The efficiency of long-term psychotherapy

Engelse vertaling aanbiedingsbrief (aanbeng)

The efficiency of long-term psychotherapy

to:

The Minister of Health, Welfare and Sport

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Contents

Executive summary

Long-term psychotherapy has been evaluated by a Health Council Committee as part of the analysis of the cost-effectiveness of medical services (the so-called “126 list”).

Research into the efficacy of long-term psychotherapy is scarce. Detailed investigations have, however, been carried out to determine whether forms of psychotherapy with a limited duration are efficacious, i.e. whether they have a therapeutic effect in an experimental setting. As a rule, this requires controlled research, which usually means that after randomization the treated group of patients are compared with a group of patients who have either received no treatment at all or else a different treatment. Because our knowledge about the natural course of psychiatric conditions is frequently inadequate, it is not usually possible to formulate any definitive conclusions with regard to the results of uncontrolled research.

Controlled research has been conducted into different forms of psychotherapy in connection with a variety of psychiatric problems. The most widely investigated technique is cognitive behavioural therapy, which can (for example) produce a substantial improvement in patients with certain anxiety disorders. Based on meta-analyses, psychotherapeutic methods can, broadly speaking, be designated as efficacious. In general, the efficacy studies relate to treatments involving less than 20 sessions.

Far less research has been conducted into the effectiveness of psychotherapy — i.e. whether the effect identified in efficacy studies is also evident in practice. In everyday practice (unlike in the efficacy studies), psychotherapy customarily involves more than 20 sessions. The numbers of sessions do not appear to vary markedly for

different conditions. Research into the connection between the number of sessions and the therapeutic effect that is achieved does, however, reveal differences between one type of condition and another. In some cases, the extent to which the patient's condition continues to improve after 20 sessions diminishes, whereas in other cases — such as borderline-type personality disorders — psychotherapy only begins to have a positive effect after prolonged treatment. A further difference between the practical situation and the efficacy studies lies in the degree of comorbidity (the simultaneous occurrence of various psychiatric disorders). In much of the research, patients have been selected on account of the presence of a specific condition and its severity. In practice, there is a far greater diversity among patients. This can give rise to disparities between efficacy and effectiveness.

The cost-effectiveness of psychotherapy — i.e. its cost-benefit ratio in comparison with other treatments — is largely unknown. It appears that cost savings are considerable if hospitalization can be avoided, or if the number of days of hospitalization can be reduced. Because the analyses performed in this area relate to the entire range of treatments, it is difficult to pinpoint the effect of psychotherapy alone.

Little data is available from controlled research with regard to the durability of the treatment results. Epidemiological research indicates not only that psychiatric disorders commonly occur, but also that their course is frequently chronic. Furthermore, relapse is common, even after psychotherapy or pharmacotherapy.

As mentioned above, research into long-term psychotherapy has — for various reasons — been sporadic. Comparison with an untreated group of patients is therefore virtually impossible and even in those cases where research has already been done, there appears to be a large number of drop-outs. Without further research, it is not possible to assess the efficacy of long-term psychotherapy — let alone its cost-effectiveness. The Committee believes that this therapy may possibly be effective in certain patient groups. Examples are patients with personality disorders and patients with persistent mood disorders. Partly in view of the seriousness of these conditions, the Committee considers that research into the cost-effectiveness of long-term psychotherapy is desirable in these patient groups.

The Committee regards the results of efficacy studies as an appropriate starting point for practitioners. Only a very limited number of national guidelines are available which incorporate these results. There have, in recent years, been moves to formulate such guidelines. In the guidelines, the Committee feels that consideration should be given to the relationship between the number of sessions and the seriousness of the disorder in question.

Until such time as there is conclusive evidence of the efficacy and the cost-effectiveness of long-term psychotherapy, restraint needs to be exercised in

administering such therapy. In exceptional cases, long-term psychotherapy may be necessary, at the discretion of clinical experts. Criteria need to be established for these indications, and likewise for assessing the progress, the success and the quality of these treatments. Rules are also needed to assist with decisions over whether long-term psychotherapy should be continued or terminated. To this end it is essential that a monitoring system should be developed.

The Committee makes the following recommendations:

- Scientific research is needed in order to gain a more accurate picture of the cost-effectiveness of long-term psychotherapy in connection with chronic relapsing depressions and personality disorders (especially the borderline personality disorders).
- In developing national guidelines based on efficacy studies, consideration needs to be given to criteria for determining the duration and frequency of a psychotherapeutic treatment.
- A monitoring system needs to be developed and implemented with a view to assessing the progress, efficacy and quality of long-term psychotherapy.

Chapter 1

Introduction

1.1 Background and request for advice

There is an increasing focus on the efficiency of medical procedures, partly because many new (and often complex) methods are becoming available and partly because studies have shown that many procedures (even though these were generally accepted and used) had little effect or were even harmful.

The recommendation entitled ‘The cost-effectiveness of existing provision’, which was published by the former ‘Ziekenfondsraad’ (Health Insurance Funds Council) in 1993, cites 126 medical procedures the rationale for which was considered doubtful. The Minister of Health, Welfare and Sport requested advice from the Health Council concerning some of these procedures, in the context of the scientific situation. One of these procedures was ‘long-term psychotherapy’. In the recommendation by the ‘Ziekenfondsraad’ it was assumed that little research had been carried out into the effects of psychotherapy. In particular, the effectiveness of some long-term and intensive methods of treatment, such as psychoanalysis, was questioned. In addition to doubts about effectiveness, the report put forward the following arguments as a means of testing cost-effectiveness: the high cost, common occurrence and rapid growth of psychotherapy in general.

Doubts about the efficiency of long-term psychotherapy are not restricted to the Netherlands. In the United States there has been considerable focus on the empirical foundations of medical procedures. The traditional, open-ended form of psychotherapy has been criticized increasingly (Sab95, She95). Research has been carried out in

Sweden into treatments that place a considerable financial burden on public health services. Such treatments include psychoanalysis and other forms of long-term psychotherapy (San97). In Germany too, research has been carried out into the efficacy of psychotherapy, in particular following the publication of a meta-analysis that described the effects of long-term therapy as dubious (Gra94).

Following this, researchers retrospectively examined the course of disorders in patients who had received psychoanalysis (Bre97, Rad98). In Canada, the psychiatric profession established a steering committee whose aim was to evaluate psychotherapy (Cam99).

