Cognitive Behaviour Therapy: The Evidence

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What is CBT?

- Brief (8-16 sessions)
- Focuses on problematic beliefs and behaviours that maintain disorders (rather than original causes).
- Strong foundation in academic psychology
- Patient is very active

Does it work?

Gold Standard Evidence is the randomized controlled trial.

CBT needs to be superior to:

- no treatment (wait list control)
- an equally credible alternative psychological treatment (to control for non-specific factors)

and at least as effective as medication in the short-term.

Common Disorders where CBT is effective[1] as a sole treatment

	recovery rate[2] in RCTs
Major depressive disorder	60%
Panic disorder	75%
Posttraumatic stress disorder	75%
Social Phobia	60%
Generalised anxiety disorder	50%
Obsessive compulsive disorder	55%
Bulimia Nervosa	50%

[1] Effective is defined as meeting the criteria specified on the previous slide.
[2] Most patients show some improvement with CBT. Recovery rate is the approximate proportion of individuals who no longer have the disorder at the end of a course of CBT.

Disorders where CBT enhances the effects of medication

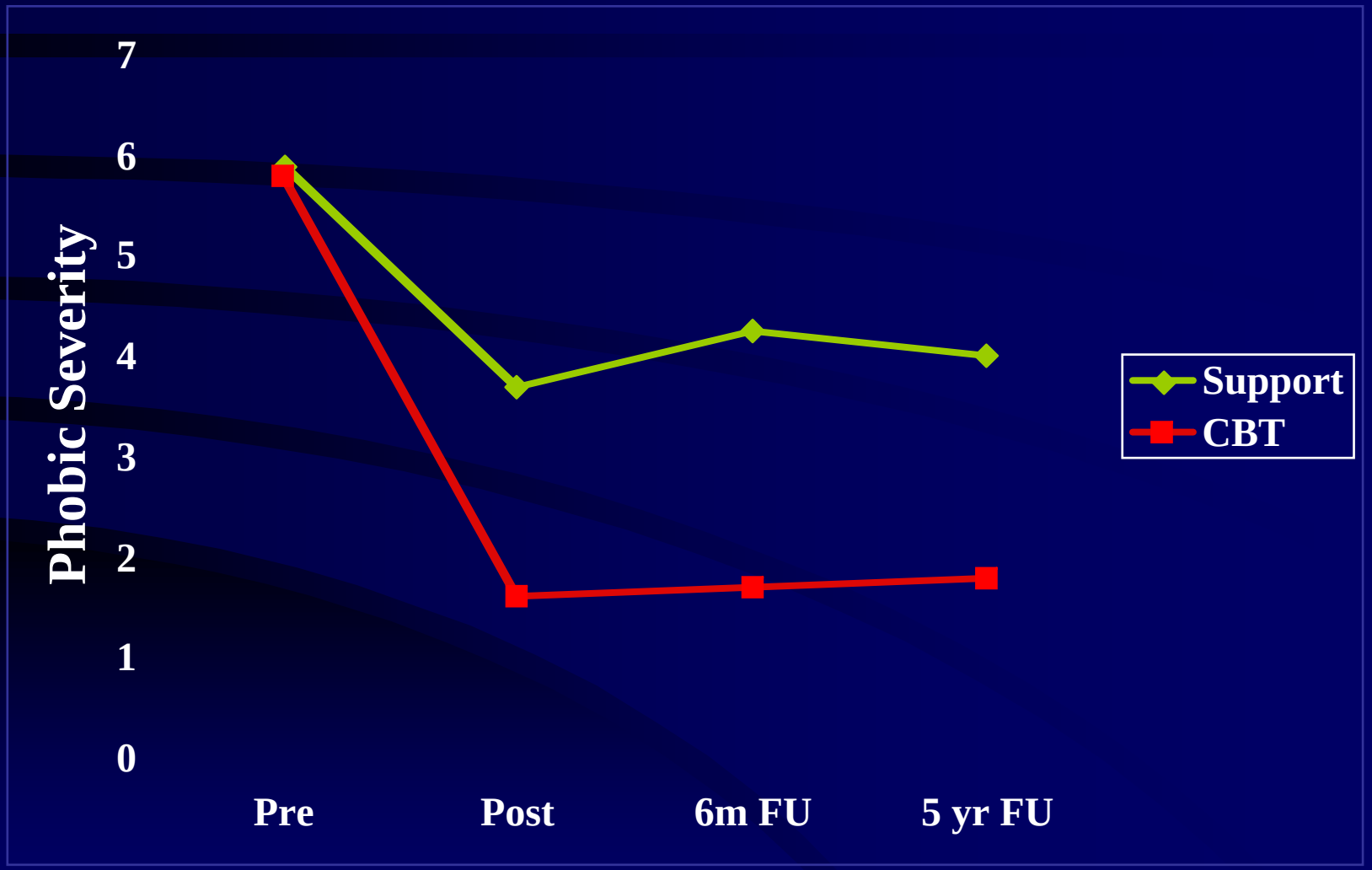
- Schizophrenia
- Bipolar disorder (manic-depression)

