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A Critical Discussion Paper Discussing the Use of Cognitive Behavioural Therapy (CBT) from a Political, Social and Clinical Practice Perspective

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Abstract

Depression, a predominant mental health issue, is a leading cause of morbidity globally. It is ranked by the global burden of disease study conducted in 2017 to fall within the top three causes of Years Lived with Disability (YLD) amongst both genders, with major depressive disorders being 2nd highest, followed by anxiety disorders. The world health ogranization has identified depression as the third cause of burden of disease, with projections of being ranked first in 2030 (the global burden of disease). Depression is screened by healthcare physicians in the primary care setting through the use of measuring scales, most commonly the Patient Health Questionnaire (PHQ), which is a self-administered questionnaire. The use of PHQ-9 on adults has been reported to have a sensitivity score of 61% and a specificity of 94%. The symptoms of depression are vast and complex, ranging from a continuous feeling of low mood and helplessness, to the loss of interest in pleasurable activities to contemplating suicide. The significant limitations on an individual's quality of life depends on the severity, with functional impairment marked on personal, work, family and social life.

Keywords: Burden of disease; Public health; Cognitive behavioural therapy; Therapy; Meta-analysis

Introduction

Given the prevalence and impact of depression in society, authoritative figures in the public health domain must prioritize the implementation of cost-effective interventions to monitor and decrease the overall burden [1]. NICE guidelines recommend the combined management of pharmacotherapy and psychotherapy approaches for patients who failed to respond to monotherapy with antidepressants alone. With NICE guidelines placing particular focus on Cognitive Behavioural Therapy for Depression (CBT-D) (depression in adults: Recognition and management). The recent popularity of cognitive behavioural therapy has raised many concerns, especially since CBT is favored above various available therapies [2].

This report will go on to introduce CBT and report the advantages and limitations of its use on mental disorders in comparison to other psychological therapies. It will aim to offer an overall outlook on the political, social and clinical perspectives on CBT in society [3]. The evidence base of CBT-D will be investigated through systematic reviews, meta-analyses, medical journals and data available through health organisations.

Cognitive Behavioral Therapy (CBT), commonly seen as a type of talk therapy, is one of the most effective interventions and considered the most common psychotherapy in the management of depression. Developed by Albert Ellis and Aaron Beck in the 1960's as two separate entities, emotive behavior and cognitive therapy, later combined into what we popularly known as CBT. Following a theoretically structured format, the main aim of CBT sessions is to target and make individuals aware of their maladaptive negative thoughts, which are skewed and often difficult to tackle. Therapists attempt to identify troubling thoughts, feelings and behaviour and examine how they contribute to negative patterns of behaviour (cognitive behavioral therapy) [4]. CBT sessions are goal-oriented, with a particular focus on current problems rather than issues from the past. These sessions help interrupt the negative cycle of emotions affecting behavior, to break down a problem into its smaller counterparts, ending that cycle and making debilitating situations more manageable (how it works cognitive behavioural therapy). Most evidence-based psychotherapies suggest an overall 16-20 sessions, but recent findings concluded the efficaciousness of 6-8 CBT sessions, each 1-2 hours in duration, as the course of treatment.

Literature Review

CBT is also effectively used in the management of other mental disorders such as: Anxiety, bipolar, eating disorders and psychosis (how it works cognitive behavioural therapy, 2019). When comparing CBT to alternative psychotherapies in a meta-analysis titled "is cognitive behavioral therapy more effective than other therapies?" CBT was evidently far superior in comparison to psychodynamic and interpersonal therapies amongst patients with anxiety or depressive disorders [5]. On the other hand, a meta-analysis of 115 studies, concluded that there was "no indication that CBT was more or less effective" when compared to other treatment modalities [6].

CBT has been the dominating psychological therapy referred to by guidelines such as NICE and the American psychological association. It is known to be the "psychological therapy with the widest and broadest evidence base". Other forms of psychotherapy have been systematically inferior in comparison to CBT. The reputation and actual efficacy of CBT is overestimated and based on the tremendous amount of empirical evidence present [7]. This may be explained by the vast research available on CBT, largely due to its strong link to the human mind and behaviour, all of which nominate CBT as the "gold standard" of choice for treatment of depression or anxiety [8]. CBT has also been criticized for failing to uncover or address probable underlying causes of mental health disorders including childhood and family history. It is also under scrutiny for being compared to weak comparisons in clinical trials, such as: Wait-listed control groups.

