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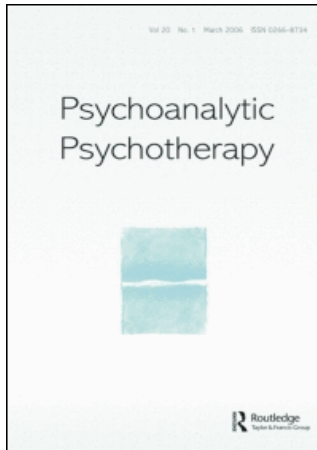
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### FROM BASE EVIDENCE THROUGH TO EVIDENCE BASE: A CONSIDERATION OF THE NICE GUIDELINES

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## FROM BASE EVIDENCE THROUGH TO EVIDENCE BASE: A CONSIDERATION OF THE NICE GUIDELINES

JONATHAN SMITH

*The author begins by noting the almost complete absence of any recommendation for Psychodynamic Psychotherapy whether Brief or Long-term in any of the Mental Health Guidelines published by the National Institute of Clinical Excellence [NICE]. He questions the scientific validity of this position, and suggests that it is the manifestation of a destructive or regressive swing within the organization that needs to be robustly confronted. He explores the historical routes of a psychodynamic approach to panic disorder and the evidence base, including Random Control Trials, which now exists and demonstrates its efficacy. He outlines the breadth of evidence that shows the efficacy, and effectiveness in the field of Psychodynamic Therapy for anxiety and depression and a broad range of other disorders and co-morbidities. He goes on to describe the problematic nature of the guidelines' categorizations of disorders for psychodynamic practitioners. He identifies ways in which their formulaic and schematic structure is likely to have a stifling and detrimental effect upon practitioner competencies whatever the modality in which they work. The author concludes with a case vignette that illustrates these themes.*

On thinking about an opening to this paper, I picked up a book by David Guttman on Psychoanalysis and Management, and searching through the pages for a passage that I had remembered reading some while ago, I stumbled across a statement that seemed to capture the essence of the process with which I was about to engage. He writes 'Knowing and understanding does not mean depreciating, but on the contrary, appreciating a little better what is a stake' (Guttman 2000: 125). In the passages which follow, and the critical appraisal of the National Institute of Clinical Excellence (NICE) guidelines that are contained within them, my aim is to draw the attention of psychodynamic

practitioners to what is now at stake within the NHS, and to reflect upon the need for an active and robust confrontation of a process that currently is in full swing.

That process is the development and adoption of Guidelines relating to Mental Health Care within the NHS. David Guttman (2000) suggests that within organizations transformation takes place in the form of a zigzag. It is not a straightforwardly linear process, but instead one that involves progressions and regressions, creativity and destruction. Regression involves a flight from reality and requires a firm confrontation when it emerges so that a creative progression can be restored. On the surface the NICE guidelines for anxiety (2004a), depression (2004b), post-traumatic stress disorder (2005) and eating disorders (2004c) appear to be rational, informed by reality, and a reflection of a carefully considered evidence base. However, in reviewing the guideline on depression Phil Richardson recently summarized his views by stating that 'The guideline is not presented with sufficient clarity, comprehensiveness or consistency for a proper scientific appraisal of the validity of its conclusions. ... serious questions arise about the adequacy of its methods of accumulation of relevant evidence'. He goes on to conclude that the guideline is 'premature, seriously misleading and unduly restrictive in its practical implications' (Richardson 2006: 5).

What is astounding is the almost complete absence of any reference to psychodynamic psychotherapy, whether long-term or brief, as a valid form of psychological treatment in any of these guidelines. The only exception to this seems to be a very brief reference to Focal Psychodynamic Therapy in the treatment of anorexia nervosa. Moreover the NICE guideline on Post-traumatic Stress Disorder (PTSD) after recommending trauma-focused Cognitive Behavioural Therapy (CBT) or Eye Movement Desensitisation Reprocessing (EMDR) specifically comments

When PTSD sufferers request other forms of psychological treatment (for example supportive therapy, non-directive therapy, hypnotherapy, *psychodynamic therapy* or systemic psychotherapy) *they should be informed that there is as yet no convincing evidence for a clinically important effect of these treatments on PTSD* (NICE Guideline on PTSD 2005: 19) (my italics).

The empirical evidence that Horowitz (1991) provides to support the Short-term Dynamic Therapy of Stress Response Syndromes and the results from a study of 112 people suffering from Post-traumatic Stress Disorder conducted by Brom *et al.* (1989) that confirmed the effectiveness of Brief Psychodynamic Psychotherapy, seems to have been completely missed in the reviewing of the evidence base for such a bald and essentially misleading statement. It is as if the whole field of psychodynamic practice has been virtually wiped off the map in each of the published guidelines. That something destructive and unscientific has happened in their formulation seems in itself to be evidenced by such an

omission, and by the absence of any engagement with the kind of reflective critique that Phil Richardson and others have articulated. It is with a view to elaborating this theme that I will now turn.

## PANIC ATTACKS AND A MOUNTAIN WALK

The NICE Guideline on Anxiety (panic disorder and generalized anxiety) merits particular attention in so far as the sole psychological therapy that is recommended as having an evidence base for this form of disorder is Cognitive Behavioural Therapy. Even counselling, as a generic term that can encompass psychodynamic therapies and which is included in the guideline on depression, is noticeable by its absence from the one on anxiety.