Long-term outcome of CBT

- On average, the gains obtained in CBT are well-maintained at follow-ups of several years.
- Recent studies have also shown that CBT can reduce relapse in depressed patients who were initially treated with medication.

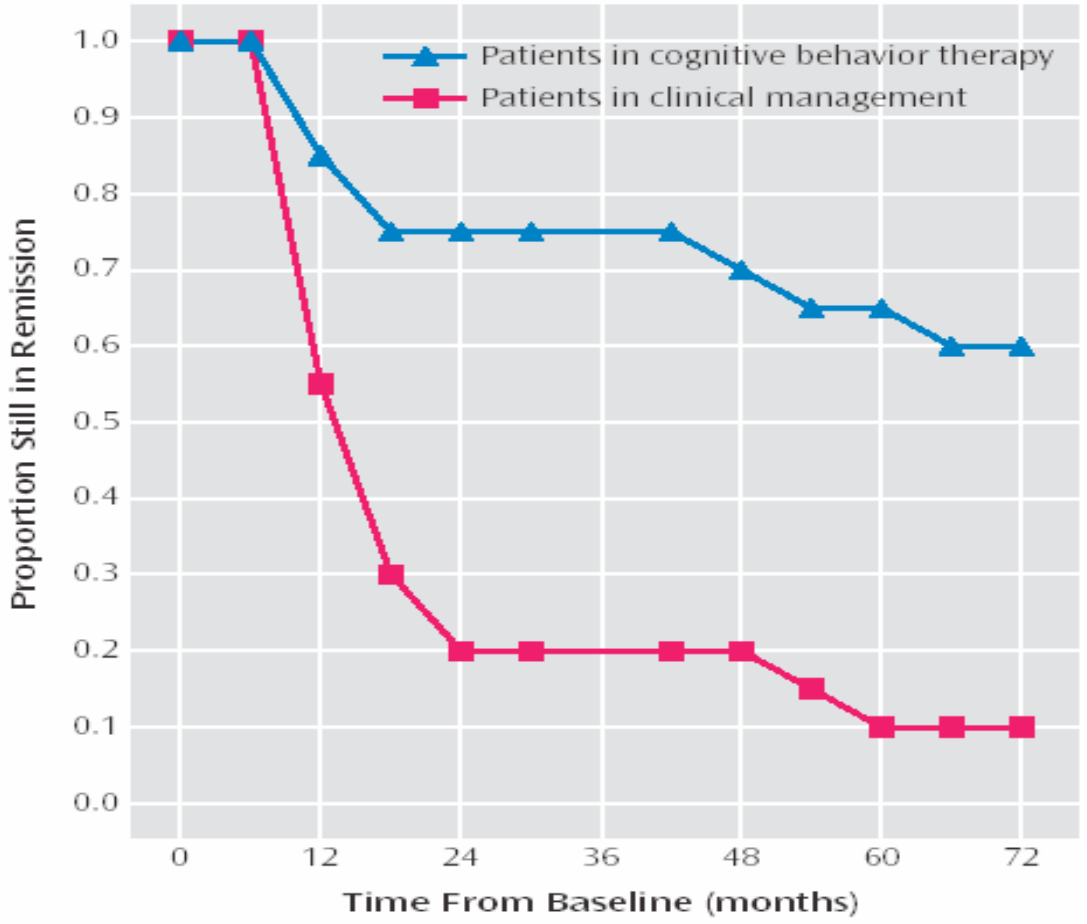
Social Phobia: 5 year Follow-Up

(Heimberg et al., 1993)



CBT prevents relapse in recurrent depression (Fava et al., 2004)

