be summarised as follows. Where emotions run high in the families of schizophrenics, family intervention prevents relapse and readmission to hospital⁴; patients suffering from depression who discontinue antidepressant drugs relapse on average within five months while those who receive cognitive behavioural or analytic psychotherapy stay well for more than two years⁵; psychological treatments for anxiety are an effective alternative to drug therapy and result in lower relapse rates once treatments are stopped⁶; women with chronic refractory irritable bowel syndrome improved physically and psychologically after a course of brief analytically oriented psychotherapy compared with those who were offered supportive "chats," and this improvement was maintained for at least one year⁷; in patients with borderline personality disorder, a year of twice weekly individual analytic therapy produced an effect size of around 1.0 on most measures of improvement.⁸ These studies suggest that in the central areas of psychiatric morbidity psychotherapy can help improve health.

Costs of psychotherapy

Attempts to estimate the annual costs of neurotic disorder in the United Kingdom suggest figures of £600m in direct medical costs, and a staggering £5.6bn in lost production—one third of the total cost of the NHS. If psychotherapy can be shown to diminish only a small fraction of this it will have proved its economic worth. Numerous studies have shown reduced offset costs—reduced use of medical services, drug bills, and social security payments—after psychotherapy.⁹ Two highly intensive inpatient psychotherapy units—the Henderson and Cassel Hospitals in London—have shown reduced use of health and social services by patients in the three years after discharge, saving sums far greater than the relatively expensive cost of a six month stay in the units.¹⁰

Not treating is unethical

Results such as these suggest an ethical dimension to the psychotherapy debate. Medical dilemmas inevitably imply questions of value. In the short term it may save money not to use expensive facilities and to make do without the luxury of effective psychotherapy—to

muddle through with a mixture of drug therapy, intermittent support, and a blind eye turned to much human misery. But is such short termism ethical given the evidence which suggests that good treatment produces lasting benefit which, from a medium or long term perspective, would save both money and unhappiness?

A wise therapist looks behind a question to the anxiety that underlies it. The NHS is in a crisis that seems to be based on underfunding—and certainly more money for health is much needed. But is it also a crisis of values, in which the personal aspect of medicine increasingly competes with rather than complements medical technology? Patient dissatisfaction and staff stress both have their roots in this conflict. Psychotherapy is concerned not just with removing distress, important though that is, but with the search for self esteem and a sense of meaning that underlies good health and has much to contribute to the managerial quest for quality and good morale.¹ Psychotherapy epitomises the values of the doctor-patient relationship, of healing as opposed to treating, that patients and doctors alike find so elusive in modern medical culture. To see psychotherapy as a luxury is to compound the heartlessness of a medicine whose values are already endangered. A vision of psychotherapy as both a necessary and ordinary part of medical practice offers hope in the bewildering world in which the NHS now finds itself.

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Unevaluated or inefficient approaches are hard to justify

Isaac Marks

The limited resources available for health make it important that money is spent in the best interests of patients. If money is spent on inefficient treatments there is less available for good care, so routine methods should have had their value proved in randomised controlled trials. This ideal is hard to attain. Randomised controlled trials cost time and money and only a minority of medical treatments have been evaluated in this way. To draw firm conclusions several randomised controlled trials in varying circumstances are usually needed and, for chronic conditions, follow up is essential to show that gains last. Finally, treatments which work in randomised controlled trials must be shown to be helpful in audit of routine care.

Given our imperfect knowledge, which are efficient psychotherapies and which not? Which have been well evaluated, for which problems in which circumstances, at what cost, and who can deliver them? Such questions can be answered firmly for some clinical problems, with less confidence for others, and hardly

at all for many. Most successful psychotherapies are brief (five to 15 sessions) and focused.

Anxiety disorders

Randomised controlled trials have shown exposure therapy to be the best treatment for phobic and obsessive-compulsive disorders.¹ It is at least twice as effective as alprazolam or relaxation.² It is effective given by nurse therapists and as self exposure under the patient's control and can be guided by phone. Exposure therapy was as successful when instructed by a manual or by a computer as by a clinician.³ Benefits exceeded costs in a randomised controlled trial. About six to 10 sessions with a doctor are sufficient for most patients, though more are needed for severe problems.

The evidence is fairly favourable for other anxiety disorders such as post-traumatic stress disorder,⁴ generalised anxiety disorder,⁵ and panic disorder without agoraphobia. Though brief behavioural or

cognitive behavioural psychotherapy was helpful in randomised controlled studies and pilot studies, the effective ingredients have yet to be identified.