In the 1890s, at the very beginning of the scientific exploration of psychological distress, an 18-year-old woman set out on a walk on a mountain side with the intention of approaching a man whom she knew to be a doctor. Upon finding him she asked him whether he could help her. She told him that her 'nerves' were bad, and that she had previously sought assistance from her own doctor, but he had proved unable to alleviate her symptoms. She went on to describe how she experienced a sensation of being out of breath and a fear that she might suffocate. The doctor whom she had now approached asked her some more questions and she described how her head became heavy, a dreadful buzzing, she felt giddy as if she were about to fall over. She experienced a crushing sensation in her chest and her throat squeezed together as though she was going to choke. She felt frightened that she was going to die. The young woman was known as Katharina and the doctor she had approached on the mountainside was of course Freud. Now the symptoms that she describes would today be considered a panic attack and in all probability she would be referred to a CBT therapist who would, to put it simply, address the symptom itself, her fear that she was going to suffocate and die, and encourage her to challenge the irrational thoughts resulting in the onset of the anxiety.

The Cognitive theory of Panic ... states that individuals who experience panic attacks do so because they have a tendency to interpret bodily sensations in a catastrophic fashion ... perceiving a slight feeling of breathlessness as evidence that they are going to choke to death (Scott *et al.* 1995: 71).

Freud however took a different, psychodynamic angle, and asked her questions that were intended to explore the meaning of the anxiety as well as the affect that lay behind the symptom (Parker 2006). It emerged that the onset of the symptoms coincided with her father's attempt to seduce her and the break-up of her parents' marriage (the full details only appear in a footnote that Freud added in 1925 clarifying that he had disguised the original account). As a result of this brief consultation Freud describes her as being 'like someone transformed' and

that the sulky unhappy face had 'grown lively, her eyes were bright, she was lightened and exalted' (Breuer and Freud 1895: 131).

A contemporary example elaborates upon this theme. Kirstin aged 40 years, was referred to the practice counsellor by her GP because she had become frightened that she could not breathe comfortably. She had presented to the Accident and Emergency Department of her local hospital a few days earlier where she was reassured that there was no physiological basis for her condition and that she had experienced a panic attack. However, she continued to be troubled by her symptoms and this resulted in the referral to the counsellor. In the first session she quickly linked the onset of the panic attack with the experience of one of her male colleagues at work making unwanted explicit sexual innuendoes, specifically directed towards her. She had reported the incident to a manager who had initiated disciplinary proceedings against the colleague. Kirstin went on to describe how a year earlier she had been raped, and was able to connect to the distress and rage that she felt in relation to this violation. The following session she described feeling much better, and that the symptoms of panic had subsided appreciably, but then reported how she had been troubled by a female colleague who had seemed to dismiss the significance of the incident involving the male colleague who had made sexual innuendoes. Kirstin seemed surprised at how strongly aggrieved she felt about this and acknowledged that she also experienced some anxiety that the counsellor would be similarly dismissive. With some encouragement from the counsellor she thought further and realized that this experience of being painfully dismissed was a very familiar one. She then recounted how her parents had separated when she was five years old and that she had had no contact with her father after this, although she recalled loving him. Later when aged 10 years, her maternal uncle who lived with her mother repeatedly sexually abused her. When she told her mother about this, her account was dismissed, her mother maintaining that it was Kirstin who had 'made eyes' at her uncle and who had thus, in her mother's view, initiated the sexual contact. Linking this narrative together to give it shape and coherence, as well as meaning to the intense feelings that were evoked, made a significant contribution to lessening Kirstin's anxiety in this brief piece of psychodynamic work.

Both examples, spanning a period of over 100 years, indicate the therapeutic potency of a psychodynamic approach to the treatment of panic attacks. They suggest that an approach such as CBT that identifies the symptom itself and the thoughts directly related to it as the target of change, may miss much deeper themes and conflicts that are likely to continue to fester and trouble the patient.

## RESEARCHING ANXIETY AND OTHER DISORDERS

In their meta-analysis, entitled 'The efficacy of short-term psychodynamic psychotherapy (STPP) in specific psychiatric disorders', Leichsenring *et al.*

(2004) concluded that 'Short-term psychodynamic psychotherapy yielded significant and large pretreatment-post-treatment effect sizes for target problems (1.39), general psychiatric symptoms (0.90) and social functioning (0.80)' and that therefore 'Short-term psychodynamic psychotherapy proved to be an effective treatment in psychiatric disorders' (Leichsenring *et al.* 2004: 1208). They go on to point out that at the time of writing their paper for both panic disorder and agoraphobia the only Random Control Trials that existed for STPP were where it was combined with drug treatment. They note their surprise at this 'as anxiety is one of the central concepts of psychoanalytic and psychodynamic theory and therapy' (Leichsenring *et al.* 2004: 1214). Indeed, one of Freud's seminal papers is entitled Inhibitions, symptoms and anxiety (1926) and is specifically devoted to this topic. Similarly, Melanie Klein's (1946) conceptual framework elaborated around the paranoid-schizoid and depressive positions affords a detailed and profound exploration of primitive anxieties.

