Psychological Medicine (2010), **40**, 1055–1056.

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Psychological Medicine, **40** (2010).
doi:10.1017/S0033291710000243
First published online 17 February 2010

Letter to the Editor

An agenda for the next decade of psychotherapy research and practice

Lynch *et al*. (2010) provide a fascinating meta-analysis showing that when cognitive behavioural therapy (CBT) is compared with a psychotherapy or pill placebo control group, CBT is no more effective in reducing symptoms of schizophrenia or bipolar disorder than other approaches, and is only slightly better at improving depression. This finding stands in stark contrast to the large literature that shows that CBT is effective when compared with waiting-list controls (e.g. Roth & Fonagy, 2005). Rather, the finding is consistent with a now overwhelming body of evidence suggesting that all the main established psychotherapies are equivalently effective (e.g. Luborsky *et al*. 1975; Wampold *et al*. 1997; Ward *et al*. 2000). Whilst CBT works, it does not appear to work better than other approaches. We suggest that the research focus should now move from establishing the effectiveness of any one technique, towards studying what common mechanisms underlie all therapeutic contact. Similarly, we suggest that practitioners should now decide what therapy to practise on grounds other than simple efficacy.

Component isolation studies do not support the argument that CBT operates through the theoretically expected mechanisms. These studies involve two therapy groups that are identical in all ways, except that one group has had the theoretically 'active' component removed. A recent meta-analysis (Ahn & Wampold, 2001) showed that removing the theoretically 'active' component had no effect on the effectiveness of the therapies. Further, the data trended towards suggesting that the group without the theoretically active component was actually more effective (an effect in the opposite direction).

Component isolation studies coupled with evidence of equivalence between psychotherapies suggest that all therapies operate through the same common mechanisms. Counselling psychology has long suggested this is the case, proposing mechanisms such as the quality of the therapeutic relationship (Rogers, 1957), whilst others have focused on the process of engaging in psychotherapy (Wampold, 2007), or the cognitive changes associated with all therapeutic change (Higginson *et al*. in press). Lynch, *et al*.'s (2010) study suggests that future research would be better advised to focus on empirically establishing the mechanisms by which all therapies work.

Unfortunately, with increasing evidence that CBT is not more effective than other therapies, the CBT movement appears to be in some crisis, and to be responding not with an increased focus on mechanisms, but rather by spawning endless 'third-wave' CBT approaches. These have not been shown to be superior to what is currently available, largely as they are not being compared with other existing therapies. Indeed, some third-wave approaches (see Mansell, 2008) appear to bear little resemblance to CBT as originally conceived. Perhaps in diversifying the practice of CBT in the search of superior efficacy, we are witnessing the dissolution of the 'brand image', and the shift to an approach that cannot be distinguished from counselling psychology. We certainly hope that attitudes within the CBT community will become so inclusive, but in this case there needs to be a greater focus on common mechanisms, and less on increasingly arbitrary divides between the 'in-group' (CBT) and the 'out-group' (counselling psychologists).

With the argument for the overwhelming superiority of the effectiveness of CBT being empirically disproven, practitioners are now left with the question of which therapy to choose, to which there are at least four possible answers. First, a defeatist approach would be that the decision is irrelevant, as all therapy is equal. Second, a more pragmatic approach would be to focus therapeutic activity around the currently best-supported mechanisms. This would be aided greatly by more empirical work into what these mechanisms are. Third, therapists could focus on outcomes other than simple effectiveness. An attractive approach would be to choose the cheapest therapy (Bower *et al*. 2000). Alternatively, other outcomes could be studied such as authenticity (Wood *et al*. 2008); there is suggestion that whilst therapies are equivalent on the outcome of the presenting problem, CBT may outpace humanistic therapy on cognitive exploration, but underperform on affective exploration and insight (Shechtman & Pastor, 2005) – thus superiority, equivalence, or inferiority may be outcome specific (Joseph & Wood, in press).

Fourth, the decision could be based on moral grounds. All therapeutic contact is based on the

therapist's assumptions and beliefs (Wood & Joseph, 2007). For example, there is a basic philosophical distinction to be made between directive and non-directive therapies. An unintended consequence of directive psychotherapies may be to disempower the client, and direct them to a life course that is wrong for them (Joseph & Linley, 2006).