The President of the Health Council has assigned the task of complying with the request for advice concerning the efficiency of long-term psychotherapy to a committee set up by him, consisting of the 'Werkgroep langdurige psychotherapie' (Long-term psychotherapy working group and the 'MTA-commissie' (Committee on medical technology assessment) (see annex B). The working group has met on eight occasions. References on research into psychotherapy (and long-term psychotherapy) were obtained via MEDLINE and PsycINFO, and via files held by individual members of the Committee. The working group presented a list of scientific references on the efficiency of long-term psychotherapy to forty professors of psychotherapy and clinical psychology in the Netherlands and Belgium. The latter were requested to add any supplementary information that they considered necessary. Several studies were cited by the addressees, virtually all of which have been incorporated into the present recommendation.

A method is described as efficient if its efficacy is not restricted to a selected test population, but also extends to the general population of patients and others. Another precondition is that the costs and benefits should compare favourably to those of other methods that can be used for the same purpose (2.1).

Research into the efficiency of psychotherapy can relate to various forms of such therapy (1.2). The question of what constitutes long-term psychotherapy, and what factors contribute to its protracted nature is addressed in 1.3.

The concepts of efficacy, effectiveness and efficiency are addressed in 2.1. It appears that there is a relatively large body of research into the efficacy of various forms of short-term psychotherapy (2.2). On the other hand, there have been very few controlled studies into the efficacy of long-term psychotherapy (2.3).

Differences between efficacy and efficiency can result from a variety of causes, as explained in chapter 3.

Chapter 4 is devoted to the efficiency of psychotherapy. First the question of the prevalence of psychological disorders is discussed (4.1), and then the lack of analyses of the costs and benefits of psychotherapy (4.2). The few research results that are

available provide no information regarding the degree of efficiency of long-term psychotherapy.

In chapter 5, the Committee makes recommendations regarding scientific research and the practice of long-term psychotherapy.

1.2 Definition and forms of psychotherapy

The two most important methods of treating patients with psychological disorders are psychotherapy and pharmacotherapy. These therapies can be used independently or in combination. An expert committee (the 'Verhagen Committee') drew up the following definition of psychotherapy in 1980:

> Psychotherapy is the administration of scientifically sound treatment, by a suitably qualified expert, to patients requiring assistance for psychological problems, conflicts or disorders by means of the methodical establishment, structuring and maintenance of a relationship with the aim of removing or diminishing these problems, conflicts or disorders.

Similar definitions of psychotherapy are used elsewhere (see, for example, the Ontario Task Force, Cam99). In accordance with article 27 of the (Dutch) Individual Health Care Professions Act, a psychotherapist's area of expertise involves methods for diminishing or eliminating a psychological disorder, abnormality or symptom.

In addition to the requirement that the approach must be scientifically sound, the above-mentioned definition includes the precondition that the therapist be a suitably qualified expert. To this end, the Netherlands has a registration system that incorporates psychiatrists, clinical psychologists and psychotherapists.

The methodical manner in which psychotherapy is given can take a variety of forms. These are not dealt with in detail in the present document. The literature contains descriptions of many different psychotherapeutic methods (Her80). These methods can be grouped on the basis of various criteria (And93, Rot96). In this way, therapies can be classified according to theoretical assumptions about psychopathology and methods for implementing change, or to the context in which treatment takes place. In the first instance, the distinction might for example be made between psychoanalytical and cognitive methods while in the second instance, individual therapies might be separated from group-based therapies. Psychoanalytical methods are based on the assumption that disorders result from disturbances in (early) development and that intensive treatment can lead to improvements. Cognitive therapies focus on the thoughts and notions ('cognitions') of patients. Therapists endeavour to improve the situation by changing these cognitions. When the major thrust of a therapist's approach is aimed at the behaviour patterns associated with

psychological problems, this is referred to as behavioural therapy. In many cases use is also made of patients' underlying cognitions, in which case the treatment is described as cognitive behavioural therapy. The so-called experiential therapies (also known as client-centered therapies) mainly highlight patients' subjective experiences, whereas systemic therapies place the emphasis on interactions with others, in particular family members.

The number of sessions required can vary markedly from one type of treatment to another. Cognitive behavioural therapy for specific phobias may sometimes require only a few sessions, while psychoanalysis may require several sessions a week for several years (one session generally takes about 45 minutes).

Although psychotherapy can be used to treat patients on an individual basis, it can also be used in the context of groups, for example one or more families or a group of patients who have the same problem.

Psychotherapy administered to patients who have been admitted to treatment institutes is referred to as inpatient psychotherapy. However, the majority of patients are treated on an outpatient basis. In the intermediate form patients receive day-treatment on a part-time basis.

The order in council appended to the Individual Health Care Professions Act states that psychotherapeutic methods are expected to be based on psychoanalytical theories, learning and cognitive theories, experiential theories and system theories. Psycho-education, occupational therapy, hypnotherapy, and the so-called maintenance treatments should not be regarded as forms of psychotherapy. Nor are psychological interventions by GPs or by health psychologists included in the definition of what constitutes psychotherapy.

1.3 Long-term psychotherapy

1.3.1 Criteria for determination of 'long-term'

Various criteria can be used to define psychotherapy as long-term. One criterion is the duration of treatment, still another is the total number of sessions included in a course of treatment. Another option is to use the nature of the disorder in question to define the boundaries.

A study of long-term psychotherapy that was carried out in Sweden used a treatment duration of two years or more as a criterion for what constituted 'long-term' (San97). When definitions of this kind are used, the actual number of sessions involved can vary considerably. For example, patients receiving psychoanalytical therapy had an average of 3.6 sessions per week, whereas the average for other forms of psychotherapy was 1.5 sessions per week.

Some researchers in the US refer to any course of psychotherapy made up of more than 20 sessions as being ‘long-term’. Using this criterion, in 1987 sixteen per cent of all courses of psychotherapy were long-term. Together these represent about two thirds of the total psychotherapeutic care package (Olf94).

In the Netherlands too, statements have been made concerning the duration of psychotherapy (Kra93):

> We generally describe as short-term psychotherapy a course of treatment consisting of 10 to 25 contacts, where each contact lasts for 45 to 60 minutes, and the entire treatment spans a period of 3 to 9 months.

