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Abstract

Cognitive behaviour therapy (CBT) is a much-debated subject in terms of its efficacy and status as the 'treatment of choice' for depression and anxiety. This article critically analyses the claimed merits of this therapy over others, and evaluates its efficacy as a standalone 'combined therapy', by examining dismantling, additive, comparative and component studies. The article examines behavioural activation in particular, as the contested active ingredient in the cognitive behavioural model, and the application of this and CBT in the context of evidence-based, person-centred and holistic mental health nursing practice.

Introduction

Over the past 40 years, cognitive behaviour therapy (CBT) has become one of the most researched and widely recommended psychological therapies for depression and anxiety-related disorders (Clark 2011). It has many applications in the treatment and management of other mental health conditions, such as psychosis and eating disorders (Roth and Fonagy 2005), however this article focuses on its application to depression. CBT is a much-debated subject in terms of its efficacy and status as the 'treatment of choice' for depression and anxiety (House and Loewenthal 2008). This critical analysis of the claimed merits of CBT, and evaluation of its efficacy as a standalone 'combined therapy', examines the evidence of dismantling, additive, comparative and component studies. These studies break down the elements of therapies, and examine them in isolation, and in comparison and in addition to others, to test which components or combinations are more efficient. The article focuses on behavioural activation (BA) as the contested active ingredient in the cognitive behavioural model, and examines the application of this and CBT in the context of evidence-based, person-centred and holistic mental health nursing practice.

Background

The National Institute for Health and Clinical Excellence (NICE) (2009) uses a stepped-care model as a framework for offering appropriate psychological interventions, depending on need (diagnosis), and cost effectiveness, that is, the most cost-effective line of treatment is offered first, appropriate to the severity of depression. In step three of the framework, for people with varying degrees of depression but without a chronic physical health problem, NICE (2009) recommends a choice of four therapies, individual CBT, interpersonal therapy (IPT), behavioural activation (BA) and behavioural couples therapy. Evidence of the efficacy of BA, however, is less robust than that for CBT and IPT (NICE 2009). Of these choices, CBT is the most extensively recommended psychological therapy in mental health services (Barker 2017), particularly since the introduction of the Improving Access to Psychological Therapies (IAPT) initiative (Department of Health 2008).

CBT combines the theories of cognitive and behavioural therapy to offer a comprehensive psychological approach to help clients explore and understand the way they make sense of their internal and external world (Salkovskis 2010). It draws on Beck's (1976) theory of emotion, which understands the causes of mental health conditions, such as anxiety and depression, in terms of associations of meaning and emotional responses. Beck et al (1979) argued that it is not our environments or situations that cause emotional responses, but the meanings we associate with them. Positive meanings are associated with positive emotional responses, and vice versa. Put simply, anxiety can be associated with thoughts about perceived future threats, personally or socially, and depression can be associated with thoughts about perceived loss (Salkovskis 2010).

CBT uses a semi-structured collaborative approach to help develop a formulation through discussion and 'guided discovery' (Beck et al 1979). Beck et al (1990) emphasised the need for 'case formulation', which seeks to identify core beliefs, for example 'I'm a dull person', conditional beliefs, such as 'no one will want to spend time with me, and I will be on my own', and compensatory strategies, for example 'if I "people please" and always cater to the demands/wishes of others, I will be liked and not be on my own'. According to Beck et al (1990), core beliefs influence clients' reactions to situations, making them vulnerable to associated stresses, for example problems associated with attending to the needs of others over their own needs.

Further, behavioural experiments are used to generate new information and understandings about alternative meanings, to enable clients to adopt more helpful beliefs about situations or environments that would otherwise provoke negative emotional responses, derived from previously unhelpful associated beliefs (Salkovskis 2010). Cognitive theorists stress the centrality of cognitive change in the treatment of psychological disorders (Longmore and Worrell 2007), citing the problematic way clients think as the 'pathology' of their illness.

Beck (1993) described the therapist's approach as 'collaborative empiricism' in terms of their role in the therapy. Beck et al (1979) placed some emphasis on the interpersonal relationship with the client to work together to investigate and develop new understandings of unhelpful beliefs that perpetuate, for example, clients' depressed state of mind. Borril and Foreman (1996) found that clients perceived their relationship with their therapists as central to the success of the CBT, over specific therapeutic techniques. Indeed, Cooper (2008) argued that there is strong evidence to suggest that relational factors, such as effective therapeutic relationships, account for a significant degree of the success of any therapeutic approach. In therapy, it is the client's role to work collaboratively with their cognitive behavioural therapist, to develop understanding, seek alternative ways of thinking, and engage with mutually-agreed behavioural experiments and activities, such as 'graded exposure', and 'activity scheduling' (Beck et al 1979). Importantly, clients must also be motivated to change. Tudor (2008) argued that client factors, such as motivation, social support, personal qualities and attributes, are significant in determining therapy outcomes. Further, Sparks et al (2006) suggested that these 'extra-therapeutic factors', or variables, are specific to clients and their environments, and are party to their recovery, regardless of the therapeutic approach or technique used.