FIGURE 1. Proportion of Depressed Patients in Remission 6 Years After Cognitive Behavior Therapy (N=20) or Clinical Management (N=20)



Cost of not treating

Less than 10% of suitable patients currently receive CBT

Greenberg et al., (1999)

Untreated anxiety disorders are very costly

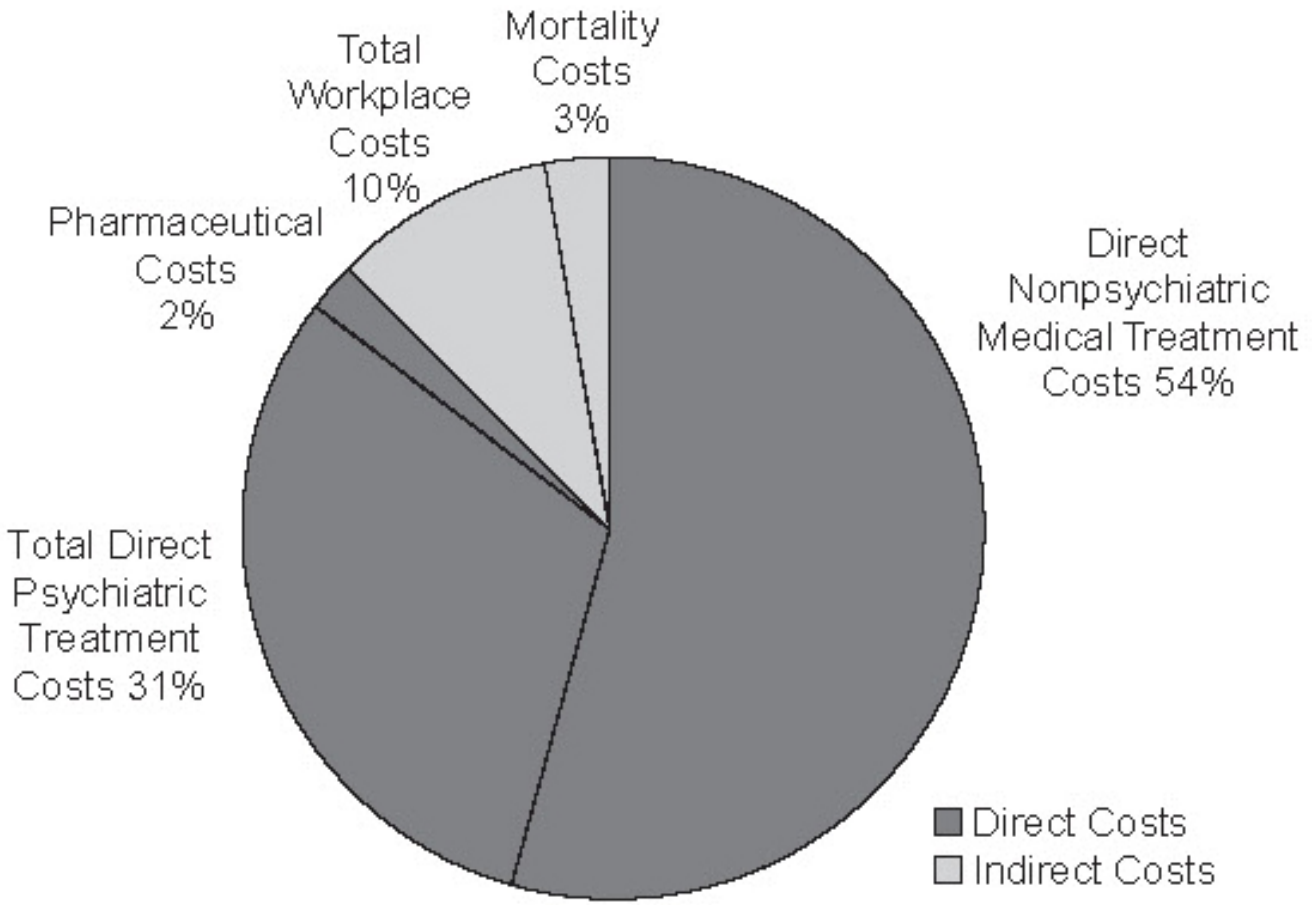
- Excess non-psychiatric medical treatment
- Workplace costs due to loss of productivity, sick leave and unemployment.