On the basis of research into the practice of psychiatry it has been concluded that the average course of treatment in the Netherlands consists of more than 90 sessions (Bru98, Hut99). That average includes a small group of patients who have been undergoing treatment for a very long time. The median value is 40 sessions (Bru98). The figure for about one in three patients of both psychiatrists and psychotherapists, is between 20 and 50. For another third, the figure is above 50 (Hut99). Conclusions drawn from research into the outpatient mental health service show that the average number of contacts at regional institutes for ambulatory mental health care is 12, for self-employed psychiatrists it is 30 and for self-employed psychotherapists it is 38 (Hav99). These figures appear to differ markedly from those obtained in the US. However, the figures presented include so-called maintenance contact, which places the emphasis on case management and support rather than psychotherapy. As an illustration, the figures for mood disorders are presented in Table 1.

Approximately the same figures were found for patients with anxiety disorders and adjustment disorders (Hut99). It should be noted, however, that such diagnoses generally were not verified systematically.

Table 1 Number of contacts in the treatment of patients with mood disorders (Hut99).

number of contacts	percentage of the patients seen by:	
	psychiatrists	psychotherapists
1-9	6	6
10-19	16	16
20-49	32	44
50-99	31	24

If a long-term course of treatment is defined as consisting of more than 20 sessions, then more than three-quarters of the treatments fall into this category. More than half of all contacts are with patients whose treatment consists of more than 50 sessions. The figures for the numbers of sessions used to treat mood disorders, anxiety disorders and adjustment disorders (Hut99) show that, in the Netherlands, the duration of psychotherapy (and related treatments such as maintenance treatments) is about the same across a wide range of disorders. As stated, these figures are not restricted to psychotherapy in the strict sense.

The figures are in contrast to the usual situation in efficacy studies. Accordingly, studies of cognitive behavioural therapy in patients with depressive disorders usually involve 8 to 16 sessions (Emm94). A committee of the American Psychological Association, which took stock of 'empirically supported' treatments, gave as the common characteristic of the treatments studied that they consisted of no more than 20 sessions (Odo00). Some researchers feel that there are few additional health benefits to be gained from a larger number of sessions (How86, see also 2.3.2). Apart from the duration of a course of treatment and the number of sessions involved, frequency is likely to be important with regard to the results.

As has been shown above, any criterion used to define long-term psychotherapy is quite arbitrary. The committee defined 'long-term' as treatments that either last for more than one year or consist of more than 25 sessions.

This definition was selected with a view both to the practical situation in psychotherapy and to efficacy studies.

1.3.2 *Determinants of 'long-term'*

Studies have been carried out into the factors predicting the duration of therapy. One of the factors that were investigated was the attitudes of patients and therapists to one another during the first session. In contrast to the expectations of the researchers, this factor proved to be of little predictive value (Ode98).

Another study, which was carried out on patients with anxiety disorders and mood disorders, concerned the relationship between the duration of treatment and the nature of the symptoms. The degree of concern in patients about their problems seems to be correlated with the duration of the treatment, but no link was found to the severity of the symptoms (Kor98).

With regard to psychoanalysis, a patient's motivation and their so-called ego structure are factors that have been said to be important in terms of the duration of therapy (Bas95b).

An extensive analysis of the connection between the duration of treatment and various other variables has been carried out with patients suffering from severe anxiety

disorders. Out of more than one thousand patients receiving inpatient psychotherapy, those without partners were treated for longer than the rest (averages of 60 and 50 days respectively; Bor99b). It is not known to what extent this relationship is a causal one. The same study showed that there was a clear improvement in more than half of the patients. On average, longer treatments produced slightly greater effects (Bor99b).

Furthermore, research has shown that there is little or no connection between the duration of the therapy and the chance that patients will experience a relapse. A follow-up study conducted after psychoanalysis in Boston revealed that the expectations of the therapists and the patients at the end of the period of therapy (lasting from three to nine years) were not consistent with the course of the patients' conditions in the subsequent five to ten years (Kan90). In view of the small number of patients involved, no definitive conclusions can be drawn from this study.

Long-term psychotherapy is often associated with the chronic character of disorders (see 4.1). Although many therapies may not be intended to be long-term in advance, the symptomatology may recur despite the use of pharmacotherapy and/or psychotherapy. A recurrence of symptoms while the patient is under treatment raises doubts about the value of long-term therapy.

Some feel that, to obtain a form of treatment that is also acceptable in terms of efficiency, the first object should be to formulate a specific treatment target (Sab95, She95). In the case of incomplete recovery or of a recurrence of symptoms, the objective of treatment might be, for example, to help the patient learn to live with the chronic character of the disorder, including any side-effects produced by their medication (She95). This may lead to a maintenance treatment in which, as stated, the emphasis is given to case management and support. In such cases, there is a shift from cure to care, and other criteria are used to determine its efficiency (Wrr97).

The results of the studies into the determinants of what constitutes 'long-term' referred to here do not provide an adequate basis for making predictions about the length of treatment in individual cases.

Chapter 2

Efficacy of psychotherapy

2.1 Definitions of efficacy, effectiveness and efficiency

The efficacy of a treatment is taken to mean the degree of health gains achieved as a result of applying the treatment under experimental conditions (GR91). Any studies used to establish efficacy must provide details of these conditions. The magnitude of the health gains produced by a treatment as used in clinical practice, is referred to as its effectiveness. Some researchers prefer to use the terms internal and external validity, rather than efficacy and effectiveness (Cha98a). External validity, however, involves the issue of whether the criteria met by the study population are applicable to the patients to be treated. The concept of effectiveness, on the other hand, relates to the degree to which the therapy is efficacious in the patient population (GR91). For a variety of reasons, there may be differences between efficacy and effectiveness, as explained in chapter 3.

The concept of efficiency relates to the cost/benefit relationship of given treatments. If two different therapies are equally effective, the cheaper one will be more efficient. The concept of efficiency therefore requires more than just an appreciation of the costs involved. It also necessitates a comparison with the costs and benefits of other therapies used to treat the same disorder.

