

Improving Access or Denying Choice?

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Abstract

This paper addresses the 'Improving Access to Psychological Therapies' programme and the reports on which it is based. It is suggested that the evidence base favouring particular psychological therapies is not as clear as is indicated in these reports. It is also proposed that there is an evidence base of at least equal relevance to the choice of psychological therapies. This body of research indicates that preferences for, and responses to, different types of psychological therapy are rooted in the 'personal styles' of, and philosophical beliefs held by, therapists & clients. It is concluded that a service can only offer a true choice of effective psychological therapies if it takes account of these diverse preferences and beliefs.

Key Words: Psychological therapies, choice, evidence base, personal styles, constructs

Following a commitment in its manifesto the previous year, in 2006 the British Government launched the Improving Access to Psychological Therapies (IAPT) programme. This focused on people suffering from depression and anxiety disorders, who it was considered had not previously had sufficient opportunity to receive effective psychological therapy, often instead being prescribed medication, referred to secondary mental health services, and/or placed on long waiting lists.

The IAPT programme largely derived from Lord Layard's Depression Report (Centre for Economic Performance, 2006), which concluded that "The demand from each of us should be quite simple: "Implement the NICE guidelines". In other words, give people with mental illness the choice of psychological therapy" (p. 14). Elsewhere in the report, it is made clear that the guidelines, to which this quote refers, produced by the National Institute for Health & Clinical Excellence (NICE), "recommend that, except for mild or recent cases, patients with anxiety disorders or depression should have the option of CBT" (p. 9). While the report acknowledges that other therapies are suggested by NICE for some conditions, cognitive-behavioural therapy¹ (CBT) is the recommended approach in the NICE guidelines for the vast majority of psychological problems (National Institute for Health & Clinical Excellence, 2005). The "choice of psychological therapy" that is promoted by the Depression Report, and by subsequent developments in the Improving Access to Psychological Therapies initiative (e.g. Clark, 2007; Clark & Richards, 2007; Pilling & Burbeck, 2007), is therefore almost exclusively a choice of cognitive-behavioural therapy. The Depression Report does indeed, therefore, make a simple demand, and, for the client, clinician, or health commissioner faced with a bewildering array of over 500 different psychological therapies (Karasu,

¹ For the reader who is unfamiliar with these terms, a glossary of definitions of different types of psychological therapy is provided at the end of this paper.

1986), this simplification of their choice may be a welcome relief. So, too, may be the assumption of the IATP programme that there is a correct approach to this choice, as reflected in such statements as:

“Successful psychological therapies ensure that the right number of people are offered a choice of the right services at the right time with the right results.” (Hewitt, 2007, p. 2).

However, this paper will explore whether choice of an appropriate psychological therapy is as simple as it may seem.

The Evidence Base for Psychological Therapies

The recommendations of such documents as the NICE guidelines derive from consideration of the ‘evidence base’ for different types of psychological therapy. Thus, in lists of evidence-based or “empirically supported” therapies, cognitive-behavioural approaches reign supreme (Chambless et al., 1998; Roth & Fonagy, 2005). However, different constructions may be placed on the evidence on which such lists are based, and on the selection of this evidence. For example, the somewhat more positive outcome of cognitive-behavioural therapy compared to other approaches revealed in early meta-analyses of the research data could be attributed to aspects of research design that favoured cognitive-behavioural approaches, and/or researcher allegiance. Indeed, some of these features of research design are reflected in the very criteria for acceptance as an empirically validated therapy (Chambless et al., 1998), which emphasise quantitative, randomised controlled trials of manualised therapies for clients with specific diagnoses. Bohart, O’Hara, & Leitner (1998) have argued that such criteria themselves are likely to lead to the disenfranchisement and “empirical violation” of humanistic and constructivist therapies, the philosophical assumptions of which may, for example, favour qualitative research designs, and may be opposed to manualisation of therapy or the use of conventional psychiatric diagnostic categories. Similarly, Slife (2004, pp. 51-2) has questioned whether it is “merely coincidental that cognitive behavioural therapy has virtually the same epistemological assumptions (values) as traditional science (i.e., a wedding of empiricism and rationalism). The positive empirical evaluations of this therapy may be the result of systematic bias rather than efficacy without such bias.”