David Malan's equally seminal research described in the two books *The Frontier of Brief Psychotherapy* (1976a) and *Towards the Validation of Dynamic Psychotherapy: A Replication* (1976b) is the detailed study of 30 cases. Of these, 14 involve the patients suffering from some form of anxiety. Five of these cases of anxiety improved slightly/moderately. Seven were improved or much improved and one deteriorated. One case was judged to have completely recovered. These are significant results. There are none the less acknowledged methodological difficulties with this study. The design did not include control groups and the measures were based upon therapist notes rather than audio tapes or transcripts of therapy sessions which limit the conclusions that can be drawn from them (Messer and Warren 1995). However 'William Piper and his colleagues have conducted two extensive methodologically sophisticated studies of Malan's brief therapy which support its efficacy' (Messer and Warren 1995: 99). In the second of these, Piper *et al.* (1990) studied 105 psychiatric outpatients with DSM III Axis I diagnoses comprising affective, adjustment, anxiety and impulse control disorders. One-third of the sample also received Axis II (personality disorder) diagnoses. The treated group was significantly more improved than the control group in 10 out of 15 measures. Effect sizes indicated that the average treated patients exceeded 78% of the control patients on a combined outcome measure. The research of Piper *et al.* (1990) supports Malan's findings in relation to psychiatric disorders in general rather than specifically in relation to anxiety, but the implication for the efficacy of Brief Psychodynamic Therapy for anxiety is clearly positive.

There can be little doubt that CBT has been quick off the mark in researching its form of therapy, but as has already been noted the conclusions that NICE have drawn from this research has been far too premature. As Phil Richardson comments 'Where one therapy appears to have an advantage over others in terms of empirical research this is usually because the others have failed to accumulate the relevant evidence' (2006: 5).

In the USA, Canada, Norway and Germany research of Short-term Psychodynamic Therapy in particular has been taking place for some time. Holm-Hadulla *et al.* (1997) at the University of Heidelberg studied the effectiveness of psychoanalytic-founded brief and dynamic psychotherapy, in a naturalistic longitudinal study. A total of 117 patients were compared with 116 people who were untreated. The effective magnitude of change was high, such that the authors were able to conclude 'Analytically orientated short-term psychotherapy and dynamic therapy are effective in the treatment of many dysthymic and anxiety disorders as well as in the treatment of personality disorders'. In New York Hilsenroth *et al.* (2003) at the Derner Institute of Psychological Studies conducted a study of Short-term Psychodynamic Psychotherapy for depression. Twenty-one patients were involved in the study, and were assessed pre- and post-treatment through clinical ratings. Once again the authors were able to note large statistical effects demonstrating improvements in depression.

In Norway Svartberg *et al.* (2004) conducted a randomized control trial of the effectiveness of Short-term Dynamic Psychotherapy and Cognitive Therapy for Cluster C personality disorders, and were able to conclude that both treatments have a place in the treatment of patients with these personality disorders. At follow-up two years after treatment, 54% of the Short-term Dynamic Psychotherapy patients and 42% of the Cognitive Therapy patients had recovered symptomatically. In the Dusseldorf Short-term Dynamic Psychotherapy Project studied by Junkert-Tress *et al.* (1999) the authors were able to conclude 'our form of focal therapy is well suited not only for neuroses but also for psychosomatic disorders and personality disorders'.

In Canada Abbass (2002) studied 89 patients of whom 52% had personality disorders, 43% had major depression, 37% had somatoform disorder, 29% had panic disorder and 21% had dysthymic disorder. Moreover this group of patients was considered 'a treatment resistant group, since 83% had had previous psychotherapy and nearly half had tried psychopharmacological interventions but without clear benefit' (Malan and Della Selva 2006: 38). Each patient was offered intensive Short-term Dynamic Psychotherapy for an average length of 15 sessions. Abbass (2002) was able to conclude 'Patient symptoms as measured by four well-established self-report measures decreased significantly from pathological levels pre-therapy to within normal ranges post-therapy' (2002: 230). Of further note is the fact that 22 of the sample of patients were unemployed, and of these 18 had returned to work within 9 weeks of treatment. This is a meaningful finding in view of the Layard proposals to provide psychological therapies to assist people to return to work, and where once again the only therapy to be recommended is CBT.

NICE are also increasingly focusing their attention on evidence of cost-effectiveness in relation to each form of therapy. Measures of cost-effectiveness were included in the design of the Abbass study. He was able to comment 'Data

gathered from prescription administration, disability insurance costs, and hospital and physician costs, suggest an overall cost reduction for these 89 patients to the system of approximately \$402 523 over the twelve-month period after therapy' (Abbass 2002: 230). This amounted to three times the cost of the psychotherapy. In England, Guthrie *et al.* (1999) studied the cost-effectiveness of Brief Psychodynamic-Interpersonal Therapy in high utilizers of psychiatric services in a random control trial involving 110 patients. The researchers enrolled patients with non-psychotic disorders unresponsive to 6 months of routine specialist mental health treatment. Intervention patients received 8 weekly sessions of psychodynamic-interpersonal psychotherapy. Control patients received care as usual from their psychiatrist. Guthrie *et al.* (1999) commented

The findings demonstrate that brief PI therapy for patients who are high utilizers of psychiatric services results in significant improvement in their psychological status and a substantial reduction in health care utilisation and health care costs in the six months following treatment. Costs associated with both primary and secondary care were significantly reduced in the follow-up period. The additional costs of psychotherapy during the intervention phase were offset by this reduction after treatment ( *et al.* 1999: 524).