2.2 Research into the efficacy of short-term psychotherapy

The efficacy of psychotherapy has been a focus of interest for many years. During the 1950s and 1960s, surveys were published in which it was stated that psychotherapy had little or no effect (Eys52, Eys61). It was claimed that no significant differences were seen when the results of various therapies were compared to the natural course of the disorders in question. This conclusion was disputed by several researchers, one of the reasons being that these surveys did not comply with the methodological requirements for research into efficacy (Smi77, Sch94). Before reliable and valid conclusions can be drawn about efficacy, it is first necessary to examine a given group of patients under established conditions. The group to be investigated must first be defined using inclusion and exclusion criteria. The therapy and the result parameters must be established, and the effect of therapy on the course of the disorder in question must be clear (Sac85, Mar97). Research in the form of a randomized controlled trial (RCT) complies with these requirements. An RCT is superior to observational methods in terms of establishing the efficacy of a given therapy (Fon99). This does not exclude the use of other methods. However, these suffer from the drawback that they are unable to test assumptions about the course of the disorder in the absence of therapy or if it was treated using another type of therapy (Kni00). Double-blind studies are impossible in psychotherapy. This means that the views of those providing treatment influence the results of studies, which only emphasizes the need for studies using RCTs. On the other hand, this research method does have its limitations (Ell98, Fon99).

Proof of efficacy obtained using RCT does not automatically mean that the treatment is effective, in other words that these effects will also be obtained in clinical practice (Beu01). Some possible causes for differences between efficacy and effectiveness are discussed in 3.2. Research into other aspects of psychotherapy, such as the relationship between the patient and the therapist, is not covered in the present advisory document.

The extent to which various forms of psychotherapy produce different results has been debated extensively (Smi77, How96). More than 20 years ago, researchers postulated that there were in fact no significant differences, a view that has become known as the dodo bird verdict (Lub75):

> ‘But who has won?’ This question the Dodo could not answer without a good deal of thought, and it sat for a long time... At last the Dodo said, ‘Everybody has won, and all must have prizes’ (Car65).

Some feel that the presumably small differences in efficacy between different psychotherapies result from the presence of factors that are common to the various types of psychotherapy. Such elements are the prospects of change, the focus on the problem and the patient, and the learning process that derives from the therapy (Gar91, Sch99). Research into common factors provides greater insight into the way in which psychotherapies work (Kar86, Lip93, Kra99). A committee of the American Psychological Association identified the following as elements of psychotherapies whose efficacy has been proven: skills training, formulation of a specific problem, regular evaluation of progress, and twenty or less sessions per treatment (Odo00). In this connection, it should be noted that the characteristics that have been identified reflect the types of therapy that had been most intensively studied. Therefore they do not necessarily represent the elements of an efficacious therapy.

Other researchers claim that the capabilities of those providing the treatment are more important than the differences between the various methods of treatment (Cri91, Wan95). However, a study of variation in the effects of psychoanalysis found no significant difference between the results obtained by experienced psychotherapists and those obtained by relatively inexperienced ones (Erl79). Researchers have also compared the results obtained by empathic laymen to those obtained by experienced psychodynamic (based on psychoanalysis) therapists. This comparative investigation, the Vanderbilt Psychotherapy Studies, found no significant differences (Str79). A meta-analysis of fifteen studies into therapist-associated effects reached the conclusion that there are smaller differences between results when more experienced psychotherapists are involved and when protocols are followed (both for psychoanalytic and for cognitive therapy; Cri91, Str93). The results of these studies indicate that relatively few differences in efficacy are dependent on the therapist. It should be noted that these are averaged results, individual differences are quite common in the practical situation (Lam94).

One major shortcoming of various studies into the differences in the results obtained from psychotherapy is the heterogeneity of the various groups of study patients (Lam94). Therefore, the effect is an averaged value that relates to different types of problems. Accordingly, several researchers have pointed out the importance of distinguishing between the problems to be treated (Pau67, Ell93, Kop99).

Studies using stricter methodology and involving well-defined groups of patients show that certain forms of psychotherapy are effective for some disorders and almost completely ineffective for others. These findings have been summarized in various surveys, for example the standard work by Roth and Fonagy (Rot96) and a report by a committee of the American Psychological Association (Tas95, Cha98a). In abridged form, these findings are as follows:

Anxiety disorders

The effect of cognitive behavioural therapy has been extensively investigated in panic disorders (a form of anxiety disorder). If the panic disorder is associated with agoraphobia, then the therapy often uses exposure *in vivo* (the patient is confronted with the object of anxiety; Emm94). Therapies of this type can considerably reduce the frequency of panic attacks in the vast majority of patients (Bro95, Bar96b, Rot96). In the case of panic disorder (whether or not associated with agoraphobia), the difference in efficacy between antidepressants, cognitive behavioural therapy and various combinations of these is very slight. A meta-analysis has shown that, on average, combinations have a slightly more marked effect (Bal95, Bak98).

Cognitive behavioural therapy has been compared with a range of other therapies for the treatment of generalized anxiety disorder. It was found that more than half of the patients who were treated with cognitive behavioural therapy showed some improvement (Bor93, Bar96b). The same result was achieved using relaxation therapy (Bor93). Research has led to the conclusion that the results of analytical psychotherapy in patients with generalized anxiety disorders are much less favourable than those obtained with cognitive behavioural therapy (Dur94).

Specific and social phobias are anxiety disorders which, in most cases, can be effectively treated using behavioural therapy (Emm94, Rot96). Short-term treatments are effective for patients with specific phobias, such as a fear of spiders. Such treatments usually involve exposure *in vivo*. Methods of this kind also achieve good results in the case of social phobias (a disproportionate fear of contact with other people) (Rot96). It might be possible to obtain slightly better results using pharmacotherapy (Hei98).

Although cognitive psychotherapy is efficacious in the case of post-traumatic stress disorder, the efficacy studies are restricted to certain types of traumas (so it may not be possible to generalize) and to relatively small numbers of patients (Rot96).

With regard to obsessive-compulsive disorder, various researchers have claimed that effects can be achieved by using a form of behavioural therapy in which the patient is confronted with the obsession while blocking the compulsive response (exposure and response prevention therapy, ERT). Sixteen studies of the effects of ERT have concluded that symptoms are considerably reduced in the vast majority of patients (Bar96b).

Depression

In patients suffering from depression and related disorders, extensive research has been carried out into the efficacy of psychotherapy (Elk89, Sha94, Rot96, Glo98). A large-scale study in the US has shown that different forms of psychotherapy have

approximately the same degree of efficacy (the Treatment of Depression, Collaborative Research Program; Elk89). Researchers in the UK came to the same conclusion with regard to cognitive behavioural therapy and interpersonal therapy (the Sheffield Psychotherapy Project, Sha94). That research project also considered the effect of the duration of treatment (see 2.3.2). Recent meta-analyses of research into pharmacotherapy and psychotherapy found no significant difference between the results for treatment with antidepressants and treatment consisting of cognitive behavioural therapy in patients with severe depression and in elderly patients (Der99, Ger99). An objection that can be raised in relation to these studies is the large number of patients dropping out of treatment (on average one in three patients), which means that generalization of the results is not possible (Der99).

