NICE Guidelines in Depression.
Making a Case for the Arts Therapies.

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These notes are derived from a review of the full Guidelines carried out by Malcolm Learmonth, May 2006. These quotations from the full Guidelines are intended to help Arts Therapies make a case for their services.

The full review includes a critique of why and how the Arts Therapies are not included in the Guidelines, and of the methodologies used to define 'quality' evidence. All references, unless stated, are to the 358 page full Guidelines, available from NICE. Most people, including in the services, will not have read this, instead relying on abbreviated versions, which omit both the caveats and the most useful statements for Arts Therapists and service users wanting an Arts Therapies or more complex psychotherapy service, that are in the full document.

Psychological therapies should be available. The audit criterion suggested is that:

'100% of patients with mild and moderate depression who have not responded to an alternative, less complex intervention (for example, guided self-help) should be considered for short-term psychological treatment.' (Short version, p53)

'It has long been recognised that focusing on their psychology can help people with depression' (p127).

The Guidelines are not *'a substitute for professional knowledge and clinical judgement'* (p8.), and have to be read in the light of *'the uniqueness of individual patients'* (p8). This point is emphasised several times: *'there will always be patients for whom Guidelines recommendations are not appropriate'* (p8).

The Guidelines are 'Evidence based', but: *'it is important to remember that the absence of empirical evidence for the effectiveness of a particular intervention is not the same as evidence for ineffectiveness'* (p8). Just because it hasn't (yet) been proved, it doesn't mean it doesn't work.

Therapeutic relationship is critical: *'to support and encourage a good therapeutic relationship, is at times more important than the specific treatments offered.'* (p8). Art Therapists can claim specific training and expertise in this area.

Depression is often complex, and includes biographical, social and other factors which have a big impact.

'premorbid difficulties (e.g. sexual abuse), psychological mindedness and current relational and social problems…. may significantly affect outcomes' (p19). Art Therapists can claim expertise in working with these areas. *'Adverse childhood experiences'* are identified as increasing vulnerability to depression, as is *'not having a confiding relationship'* and *'separation or loss of a loved one'*. (p20)

Other factors of Arts Therapies practice are also effective: *'factors like acknowledgement of distress, reinterpretation of symptoms, providing hope and social support were suggested to contribute to better patient outcomes.'* (p24), and *'Psychological treatment for depression often reduces anxiety*.' (p25)

Patient choice is important: *'the healthcare professional should discuss alternatives with the patient'* (p25)

'For any guideline on the treatment of depression to be credible it has to be informed at every stage of its development by the perspective of patients' (p31). The sole service user quoted in the Guidelines says: *'The provision of alternative therapies is paramount, instead of the reliance on medication as an ongoing first line defence.'* (p32).

'Psychological treatments have expanded rapidly in recent years and generally have more widespread acceptance from patients' (p29),

In terms of psychological therapies: *'the choice of treatment should reflect the patients preference based on informed discussion'*. (p60).

Depression itself maybe a misleading way of understanding complex situations*: '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'*. (p54).

'depression is a highly heterogeneous disorder with many variables affecting outcome, including history (e.g. of child abuse) personality (e.g. perfectionism and self-criticalness) and life events.' (p132).

While the abbreviated versions of the Guidelines read with a great deal of certainty, the full Guidelines are considerably more cautions about their evidence: *'there are some significant limitations to the current evidence base, which have considerable implications for this guideline….. In part, these limitations arise from the problems associated with the randomised control trial methodology for all interventions, but particularly for psychological and service interventions.'* (p54).

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It is important to claim particular training an expertise in therapeutic relationship, and in general high levels of training:

'Healthcare professionals providing psychological treatment should be experienced in the treatment of the disorder and competent in the delivery of the treatment provided'. (p61).

'In all psychological interventions, healthcare professionals should develop and maintain an appropriate therapeutic alliance, because this is associated with a positive outcome independent of the type of therapy provided.' (p61).

'Healthcare professionals providing psychological treatment should be experienced in the treatment of the disorder and competent in the delivery of the treatment provided' (p130)

The Guidelines **only** refer to 'single diagnosis's depression. It is where there are multiple problems that the case for complex interventions like Art Therapies is strongest:

'In patients with depression who have significant co morbidity, consideration should be given to extending the duration of treatment for depression, making use, where appropriate, of treatments that focus specifically on the co morbid problems' (p61)

'Where depression is comorbid with another significant disorder, such as personality disorder, then treatment may need to be extended or varied' (p69).

'Psychodynamic psychotherapy may be considered for the treatment of the complex comorbidities that may be present along with depression.' (p69)

'psychodynamic psychotherapy may be of value in the treatment of the complex comorbidities that may be present along with depression'. (p161).

