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NICE recommendations for psychotherapy in depression: Of limited clinical utility

D. McQueen,¹ P.St. John Smith²

¹West London Mental Health NHS Trust, London, ²National Health Service, Redditch, UK

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In 2009/10 NICE partially updated its guidelines on the treatment and management of depression in adults. Due to methodological shortcomings the recommendations for psychotherapy must be treated with caution. Despite recognising the heterogeneous and comorbid nature of depression, and the limitations of depression as a unitary diagnostic category, NICE treats depression as if it were a unitary entity differentiated only by severity. The guidance ignores important aetiological factors such as trauma, loss and maltreatment, personality and interpersonal difficulties. It excludes the largest naturalistic studies on clinical populations treated in the National Health Service on the grounds that they are observational studies conducted in heterogeneous groups with mixed neurotic disorders. It unquestioningly accepts that the “brand” of psychotherapy has construct validity, and ignores psychotherapy process research indicating significant commonalities, and overlap, between treatment modalities and evidence that individual practitioner effects are larger than the differences between treatment modalities. It fails to consider patient differences and preferences, which are known to influence uptake, completion and response. It takes an exclusively short-term perspective on a chronic relapsing disorder. It does not consider the evidence for longer-term treatments. It is of special concern that NICE misrepresents the findings of its own systematic review by implying that CBT and IPT are superior treatments. NICE’s systematic review actually found no evidence of superiority between CBT, IPT, psychodynamic psychotherapy, or counselling. Based on the exclusion of much clinically relevant research demonstrating the effectiveness of psychodynamic psychotherapy and counselling many commentators have alleged a bias towards CBT in the guidance. With regard to service delivery NICE proposes the replacement of psychiatric assessment and individualised treatment plans, with an unproven stepped-care model. These clinical and theoretical limitations, perceived bias in the selection of studies, neglect of patient differences, preferences and values, misrepresentation of results of the systematic review, and the

proposal for an unproven service delivery model together seriously undermine the validity of the guidance. The guidance, lacking validity is of questionable use, it undermines patient autonomy, professional expertise and, ultimately, patient welfare.

Key words: Depression, psychotherapy, guidelines, NICE.

The National Institute for Health and Clinical Excellence (NICE) provides national guidance on promoting good health and preventing and treating ill health. It aspires to be based on the best available evidence and involve all stakeholders in a transparent and collaborative manner.¹ Once published, health professionals (and employing organisations) are expected to take NICE guidance fully into account when deciding treatments.² The guidance on depression is aimed at clinicians, managers and commissioners. It makes recommendations on assessment, pharmacotherapy, psychosocial interventions, relapse prevention and service delivery.

The full updated guideline on depression (707 pages)³ starts by describing depression as a broad, heterogeneous condition, influenced by diverse biological, psychological and social factors, and concludes that current diagnostic systems do not capture this complexity. However, having established these facts the guideline oversimplifies in key areas. Firstly it treats depression as a unitary diagnosis. Secondly it takes different psychotherapies at face value as representing distinct well-characterised interventions rather than the complex interventions that they are. Thirdly it treats patients as homogenous, without comorbidity, personality traits or preferences that moderate their responses to treatment. Fourthly it only considers short-term studies in what is a chronic relapsing disorder. Fifthly it excludes effectiveness studies, because of diagnostic heterogeneity or not being from randomised controlled trials (RCTs). In addition to these oversimplifications NICE actually misrepresents the results of its systematic review and erroneously implies that it has demonstrated that cognitive behavioural therapy (CBT) and interpersonal therapy (IPT) are superior treatments,

whereas it has actually showed a lack of difference. Finally NICE recommends replacing clinical assessment and personalised treatment with an untested service delivery model.

Clinicians will be only too aware that "pure depression" if it exists at all rarely comes to the attention of psychiatrists working in the National Health Service, where comorbidity of all kinds and clinical heterogeneity are the norm. Epidemiological data suggest that NICE's model of depression separate from mixed neurotic conditions does not exist, the depressive syndrome overlaps with other common neurotic conditions.⁴ Depressive symptoms occur in most mental and many physical disorders. Just consider the core depressive syndromes; depressive adjustment reactions, dysthymia and melancholia:⁵ Adjustment disorder may be criticized for vagueness and medicalising problems of living.⁶ Dysthymia is defined by mild symptoms, but sufferers spend more time depressed, have more admissions, more self-harm,⁷ higher rates of personality disorder,⁸ and it is more resistant to brief psychotherapy.⁹ Depressive episodes have worse prognoses when co-occurring with dysthymia.¹⁰ Furthermore depression has diverse aetiologies: Depressions arising from feelings of loss and activation of the attachment system (anaclitic depression) are associated with tearfulness, somatic complaints, parasuicide and care seeking. Depressions associated with failure, and activation of the social rank system (introjective depression) lead to fatigue, pessimism, guilt, inability to seek help and serious suicide attempts.^{11,12} Anaclitic and introjective depressions appear to have differential responses to psychotherapy.¹³ Some depressive behaviour can be seen as adaptive:¹⁴ After loss of an attachment figure, depression inhibits searching and pro-