Relatively little research has been done into the efficacy of psychotherapy in cases where pharmacotherapy has proved ineffective, or vice versa, although it may well be possible to achieve better results in this way (Kar82, Mer92). According to a meta-analysis published in 1990, simultaneous treatment with psychotherapy and pharmacotherapy does not produce better results than the two treatments given separately (Rob90). However, recent research into the effect of combining cognitive behavioural therapy and antidepressants showed that better results were obtained (Kel00).

Eating disorders

Research into the efficacy of psychotherapy for patients with anorexia nervosa has not shown the treatment to be effective (Rot96, Apa00). In patients with bulimia nervosa, a considerable reduction in symptoms can be achieved using psychotherapy and cognitive behavioural therapy in particular (Wal98, Agr00, Hay00). A meta-analysis comparing the efficacy of psychotherapy and pharmacotherapy found no significant difference (see also chapter 4; Wal98, Bac99). The efficacy of cognitive behavioural therapy has been found to be almost the same as that of interpersonal therapy and greater than that of analytical therapy (Apa00). Research has also been done into the effect of a combination of psychotherapy and pharmacotherapy. Some researchers claim that this produces better results than treatment with only one of the two therapies (Wal97).

Personality disorders

A personality disorder is characterized by inadequate, fixated behavioural patterns. A distinction is made between a cluster of paranoid, schizoid and schizotypical personality disorders, a cluster of borderline histrionic, narcissistic and antisocial personality disorders and a cluster of dependency, avoidance and obsessive-compulsive disorders.

Personality disorders often occur in combination with other psychological disorders (Ver99, see also 4.1). It is partly for this reason that little comparative research has been carried out into the effects of psychotherapy on patients with these complaints (Rot96). Various arguments are used to support the assertion that cognitive behavioural therapy, interpersonal therapy and psychodynamic therapy can be of use in the treatment of these patients (Rot96, Arn99, Per99, Gab00).

The term borderline refers to the classical view of a boundary area between psychotic and what used to be known as neurotic functioning (see also chapter 5). Research has been carried out into the efficacy of psychotherapy for patients with this type of disorder. The results of research without control groups indicated the possibility of a favourable effect (Ste92, Mon95, Naj95). It is thought that considerable reductions in symptoms can be achieved with the aid of cognitive behavioural therapy and psychoanalytic treatment. As a rule, these treatments tend to be long-term. Therapy for patients with a borderline personality disorder is discussed in greater detail in 2.3.1.

The possibility of using psychotherapy to treat children and adolescents with an antisocial personality disorder is currently under investigation (Kaz95, Eng98, Bor99a).

Other disorders

Many efficacy studies use diagnostic criteria derived from the classification system of the Diagnostic and Statistical Manual of Mental Disorders (DSM) issued by the American Psychiatric Association (Apa94). This does not mean that these are the only criteria suited to this purpose or that only they can serve as a basis for result parameters. For instance, psychological tests can show that the personality development of a patient has been seriously disrupted without the person in question fully meeting the criteria stated in the DSM. Such patients may benefit from long-term and intensive psychotherapy. In addition, the efficacy of psychotherapy has been shown in relation to headaches, rheumatic pains, and problems like bedwetting and giving up smoking (Cha98b).

Furthermore a meta-analysis has shown that psychotherapy is efficacious in treating behavioural and emotional problems in children and adolescents (Cas85, Wei95a). However, follow-up studies to determine effectiveness found a much smaller effect (see 3.4).

The studies mentioned here deal with short-term forms of psychotherapy. It would appear that this form of therapy, whether or not in combination with pharmacotherapy, is efficacious in patients with a range of psychiatric problems.

2.3 Efficacy of long-term psychotherapy

Several researchers have given accounts of the results of long-term psychotherapy. Some of these studies are concerned with comparisons between various forms of psychotherapy, while others focus on the relationship between the duration of treatment and the effect.

2.3.1 Comparative research

In Germany, research has been carried out into the results of long-term psychotherapies, including psychoanalytic therapy (Man95, Heu96, Rad98). After a comparison of the results of various forms of treatment, some researchers have concluded that psychoanalysis is preferable to other forms of psychotherapy. However, they do not specifically indicate a certain type of treatment, nor do they specify the duration of the therapy. The researchers admit that the requirements for an experimental study were not met (Berliner Psychotherapiestudie; Man95). The course of the patients' conditions after the therapy was also studied in Germany. A positive result was achieved with almost half of a group of patients receiving psychoanalysis, but as time went on (an average period of 3.5 years), the results appear to be less favourable than those for the group of patients who received other forms of psychotherapy (Heidelberger Katamneseprojekt; Rad98). In a second study, interviews two years after the end of a course of psychotherapy (participation 91%) revealed that over half of the patients had achieved good or very good results and in most cases the result was consistent with the objective for the therapy established before treatment began (Heu96). Since the method of treatment selected partly depends on the nature of the problems and the patient's level of education, and also given the absence of a control group, the conclusions reached on the basis of these studies cannot be regarded as definitive.

In Sweden the results of two years of psychotherapy were studied in patients with various psychological problems (the Stockholm outcome of psychotherapy project; San97, San99, San00). The symptoms and the level of social functioning were recorded for two years after the treatment ended. Psychoanalysis, individual psychotherapy and little or no treatment were compared. Over the long term, the researchers reported the best results for psychoanalysis. However, the results are based on comparison between different groups of patients. The researchers describe their approach as quasi-experimental (San97). Within a period of one year after the treatment period lasting two years or more, 17 per cent of the patients who received psychoanalytic treatment were admitted to another course of treatment. This figure was

20 per cent for other forms of long-term psychotherapy and 63 per cent for patients who were given less intensive treatment (San99). However, the research was not randomized and it emerged that many patients from the non-treatment group had in fact received treatment during the period in question (San00).

