression I want to be told the evidence and the limitations of that evidence, what each therapy consists of and how much commitment it will involve on my part. At present there is 570

no effective choice of cost effective treatments and the NICE guidelines are not being delivered.

- 575 (4) It informs service delivery – an example in my unit, is my colleagues have tried delivering intensive CBT for PTSD or for OCD over 1 week (15 hours) and found that the results were just as good as once a week for 15 weeks. Of course the long-term follow up is crucial but it is popular with individuals who have difficulty in taking time off
580 work or their normal roles.

I was aware of several of the references you sent me. I am sorry I can't go through each of them and respond. Many of the studies and issues are discussed in the longer version of the depression guideline on pp. 127–132. I
585 have however responded to some of the political issues below.

Support for the proposals

590 I still maintain that nearly every organization including the mental health charities, users and psychotherapy support the Government's decision to expand evidence-based psychological therapies. The agenda is to reconfigure services to that recommended by the NICE guidelines and we look forward to seeing the audit data to enable the evaluation of the pilot sites and the effect on mental health and unemployment in the long term.
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The Savoy conference

600 BABCP were not formally involved in the Savoy conference. We were invited to be part of the organizers but we were unhappy with the business model and were not involved with the scientific committee at an early enough stage to be able to influence the scientific programme. The programme was of far more interest to psychotherapists and counsellors than members of the BABCP who are well served by national and international conferences. However we
605 wished it well and I was asked to speak for someone who had to step down two days before the conference opened. We will discuss with the organizers whether we can be part of any future conferences as we believe it has a genuine desire to foster dialogue in evidence-based psychological therapies. I regret that you would need to expand upon some of your questions to the organizers about the empirical evaluation of psychotherapy. I suspect this is
610 a clash of culture and training as scientists.

Training

615 Details of the training in evidence-based psychotherapies has not been published as the Department of Health is consulting on the nature of

courses to be offered. I do know that it will be focused on treating depression and anxiety disorders and that it will be for about a year and not just in CBT. Applications will be open to a range of mental health professionals such as psychologists, nursing staff and counsellors. The therapists will be well supervised after they have trained and expected to collect audit data at the end of each session.

Existing approved courses in CBT, which lead to accreditation for a minimum training, are at least a year long. Many of the students on such courses are already qualified in a core and it is a postgraduate training. There will also be a separate training of low-intensity workers to support computerized CBT and bibliotherapy. This is based on the stepped care model.

Equity of access

There is no suggestion that there will not be equity of access to the new psychological treatment centres. IAPT is trying to solve the problem that at present a few privileged individuals can get access to CBT privately. One of the pilot sites at Newham is based in a highly under-privileged area and there is no evidence that the people accessing the service do not reflect the population from which it is drawn. This is assisted by making it possible for people to refer themselves without the stigma of going through a GP. Initial analysis suggests self-referrals at the pilot sites are no different from those referred by their GP apart from being more chronic.

Counselling

I can't speak for the authors of the Layard report but counselling is recommended by the NICE guidelines for mild depression (along with physical exercise, St John's Wort, problem-solving therapy, computerized CBT, CBT, watchful waiting). A placebo does just as well as antidepressants and the latter are not therefore recommended for mild depression where people tend to get better over time and some support. There is no evidence for the benefit of counselling in recurrent depression, moderate to severe depression, and all the anxiety disorders (PTSD, social phobia, panic/agoraphobia, generalized anxiety disorder, obsessive compulsive disorder, body dysmorphic disorder, health anxiety) where there is good evidence for the benefit of CBT. It is really not therefore that surprising that counselling is unlikely to be expanded in the way that you wish because there is relatively easier access to counselling in primary care and counsellors do not generally deliver the rest of NICE guidelines in various anxiety disorders or recurrent depression, etc. Waiting lists for CBT are often 6 to 18 months long.

I am sure these issues will not go away and my colleagues or I will continue to debate these issues.

Kind regards

Yours sincerely

Dr David Veale

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