Other problems

For depression, interpersonal and cognitive psychotherapies were each as effective as imipramine.⁶ In fairly severe depression cognitive behaviour therapy and dynamic-interpersonal therapy each had more effect with 16 than eight sessions; results of follow up are not yet available.⁷ Couple therapy was also useful. Behaviour therapy had favourable results for marital problems in random controlled trial. Randomised controlled trials have found people with eating disorders benefit from interpersonal psychotherapy and from cognitive behaviour therapy,⁸ from cognitive behaviour therapy given as a self help manual,⁹ and from family psychotherapy in young patients. Cognitive behaviour therapy is useful in treating children's conduct and other disorders, though questions remain about their usefulness in non-research settings. The behavioural-cognitive approach reduced stress and risk factors for coronary artery disease,¹⁰ and is promising for chronic pain, chronic viral fatigue, and some patients with epilepsy or other physical disorders. Brief dynamic psychotherapy helped irritable bowel syndrome. For all these conditions and for depression, which particular aspects of the treatment packages are worthwhile await dissection.

Brief focused psychotherapeutic approaches can be more cost effective than drugs in the long term. The figure shows this schematically for chronic agoraphobia with panic disorder. Relapse is much less of a problem on stopping exposure therapy than after stopping alprazolam, which usually has to be given for years to avoid relapse. In the first year the cost is similar for drugs and for exposure, but thereafter the cumulative cost of drugs becomes steadily greater since exposure therapy—unlike alprazolam—is usually a one off treatment and requires no long term monitoring by a doctor. Furthermore, exposure therapy was twice as effective as alprazolam.²

Schematic cumulative cost (1992 prices) of exposure therapy by a doctor, nurse practitioner, or computer and treatment with alprazolam for chronic agoraphobia with panic disorder. Costs are order of magnitude estimates and ignore the greater improvement from exposure therapy than from alprazolam

Ineffective treatments

Given these successes, is psychotherapy a luxury the NHS cannot afford? The answer is yes for prolonged inefficient or unevaluated psychotherapies. The same is true for any other costly untested medical care. It is not uncommon to see patients with anxiety disorders who have had over 50 sessions of relaxation or dynamic psychotherapy without benefit, even though exposure therapy helps most patients in under 15 sessions. Undue psychotherapeutic effort of uncertain value goes on long term treatment of a few patients. It would be justifiable to give some patients with chronic personality problems prolonged psychotherapy in the NHS if benefit from it is shown and there are no good brief alternatives. Unless value is proved, however, prolonged treatment should not be part of routine care.

There is a bizarre skewing in the types of psychotherapy for which consultant psychotherapists in the NHS are trained. Most receive more training in lengthy psychoanalytic psychotherapy of unclear usefulness than in brief psychotherapies that are known to work. Training guidelines from the Royal College of Psychiatrists emphasise personal psychotherapy experience which lasts for years. It is popular with trainees. There is no evidence, however, that psychotherapists with such personal experience obtain better outcomes in the patients they treat. Such prolonged experience can lead trainees to wrongly dismiss effective brief methods as "superficial, missing the

Commentary: look at long term results

Professor P C Rubin

Psychotherapy has an image problem in today's NHS. The treatment does not involve some expensive new wonder drug or the latest in breathtaking technology. People who may benefit from psychotherapy are not about to die of their condition and they do not gain the political attention afforded those whose operations are cancelled because of lack of intensive care beds. Purchasers in the NHS must now decide how to use their limited resources, and if the choice comes down to keeping operations going or providing psychotherapy for neurotic patients it would be a brave chief executive who opted for the psychotherapy option. However, both authors agree that psychotherapy can be effective, particularly when used in the form of brief intervention. In addition, the cumulative effects of neurotic disorders on quality of life and effectiveness at work are staggering, particularly since many of those who are badly affected are in what should be their most productive years. The question of whether psychotherapy is a luxury which the NHS cannot afford really comes down to the broader question of what quality of health care we are hoping to provide in Britain. The case for short term psychotherapeutic intervention seems to me to be very strong. Failing to provide adequate treatment of this type will in the long run lead to more rather than less expense for the NHS. It would be most unfortunate if the purchasers were to take the prevailing short term view.—PETER C RUBIN, *professor of therapeutics, University of Nottingham*

deeper underlying problem." Their patients suffer needlessly if denied helpful brief treatment. Prolonged psychotherapy for most trainees cannot be afforded by the NHS.

Computerised audit now makes it possible to show the outcome and cost of psychotherapy. Outcome of the problem and cost of the treatment can be displayed as routinely as are temperature, blood pressure, and weight charts for other conditions. With such quick audit methods the NHS could have value for money with some psychotherapies.

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