However, even when conventional empirical outcome studies are considered, the superiority of one form of therapy over any other is generally not evident in recent meta-analyses (Wampold, 2001), which mostly support the “dodo bird verdict” that “everyone has won and all must have prizes” (Luborsky, Singer, & Luborsky, 1975). Faced with the demands of evidence-based practice, researchers studying such non-cognitive-behavioural approaches as psychodynamic (Anderson & Lambert, 1995; Crits-Christoph, 1992), humanistic (Elliott, 2002; Elliott, Greenberg, & Lietaer, 2004), personal construct (Metcalfe, Winter, & Viney, 2007; Viney, Metcalfe, & Winter, 2005), and systemic (Shadish & Baldwin, 2003; Sexton, Alexander, & Mease, 2004; Stratton, 2005) therapies are increasingly playing by the rules of conventional

outcome research (although in many cases not studying DSM-IV-defined diagnostic groups) and demonstrating the effectiveness of these therapies (Winter, Metcalfe, & Grenyer, 2008).

Neither is there much in the way of evidence of the effects of supposed active ingredients of therapy, such as therapeutic techniques, in contrast to non-specific factors, such as aspects of the therapeutic relationship or therapist variables. For example, Wampold (2001, pp. 147-8) concludes that “the ingredients of the most conspicuous treatment on the landscape, cognitive-behavioural treatment, are apparently not responsible for the benefits of this treatment”.

It may be, therefore, that the current evidence base does not provide such clear pointers to therapeutic choice for many clients as is generally assumed. If this is the case, what other basis might there be for the choice of a particular therapy?

Therapeutic Choice & Personal Styles

From the perspective of personal construct theory (Kelly, 1955/1991), the choice that an individual makes is always directed towards elaborating the system of constructs, which he or she employs to anticipate the world. The theory's underlying philosophical assumption of “constructive alternativism” essentially states that no one way of construing the world can be considered correct or final. Therefore, since each individual's construct system is unique, it is to be expected that people will differ in the choices that they make. A person's choice of psychological therapy, as with any other choice, is likely to reflect their more general pattern of construing the world and in particular their core constructs, those most central to the individual's identity. This relationship has been explored in a research programme that commenced in the 1960s, initially to explore resistance to the introduction of a therapeutic community in a traditional psychiatric hospital. The studies concerned have consistently provided evidence that the preferences of both clients and clinicians for different treatment approaches for psychological problems reflect these individuals' “personal styles” (Caine, Wijesinghe, & Winter, 1981; Caine & Winter, 1993). More specifically, people who preferred, chose to practise, were allocated to, or improved in more structured, directive therapeutic approaches, such as behaviour therapy, were shown to be more outer-directed (focusing more on the external than on the subjective world) and conservative than those who preferred, chose to practise, were allocated to, or improved in a less directive, more interpersonally-focused approach, such as group-analytic psychotherapy. Of particular note was that clients' personal styles and features of their construct systems were differentially predictive of their outcome in behaviour therapy and in group-analytic psychotherapy. Specifically, while clients who improved in behaviour therapy were more conservative, and had more tightly organised, logically consistent construct systems, in which constructs relating to their symptoms carried more implications than did non-improvers, the reverse was the case in group-analytic psychotherapy. Clients' personal styles and therapeutic preferences were also reflected in their “choice” of symptoms, the structure and content of their personal construct

systems as assessed by repertory grid technique, and scores on measures of openness to experience and convergent/divergent thinking.

A further body of research has provided evidence of the epistemological beliefs held by practitioners and proponents of particular types of therapy. For example, Schacht & Black (1985) differentiated behaviour therapists from psychoanalytic psychotherapists in terms of the empirical “epistemic style” of the former, concerned with the correspondence of beliefs with observations, and the metaphorical style of the latter, concerned with symbolic representations and the ability to generalise from beliefs. The distinction between these therapists on the latter dimension was confirmed by Arthur (2000), who also found cognitive-behavioural therapists to hold an objectivist, or mechanistic, and psychoanalytic psychotherapists a subjectivist, or organicist, world view. Individuals’ epistemic styles have also been found by Neimeyer et al. (1993) to be reflected in their therapeutic preferences.