In reviewing the research literature Abbass has reported that there exist '49 published controlled STDP (Short-term Dynamic Psychotherapy) trials supporting efficacy with a range of conditions including personality disorders, substance dependence, depression and panic disorder' (Malan and Della Selva 2006: 38). In another recent review of the empirical data for both short and long-term Psychoanalytic Psychotherapy, Leichsenring identified 22 random control trials that support the efficacy of Psychodynamic Psychotherapy. He identified four RCTs that support its efficacy for depression, 1 for anxiety disorder, 1 for post-traumatic stress disorder, 4 for somatoform disorder, 3 for bulimia nervosa, 2 for anorexia nervosa, 2 for personality disorder, 1 for cluster C personality disorder, and 4 for substance-related disorders. He also concludes 'With regard to psychoanalytic therapy, controlled quasi-experimental effectiveness studies provide evidence that psychoanalytic therapy is (1) more effective than no treatment or treatment as usual, and (2) more effective than shorter forms of psychodynamic therapy' (Leichsenring 2005: 841). Leichsenring *et al.* have also reported the first results of the Gottingen naturalistic study of longer-term psychoanalytic therapy. Thirty-six patients were included in the study of whom a sample of 23 patients have been rated at 1 year follow-up. The self-reported improvements in symptoms were corroborated by the ratings of the psychoanalysts. 'At the end of therapy 77% of patients showed clinically significant improvements. In the 1-year follow-up group this was true for 80%' (Leichsenring *et al.* 2005: 433).

Barbara Milrod *et al.* (2007) have recently published a paper on some further very significant research on panic disorder. They have conducted a randomized control trial of Panic-focused Psychoanalytic Psychotherapy. Patients were offered 24 sessions of therapy spread over 12 weeks. The control group of patients received Applied Relaxation Training, a manualized behavioural psychotherapy that is related to but less elaborate than CBT, and that utilized progressive muscle relaxation techniques and exposure. Patients with co-morbid major depression, personality disorder and severe agoraphobia were included in the study, making it more representative of panic disorder described in the epidemiological literature. Commenting upon the comparative efficacy of the two treatments the researchers were able to conclude 'PFPP (Panic-focused Psychoanalytic Psychotherapy) showed significantly superior reduction in severity of a broad range of panic symptoms ...'. It yielded 'significantly greater reduction in functional impairment ... and a trend toward greater reduction in HDRS depressive symptoms' (2007: 4).

Interestingly the study noted that the PFPP group had a low drop out rate of 7% compared to the ART groups' rate of 34%. The authors note in comparison that in the Multicentre Panic Disorder Study (Barlow *et al.* 2000) the drop-out rate for CBT alone was 27% and was 28% for CBT with imipramine. The authors go on to comment

The low PFPP attrition rate may reflect the relatively flexible approach of psychodynamic psychotherapy, which can be accommodated to a more generalisable sample of PD patients with a wide variety of co-morbidities within the constraints of a manualised treatment, as it is based on an approach not limited to specific psychiatric symptoms (Milrod *et al.* 2007: 6).

Phil Richardson (2006) draws attention to another piece of research by Leff *et al.* (2000) in which a clinically representative patient sample of patients suffering from moderate to severe clinical depression was studied. The study was unable to maintain the CBT strand because of the high drop-out level which was associated with the therapists' observation that the patients were atypical, meaning that there were significant co-morbidities. Clinically representative samples are, as Milrod *et al.* (2007) have noted in relation to panic disorder, likely to include substantial co-morbidities. The low drop-out rate for PFPP and the comparatively high drop-out rates for CBT in studies of both PD and depression together suggest that psychoanalytic psychotherapy may be a particularly well suited therapeutic modality for clinically representative samples of patients with co-morbidities. That is, psychoanalytic psychotherapy may prove to be particularly effective when tested in the field.

This implication will need further research in the form of naturalistic studies to establish its validity, but it none the less raises the important issue of the

external validity of the random control trial research that has been conducted on CBT and upon which NICE have largely based its current recommendations. Leichsenring (2004) has recently reviewed the relationship between random control trials and psychotherapy conducted in the field and concluded that it is simply not possible to transfer evidence unequivocally from random control trials to the field. He suggests that there is consequently a need to conduct research in naturalistic settings, a point that further underlines the premature nature of the NICE recommendations, as well as indicating one route that needs to be taken in steering the recommendations of the NICE guidelines back onto a plausible scientific and rational basis.

In the introduction to their new book Malan and Della Selva (2006) make a case for the importance of single case  $N=1$  research studies and for placing this form of research on a par with that of random control trials, by those developing policies in Mental Health. They point out, in quoting a recent paper by Foxall (2000) that the USA National Institute of Mental Health (NIMH) has 're-written nearly all its funding announcements to reflect the change in priority from large scale trials in controlled settings, to research designed to study large numbers of diverse patients in real-world settings' (Malan and Della Selva 2006: 8). There is thus an explicitly articulated realization in the USA that establishing an evidence base for particular therapeutic modalities is a significantly more subtle, elaborate and complex task than has hitherto been acknowledged here in the UK by NICE.