Salvador-Carulla et al. (1995)

In the first year alone, successful treatment of one anxiety disorder was associated with:

- 94% decrease in excess non-psychiatric medical treatment costs.
- 80% decrease in workplace costs.

Figure 2. Distribution of Costs of Anxiety Disorder:
(total costs = $42.3 billion per year in 1990 dollars)



Can the results of RCTs be achieved in more routine NHS settings?

Omagh Bomb Example (Gillespie et al, 2002)

- No local expertise in PTSD treatment at the time
- Clark team provided specialist training
- Therapists: psychiatrist, social worker, nurses.
- All patients with PTSD accepted. No exclusions.
- Outcome audited
- Improvement equivalent to that obtained in RCTs from specialist centres.

Conclusions

- CBT works
- It's effects are enduring (& can prevent future disorder)
- Most patients in the NHS don't get CBT
- With additional trained therapists, successful dissemination is possible
- Therapist attrition is very low (approx 1% pa for clinical psychologists[1])
- Likely Cost benefits (indirect medical and workplace)

[1] Lavender et al. Survey of 1993 graduates from South-East Thames Course.

Illustrative References (1)

Nice Guidelines (www.nice.org.uk)

- CG22 Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care – Full guideline. 22 December 2004. (www.nice.org.uk/page.aspx?o=cg022)
- CG22 Depression: management of depression in primary and secondary care – Full Guidance and Appendices. 15 December 2004. (www.nice.org.uk/page.aspx?o=cg023)
- CG01 Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care – Nice Guideline. (www.nice.org.uk/page.aspx?o=cg1)

Illustrative References (2)

Some reviews, meta-analyses and individual randomized controlled trials

Hollon, S. D., & Beck, A. T. (2004). Cognitive and cognitive behavioral therapies. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (pp. 447-492). New York: Wiley.

Gloaguen, V., Cottraux, J., Cucherat, M., & Blackburn, I. M. (1998). A meta-analysis of the effects of cognitive therapy in depressed patients. *Journal of Affective Disorders, 49*(1), 59-72.

Clark, D. M., Ehlers, A., McManus, F., Hackmann, A., Fennell, M., Campbell, H., et al. (2003). Cognitive therapy versus fluoxetine in generalized social phobia: a randomized placebo-controlled trial. *Journal of Consulting & Clinical Psychology, 71*(6), 1058-1067.

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Fava, G. A., Ruini, C., Rafanelli, C., Finos, L., Conti, S., & Grandi, S. (2004). Six-year outcome of cognitive behavior therapy for prevention of recurrent depression. *American Journal of Psychiatry, 161*(10), 1872-1876.

Lam, D. H., Watkins, E. R., Hayward, P., Bright, J., Wright, K., Kerr, N., et al. (2003). A randomized controlled study of cognitive therapy for relapse prevention for bipolar affective disorder: outcome of the first year. *Archives of General Psychiatry, 60*(2), 145-152.

Illustrative References (3)

Costs and Cost-Effectiveness

Issakidis, C., Sanderson, K., Corry, J., Andrews, G., & Lapsley, H. (2004). Modelling the population cost-effectiveness of current and evidence-based optimal treatment for anxiety disorders. *Psychological Medicine*, *34*(1), 19-35.

Greenberg, P. E., Sisitsky, T., Kessler, R. C., Finkelstein, S. N., Berndt, E. R., Davidson, J. R. T., et al. (1999). The economic burden of anxiety disorders in the 1990s. *60*(7), 427-435.

Lam, D. H., McCrone, P., Wright, K., & Kerr, N. (2005). Cost-effectiveness of 30 month study of relapse prevention cognitive therapy for bipolar disorder. *British Journal of Psychiatry, in press*.

Salvador-Carulla, L., Segui, J., Fernandez-Cano, P., & Canet, J. (1995). Costs and offset effect in panic disorders. *British Journal of Psychiatry Supplement*(27), 23-28.

Dissemination of evidence based treatment

Gillespie, K., Duffy, M., Hackmann, A., & Clark, D. M. (2002). Community based cognitive therapy in the treatment of post-traumatic stress disorder following the Omagh bomb. *Behaviour Research and Therapy, 40*, 345-357.

Wade, W. A., Treat, T. A., & Stuart, G. L. (1998). Transporting an empirically supported treatment for panic disorder to a service clinic setting: A benchmarking strategy. *Journal of Consulting and Clinical Psychology, 66*, 231-239.