Some research quantifies these extra-therapeutic factors in terms of their role in clients' recovery during the therapy. For example, Wampold (2001) attributed 87% of client change in therapy to extra-therapeutic factors, which included a measure of unexplained variance and idiosyncratic client factors. Clients do not engage with, or experience, CBT in a vacuum, and have their own strengths and influences. Sparks et al (2006) suggested that there is such a variety of client factors that it is difficult to determine which are responsible for improvement. There is a need for further qualitative research regarding other factors affecting recovery, as researchers using scientific research methods, such as RCTs, claim credit for psychotherapeutic and pharmacotherapeutic interventions (Sparks et al, 2006). Indeed, Kelly and Howie (2011) argue that research methodology should reflect and be consistent with the philosophical ethos of individual therapeutic approaches.

Evidence review

Evidence is one of the most significant factors in terms of the provision of therapies in the NHS (Clark 2011). With reference to the NICE (2009) caveat mentioned above, that BA lacks robustness compared to CBT and IPT, it is presumed that 'robust' in this context refers to the strength of evidence for these therapies. In this respect, evidence of the efficacy of CBT has an advantage over other therapies in terms of the number of published studies (Ruddick 2012), and it lends itself easily to the paradigm of RCTs in terms of outcome measurement, the highest-ranking research methodology in the hierarchy of evidence (Sheldon et al 1993). There is, however, good evidence to suggest that the behavioural element of CBT is in fact the efficacious ingredient in terms of recovery.

Jacobson et al (1996) challenged Beck's (1976) cognitive model, and other established theories of depression, arguing that they assume that the 'fault' lies within the individual (Martell et al 2010). Further, Jacobson et al (1996) questioned the assumption that all elements of CBT are required to effect positive change. In their component study, Jacobson et al (1996) compared the elements of the therapy in isolation with the efficacy of the full treatment, and found that the BA component alone was equally effective as the full CBT treatment, raising questions about the active ingredient in CBT.

Researchers have compared the efficacy and active components of CBT and BA, and antidepressant medication, for the treatment of depression. Dimidjian et al (2006) argued that CBT and antidepressant medication are the standard treatment for severe depression, and NICE (2009) recommends considering offering clients 'both individual CBT and an antidepressant', namely a selective serotonin reuptake inhibitor (SSRI).

In their comparative study, Dimidjian et al (2006) examined the efficacy of BA, CBT, and antidepressant medication through an RCT. It is important to note that studies conducted by Dimidjian et al (2006) and Coffman et al (2007) refer to CBT as cognitive therapy (CT). The studies state that their treatment of CT included components of cognitive and behavioural elements, as outlined in the Beck et al (1979) integrated model. This distinction of CT classified as CBT is also referred to in Spates et al's (2006) qualitative and quantitative review.

Dimidjian et al (2006) discovered that BA significantly outperformed CBT for the treatment of severe depression, and both BA and antidepressant medication were more efficacious than CBT. The study also revealed a subset of clients who were severely depressed with functional impairment, and who reported an 'extreme non-response' to CBT, a pattern of response not reported by clients who received the treatment with BA. This raises further questions about the efficacy of CBT for some severely depressed clients, and challenges the status of CBT as the preferred psychological therapy for this group. Between 2015 and 2016, CBT was the most common high intensity therapy recommended within IAPT services, with more than 163,000 courses of CBT completed; only 10,500 completed courses of the Low Intensity BA therapy were reported in the same period (Barker 2017).

In their analysis of these findings, Coffman et al (2007) postulated the theory that these clients reported extreme non-response to CBT, and not to BA, for the following reasons:

- » It may be easier for clients to activate toward goals and solutions, than to focus on challenging and changing core beliefs.
- » BA therapists consistently apply straightforward behavioural techniques throughout the course of therapy, designed to effect change in environmental and psychological states themselves, and are not just a means to test assumptions, as with CBT.
- » Due to the time-limited nature of CBT and BA, cognitive behavioural therapists are perhaps trying to achieve too much in terms of cognitive and behavioural change, and in doing so inadvertently achieve less in terms of solid goals and effective change, that clients can perceive as beneficial to them in the 'real world'.