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There are numerous randomized clinical trials and an accumulation of studies since Rush et al published the original work in 1977 all indicating the effectiveness of CBT in alleviating symptoms. Hofman, reviewed the response rates of eleven meta-analytic studies using CBT versus comparison treatments. With seven studies reporting higher response rates with the use of CBT, only one study indicated a lower response. Many studies have also compared CBT to strong opponents and conditions, such as: Pharmacotherapy, other psychotherapies and psychological placebo [9]. A study published by dobson 1989, indicate that the symptom improvement produced by CBT use is greater and more notable compared to results of patients placed in control groups receiving no treatment or those on longer waitlists.

Political

As published, mental health conditions cost England a total of £105 billion annually, which accounts for only 13% of NHS spending. In 2011, The UK government alongside department of health and social care, released their mental health strategy “no health without mental health”. It is a policy framework used to monitor progress through outcomes, improve mental and physical wellbeing, increase access to mental health services and enhance end user experience and available support. The need to tackle and provide mental health services has been advised by lord layard, an economist and adviser to the UK government. Mental illness has a substantial impact on the general wellbeing of individuals, influencing their ability to carry on with daily activities, mainly their ability to return to work, resulting in a £ 29 billion loss to businesses [10].

With efforts to increase investments on psychological therapies available to the public, there has been high emphasis on making CBT more accessible to subsequently reduce the number of employees missing work and thus saving on unemployment benefits (basic theory, development and current status of CBT). Improving Access to Psychological Therapies, “IAPT”, is an ambitious talking therapy that has shown success in helping individuals overcome depression, anxiety and have an overall better understanding on how to manage their mental issues. IAPT prioritizes the need to have this service delivered by trained and accredited practitioners who are regularly supported to provide high quality care in which patient progress can be monitored routinely (adult improving access to psychological therapies programme). In 2007 the NHS promised to increase available funding of IAPT to £170 million annually, with hopes of increasing access to talking therapy to reach an estimate of 1.9 million individuals by the year 2024 (adult improving access to psychological therapies programme).

The health and social care act released in 2012 and the NHS five year forward view shed light on the need to recognize mental health and place it on par with physical health, with hopes of achieving parity of esteem by 2020. As of such, in 2019, the NHS published its long term plan, committing to the improvement of mental health services available, with the introduction of services supporting patients undergoing mental health crises. Seeing as children and adolescent require early identification and intervention, the NHS recommended implementing “future in mind”, an initiative providing high-quality of mental health care reaching at least 70,000 more adolescents by 2020/2021 (the five year forward view for mental health). In regards to the economic expenditure of mental illnesses in England, a review done by the kings fund in 2006 showed an expected rise from £ 1.7 billion in 2007 to £ 3 billion in 2026 as the total cost for management of depression (depression: The treatment and management of depression in adults). Randomized clinical trials testing the use of online therapist-assisted CBT concluded that this method is as effective as delivering CBT in the clinical setting. This approach will be of economic significance, limiting the amount of funding needed and would reduce inequality of access present amongst patients in geographic locations that are considered rural, underserved or difficult to reach.

Social

Many social and cultural barriers to accessing mental health services exist, with reports indicating that 50% of depressed patients never consult a doctor and 95% never receive access to secondary services. This excludes the vast number of patients whose illnesses go unrecognized or untreated (depression: The treatment and management of depression in adults). Taking into consideration that individuals within culturally diverse communities tend to seek and utilize help from multiple resources, other than professional therapists when contemplating whom to seek for treatment. These resources include: Elders in the community, religious figures and traditional healers.

Nonetheless, access to psychological therapies has improved, specifically after the implementation of the national IAPT program. However, service users still face long waiting times, ranging up to six days. One-fifth of users with more complex disorders whom are registered within the care programme approach have not been formally reviewed by a practitioner in the previous 12 months (the five year forward view for mental health). Despite the evidence regarding CBT’s effectiveness, uptake remains low. Barriers to the access and delivery of exposure-based CBT is a multi-system problem, encompassing concerns expressed by the end user, provider, organization and overall system.

Patients usually express fear that professionals are not competently trained to deliver evidence based psychotherapies, mainly discussing cognitive behavioral therapy. Patients tend to feel embarrassed to discuss such sensitive matters, while others are afraid of the consequences associated with consulting a professional, such as: Undergoing tests, starting treatment, being hospitalized or detained under the mental health act (depression: The treatment and management of depression in adults). Another major barrier is the inability to afford CBT sessions and the lack of access to facilities providing those sessions. Difficulty in access may be due to geographic location or lack of transport.

Patients living in rural areas or those with poor educational background may have no knowledge on psychological conditions and are unaware of the available options and services offered by the government. They often lack information on CBT as well, adding to an extensive list of barriers to effective therapy.