Other researchers have focused on the differentiation between rationalist and constructivist epistemological positions, namely between whether people are viewed as passively perceiving an independently existing real world or actively constructing their realities. Neimeyer and his colleagues have found rational-emotive therapists to be more rationalist and less constructivist than personal construct psychotherapists (Neimeyer & Morton, 1997), and that therapists’ epistemological positions relate to their personal characteristics, therapeutic styles, and choice of interventions (Neimeyer et al., 2006). For example, therapists who subscribed to a rationalist position were more likely to use cognitive-behavioural techniques. Characteristic features of the therapeutic practice of rationalist and constructivist therapists have also been demonstrated in other studies. For example, Vasco (1994) found constructivist therapists to show low levels of structure, directiveness, focus on current issues, and confrontation regarding resistance. Similarly, Winter & Watson (1999) found personal construct psychotherapy sessions to be less structured and directive, less characterised by a negative therapeutic attitude, and to involve greater therapist exploration, client participation and complexity of perceptual processing than cognitive therapy sessions. Viney (1994) also provided evidence of greater acknowledgement of clients’ emotional distress in personal construct than in rational-emotive therapy.

A study of psychotherapists from nine theoretical models registered with the United Kingdom Council for Psychotherapy incorporated measures of personal styles, epistemological positions, and personal construct systems (Winter, Tschudi, & Gilbert, 2006). This found cognitive-behavioural therapists to be more outer-directed than therapists of every other orientation, and more rationalist than all except hypnotherapists. Differences were also demonstrated between therapists of different orientations in their construing of therapeutic approaches.

To summarise, research has supported the view that different models of psychological therapy are based upon very different philosophical beliefs, reflected in differences between therapists who choose to practise the therapies concerned, clients who prefer, or respond favourably to them, and therapist and client behaviour in sessions. This particular “evidence base”

would suggest that the most effective therapeutic service is likely to be one based on the principle of constructive alternativism, which can accommodate the varying personal styles of both clients and therapists (Winter, 1986).

Conclusions

A broad view of the available research evidence, focusing not simply on studies of particular diagnostic groups, suggests that the superiority of one form of psychological therapy over any other is less apparent than many therapeutic guidelines might suggest. Furthermore, there is evidence that clients are more likely to have a positive therapeutic outcome if allocated to therapies that reflect their philosophical beliefs. For example, the client who has radical beliefs, and a complex system of constructs in which his or her symptoms carry few implications, is unlikely to respond favourably to cognitive-behavioural therapy. For such a client, a choice between therapist and computer-administered, or individual and group, or self-study assisted and conventional, cognitive-behavioural therapy, as advocated by some who have contributed to the "Improving Access to Psychological Therapies" initiative (Clark & Richards, 2007) in a report that states that "Patients should be offered a choice of effective treatments when several exist" (p. 9)), is no choice. This will also be the case for therapists whose philosophical beliefs are incompatible with such approaches and who, if forced to practise them because no other approaches are funded, will be unlikely to do so with the conviction that is likely to be conducive to a positive therapeutic outcome.

Admittedly, with the "third wave" of cognitive-behavioural treatments (Hayes, 2004), the degree of choice within this therapeutic model now seems not inconsiderable. However, to what extent can these new variants of cognitive-behavioural therapy, some of which incorporate ideas more commonly associated with humanistic or constructivist approaches, really be regarded as cognitive-behavioural? Or is cognitive-behavioural therapy becoming so hyphenated (one can perhaps imagine the development of a humanistic-constructivist-existential-systemic-cognitive-behavioural therapy) that it has lost any coherent identity? If so, perhaps most therapeutic approaches can now jump on the bandwagon of recommended, evidence-based treatments by claiming to be essentially cognitive-behavioural.

The choice of psychological therapies which appears to be promoted by the 'Improving Access to Psychological Therapies' initiative, other similar initiatives, and the guidelines upon which they are based is reminiscent of the Monty Python sketch where a café appears to have numerous options on the menu but in fact virtually every option is a variant on spam. When a customer asks 'Have you got anything without spam?', the waitress's reply is 'Well, there's spam egg sausage and spam, that's not got much spam in it'. Now, I have nothing against spam. Some of my best friends are spam-eaters. Indeed, I am not averse to the odd plate of spam myself. However, I would not choose to eat spam for every meal nor would I expect it to be acceptable to everyone's palate or to be part of every café proprietor's repertoire. If we are truly to improve access to psychological therapies, let us ensure that the menu that is offered to our clients, and deemed permissible for therapists to practice, is one that truly caters for a diverse range of tastes.