## LONG-TERM RESEARCH

The NICE guidelines on both depression and anxiety introduce a note of caution in relation to their recommendations which needs to be noted in the light of some further recent research. The guideline on depression is the most explicit in this respect. The authors write

there are some significant limitations to the current evidence base, which have considerable implications for this guideline. These include very limited data on both long-term outcomes for most, if not all, interventions, and outcomes generally for the type of severe depression that often presents major challenges in secondary care mental health services. In part these limitations arise from problems associated with the random control trial methodology for all interventions, but particularly for psychological and service interventions (NICE 2004b: 8).

This is a very important qualification to the recommendations but one that does not appear to have been as widely publicized as the overall recommendation of CBT for depression for both mild to moderate and severe depression. The guideline on anxiety makes the rather terse statement that 'Long-term follow-up studies for all therapies are also needed' (NICE 2004b: 35). Although less clearly

elaborated than the guideline on depression its implications can be considered to be essentially similar.

A recently published random control trial by Durham *et al.* (2005) explored the long-term outcome of CBT in Scotland. Significantly, in view of the statements from the NICE guidelines quoted above, this is a piece of research which has been commissioned by the NHS R&D Health Technology Assessment (HTA) Programme. 'The HTA Programme commissions research only on topics where it has identified key gaps in the evidence needed by the NHS' (Durham *et al.* 2005: 2). The key objective of this study, that is relevant to the discussion here, is to determine the long-term outcome of participants in clinical trials of Cognitive Behaviour Therapy for anxiety disorders and psychosis. The study aimed to contact and interview all of the participants in eight randomized control trials of CBT for anxiety disorders and two randomized control trials of CBT for schizophrenia conducted between 1985 and 2001. The anxiety disorder trials were conducted mainly in Primary Care and included three with generalized anxiety disorder, four with panic disorder and one with post-traumatic stress disorder. Focusing here upon the RCTs for anxiety disorder the study found that at long-term follow-up only 18% of patients had none or only mild symptoms and a significant proportion had sub-threshold symptoms of at least moderate severity. Only 36% of patients reported receiving no interim treatment for anxiety over the duration of the follow-up period and 19% had received almost constant treatment during this time. The authors also note that patients with post-traumatic stress disorder did particularly poorly, a point that of course has particular relevance to the NICE guideline on PTSD where CBT is one of only two modalities for which it is claimed there is an evidence base for its efficacy.

It may also be worth pausing here to compare the evidence of this long-term outcome study of random control trials for CBT with the long-term follow-ups that Malan and Della Selva (2006) included in the design of the four individual case studies that appear in their recent book on Brief Dynamic Psychotherapy. Each patient was interviewed at follow-up. In one case this was 18 months after the original treatment had ended. In another case the follow-up took place 7 years after termination. In the two remaining cases there were a number of follow-ups at 1, 2 and 10 years and 2, 8 and 10 years after termination. In each case the authors provide substantial and convincing evidence that demonstrates the long-term effectiveness of the therapy and that the gains reported at termination had been sustained over a substantial period. As a significant and carefully crafted piece of  $N=1$  qualitative research it warrants incorporation into the overall body of accumulated evidence that demonstrates the effectiveness of psychodynamic psychotherapy (Malan and Della Selva 2006) and presentation for consideration by NICE. Although it is small in scale it is a sophisticated and incisive piece of qualitative research.

## NICE AND CATEGORIES THAT ARE EMPTY OF PSYCHODYNAMIC MEANING

It has already been noted that Psychodynamic Psychotherapy is inherently flexible in its approach to mental health problems in so far as it is based on an approach that is not limited to specific symptoms (Milrod 2007). In this respect it contrasts markedly with CBT, which by its very nature aims to address specific symptoms very directly. The NICE guidelines, rather like DSM manuals used in psychiatry, divide psychological problems into a number of categories based around specific symptoms, generalized anxiety, depression, PTSD, eating disorders, etc. Now these categories fit in well with CBT and a method that focuses intrinsically upon symptoms, but there is something inherently problematic about these categories for psychodynamic practitioners.

It makes sense to the CBT practitioner to formulate an assessment on the basis of the patient's symptom, and to adjust the therapy accordingly because CBT is essentially geared to specific symptoms. However, the same is generally not true for psychodynamic practitioners when they engage in the process of assessing the suitability of a patient for psychodynamic psychotherapy. Even the Panic-focused Psychoanalytic Therapy that Milrod *et al.* (2007) have manualized for their research emphasizes the flexibility of the approach, and one that transcends the specific symptom of panic disorder.

In their sophisticated process research of the transference in which independent judges identified patterns in the transcripts of taped therapy sessions, known as the Core Conflict Relationship Theme, Luborsky and Crits-Christoph (1990) make the following statement. They write 'The DSM diagnoses by themselves are empty of content about the patient's psychodynamics. ... These diagnoses lack information about the patient's typical relationship patterns and the conflicts within them' (1990: 215). The emptiness of content about the patient's psychodynamics is equally true of the NICE categorizations. This is of course not to deny that both DSM diagnoses and NICE categorizations have useful contributions to make in the treatment of various disorders, and in identifying those patients who may need specialist care, but to point out their very real and problematic limitations for psychodynamic practitioners.