The course of the condition of patients who had received psychoanalytic treatment was the subject of a long-term follow up in the context of the Menninger Foundation Psychotherapy Research Project. The results led to the conclusion that supportive measures contributed to the effect of the therapy. However, no randomized control groups were involved in the research (Wal89). That study together with other research into the results of psychoanalytic therapy have been summarized in the Open Door Review (Ipa99). This summary points out the difficulties involved in research into the efficacy of psychoanalysis. The duration of the treatment presents a problem, but so does comparison with other types of therapy, the selection of patients suited to psychoanalysis and the result parameters to be applied. The research results led to the conclusion that there is no unambiguous evidence for the efficacy of psychoanalysis and that most of the research in this field suffers from methodological limitations. However, the results do seem to indicate that many patients benefit from psychoanalysis (Ipa99). For the validation of these results a joint quality system was set up by various institutions, including the Netherlands Institute for Psychoanalysis (Bee98).

In many of the studies into the effects of long-term treatment mentioned above, no distinction was made between patients with various disorders. However, just as was observed with regard to short-term psychotherapies (see 3.1), it is reasonable to assume that the type of disorder partially determines the efficacy of long-term therapy.

For a small number of disorders, research has been carried out into the effect of long-term therapy. In a meta-analysis of psychoanalytic treatment of patients with anorexia nervosa, the results of various studies were evaluated, including 7 follow-up studies (Her97). The analysis would seem to show that long-term psychodynamic therapy (50 weeks or more) has more effect than short-term treatments. However, the extent to which this effect occurs requires further research (Rot96):

> Studies of the psychotherapeutic treatment of anorexia suffer from major methodological weaknesses — in particular, small sample size and non-representative (tertiary referral) samples — limiting conclusions about the comparative benefits of differing therapeutic modalities (Rot96).

The effect of long-term treatment has also been studied in patients with personality disorders (Bat00). After an average of over two years of psychodynamic therapy, it was established that three out of four patients attained a significant improvement; after an average of over five years the result remained stable (Mon95). After 18 weeks of

outpatient treatment at a hospital, improvements in a number of aspects, including ability to function and self-respect, were found in comparison with a control group (whose treatment was postponed; Pip93). Clear improvements after long-term treatment were also observed in adolescents and young adults suffering from personality disorders, although the study lacked a control group (Bla96). Other researchers question whether treatment should have to be long-term. Research involving a group of seriously affected patients with various personality disorders found no correlation between the duration of the therapy and the degree of improvement (Bas95a). Research also reveals that there is sometimes no correlation between the duration of the therapy and the severity of the disorder (although correlation was found with patient satisfaction about the therapeutic relationship, Bas95a).

Long-term psychotherapy has been found to be effective in the treatment of borderline personality disorder (Lin91, Bat99). It was found that, following one year of cognitive behavioural therapy, there was a reduction in the number of suicide attempts. In comparison to a control group, there was also a reduction in the number of hospital admissions (Lin91, Lin93). An 18-month study into the effect of a psychoanalytically oriented outpatient treatment also showed an improvement relative to a control group (Bat99). An 18-month follow-up study subsequently revealed that this improvement was maintained (Bat01).

The research results referred to here indicate the efficacy of long-term psychotherapy in patients with a borderline personality disorder.

2.3.2 The relationship between number of sessions and efficacy

An important question with regard to the efficacy of long-term psychotherapy is whether the effect increases as treatment continues or whether a plateau is reached. In 1986 a meta-analysis was carried out that incorporated the results for more than 2400 patients who had received various forms of psychotherapy (How86). The number of sessions was compared to the improvements achieved. After 13 sessions, the condition of more than half of these patients showed a clear improvement. This increased to three out of four patients after 26 sessions. The researchers stated that increasing the number of sessions produced diminishing returns (How86). Nevertheless, it is unclear how these findings might have been affected by the severity of the disorder in question or by possible patient selection. No indication is given of the size of these effects or of the course of disorders in control groups. It should also be noted that these figures do not reflect the course of a disorder in an individual patient. While the figures do indicate the average number of sessions that took place before treatment came to an end, they do not show whether or not this length of treatment produced the best results.

Table 2 The relationship between the number of sessions and improvement in a patient's condition (How86).

diagnosis	number of sessions								
	0	1	2	4	8	13	26	52	104
	significantly improved patients (%)								
depression	6	13	20	31	46	57	73	86	94
anxiety disorder	0	0	0	5	25	53	87	99	99
borderline	0	0	0	0	3	11	38	74	95

Also, the variety of disorders treated was not considered. Strangely enough, earlier work often did not take account of this (for a summary see Ste94). Classification of the results reveals considerable differences, dependent on the type of disorder involved (see Table 2).

More recent research has also focused on the relationship between duration and effect in various types of disorder. One example is a study carried out in the United Kingdom into the efficacy of psychotherapy in patients suffering from depression (Sheffield Psychotherapy Project; Sha95, Bar96a). In over 100 patients, results after eight sessions were compared with results after sixteen sessions. No significant differences were found. The average improvement was about what might be expected on the basis of the results of a previous meta-analysis (Nie87).

A study into the effects of the duration of psychotherapy on drug addicts in Israel showed that the results of long-term therapy were no better than those achieved by short-term therapy. In both cases a high percentage of subjects withdrew from the study (53 per cent and 47 per cent respectively, Ler92).

In patients with a generalized anxiety disorder, the results of cognitive therapy or analytical psychotherapy were compared to those achieved following anxiety control training (Dur94, Fis99). The researchers also investigated six-month treatment periods that consisted of 8 to 10 sessions and those that consisted of 16 to 20 sessions, to see if there were any differences in the effects produced. It was concluded that cognitive therapy produced the best results and that extending the number of sessions beyond ten produced no further improvement (Dur94).

The above research results fail to show that, in the case of depression, drug addiction, specific phobias and generalized anxiety disorder, longer periods of treatment lead to better results.

Chapter 3

Effectiveness and clinical significance

The results of research into the efficacy of psychotherapy cannot simply be extrapolated into clinical practice. In other words, effectiveness can differ quite markedly from efficacy. An efficacious treatment may prove less effective in practice, due to differences between patients, therapists or circumstances. Thus the simultaneous occurrence of different psychological disorders (co-morbidity), the level of training given to therapists, the context in which the treatment takes place or the length of waiting lists can all affect the result of treatment in practice (see 3.2).

Effectiveness may also be influenced by the expectations that patients have concerning a given method of treatment. It is reasonable to assume that this has little or no influence on efficacy, but there is no data to show whether or not there is an effect on effectiveness. Furthermore, the results of studies into patient satisfaction are somewhat ambiguous (see 3.3).

Research into effectiveness is needed to identify the factors that influence the effect of empirically efficacious treatments. The extent to which efficacy differs from effectiveness is something of an open question (Spi99). Some studies have concluded that the effectiveness of certain interventions corresponded to expectations that were based on efficacy studies (Sha97, Wad98, Stu00). The Committee takes the view that there is a clear need for more research in this field.