Debates over the role of therapy are not new, but recent years have seen the debate become over-shadowed by arguments for effectiveness when in fact this is in part a political and moral decision (Proctor, 2005). We welcome Lynch *et al.*'s (2010) landmark study as it provides a compelling argument that the psychological science of therapeutic practice needs to chart a new course, one that can now focus on finding common mechanisms, and seriously debate the considerations underpinning the choice of therapy. Such work is especially urgent if new attempts to improve access to psychotherapy services (Layard, 2006; Boyce & Wood, 2009) end up supporting one therapy over another, on the false assumption that it is superior, to the disenfranchisement of other effective therapies.

Declaration of Interest

S.J. is an accredited and practising Person Centred Counsellor.

References

Ahn HN, Wampold BE (2001). Where oh where are the specific ingredients? A meta-analysis of component studies in counseling and psychotherapy. *Journal of Counseling Psychology* **48**, 251–257.

Bower P, Byford S, Sibbald B, Ward E, King M, Lloyd R, Gabbay M (2000). Randomised controlled trial of non-directive counselling, cognitive-behaviour therapy, and usual general practitioner care for patients with depression. II: Cost effectiveness. *British Medical Journal* **321**, 1389–1392.

Boyce C, Wood AM (2009). Money or mental health: the cost of alleviating psychological distress with monetary compensation *versus* psychological therapy. *Health Economics, Policy and Law*. Published online: 18 November 2009. doi:10.1017/S1744133109990326.

Higginson S, Mansell W, Wood AM (in press). An integrative mechanistic account of psychological distress, therapeutic change and recovery: The Perceptual Control Theory Approach. *Clinical Psychology Review*. doi:10.1016/j.cpr.2010.01.005.

Joseph S, Linley PA (2006). *Positive Therapy: A Meta-theory for Positive Psychological Practice*. Routledge: New York.

Joseph S, Wood AM (in press). Assessment of positive functioning in clinical psychology: theoretical and practical issues. *Clinical Psychology Review*. doi:10.1016/j.cpr.2010.01.002.

Layard R (2006). Health policy – the case for psychological treatment centres. *British Medical Journal* **332**, 1030–1032.

Luborsky L, Singer B, Luborsky L (1975). Comparative studies of psychotherapies – is it true that everyone has won and all must have prizes? *Archives of General Psychiatry* **32**, 995–1008.

Lynch D, Laws KR, McKenna PJ (2010). Cognitive behavioural therapy for major psychiatric disorder: does it really work? A meta-analytical review of well-controlled trials. *Psychological Medicine* **40**, 9–24.

Mansell W (2008). What is CBT really and how can we enhance the impact of effective psychotherapies such as CBT? In *Against and For CBT: Towards a Constructive Dialogue* (ed. R. House and R. Loewenthal), pp. 19–32. PCCS Books: Ross-on-Wye, UK.

Proctor G (2005). Clinical psychology and the person-centred approach: an uncomfortable fit? In *Person-Centred Psychopathology: A Positive Psychology of Mental Health* (ed. S. Joseph and R. Worsley), pp. 276–292. PCCS Books: Ross-on-Wye, UK.

Rogers CR (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting and Clinical Psychology* **60**, 827–832.

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

Shechtman Z, Pastor R (2005). Cognitive–behavioral and humanistic group treatment for children with learning disabilities: a comparison of outcomes and process. *Journal of Counseling Psychology* **52**, 322–336.

Wampold BE (2007). Psychotherapy: 'The' humanistic (and effective) treatment. *American Psychologist* **62**, 857–873.

Wampold BE, Mondin GW, Moody M, Stich F, Benson K, Ahn HN (1997). A meta-analysis of outcome studies comparing *bona fide* psychotherapies: empirically, 'all must have prizes'. *Psychological Bulletin* **122**, 203–215.

Ward E, King M, Lloyd M, Bower P, Sibbald B, Farrelly S, Gabbay M, Tarrier N, Addington-Hall J (2000). Randomised controlled trial of non-directive counselling, cognitive–behaviour therapy, and usual general practitioner care for patients with depression. I: Clinical effectiveness. *British Medical Journal* **321**, 1383–1388.

Wood AM, Joseph S (2007). Grand theories of personality cannot be integrated. *American Psychologist* **62**, 57–58.

Wood AM, Linley PA, Maltby J, Baliousis M, Joseph S (2008). The authentic personality: a theoretical and empirical conceptualization, and the development of the Authenticity Scale. *Journal of Counseling Psychology* **55**, 385–399.

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