References

Anderson, E.M. & Lambert, M.J. 1995. Short-term dynamically oriented psychotherapy: A review and meta-analysis. *Clinical Psychology Review* 15, 503-14.

Arthur, A.R. 2000. The personality and cognitive-epistemological traits of cognitive behavioural and psychoanalytic psychotherapists. *British Journal of Medical Psychology* 73, 243-57.

Bohart, A. C., O'Hara, M., & Leitner, L.M. 1998. Empirically violated treatments: Disenfranchisement of humanistic and other psychotherapies. *Psychotherapy Research* 8, 1-57.

Caine, T.M., Wijesinghe, O.B.A. & Winter, D.A. 1981. *Personal Styles In Neurosis: Implications for Small Group Psychotherapy and Behaviour Therapy*. London: Routledge & Kegan Paul.

Caine, T.M. & Winter, D.A. 1993. Personal styles and universal polarities: Implications for therapeutic practice. *Therapeutic Communities* 14, 91-102.

Centre for Economic Performance's Mental Health Policy Group 2006. *The Depression Report: A New Deal for Depression and Anxiety Disorders*. London: London School of Economics.

Chambless, D.L., Baker, M.J., Baucom, D.H., Beutler, L.E., Calhoun, K.S., Crits-Christoph, P., Daiuto, A., DeRubeis, R., Detweiler, J., Haaga, D.A.F., Johnson, S.B., McCurry, S., Mueser, K.T., Pope, K.S., Sanderson, W.C., Shoham, V., Stickle, T., Williams, D.A. & Woody, S.R. 1998. Update on empirically validated therapies, 11. *The Clinical Psychologist* 51, 3-16.

Clark, D.M. 2007. *Effective Psychological Treatments for Anxiety Disorders*. Paper submitted to the IAPT Expert Reference Group in support of the Department of Health submission to the Comprehensive Spending Review.

Clark, D.M. & Richards, D.A. 2007. *Delivery Options for Evidence Based Psychological Treatments*. Paper submitted to the IAPT Expert Reference Group in support of the Department of Health submission to the Comprehensive Spending Review.

Crits-Christoph, P. 1992. The efficacy of brief dynamic psychotherapy: A meta-analysis. *American Journal of Psychiatry* 149, 151-8.

Elliott, R. 2002. The effectiveness of humanistic therapies: A meta-analysis. In D.J. Cain & J. Seeman (Eds.), *Humanistic Psychotherapies: Handbook of Research and Practice* (pp. 57-81). Washington, DC: American Psychological Association.

Elliott, R., Greenberg, S.L. & Lietaer, G. 2004. Research on experiential psychotherapies. In M.J. Lambert (Ed.), Bergin & Garfield's Handbook of Psychotherapy and Behaviour Change. Chichester: Wiley.

Hayes, S.C. 2004. Acceptance and commitment therapy, Relational frame theory, and the third wave of behavioural and cognitive therapies. Behaviour Therapy 35, 639-65.

Karasu, T.B. 1986. The psychotherapies: Benefits and limitations. American Journal of Psychotherapy 40, 324-43.

Kelly, G.A. 1955. The Psychology of Personal Constructs. New York: Norton (reprinted by Routledge, 1991).

Metcalfe, C., Winter, D.A. & Viney, L.L. 2007. The effectiveness of personal construct psychotherapy in clinical practice: A systematic review and meta-analysis. Psychotherapy Research, in press.

National Institute for Health and Clinical Excellence 2005. Compilation Issue 10: Mental Health. www.nice.org.uk.

Neimeyer, G.J., Lee, J., Aksoy, G. & Phillip, D. 2006. Epistemic styles among seasoned psychotherapists: some practical implications. In J. Raskin & S. Bridges (Eds.), Studies in Meaning, Vol. 3. New York: Pace University Press.

Neimeyer, G.J. & Morton, R.J. 1997. Personal epistemologies and preferences for rationalist versus constructivist psychotherapies. Journal of Constructivist Psychology 10, 109-23.