If we examine the assessment criteria for Brief Dynamic Therapy, based upon years of clinical practice as well as research, we find that the categories mentioned by NICE simply do not appear. The question of whether a patient is suffering from generalized anxiety, panic disorder, phobias, depression, etc. is generally not included in these assessment criteria. Malan for example quite simply identifies focality and motivation as key factors in assessing a patient's suitability for Brief Dynamic Therapy. Two other criteria mentioned are whether the patient has responded to interpretations relevant to the focus, and whether the possible dangers of giving interpretative Brief Therapy have been considered and they can be either discounted or foreseen and overcome (Malan

and Osimo 1992). Similarly, the Dynamic Relational Model of the Vanderbilt school identifies five criteria for suitability. These are emotional discomfort, basic trust and hope for relief from distress through talking about his or her life, a willingness to consider conflicts in interpersonal terms, a willingness to examine feelings, and a capacity to relate to the therapist in a meaningful way (Levenson 1995). Whether the patient is suffering panic disorder or depression, for example, is simply not an issue for consideration.

What may also be included in the assessment criteria and can influence the way in which the therapy is conducted is the quality of the patient's object relationships. In a fascinating and sophisticated outcome study conducted by Piper *et al.* (2002), the authors distinguished two forms of Brief Dynamic Therapy, Interpretative and Supportive. Each patient's QOR (quality of object relationships) and psychological mindedness were carefully assessed using specifically designed methods. Amongst their findings they discovered that those patients with poor QOR were most effectively helped by a dynamically Supportive Model of Therapy while those patients whose QOR was good were more effectively helped by an Interpretative Model. In both cases, however, the question of diagnosis in terms of DSM categorization was not considered to be a relevant or necessary feature, and was not therefore included in the research design.

The implications of these reflections and research findings is that the NICE guidelines by the very way in which they are divided into diagnostic categorizations based upon specific symptoms, skew the questions which the practitioner is required to ask himself about the patient's condition in a way that is compatible with CBT but essentially irrelevant to the psychodynamic practitioner. Thus, faced with a patient who presents with panic attacks, the psychodynamic practitioner may be enjoined to explore the quality of the patient's object relationships or other factors such as whether it is possible to identify a focus. However, the symptom itself is simply not an issue. The practitioner's manager, guided by the NICE guidelines, may indeed think otherwise so that the very nature of the guidelines is presenting psychodynamic practitioners with real difficulties in the field, whether this is Primary or Secondary care.

It is only recently that researchers of psychodynamic psychotherapy have begun to generate research designs that focus upon specific symptoms or diagnostic categories. The fact that these diagnostic categories are empty of psychodynamic content may help to explain how this situation has come to pass. It is the political realities prompted by the appearance of the NICE guidelines that have required psychodynamic practitioners to re-orientate their research to take account of specific symptomatology. This has placed psychodynamic practitioners at an inherent disadvantage compared to CBT. For in the case of the latter, research designs focused upon diagnostic categories make sense therapeutically and can therefore inform therapeutic practice. For

psychodynamic practitioners this is not intrinsically the case. It should come as no surprise then that CBT has had a significant, inherent and iniquitable advantage in accumulating research linked to the specific categories of the NICE guidelines.

## CBT AND ECLECTICISM

It is evident that in some parts of the country in several Primary Care or Mental Health Trusts considerable pressure is being placed upon qualified psychodynamic practitioners to train in CBT and to offer it as a discrete modality to certain patients, principally those diagnosed as suffering from panic disorder or generalized anxiety. The rationale that is given for this is that psychodynamic practitioners need to train in CBT in order to practice according to the evidence base as reflected in the NICE guidelines and therefore what is deemed to be best practice. The evidence base for this supposition is highly questionable and not only because of the limitations to the evidence base already described.

There are certain inherent problems in an eclectic approach to therapeutic work that involves switching modalities. A number of writers have pointed out that Psychodynamic Therapy and CBT start from different philosophical as well as technical assumptions (Bloom 1992, Messer and Warren 1995, Milton 2001). As Milton notes some psychodynamic practitioners are more comfortable with establishing some conceptual rapprochement between the two approaches than others. She herself doubts the possibility of a true rapprochement between them. For those psychodynamic practitioners, and there are many, who share her position then such a switch of modalities is highly problematic. Indeed it is likely to have a damaging effect upon the practitioners' work as they struggle to encompass an approach that simply does not fit the technical and philosophical assumptions upon which they have hitherto functioned as therapists. This is likely in itself to lead to poor practice, a low level of therapeutic competence, and an undermining of the practitioner's confidence in their work.