test when it has become futile. In respect of social dominance and competition the depressive state may operate as an unconscious, involuntary, losing strategy, enabling the individual to accept defeat and accommodate to what would otherwise be unacceptably low rank.¹⁵ Displays of unhappiness also evoke sympathy and caring from others.¹⁶ Understanding the functions of depression helps distinguish between situations in which depression may be considered in some way adaptive, and where it is dysfunctional.¹⁷ Most patients with clinically significant depression meet the criteria for several different diagnoses and personality dysfunctions.¹⁸ Co-morbidity is critically important in outcome research.¹⁹ Depression arising in the context of early relational trauma (childhood bereavement, abuse or neglect) changes brain function²⁰ and may be differentially responsive to psychotherapy rather than pharmacotherapy.²¹ The patients referred to secondary care psychotherapy services with depressive symptoms have high levels of personality disorder, psychotic disorders, comorbid neurotic disorders, and psychosocial or behavioural difficulties.²²

As NICE itself writes in its guidance on the treatment of depression in children:²³ “the most significant limitation (to the evidence base) is the concept of depression itself... it is too broad and heterogeneous a category, and has limited validity as a basis for effective treatment plans. A focus on symptoms alone is not sufficient because a wide range of biological, psychological and social factors have a significant impact on response to treatment and are not captured by the current diagnostic systems” (p9).

Is the “brand” of psychotherapy the most useful level of analysis? In the guideline the different ‘brands’ of psychotherapy are accepted at face value as having construct validity. However the literature on psychotherapy process research reveals that psychotherapy is a complex intervention, and that ‘brand’ of psychotherapy has a loose relationship to what takes place within psychotherapy or what the effective ingredients of successful psychotherapy are. Psychotherapies are often con-

sidered to have non-specific effects (qualities inherent in any helping relationship that improve morale or lead to personal development) and specific effects (well defined intentional actions by the psychotherapist, usually considered as techniques). Both types of effects have been shown to be important.²⁴ The branding of different modalities of psychotherapy belies fundamental overlap in psychotherapeutic processes, for instance in the US National Institute of Mental Health's 1985 Treatment of Depression Collaborative Research Program (TDCRP) IPT was found to correlate more strongly with the CBT prototype than the IPT prototype.²⁵ Psychoanalytic psychotherapy often contains significant CBT elements, and change-promoting processes in CBT can be psychoanalytic.²⁶ Convergence is greater when conducted by master therapists.²⁷ Rigid adherence to a particular model can be negatively associated with outcome,^{28,29} and effective therapists adjust their use of techniques to the individual patient.³⁰ This has led to calls for a move away from what ‘brand’ is best, to what techniques or interpersonal processes achieve what ends with which kinds of patients.³¹ If specific techniques account for little of the variance in outcome, then what are the change promoting ingredients? In psychotherapy, as in psychiatry generally, the interpersonal relationship is often said to be the basic vehicle for producing improvement. The TDCRP showed that the contribution of the therapeutic alliance outweighs the modality of treatment, whether CBT, IPT, imipramine or placebo.³² Even with pharmacotherapy individual psychiatrist effects accounted for more variance in outcome than did medication over placebo (9.1% vs 3.4% of variance in BDI score).³³

The third oversimplification is ignoring individual differences and preferences, instead treating patients as homogeneous and passive recipients of psychotherapy. Outcome in psychotherapy and psychiatry is generally highly personal and can be difficult to measure precisely. Increasing emphasis is placed on patient values and recovery. Patient preferences strongly influence take-up and completion rates in mental health treatments.³⁴ The

personality characteristic perfectionism predicts poorer response to brief treatments.³⁵ Different personality types respond differentially to exploratory versus supportive treatments, and to short-term versus long-term treatments.³⁶ Personality dysfunction reduces treatment responses in depression.³⁷ Patients with borderline personality traits may even be harmed by short-term or directive treatments.^{38,39} Interestingly the full guideline contains seven personal accounts of depression (p. 52–68), the majority identified long-term psychodynamic psychotherapy and counselling as most helpful, none preferred CBT. Most wrote about the importance of making sense of childhood trauma and difficulties.