Neimeyer, G.J., Prichard, S., Lyddon, W.J. & Sherrard, P.A.D. 1993. The role of epistemic style in counselling preference and orientation. Journal of Counselling and Development 71, 515-23.

Pilling, S. & Burbeck, R. 2007. Cognitive Behavioural Therapy and the Effective Treatment of Depression. Paper submitted to the IAPT Expert Reference group in support of the Department of Health submission to the Comprehensive Spending Review.

Roth, A. & Fonagy, P. 2005. What Works for Whom? A Critical Review of Psychotherapy Research. New York: Guilford.

Schacht, T.E. & Black, D.A. 1985. Epistemological commitments of behavioural and psychoanalytic therapists. Professional Psychology: Research and Practice 16, 316-323.

Sexton, T.L., Alexander, J.F. & Mease, A.L. 2004. Levels of evidence for the models and mechanisms of therapeutic change in family and couple therapy. In M.J. Lambert (Ed.), Bergin & Garfield's Handbook of Psychotherapy and Behaviour Change. New York: Wiley.

Shadish, W.R. & Baldwin, S.A. 2003. Meta-analysis of MFT interventions. *Journal of Marital and Family Therapy* 29, 547.

Stratton, P. 2005. Report on the Evidence Base of Systemic Family Therapy. Association for Family Therapy.

Slife, B.D. 2004. Theoretical challenges to therapy practice and research: the constraint of naturalism. In M.J. Lambert (Ed.), *Bergin & Garfield's Handbook of Psychotherapy and Behaviour Change* (pp. 44-83). New York: Wiley.

Vasco, A.B. 1994. Correlates of constructivism among Portuguese therapists. *Journal of Constructivist Psychology* 7, 1-16.

Viney, L.L. 1994. Sequences of emotional distress expressed by clients and acknowledged by therapists: Are they associated more with some therapists than others? *British Journal of Clinical Psychology*, 33 469-481.

Viney, L.L., Metcalfe, C. & Winter, D.A. 2005. The effectiveness of personal construct psychotherapy: A meta-analysis. In D.A. Winter & L.L. Viney (Eds.), *Personal Construct Psychotherapy: Advances in Theory, Practice and Research* (pp. 347-364). London: Whurr.

Wampold, B.E. 2001. *The Great Psychotherapy Debate: Models, Methods and Findings*. Mahwah, NJ: Erlbaum.

Winter, D.A., Metcalfe, C., & Grenyer, B. 2008. *Effective Psychotherapies: What Else Works for Whom?* Chichester: Wiley.

Winter, D.A. & Watson, S. 1999. Personal Construct Psychotherapy and the cognitive therapies: Different in theory but can they be differentiated in practice? *Journal of Constructivist Psychology* 12, 1-22.

Winter, D., Tschudi, F. & Gilbert, N. 2006. Psychotherapists' theoretical orientations as elaborative choices. In P. Caputi, H. Foster, & L.L. Viney (Eds.), *Personal Construct Psychology: New Ideas*, pp. 131-50. Chichester: Wiley.

Glossary of Therapies

Behaviour therapy is primarily concerned with the client's behaviour and with changing this.

Cognitive-behavioural therapy focuses on changing the client's cognitions (thoughts) as well as his/her behaviour.

Constructivist therapies are concerned with the way in which the client constructs (gives meaning to) his or her world and with facilitating reconstruction.

Group-analytic therapy focuses on analysis of processes in a therapy group consisting of a number of clients and one or two therapists.

Humanistic therapies encompass a range of approaches that view the client holistically and encourage personal growth.

Hypnotherapy employs hypnosis as a therapeutic technique.

Personal construct psychotherapy encourages the client to experiment with alternative constructions (interpretations) of the world.

Person-centred therapy is concerned with providing a therapeutic relationship that offers the client the necessary facilitative conditions for growth.

Psychodynamic psychotherapy is concerned with helping the client to become more aware of material, perhaps related to childhood experiences, that was previously 'unconscious', and with the provision of a reparative therapeutic relationship.

Rational-emotive therapy focuses on encouraging the client to think more rationally.

Systemic therapy focuses on the social context (e.g. family) within which problems occur rather than on individuals within this context.