Even where a practitioner feels comfortable that they can make such a rapprochement between the two approaches, it may not be in the interests of best practice to try to develop an eclectic approach that attempts to match a patient's symptom to a specific and discrete therapeutic modality. In a review of the efficacy and effectiveness of psychotherapy Lambert and Ogles (2004: 167) conclude that two decades of manually guided psychotherapy process and outcome research 'have not produced support for more superior treatment or sets of techniques for specific disorders'. They go on to write 'Little evidence supports the notion that specific techniques make a substantial contribution to treatment effects' (Lambert and Ogles 2004: 176). In citing this review Jeffrey Binder suggests two reasons for their conclusions. First, he makes a similar point to Phil Richardson in suggesting that 'most patients desire help for a mix of symptomatic, interpersonal, and environmental difficulties that defies the

circumscribed diagnoses used to generate outcome criteria in controlled studies' (Binder 2004: 6). Second, he cites a piece of innovative research by Luborsky *et al.* (1997) that compiled data from therapists who had treated sufficient numbers of patients in research studies for the researchers to be able to use each therapist's caseload as a unit of measure, so that therapists' caseloads could be compared for relative treatment effectiveness. The research demonstrated significant differences in therapeutic effectiveness across therapists. Jeffrey Binder concludes from this that 'what needs to be identified are not empirically supported treatments but empirically supported psychotherapists' (Binder 2004: 6). In other words, what needs to be identified are the key determinants of therapeutic competence, whatever the modality in which one is working.

One factor in therapeutic effectiveness that Wampold (2001) identified in an overview of research on this topic is the allegiance that the therapist has to their own approach. Where the therapist believes enthusiastically that their treatment approach is efficacious, this is likely to be communicated to the client. This in turn contributes to therapeutic effectiveness. In the USA, Blatt *et al.* (1996) studied the efficacy of individual therapists in the Treatment of Depression Collaborative Research Programme. In reviewing this piece of research Charman comments, 'Significantly the two most efficacious therapists ... were providing treatment consistent with their preferred mode of working' (Charman 2004: 5).

These points have relevance to the specific context of the NICE guidelines. Take the hypothetical case of a skilled and competent psychodynamic practitioner, who has recently been required to undertake a CBT training, whose patient is suffering from a panic disorder. On the basis of the practitioner's avowed competencies, the research evidence would support the practitioner working psychodynamically with this patient, rather than switching to CBT in which he will have had a more recent and in all probability far less developed training, in which he is likely to be significantly less competent, and towards which he is also likely to have a lower level of allegiance and enthusiasm. Yet in many services managers would cite the NICE guidelines as a reason for switching to CBT, completely by-passing the evidence base relating to the question of individual therapist's competencies and preferred modality.

Jeffery Binder suggests that the key factor in therapist competence is not simply the ability to employ prescribed techniques. 'What is required are complex interpersonal skills deployed under the guidance of very sophisticated mental activities. The use of techniques associated with a particular model of treatment or with an eclectic strategy is not synonymous with competent (or expert) performance' (Binder 2004: 8). He identifies the capacity to respond *flexibly* and to be able to *improvise* as key determinants of therapeutic competency. This capacity to work flexibly may be one that operates within one specific modality or may include more than one modality depending upon the individual practitioner.

It can be further noted that the formulaic nature of the NICE guidelines, which try to link specific diagnoses to specific treatment modalities, is likely to result in a stifling of therapeutic flexibility and improvisation, that is, of the very qualities upon which therapeutic competence may be considered to rest. This point has been highlighted by Gustafson and Meyer (2004). They give an example of the case of a patient with panic disorder who was on the edge of a relapse into alcoholism. It illustrates how the patient's anxiety was contained by a combination of medication, psychodynamic psychotherapy and what they describe as socio-therapy, that is the support that the patient received from Alcoholics Anonymous, which reduced the danger of the patient pushing himself too far at work, which otherwise would have resulted in a catastrophic relapse. This is an example of the very flexibility and improvisation in technique which Binder considers to be at the heart of therapeutic competence. Significantly Gustafson and Meyer conclude

We want to distinguish ourselves from the dominant paradigm of American psychiatry, which makes a fiat out of its standard treatment of panic disorder, and of all other disorders. Regarding panic disorder, it says that the treatment is an SSRI, plus behaviour therapy (exposure therapy) for the agoraphobia that is often a sequel to the panic disorder. It backs this up with large studies, and statistics, and horse races between different models. Our paper is a kind of thought experiment for a different set of possibilities (2004: 488).

The following vignette is another illustration of a flexible improvisation in which there was an integration of a fundamentally psychodynamic approach with some CBT-derived techniques, in the work with a young woman experiencing generalized anxiety. It is worth noting that as in the case of the therapeutic work described by Gustafson and Meyer (2004) there is no specific evidence base for such an improvised approach. On the contrary according to the prescriptions of the NICE guidelines she should simply have been offered CBT.

### **Sinead**

Sinead was referred for counselling by her GP because she was experiencing acute anxiety. She had become agoraphobic, feeling largely unable to venture out of her home without the presence of someone she trusted. She had not travelled on the tube for over 2 years. She arrived for her first appointment accompanied by her boyfriend who waited in the reception of the surgery while she had her session. Her self-esteem was very low. She had stopped work in a shoe shop about 2 years earlier and dropped plans to go to university to study science. She was 20 years old at the time of the referral. She had two older sisters one of whom was 9 years older and lived with Sinead, the other was 11

years older and lived separately in her own flat nearby. An older brother had migrated to Ireland. Sinead's father had died when she was a baby and her mother had died when she was 18 years old. When she was 12 years old she had developed a severe and disfiguring condition which principally affected her face. This had been a very difficult experience for her and for about a month she had remained at home until she recovered. It was another two months before she returned to school, and when she did so she described being treated insensitively by her teachers. She had been performing well in her studies but now found herself placed in the bottom class at school. She lost confidence in her academic abilities and was also feeling very self-conscious in case other people noticed her face, and thought that she was 'deformed'. She felt particularly anxious about travelling to school by bus but her mother was supportive and encouraged her to continue going out to meet people, so that eventually her anxieties subsided.