Unfortunately short-term psychological and pharmacological treatments are only partially effective in the treatment of depression, at 1-year follow-up about 60% of those treated with drugs still meet criteria for caseness,⁴⁰ and despite improving depression they do not lead to normal mood.⁴¹ Despite these limitations of short-term treatments NICE excluded evidence for differential outcomes in long-term psychotherapy because the research is in mixed neurotic conditions or is observational.^{42,43}

The exclusion of much research supporting psychodynamic psychotherapy and counselling on the grounds that it was conducted in heterogeneous groups with mixed neurotic disorders⁴⁴ or was from observational studies,⁴⁵ of long-term psychodynamic psychotherapy, both RCT^{42–46} and observational,^{43–47} and of cost effectiveness,^{48,49} lead many commentators to the consultation phase to suggest a bias towards CBT.⁵⁰ Close reading of the draft guideline⁵¹ reveals that the decision to withdraw the previous recommendation for psychodynamic psychotherapy “was influenced by contextual changes in the NHS including the significant increase in evidenced based psychological interventions (guided self help and CBT) made available through the IAPT programme” (p. 196). This commitment to one model, self-help and CBT, introduces bias and undermines the impartiality and credibility of the guideline.

The exclusion of many well-conducted observational and naturalistic studies is unsatisfactory. RCTs have been described as “experimental tools used to test hypotheses not well designed to assess clinical effectiveness”⁵² (p. 67). The danger of over reliance on RCTs with their controlled settings and atypical patients has been widely commented on.^{53,54} There are specific problems in using RCTs to assess psychotherapy: Firstly, treatments cannot be blinded. Secondly, the act of randomisation may reduce the effectiveness of psychotherapy, because its effectiveness depends on the subjects active participation, beliefs and preferences.⁵⁵ Thirdly, while RCTs are excellent for assessing drugs, psychotherapy contains no directly acting chemical ingredient, and is analogous with a chemotherapy placebo.⁵⁶ RCTs are designed to control for –and exclude– precisely those interpersonal processes that are at the core of psychodynamic psychotherapy. Psychodynamic psychotherapy requires entering into an interactive, interpersonal process of exploration of the meaning of interpersonal events in the patients’ life and in the psychotherapeutic relationship, and relationships cannot be randomised any more than friendship, values, or beliefs. Thus “the idea of evaluating the efficacy of psychotherapy by controlling for non-specific or placebo factors is based on a flawed analogy.”⁵⁷ Fourthly RCTs are less reliable assessing complex interventions with multiple “active ingredients”.⁵⁸ Naturalistic studies offer additional means of assessing the effectiveness of interventions, particularly complex interventions like psychotherapy.⁵⁹

There is an irony that this NICE guideline, which only admits RCT evidence, has not been tested in any RCT or shown to lead to improved care.

Having systematically reviewed its selected evidence NICE identifies “no clinically important differences” between CBT, interpersonal psychotherapy (IPT), short-term psychodynamic psychotherapy and brief supportive counselling, behavioural activation or GP treatment as usual (Full Guidance³ p. 234–235). Thus NICE’s review actually supports the ‘equivalence paradox’ that different short-term

psychotherapies appear equally effective, globally, in the short-term, in a range of conditions. The equivalence paradox has survived over thirty years⁶⁰ and has been confirmed naturalistically in the NHS.⁶¹ Even though the overall effectiveness is similar, this does not mean that all individuals or types of depression respond equally; individual factors significantly influence outcome. Despite the absence of evidence of superiority NICE recommends CBT and IPT alone. The full guidance states "cognitive behavioural therapies have the largest evidence base" (p. 291) and in the research recommendations section "CBT has the best evidence base for efficacy but it is not effective for everyone. The availability of alternatives drawing from a different theoretical model is therefore important" (p. 300). This essential detail is lacking from the shorter NICE Guidance⁶² (64 pages) and Quick Reference Guide⁶³ (28 pages), which are most widely read, and are likely to be misconstrued as presenting evidence that CBT and IPT have been proven to be superior treatments.