Besides the distinction between efficacy and effectiveness, it is also important that the effect may be too small to have any clinical significance (see 3.1).

3.1 Effect size

In order to answer questions about the size of the effect, researchers studying psychotherapy often calculate the effect size, or (M1 - M2) / s.d. Here, M1 and M2 are the averages of result parameters for the treated and untreated groups respectively, while s.d. is the average standard deviation. A weighted average can be used for the s.d., and in some cases the s.d. of the treated group is used. The s.d. is partly dependent on the number of patients and on any patient selection. A larger s.d. produces a smaller effect size, while the converse is also true. Effect size is therefore a relative measure. It can be used to compare different studies, but not to evaluate the absolute magnitude of the effect.

However, effect size does not indicate whether the treatment of a given patient produced a clinically significant effect. Clinical significance relates to the practical value of an intervention for an individual patient. Various methods have been developed to provide estimates of clinical significance. One is to indicate the fraction of the patient population that, following the treatment, no longer meets the diagnostic criteria (for example, DSM-IV). Another is to establish the effect per patient, in comparison to the condition of normative or dysfunctional groups (Jac91, Jac99). Alternatively, the changes produced can be subjectively evaluated or an attempt can be made to establish the social impact of the therapy. However, many published studies on psychotherapy make no mention of clinical significance.

3.2 Difference between the research situation and the practical situation

If the circumstances under which the study took place differ from those encountered in practice, then this may be responsible for any differences between efficacy and effectiveness (Fon99). When conducting studies into the efficacy of psychotherapy, it is inevitable that patients will be selected for the presence of a given disorder and often for a given degree of severity of that disorder (homogenous group). Comorbidity can cause patients to be excluded from the study. Comorbidity occurs quite commonly in practice (see 4.1).

In addition, the treatments are standardized in the interests of research. This means that, in the context of the study, little or no account can be taken of any additional patient problems or requirements during treatment. These may well be raised once the study has been completed, or they may lead to patients being referred to clinical practice. Such standardization may lead to a reduction of the s.d. mentioned above (see 3.1), and to a concomitant increase in effect size.

Moreover, studies and clinical practice differ from one another in terms of the length of treatment and the number of sessions involved. The majority of efficacy studies involve only eight to sixteen sessions (for example, see Emm94) whereas a recent random sample survey in the Netherlands showed that three-quarters of patients had considerably more sessions (Hut99; see 1.3.1).

3.3 The patient's perspective

Expectation is another factor that can cause effectiveness to differ from efficacy. This is because the expectations of patients in practice can differ from expectations within the context of the study. Any therapy that patients judge to be poor will generally produce inferior results (for example, due to a lack of patient compliance with medication treatment). When a patient is motivated this can enhance the effect of therapy (Bur91). A study of patients receiving psychotherapy appears to indicate that many of them have positive expectations regarding the treatment. However, it is not entirely clear whether this study is truly representative (Sel95):

A more sweeping limit on generalizability comes from the fact that the entire sample *chose* their treatment.

The expectation is generally based on the opinion of patients concerning the method of treatment. A study of the relationship between the patient's evaluation and the changes in the patient brought about by the therapy failed to find any relationship between these factors (Pek99).

Nevertheless, the Committee feels that the results of research into the opinions of patients are of importance in the evaluation of psychotherapy. In a previous Health Council advisory document (concerning the issue of implementation) it was stated that patient satisfaction is an important indicator of the quality of care (GR00).

One often quoted study of patient opinion is The Consumer Reports Study, carried out by a consumer organization in the US (Con95, Sel95). Readers of Consumer Reports magazine who had undergone psychotherapy were asked whether they were satisfied with the results of their treatment. From the results of this poll it was concluded that most of those receiving such treatment were satisfied. There were no differences between the various forms of therapy. However, it is not known what the result might have been if the poll had included the views of those who withdrew from treatment (Con95, Sel95).

In Germany, a study has been carried out into the views of patients regarding the results of psychoanalytical treatment. Most of those who participated in the study felt that both their general condition and their relations with others had improved. Here

also there are doubts about how representative these views are, since responses were only received from a small proportion of the patients treated (Bre97).

In the Netherlands, patients' opinions about inpatient psychotherapy were surveyed by the Foundation for Scientific Research in Psychotherapeutic Communities (SWOPG). This took the form of a standardized study, the Standard Evaluation Project. Of more than one thousand discharged patients, 850 were satisfied (Har99).

Patients' views about the treatment of phobias in the Netherlands were investigated by a Consumers' Association poll. It emerged that the 380 respondents had each consulted an average of five practitioners. One in three of the patients had been in therapy for two years or more. The respondents rated the treatment given by self-employed psychotherapists and hypnotherapists as 'good', but found the treatment received at the 'Riagg's' (Regional Institutes for Ambulatory Mental Health Care) to be relatively poor (Con94). However, the extent to which the patients consulted are representative of the entire patient population is unclear.

The results of the studies discussed in this section do not indicate that patients are unanimously satisfied with the quality of care provided.

3.4 Unexplained difference

It is also possible for a difference to occur between efficacy and effectiveness, without a clearly demonstrable cause. For example, the efficacy of psychotherapy in children with behavioural and emotional problems has been clearly demonstrated (see 2.2). In practice, however, the results do not live up to expectation (Jen96, Wei95b). A recent example was a study of 160 children with various problems, such as criminal behaviour, aggression, hyperactivity, depression, anxiety disorder and somatization (Wei99). The children had an average of 60 sessions over a two-year period of treatment. The methods used were behavioural therapy, cognitive or psychodynamic therapy. The therapies were found to have no effect, either with regard to psychological problems (the target problems scale showed no significant difference either in the treated children or in the control group), overall score on the mental health scale or educational achievements (Wei99). The researchers were unable to explain the difference between efficacy and effectiveness. No association was found between the severity of the problems and the individual changes in scores on the scales used.

Chapter 4

Efficiency of psychotherapy

Efficiency studies compare the costs and benefits of various treatments, and of the option of not treating the disorder in question (Mil99). In many instances it emerged that some interventions are more effective than others, but that they are also more expensive. In such cases, the issue to be considered is whether the effect involved justifies the additional costs. In some of those cases, efficiency studies will identify the preferred treatment. If there is little difference between the cost-effectiveness of two treatments, then the selection of a given treatment will partly depend on aspects other than efficiency, such as ethical or legal considerations.