'it is common for depressed patients to have different comorbid diagnoses, such as social phobia, panic and various personality disorders (Brown et al, 2001), which can affect outcome. Pre-existing disorders such as social anxiety disorders may, for example, increase vulnerability to depression, influence treatment seeking, the therapeutic relationship, and staying in treatment.' (p131).

In addition, there are complex factors affecting length of therapy, and a recommendation that this is recognised:

'In patients with depression who have significant comorbidity consideration should be given to extending the duration of treatment for depression, making use where appropriate of treatments that focus specifically on the comorbid problems' (p132.)

'Key issues relating to the ability to form a therapeutic relationship will have an impact on time course and responses to time limited therapies …. historical factors such as sexual abuse may significantly impact upon speed of engagement and recovery'. (p130).

'psychodynamic psychotherapy may be of value in the treatment of the complex comorbidities that may be present along with depression'. (p161).

Short term psychological therapies *'cover the same material as long-term therapies, but introduce it at a faster rate. In addition, therapists aim to establish a therapeutic relationship with clients much more quickly. Clients are expected to be able to articulate their problems clearly, not to have difficult interpersonal problems that*

would interfere with the establishing of a good therapeutic alliance, to be able to understand and appreciate the rationale of the therapy, and to be able to engage in independent work outside the therapy sessions' (p168). It is frequent that these factors are not in place with users of Arts therapies services.

Nevertheless, short term therapies *'are more effective and more acceptable to patients than either placebo or wait list control. There is evidence that there is no difference in efficacy between short-term psychological therapies and other treatments (mostly antidepressants and GP care), although psychological therapy appears to be more tolerable'* (p171)

Age is no disqualification for Psychological Therapies: *'The full range of psychological interventions should be made available to older adults with depression, because they may have the same response to psychological interventions as younger people'*.(p61).

'Antidepressants are as effective as psychological interventions, widely available and cost less'.(p62).

It is worth inverting this statement: 'psychological interventions are as effective as antidepressants' and see 'costs' below.

'Patients whose depression is treatment-resistant may benefit from psychological interventions' (p72).

'many patients generally prefer psychological therapies over other interventions for depression, and the National Service Framework for Mental Health (Department of Health, 1999b) has called for increased availability of such treatments for common mental health problems, such treatments are often not available. This limited access arises from the shortage of trained therapists, expense, waiting lists and the reluctance of some patients to enter therapy.' (p95)

There is a research need: *'An adequately powered RCT reporting all relevant outcomes to assess the efficacy of short-term psychodynamic therapy for depression should be undertaken'* (p79)

While the Guidelines repeatedly emphasises Psychological Therapies 'specifically designed for Depression', (CBT in particular), by no means all the evidence validates this:

'Recently, the Health Technology Assessment Group published a 'Systematic review of controlled trials of the effectiveness and cost-effectiveness of brief psychological treatments for depression' Their general finding was that psychological therapies were effective, with 50% or more of those taking part having recovered by the end of treatment. However, they caution that a sizeable proportion of this may be due to non-specific factors, such as the therapeutic relationship and natural time course of depression. No significant differences were found between treatments that were specifically designed for depression, such as cognitive therapy, behavioural therapy and interpersonal therapy '(p127).

'Leichsenring's (2001) meta-analytic study on the comparative effects of short-term cognitive behavioural therapy and psychodynamic therapy found little evidence of difference. This may be a result of large numbers of patients who respond in trials independent of the nature of the intervention as a result of non-specific therapeutic factors' (p128) It is likely that the 'non specific factor' is therapeutic relationship.

The Guidelines separation of CBT in particular from other approaches may be questionable:

'in practice most psychological treatments for depression share common features. Indeed, there has been long debate about the 'specificity versus the nonspecificity' of treatment. Many of these common features relate to the therapeutic relationship such as providing an accepting, open and active listening relationship that helps to de-shame and remoralise people. In addition, however, there have been many suggestions for psychotherapy integration. Even without a deliberate attempt to integrate therapies many approaches have evolved overlapping features in focus and intervention' (p128)

Given that CBT is identified as 'treatment of choice', it is important to note the overlaps with Arts therapies practice.