With regard to service delivery NICE recommends the replacement of assessment by experienced clinicians able to refer on to a broad range of psychotherapeutic modalities according to clinical judgment and patient characteristics and preferences with a stepped-care model offering self-help, CBT and IPT. This is despite "very limited evidence from direct studies in the support of a stepped care model" (draft for consultation,⁵² p. 100). This stepped care model creates an illusion of objective standards, but deprives patients of professional expertise, individualised treatment and choice.⁶⁴

Depressions are characterised by the interplay of biological, social and psychological factors, shaped by the individual, education, social class, beliefs, values and environment. Judgement is required to separate abnormal from normal.⁶⁵ Idiographic patient factors and values are increasingly recognised in causation and recovery from depression.⁶⁶ Psychiatric treatment should be based on diagnosis and formulation after detailed clinical assessment, taking into account patient values and pref-

erences.⁶⁷ Experienced clinicians consider a wide array of patient preferences, characteristics and values in deciding management.⁶⁸ A diagnosis of depression alone is insufficient for optimal clinical decision-making. The draft for consultation⁵² states: "The guideline development group consider that it is important to acknowledge the uncertainty inherent in our current understanding of depression and its classification and that assuming a false categorical certainty is likely to be unhelpful and worst damaging" (p. 18). However the guidance does just that.

The needs of the majority of patients, who do not respond to CBT or relapse within two years (Full guidance p. 158), or for whom CBT is unacceptable or ill-suited, must be addressed. Can they benefit from other psychotherapeutic modalities? Do long-term treatments or different modalities have superior long-term outcomes? Which psychotherapeutic processes, cognitive, behavioural, affective or interpersonal, and which aspects of the patient, clinician, and clinician-patient relationship promote change? Which modalities or processes are best suited to whom?

In 2009 Andy Burnham, then Secretary of State for Health, speaking about the Improving Access to Psychological Therapies programme, declared: "IAPT stands and falls on choice" and henceforth will be "providing people with a choice between different NICE approved treatments, such as CBT, Interpersonal Therapy, Couples Therapy, Brief Dynamic Therapy, Counselling and Collaborative Care".⁶⁹ The recognition of the importance of choice and the shift from NICE's narrow recommendations for guided self help, CBT and IPT to a wider provision of "approved" therapeutic modalities is welcome. However the shift from "NICE recommended" to "NICE approved" begs the question of what process was followed by NICE in "approving" treatments, because this is not described in the guidance.

Within the narrow framework established by NICE the review and statistics may be technically correct, but the method chosen is inadequate to com-

prehend the complexity of clinical condition, the complexity of the interventions and the range of evidence available. This reduces the clinical utility of the guidance. Credibility is reduced by commitment to a particular model and “one-size-fits-all” ecological fallacy (assuming because certain interventions have general efficacy they should be applied routinely to all cases). The proposal to replace expert clinical assessment with an untested model is wrong and dangerous because by inappropriate restriction of choice it undermines patient autonomy, professional expertise and, ultimately, patient welfare.

Future revisions of the guideline should reflect what the data show, not simply “count votes”; use an ecologically valid definition of depression; pay

due consideration to factors influencing outcome: heterogeneity, aetiology, comorbidity, patient preferences; and consider long-term psychotherapy and naturalistic trials of effectiveness. NICE should heed the advice of its own chair Michael Rawlins, who criticising the “undeserved pedestal” that RCTs occupy⁷⁰ quotes Bradford Hill, architect of the RCT:

Any belief that the controlled trial is the only way would mean not that the pendulum had swung too far but that it had come right off the hook.⁷¹

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Focus of the intervention	Nature of the intervention
STEP 4: Severe and complex ² depression, risk to life, severe self-neglect	Medication, high-intensity psychological interventions, ECT, crisis service, combined treatments, multiprofessional and inpatient care
STEP 3: Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions, moderate and severe depression	Medication, high-intensity psychological interventions, combined treatments, collaborative care ¹ and referral for further assessment and interventions
STEP 2: Persistent subthreshold depressive symptoms, mild to moderate depression	Low-intensity psychosocial interventions, psychological interventions, medication and referral for further assessment and interventions
STEP 1: All known and suspected presentations of depression	Assessment, support, psychoeducation, active monitoring and referral for further assessment and interventions

Low-intensity psychological/psychosocial interventions;
 individual guided self-help based on CBT principles
 computerised CBT
 structured group physical activity programme.
 group CBT

High-intensity psychological interventions:
 CBT
 IPT
 Behavioural activation
 Behavioural couples therapy

Additionally those at significant risk of relapse or with residual symptoms should have;
 individual CBT
 mindfulness-based cognitive therapy

Συστάσεις από το NICE για την ψυχοθεραπεία της κατάθλιψης: Περιορισμένη κλινική χρησιμότητα

D. McQueen,¹ P.St. John Smith²

¹West London Mental Health NHS Trust, London, ²National Health Service, Redditch, UK