It was following her mother's death that Sinead became acutely anxious again. Her anxiety started some weeks after her mother's death when she was travelling on a bus to visit her elder sister. A man was standing in the way of her exit from the bus. She began to panic, and became increasingly fearful that other people were looking at her and thinking that she was a 'freak'. She remained panic-stricken until she reached the bus terminal, where she phoned her elder sister, who came to collect her.

The work in the eight sessions which followed focused upon her need to regain a sense of confidence in herself and her capacity to engage once again in the adult world. Sinead quite quickly saw the pattern that connected the onset of her current anxieties, to the death of her mother, and to the earlier disfiguring condition affecting her face in her early adolescence. She began to connect to feelings of sadness and anger as well as guilt in having these feelings, in relation to her mother's death. She also responded well to interpretations that were made in relation to anxieties that were emerging in the transference, that I as her counsellor would think that 'something was wrong with her', and would fail to notice her capabilities, just as her teachers had done. These interpretive interventions resulted in quite significant reductions in the levels of her anxiety.

Alongside these interpretative features of the therapy I also included some supportive ones directly intended to enable her to regain her ego-strengths and her capacity to draw upon the support of her sisters and boyfriend who were clearly concerned about her and willing to help her. In this flexible approach I drew from skills I had acquired in CBT that I felt could be integrated within the psychodynamic framework of the therapeutic work with Sinead.

Sinead requested some direct assistance with travelling on public transport. We explored how she might begin to do this in a way that would not provoke too much anxiety for her, with the aim of gradually exposing her to the feared situations in the outside world, in between her counselling sessions. It was important for Sinead that as she began to explore further afield we consider ways in which she could keep a connection to others and to her sense of the security,

the secure base which they provided for her. I was aware that in working with her in this deliberately supportive ego-strengthening way that, through the transference, I was facilitating Sinead's more secure re-connection to her internalized maternal good object. Her mother had both provided her with an overall sense of security, as well as encouraging her to face the world and engage with it after Sinead had originally lost confidence in doing so after her illness in her early adolescence.

From the third session she travelled to the counselling sessions unaccompanied. We noted how it helped her to feel less anxious about travelling on her own if she had a friend or relative waiting for her at the other end of the journey, available for her to contact by mobile phone if she felt anxious. She was soon travelling to meet friends for coffee and then reported that she had been able to travel on the tube for the first time in 2 years accompanied on this first occasion by her boyfriend. Her confidence grew appreciably and she seemed to be responding well to the particular balance of interpretative and supportive features in the therapy and to the flexible integration of some CBT techniques within an overall psychodynamic framework.

After the ninth session I received a letter from Sinead. She explained that she had started a new job and was travelling to work each day by public transport. She thanked me for the help that she had received through the counselling sessions but explained that she would be unable to come to any more of them due to her new work commitments. I was aware that this seemed possibly a defensive flight into health, and one that avoided facing the loss of her counselling sessions with me. However 6 months later her GP commented that there had been a 'complete transformation from earlier in the year' and although there were subsequent difficulties when she lost her job, overall she was able to sustain the restoration of her self-confidence and the reduction in her anxiety and a further 12 months later her GP reported that she was continuing to travel by public transport, was working again, and was not requesting or requiring any medication for anxiety.

## CONCLUSION

The NICE guidelines as presently formulated are in each case based upon an essentially misleading interpretation of the overall evidence, and at the very least are grossly premature in their conclusions. There is no scientific or rational basis to the repeated absence of psychodynamic psychotherapy both brief and long-term from their recommendations as an effective form of evidenced-based treatment. It is contended that the diagnostic categorizations into which the NICE guidelines are divided have created an inherent bias towards CBT and are likely to promote an inflexibility of approach to mental health problems which can only be counterproductive to the development of competent practitioners whatever their modality. Larry Hirschhorn has written

People psychologically injure one another because they are unable to mobilise aggression at the boundary of the role, task or organization. By retreating from the boundary and enacting a psychological fantasy they wind up chronically discounting and hurting one another. They replace the focused and task-appropriate mobilisation of aggression with the diffuse and displaced expression of hostility and discontent (Hirschhorn 1990: 36).

It is suggested here that within the NICE guidelines there is a current fantasy, namely that their recommendations are rationally based upon sound scientific evidence. The destructive implications of this fantasy require a robust and appropriately aggressive confrontation if psychodynamic practitioners as well as their CBT colleagues are not to be caught up in psychologically damaging exchanges. The APP together with the British Psychoanalytic Council and the Tavistock Clinic have embarked together to work on a rational presentation of the relevant evidence. The particular strategy and the tactics require further elaboration, but the need for such an engagement cannot be doubted.

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JONATHAN SMITH

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