There is an interesting assumption made in the definitions offered of how CBT differs from psychodynamic therapy. CBT's original focus

' was on the styles of conscious thinking and reasoning of depressed people. For example, when depressed, people focus on negative views of themselves, the world and the future. A key aspect of the therapy is to take an educative approach where, through collaboration and guided discovery, the depressed person learns to recognise his or her negative thinking patterns and how to re-evaluate his or her thinking. This approach also requires people to practise re-evaluating their thoughts and new behaviours (called homework). The approach does not focus on unconscious conflicts, transference or offer interpretation as in psychodynamic therapy. As with any psychological treatment, cognitive behavioural therapy is not static and has been evolving and changing. For example, as noted, some cognitive therapies for depression may now focus on a schema-based approach' (p133)

If the process is one of discovery, learning, and recognition, then what is *discovered, learned* or *recognised* was, by definition previously not conscious. It is hard then to see how definitively separate from other psychotherapeutic approaches this really is. Any psychotherapist is working through 'collaboration and guided discovery' towards changes that include changes in how people think (cognition), and what people do (behaviour), by learning and discovering patterns of which we were previously unaware (schema). Schema thinking comes directly from attachment theory, and the early creation of 'working models' based on early experience

The Guidelines definition of CBT is certainly congruent with aspects of the practice of art psychotherapy, but omits other key areas: therapeutic relationship, imagination, non-verbal thinking, dealing with emotions, 'autobiographical competence and

affective processing', cultural context, emotional intelligence, creativity, empowerment and self esteem, all of which are key areas in depression.

The evidences base for CBT is far weaker than generally presented: here are just a few surprising statements from the full Guidelines:

*'there is **no** clinically significant difference between CBT and antidepressants on reducing depression symptoms by the end of treatment in moderate, severe, very severe or chronic depression'*. (p140)

' there is no clinically significant difference between CBT plus antidepressants and antidepressants (with clinical management) in people with residual depression on reducing depression symptoms 17 months after the end of treatment' (p143).

'there was insufficient evidence to determine the efficacy of individual CBT for depression compared to either pill placebo (plus clinical management) or other psychotherapies'. p144

'the clinical evidence review showed no overall superiority for CBT alone on treatment outcomes over antidepressants.' (p300).

There are many more of these, and it is worth looking at the full Arts Therapies review these notes are drawn from, and the full Guidelines.

Therapeutic relationship:

'Many approaches advocate a therapeutic stance of genuineness, empathy and positive regard as derived from early counselling models of change. Indeed, there have been important developments in understanding the role of the therapeutic relationship and alliance and therapeutic 'universals' such as remoralisation, social support and reassurance are also regarded as important factors for treatments. The quality of the alliance/relationship may account for a significant percentage of variance in outcome. Despite this, few research trials offer data on therapist characteristics or capacity to create a good therapeutic relationship.' (p130).

'In all psychological interventions, healthcare professionals should develop and maintain an appropriate therapeutic alliance, because this is associated with a positive outcome independent of the type of therapy provided.' (p130).

Costs:

'it is likely that the additional costs, if any, of brief psychological interventions provided in primary care are offset by savings on other healthcare costs. Hence, other factors such as clinical benefits, patient preferences and staff availability should be taken into consideration when choosing between these alternatives' (p297)

'The study by Guthrie et al (1999) compared brief psychodynamic interpersonal therapy with usual psychiatrist care. They found psychotherapy to be both more effective and cost saving'. (p298)

This is not surprising given that the cost of Psychiatrist care per hour of patient contact, is £207. (p305).

For comparison, a 16 week course of CBT:

'The cost of a full course of CBT was estimated at £867 when provided by a suitably qualified and trained clinical psychologist.' (p307.) (That's £54 a session: a top of Band 8 Art Psychotherapist's time is valued at around £19ph and at the bottom at around £16 ph.. Even allowing for other employments costs, planning, notes and admin around sessions, that is considerably cheaper).

Antidepressants (typical costs per patient were between £70 and £196) look cheap until the en masse implications are considered:

'The number of prescriptions for antidepressant drugs dispensed in England has been increasing steadily since 1992 and reached 23.3 million in 2002. Spend on antidepressant drugs reached £380.9 million in 2002 . (p177). I make that equivalent to around 19 million hours of Arts Psychotherapy. Even for a long therapy of 80 hours, that would be 2.3 million treatments.

Conclusions:

The best case that can be made for the Arts Therapies working with adults with depression, backed up with the quotations above is:

- Our emphasis on therapeutic relationship is backed up by research evidence as effective.
- Our high level of training means we can meet the Guidelines requirements on this.
- Our ability to work with 'comorbidity', complexity, and issues like Sexual Abuse, all of which are specifically indicated to need different approaches.
- The extent to which the evidence that CBT really is 'better' is questionable, and in any case there are many overlaps between Psychological Therapies approaches.
- We are still comparatively a very cheap option.
- Patients should be offered informed choices about therapies.
- All patients who need them should be offered Psychological Therapies, and there is a shortage.

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