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Το 2009/10 το Εθνικό Ινστιτούτο Κλινικής Αριστείας (NICE) επικαιροποίησε εν μέρει τις κατευθυντήριες οδηγίες του για τη θεραπεία και τη διαχείριση της κατάθλιψης σε ενήλικες. Λόγω μεθοδολογικών αδυναμιών οι συστάσεις για την ψυχοθεραπεία θα πρέπει να αντιμετωπίζονται με προσοχή. Παρά την αναγνώριση της ετερογένειας και της συννοσηρής φύσης της κατάθλιψης, και τους περιορισμούς της κατάθλιψης ως ενιαίας διαγνωστικής κατηγορίας, το NICE αντιμετωπίζει την κατάθλιψη σαν να επρόκειτο για μια ενιαία οντότητα που διαφοροποιείται μόνον ως προς τη βαρύτητα. Οι οδηγίες αγνοούν σημαντικούς αιτιολογικούς παράγοντες, όπως το ψυχολογικό τραύμα, η απώλεια και η κακομεταχείριση, η προσωπικότητα και οι δυσκολίες στις διαπροσωπικές σχέσεις. Αποκλείει τις μεγαλύτερες νατουραλιστικές μελέτες σε κλινικούς πληθυσμούς μέσα στο Εθνικό Σύστημα Υγείας (NHS) με την επιχειρηματολογία ότι είναι μελέτες παρατήρησης σε ετερογενείς ομάδες με μικτές νευρωτικές διαταραχές. Δέχεται αναντίρρητα ότι γενικότερα η ψυχοθεραπεία έχει δομική εγκυρότητα, και αγνοεί την έρευνα πάνω στη διαδικασία της ψυχοθεραπείας που δείχνει σημαντικές ομοιότητες και επικαλύψεις μεταξύ των διαφόρων ειδών ψυχοθεραπείας, και στοιχεία που δείχνουν ότι η επίδραση του θεραπευτή είναι σημαντικότερη από τις διαφορές μεταξύ των ειδών ψυχοθεραπείας. Αποτυγχάνει να εξετάσει τις διαφορές και τις προτιμήσεις των ασθενών, οι οποίες είναι γνωστό ότι επηρεάζουν την άποψη για την ψυχοθεραπεία, την ολοκλήρωση και την ανταπόκριση στη θεραπεία. Υιοθετεί μια αποκλειστικά βραχυπρόθεσμη προοπτική για μια χρόνια υποτροπιάζουσα διαταραχή. Δεν συμεριρίζεται αποδεικτικά στοιχεία για τις μακροπρόθεσμες θεραπείες. Είναι ιδιαίτερα ανησυχητικό το γεγονός ότι το NICE διαστρεβλώνει τα αποτελέσματα των δικών του συστηματικών ανασκοπήσεων υπονοώντας ότι η CBT και η IPT είναι ανώτερες ψυχοθεραπείες. Στην πραγματικότητα, συστηματική ανασκόπηση του NICE δεν απέδειξε ανώτερη καμία εκ των CBT, IPT, ψυχοδυναμική ή συμβουλευτική ψυχοθεραπεία. Με βάση την εξαίρεση κλινικά σχετικών ερευνών που αποδεικνύουν την αποτελεσματικότητα της ψυχοδυναμικής και της συμβουλευτικής ψυχοθεραπείας, πολλοί σχολιαστές έχουν ισχυριστεί ότι οι οδηγίες έχουν προκατάληψη υπέρ της CBT. Όσον αφορά στην παροχή υπηρεσιών, το NICE προτείνει την αντικατάσταση της ψυχιατρικής εκτίμησης και της εξατομικευμένης θεραπείας με ένα αναπόδεικτο μοντέλο κλιμακωτής φροντίδας. Αυτοί οι κλινικοί και θεωρητικοί περιορισμοί, η μεροληπτική επιλογή μελετών, η παράληψη στην αξιολόγηση των διαφορών, των προτιμήσεων και τις αξιών των ασθενών, η μη αντικειμενική παράθεση των αποτελεσμάτων των συστηματικών ανασκοπήσεων, και η πρόταση για ένα αναπόδεικτο μοντέλο παροχής υπηρεσιών, υπονομεύουν σοβαρά το κύρος των οδηγιών. Οι κατευθυντήριες οδηγίες με ελλιπή εγκυρότητα είναι αμφίβολης χρήσης, υπονομεύουν την αυτονομία του ασθενούς, την επαγγελματική εμπειρία και, εν τέλει, τη φροντίδα των ασθενών.

Λέξεις ευρητηρίου: Κατάθλιψη, ψυχοθεραπεία, κατευθυντήριες οδηγίες, NICE.

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Corresponding author: D. McQueen, Psychiatrist, West London Mental Health NHS Trust, Trust Headquarters, 1 Armstrong Way, Southall, UB2 4SD, UK
Tel: (+20) 8354 8354
e-mail: communications@wlmht.nhs.uk