Predetermined cultural beliefs and stigma revolving around mental health impacts how early a member in society decides to seek help or treatment. These factors delay proper diagnoses and management. It has been noted that people from black or ethnic minority backgrounds tend to enter mental health services only at times of emergency or breakdown (the invisible costs of mental ill health). Little or no research has been conducted discussing CBT use by particular subgroups, such as ethnic minorities or individuals from low socioeconomic statuses. This must be taken into consideration when looking at different avenues to increase delivery of mental health services to subsets.

To overcome long waiting lists, a barrier expressed by end users, suggestions to deliver CBT virtually through email are under practice. The success of this approach has been measured using the BDI (Becks Depression Index) scale pre and post CBT delivery. Suggestions that

physicians should seek and modify their understanding of the cultural context to fit the non-western backgrounds of end users. Another recommendation is to form collaborations between mental health workers and traditional healers. This is entailed under "cultural adaptation" a process by which evidence based treatment is modified in terms of "language, culture and context" and is in consensus with the patient's belief and values.

Clinical

Seeing that a patient's first point of contact in the healthcare setting is a primary care facility, whether seen by a general practitioner or other aligned health professional. It has been reported that "of the 80 depressed people per 1000 population" that consult their GP only half are correctly diagnosed with depression, while others are diagnosed with somatic symptoms. Noting that 1 in 4 of the general population will seek assistance from their primary GP, only 1 out of 4 will be further referred to secondary mental health services. Those selected for referral are patients with the following particular characteristics: Are usually women under the age of 35 who fail to respond to pharmacotherapy or are diagnosed with a severe form of depression (depression: The treatment and management of depression in adults). Regardless of such, CBT's efficacy has been demonstrated in ordinary clinical practice and is not limited to specialist centers, allowing for its application in various settings by multiple healthcare practitioners (basic theory, development and current status of CBT).

Discussion

Based on medical guidelines, Antidepressant Medication (ADM) is considered first line treatment for patients diagnosed with depression, with its efficacy exhibited in "thousands of placebo-controlled clinical trials". Nonetheless, the effects of ADM are seen to diminish if discontinued, making the risk of symptom relapse high. In a study comparing relapse of depressive symptoms, it was reported that 76% patients relapsed after ADM withdrawal, in comparison to the relapse of only 31% of patients after CBT-D discontinuation.

In regards to psychosocial treatments, CBT dominates the field based on guidelines produced by NICE and the American psychological association and is greatly supported as therapy of choice for most psychological disorders seen in adults (basic theory, development and current status of CBT). Surprisingly, observations on CBT use in the primary care setting indicate that "fewer sessions are taken" than the 12-20 sessions recommended by NICE guidelines. This can be explained by the fact that many health care professionals have negative beliefs about CBT, such as: It being harmful and irrelevant to patients' psychopathology. Nonetheless, the royal college of psychiatrists emphasize the importance of adhering and combining antidepressants alongside psychotherapy for best prognosis. The combination of the two is regarded as the superior approach in the management of severe cases of depression.

Another concern voiced by community providers and physicians, is the lack of sufficient training in evidence based psychotherapies, mainly an incompetency in conducting CBT sessions. Worry has also been expressed in regards to service users consulting spiritual and faith healers in the community, who provide more of a directive style of therapy rather than collaborative. As of such, physicians are encouraged to develop a "therapeutic attitude or stance" and to self-educate regarding the difficulties facing patients from diverse cultures, such as: Language barriers, lack of access, lack of resources and knowledge about available treatments. Also, of great benefit, is to perform an assessment of patients' knowledge and background of available mental health services, both pharmacotherapy and psychotherapy options. All of the above is considered key to bridging the gap between service users and healthcare professionals.

Conclusion

In conclusion, regardless of the scrutiny and uncertainty expressed regarding the use of CBT in the management of depression, it remains the treatment of choice enlisted in guidelines published by NICE and the American psychological association. Majority of meta-analyses prove and support its efficacy in comparison to other measures of therapy, with most studies reporting a high response rate and a low relapse rate post CBT session period. Service users who were monitored and fully cooperative with counsellors expressed positive symptoms and lower scores on the depression scale, indicating a reduction in morbidity, improvement in quality of life and psychosocial functioning. The importance of combining pharmacological and psychological therapy in the treatment of moderate-severe depressive cases has been greatly emphasized as well. The cost effectiveness of CBT as an intervention should motivate developed and underdeveloped countries to implement services such as a first-line intervention, similar to the IAPT programme initiated by the NHS. Despite the weakness of control group studies, the evidence base on CBT use for multiple psychological conditions is considerable. Since it is an evolving psychotherapy with limitations and questionable effectiveness, a comprehensive review is recommended to further strengthen the empirical evidence available and guide future clinical development.

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