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Debate over cognitive, traditional mental health therapy

Psychologists who favor the more medical-minded cognitive behavioral model point to growing evidence of its efficacy. Proponents of psychoanalysis deride a one-size-fits-all approach.

By Eric Jaffe >>>

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If your doctor advised a treatment that involved leeches and bloodletting, you might take a second glance at that diploma on the wall. For the same reason, you should think twice about whom you see as a therapist, says a team of psychological researchers.

In a November report that's attracting controversy the way couches attract loose change, three professors charge that many mental health practitioners are using antiquated, unproved methods and that many clinical psychology training programs lack scientific rigor.

The accusation has reignited a long-standing "holy war" within the psychological profession.

On the one side sit the report's authors and other like-minded psychologists who say that too many clinicians favor personal experience over scientific evidence when deciding on a patient's treatment. They are particularly unsettled by the number of therapists -- especially from training programs that grant a higher degree known as doctor of psychology, or PsyD -- who ignore the most-studied type of treatment: cognitive behavioral therapy.

"Too many clinical psychologists tell us they don't look to research, they don't look to science," says Timothy Baker of the University of Wisconsin, lead author of [the report](#), published in the journal *Psychological Science in the Public Interest*.

On the other side of the fight are psychologists who say that what matters most is not the type but the quality of mental health treatment and who fear that the push toward cognitive behavioral therapy -- which is cheaper but not effective for everyone -- is being used by insurance companies to cut down on costs.

The new report's authors and their supporters "are largely people who not only don't practice themselves -- and therefore have no idea what would be relevant to practice -- but have a tremendous disdain for people who do practice," says psychologist Drew Westen of Emory University.

The debate comes at a critical moment in mental health care. In the last 20 years, the treatment rate for

people with mental disorders has nearly doubled. In October, a long-term Duke University study reported that some afflictions -- including depression and anxiety disorder -- affect twice as many as previously believed.

The situation stands to worsen. The National Alliance on Mental Illness recently found that the unemployed were four times as likely as job holders to report symptoms of mental illness. A need for clinicians capable of treating post-traumatic stress disorder will rise dramatically as more soldiers return from Iraq and Afghanistan.

"Many people in the general public are not getting ideal care," says psychologist Scott O. Lilienfeld of Emory University. He describes the new report as an "accumulation of frustration."

Medical standard

At the core of the debate is a difference over how clinical psychologists approach therapeutic practice.

One group, largely academic, believes psychology should follow a medical model, addressing specific ailments with specific treatments developed and tested for that purpose. This group overwhelmingly embraces cognitive behavioral therapy that -- briefly put -- aims to correct misguided beliefs and reactions that contribute to mental disorders.

Patients with obsessive-compulsive disorder, for example, are treated with a type of cognitive behavioral therapy known as exposure therapy, which gradually teaches them to confront their fear of contamination. Only after symptoms have been alleviated do therapist and patient then delve into the root of the problem -- a place where many traditional therapists begin.

A mounting pile of research shows that cognitive behavioral therapy can effectively treat anxiety disorders, post-traumatic stress disorder, depression, bulimia and substance abuse problems. The method has performed as well as antidepressant medication in treating depression in recent studies. What's more, patients receiving cognitive behavioral therapy have shown less likelihood of relapse than their medicated peers because the therapy teaches them how to handle their disorder.

"Evidence-based therapies work a little faster, a little better, and for more problematic situations, more powerfully," says psychologist Steven D. Hollon of Vanderbilt University.

Research shows that many patients respond to the therapy within 12 to 16 sessions, far more quickly than in traditional psychoanalysis, making the treatment highly cost-effective.

England is convinced. In 2007, the British government -- a "decade ahead of us," Hollon says -- adopted a massive program to train 3,600 therapists in cognitive behavioral therapy with the hope of weaning 900,000 people off medication.

But U.S. therapists have been reluctant to embrace the technique. A [survey of 591 practitioners](#), published in the *Journal of Clinical Psychology* in 2007, found they relied "primarily on clinical experiences," as opposed to new research, when treating patients. The therapists stuck with methods that hadn't been confirmed in randomized controlled trials, says the study's co-author, Dianne L. Chambless of the University of Pennsylvania.

As a result, she says, many people are suffering from mental health problems who wouldn't be if their therapists "provided the right kinds of treatments."

Traditional mode

That is not how the other camp sees the situation. This group, largely practicing therapists, prefers a less confining treatment method that emphasizes a strong relationship between therapist and patient. It tends to favor more traditional approaches such as psychodynamic therapy, in which the therapist plumbs the patient's unconscious, or humanistic therapy, which stresses self-determination.

This camp says that these methods are harder to test than cognitive behavioral therapy, which follows a step-by-step treatment plan.

The scientific reputation of cognitive behavioral therapy has left many with the impression that all other therapies are unproved -- quack methods, invented by clinicians on the fly -- but that's sensationalism, says psychologist John Norcross of the University of Scranton, Pa. He says there's plenty of support for traditional psychotherapies from careful case studies and data collected by therapists working in clinics.

And just because cognitive behavioral therapy has performed well in randomized controlled research doesn't make it "right," Norcross and others add. Its one-size-fits-all approach denies that different people may need different strategies for dealing with similar mental health problems.

"[Cognitive-behavior therapy] is deliberately designed to ignore any relevant features of the personality of the individual," Westen says.

In [an October review of scientific literature](#) in the Behavior Therapist, three psychologists argue that cognitive behavioral studies contain flaws -- dropout rates are as high as 40%, for example. This leaves only patients well-suited to the treatment as test subjects.

And some significant studies are not included in the new report, adds one of those three psychologists, Bruce Wampold of the University of Wisconsin. He cites a 2003 University of Toronto study that tested cognitive behavioral therapy against process-experiential therapy, which focuses on emotions rather than rational thoughts. Both treatments improved depression, but patients receiving process-experiential therapy reported a greater decrease in interpersonal problems.

"Frankly, it baffles me that they can ignore so much research evidence so cavalierly," Wampold says.

'Outcomes' method

Maybe there's a middle way through the morass. Instead of rigidly dictating the "right" type of therapy up front, some health plans have shifted toward an "outcomes" system that measures a patient's response to treatment regardless of what kind it is.

In Utah, for instance, publicly funded healthcare plans follow the Outcome Questionnaire system developed by psychologist Michael Lambert of Brigham Young University.

In his system, patients respond to questionnaires designed to track the effectiveness of their therapy. Each week over the course of their treatment, patients rate the frequency of 45 "mental health vital signs," such as "I blame myself for things" or "I am satisfied with my relationships." If patients aren't improving, an alarm signal is sent to therapists, asking them to consider modifying their approach.

The outcomes movement has some traction. Scott D. Miller, a psychologist in Chicago, has co-developed a similar system called MyOutcomes, used by the U.S. military and in thousands of private practices. OptumHealth, which covers 58 million Americans, now uses a similar outcomes process called the ALERT system.

Improvement, after all, matters more than how the change was achieved.

"I don't care what psychotherapy the person is getting," Lambert says. "I care whether they're responding."

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