There are many similarities between CBT and BA, including the collaborative nature of the therapeutic relationship, the semi-structured approach within a time-limited framework, and use of homework strategies. However, Coffman et al (2007) suggested that the way depression is conceptualised is the important difference, and argued that BA sites the problem within the environment, and the behavioural consequences of this. BA seeks to alleviate depression by encouraging activation towards engagement and changing the context, to overcome the consequences of avoidance and withdrawal. In contrast, Coffman et al (2007) argued that CBT assumes the cause of depression as clients' problematic perceptions of their environments, which

could leave them feeling they are to blame for the cause of their depression, or that the reality of what they think and feel, in relation to their environment, is dismissed.

That is not to say that CBT does not have its merits. Indeed, in their meta-analyses of rigorous RCTs, Roth and Fonagy (2005) discovered that a course of CBT with at least 16 sessions, and up to three maintenance sessions, is an effective intervention for moderate to severe depression, particularly in preventing relapse. Relapse prevention studies, that compare the efficacy of CBT and maintenance pharmacotherapy for a follow-up period of 12 months, found the therapies were equivalent, with relapse rates of 47% (Roth and Fonagy 2005). In comparison, those in the placebo medication-control group had a significantly higher rate of relapse, at 76%. The obvious benefit of CBT over antidepressant medication in this respect is that only three maintenance sessions were required to achieve the same results as continuous, daily pharmacotherapy, which could present issues with concordance, drug interactions and side effects over a 12-month period in a 'real world', rather than clinical trial, setting. Such issues are encountered regularly in practice, when clients do not want to take medication, or continue with it long term.

Barker and Fraser (1985) placed the client-nurse relationship at the heart of mental health nursing practice, as developing a therapeutic alliance is vital to effecting therapeutic change. Therefore, interventions that rely solely on long-term medication concordance do not sit easily within the remit of mental health nursing practice, particularly when clients regard medication as a contentious issue.

In my experience as a nurse in practice, some clients found that antidepressant medication had no clinical benefit, and that it exacerbated symptoms of depression, for example increased insomnia. Further, these clients experienced an improvement in their symptoms with a combination of psycho-educative measures, health promotion and application of basic CBT and BA techniques, delivered in the context of a therapeutic relationship. Indeed, research supports the use of a variety of psychological approaches delivered by mental health nurses to support the recovery of their patients (Kelly and Howie 2011, Seo et al 2015). In practice, many clients are clear about what they do not want in terms of therapy, and it is the nurse's role to respect their clients' 'expertise' about their own condition, and to offer choices, working collaboratively to achieve mutually-agreed goals for whatever therapeutic approach, or combination of therapeutic techniques, are used.

The long-term efficacy of interventions to treat depression is an important issue, as prevention of relapse is a significant challenge. In an examination of longitudinal studies of patients with major depressive disorder (MDD), Roth and Fonagy (2005) found that during follow-up periods of ten and 15 years, 75% and 85% of patients respectively experienced relapse. Bearing in mind the comparative studies for CBT and pharmacotherapy mentioned above, although they proved equally efficacious in 12-month follow-up studies, Roth and Fonagy (2005) found neither intervention demonstrated significant long-term efficacy, with remission rates at no more than 25% at 18 months post treatment. This raises yet more questions about the status ascribed to CBT in the treatment of severe depression.

Spates et al (2006), in their qualitative and quantitative review of BA treatment for MDD, concluded that BA is an 'empirically supported intervention', and cited several good-quality studies that averaged five of the seven 'gold standards' for therapeutic outcome research Foa and Meadows (1997). Spates et al (2006) also concluded, however, that more good-quality comparative clinical trials, with larger sample sizes, were needed to enhance the body of evidence for BA, and to be able to recommend it as a frontline treatment for depression and MDD. This perhaps explains NICE's (2009) position on the lack of robust evidence for BA compared to CBT and IPT.

Some research has focused attention on the effects of additional components to standalone therapies, such as CBT, to determine if there are benefits in terms of boosting the efficacy of non-pharmacological interventions. Westra and Dozois (2006), for example, argued that the efficacy of CBT could be improved, in terms of engagement and outcomes, if clients were offered pre-treatment with motivational interviewing (MI). They also suggested that future research might

investigate the nature of this increased efficacy, for example, are the effects due specifically to the addition of MI, or is pre-treatment, regardless of therapeutic approach, the activator? Buckner (2009), for example, found that motivation-enhanced therapy increased the use of CBT in social anxiety disorder. Such studies highlight the need for additional and alternative approaches to help clients, who would not seek support otherwise, and whether due to their condition or not, to access psychotherapies. This also raises another issue about the samples used in clinical trials; Roth and Fonagy (2005) argued it is likely that participants in the vast number of clinical trials for CBT did not necessarily represent patients who required help in the 'real world'.

Discussion

There is considerable debate in clinical science and clinical psychology, about the merits of their respective approaches to explaining the causes, and alleviating the experiences, of mental ill health (Forsyth and Kelly 2001). In psychology alone, dismantling, component, comparative and additive studies support the argument for the efficacy of specific components of therapy in isolation, and the addition of other therapeutic techniques to boost the value of specific psychotherapies (Ahn and Wampold 2001, Bell et al 2013). A resounding feature of the studies discussed above is how they highlight the case for therapeutic pluralism in the treatment of depression and anxiety-related disorders. One size does not fit all, and although there is no doubt that CBT has its place as a treatment option, Hurley et al (2006) suggested that a wealth of psychotherapeutic approaches, and perhaps combinations of non-pharmacological therapies, should be equally considered as evidence-based interventions.

It could be argued that, by advocating CBT and antidepressant medication for the treatment of depression, NICE (2009) is taking a narrow view of the condition by subscribing to the medical model. Medical models assume the causes of depression lie within the client, that is, that antidepressants work at the site of the brain on noradrenaline and serotonin systems, despite there being no evidence that anything is wrong with these systems in depressed people (Healy 2009). CBT considers depression a consequence of problematic thinking in relation to perceptions of the environment. This raises questions about where it sits as a therapeutic approach, and the application of the NICE (2009) guidelines, particularly in mental health nursing practice.

The Nursing and Midwifery Council (2010) expects mental health nurses to provide care using a person-centred approach, ensuring that assessments are holistic, and practice and care is evidenced-based. CBT is the recommended non-pharmaco-therapeutic intervention for the treatment of depression, yet its conceptualisation of depression appears to contradict the notion of being truly person-centred in Rogers' (1951) humanistic sense.

Hurley et al (2006) argued that exclusive adherence to CBT theories is the antithesis of the humanistic ethos of mental health nursing practice, and should be challenged by mental health nurses, and that other therapeutic approaches, such as Gestalt and narrative therapy, have much to offer clients. They also suggested that nurses should be equipped with a multitude of skills, and have a wealth and depth of knowledge about various therapeutic approaches, to enable them to support the range and diversity of clients, with varying therapeutic needs, they encounter in practice.

CBT is a well established therapy for depression and other mental health conditions, with a wealth of quantitative and qualitative research to justify its empirical status as 'the evidence-based therapy of choice'. However, this position is contested on more than one front. First, dismantling, component and additive studies demonstrate that CBT can be improved, in terms of efficacy, by combining it with other therapies, and that the behavioural element has been the main component all along, thus discrediting the centrality of cognitivism in this approach.

Such is the trend of almost exclusive expounding of Beck et al's (1979) cognitive behavioural model as the theory of causation and treatment of depression, that it calls to mind the question

posed by Beck in 1976, 'can a fledgling psychotherapy challenge the giants in the field – psychoanalysis and behaviour therapy?' (Beck et al 1990). Now CBT is the giant in the field, and there is a gathering tide of dissent challenging its status as the treatment of choice, with the evidence to back it up. Indeed, BA is making more than simply a claim for its own efficacy, it is also claiming that it is the active ingredient in CBT.

Second, there has also been a backlash against what is seen by some in the psychotherapies community as narrowing of therapeutic perspectives and opportunities, with the Improving Access to Psychological Therapies initiative's focus on CBT for everyone and everything. The case for therapeutic pluralism is gathering pace with the support of research, arguing that CBT is only well established because of the sheer number of studies. Indeed, comparative studies have shown that CBT is no more effective than other pharmacological and non-pharmacological interventions.

Finally, the third wave of criticism for CBT exclusivity comes from the mental health nursing community, with challenges to how clients and their conditions are conceptualised and prejudged as 'problematic thinkers'. They argue that nurses should be trained in other therapeutic approaches that are aligned with the humanistic ethos of mental health nursing (Kelly and Howie 2011, Seo et al 2015), and some go as far as to deem CBT the antithesis of mental health nursing values (Hurley et al 2006).

Conclusion

There is empirical support for therapeutic pluralism, and sound ethical argument for mental health nursing practice to resist exclusive adherence to one therapeutic approach. It is incongruent with our role as humanistic and holistic practitioners, seeking to understand our clients as they experience themselves and the world around them, and focusing on their strengths and resources. We need a diversity of knowledge and skills, including CBT, so that we can serve our clients' needs which are, importantly, identified through holistic assessment and not assumed by one, domineering therapeutic approach. The studies discussed reveal a much-overlooked contention, that extra-therapeutic and relational factors are significant activators of therapeutic change, and that mental health nurses are in the best position to develop these in the context of a therapeutic alliance. Further, we are best placed to seek better understanding of such factors through qualitative research, because such statistically significant, yet unknown 'variables', have so far eluded more 'scientific' research methods in clinical trials.