4.1 Economic costs

Economic costs within the health service can be broken down into the direct costs of the intervention itself and the indirect costs that can arise from the additional years of life gained from the treatment. There is generally insufficient information available with regard to the latter cost item. The costs incurred outside the health service can also be divided into direct and indirect costs. Direct costs are those paid by the patients themselves. Indirect costs relate to the economic value of the production that was lost as a result of the illness (loss of production due to reduced efficiency, absenteeism and work disability, and by premature death as a result of the disorder in question). There are various approaches to the calculation of indirect costs. The human capital method is based on the production that the patient would have generated had they remained healthy. Another method is the friction cost approach (Koo95). This is based on the

idea that, within the production process, everyone is replaceable. The indirect costs relate to the loss of production in the period during which the vacancy created by the illness remains unfilled. The length of this friction period, and the associated friction costs, depends for example on unemployment levels and on mobility within the labour market.

Psychiatric disorders impose considerable direct costs on the health service, primarily because of the large numbers of patients involved, as illustrated in Table 3.

The table shows that more than forty per cent of adults in the Netherlands have suffered from one or more psychological disorders at some point in their lives. The figure for the month during which the study was carried out was over sixteen per cent (Bijl97). The strong association between prevalence in the month during which the study was carried out and life-time prevalence indicates that the disorders involved are generally chronic in nature. There is also a strong association between the prevalence during the last month and during last year, which shows that these disorders often are long-lasting. The data relate to the axis-I-disorders (Apa94).

As stated in 2.2, personality disorders (axis-II-disorders; Apa94) often occur in combination with other psychiatric disorders. Research has shown that 13.5 per cent of the normal population suffers from one or more disorders (see Ver99). Prevalence among psychiatric patients is estimated to be 60 per cent, including 36 per cent with

Table 3 Prevalence of psychological disorders as a percentage of the population (Bijl97).

prevalence (%)	life-time	year	month
anxiety disorders	19,3	12,4	9,7
mood disorders	19	7,6	3,9
substance abuse	18,7	8,9	5,8
schizophrenia	0,4	0,2	0,2
eating disorders	0,7	0,4	0,3
total (one or more)	*41,2*	*23,5*	*16,5*

The table depicts the prevalence rates of a sample of 7076 individuals aged 18-64, using DSM-III-R diagnoses as a basis. Anxiety disorders include single phobia (10.1 per cent), social phobia (7.8 per cent), panic disorders (3.8 per cent), agoraphobia without panic disorder (3.4 per cent) and obsessive-compulsive disorders (0.9 per cent). Mood disorders include depression (15.4 per cent), dysthymia (6.3 per cent) and bipolar disorder (1.8 per cent). Many cases involve comorbidity.

borderline personality disorder, 15 per cent with histrionic personality disorder, 15 per cent with avoidant personality disorder and 13 per cent with schizotypal personality disorder (median values; Ver99). The research results show no clear distinction between life-time prevalence and prevalence during the period in which the study was carried out (point prevalence). Some researchers assumed (incorrectly) that personality disorders are permanent. Furthermore, the research methods used varied considerably (Ver99). Although this has raised doubts about the exact percentages involved, the data confirm the Committee's view that comorbidity in the form of personality disorders is common among psychiatric patients.

A portion of the patients with psychiatric disorders receive some type of treatment. In the Netherlands it is estimated that 27 per cent are treated by their GP and 15 per cent at a mental health institution (Bijl00). The latter group of patients are treated at the 'Riagg's' (Regional Institutes for Ambulatory Mental Health Care; 50 per cent), by self-employed psychiatrists, psychologists and psychotherapists (38 per cent), the Alcohol and Drug Abuse Clinics (3 per cent), psychiatric outpatients departments (6 per cent) and other institutes (5 per cent). In some cases more than one institute is involved (Syt98). Results obtained in epidemiological research show that approximately three out of every thousand Dutch citizens receive long-term psychiatric care (Kro98).

It is estimated that there were 260,000 outpatient treatments in 1996, and that there were over six million contacts (The Netherlands has 16 million inhabitants). About half of the contacts took place at the 'Riagg's' (420,000 active clients in 1997). These individuals received 2.4 million contacts (GGZ98).

Research into the use of psychotherapy in the Netherlands revealed that the largest group of patients (45 per cent) are those with mood disorders. Psychiatrists estimate that this group makes up as much as 60 per cent of the patient population (Hut99). In second and third place respectively are patients with anxiety disorders and adjustment disorders. As stated in 1.3, about two out of every three patients treated have more than 20 contacts (Hut99).

The costs per contact at the 'Riagg's' are estimated at 102 euro (personal communication by Dr L Hakkaart-van Roijen). An outpatient contact at a general psychiatric hospital (GPH), which takes less time than a contact at a Riagg, costs an estimated 78 euro (personal communication by Dr L Hakkaart-van Roijen). These estimates, which are based on time-planning data by those providing treatment, relate both to the costs of direct contact and to other costs (such as discussions about patients and overheads; Hoe95). A visit to the outpatients unit of a psychiatric department in a general hospital (PDGH) costs 56 euro (Oos00). The cost of an overnight stay at a

GPH have been estimated at 178 euro, while this would cost 213 euro at a PDGH (Oos00).

The charges for psychotherapy by self-employed therapists are 68 euro (in accordance with the recommendation of the Platform for Psychotherapy; this covers 45 minutes of therapy and 15 minutes of administration) and 54 euro (in accordance with the rate specified by the 'AWBZ' (Special medical expenses Act, including a private contribution by the patient of 9 euro per session, with a maximum of 180 euro per annum).

The total direct cost to the health service of psychological disorders among adults in the Netherlands is estimated at about three billion euro per annum, or about ten per cent of the total cost of the health service. Of this, about two billion is spent by mental health care institutions and one billion in nursing homes (Syt98).

An estimate of the indirect costs requires data on the number of working days lost through illness, in addition to details of the amount of production lost. It is estimated that, in the Netherlands, about 20 million of the 115 million days lost through illness in 1993 were the result of psychological problems (17 per cent; Pol97). The cost to industry of absenteeism caused by psychological disorders has been estimated to be at least three billion euro per annum (Syt98). Without psychotherapy, it is reasonable to assume that production losses would be even higher. However, the extent of the losses involved is unknown. Various studies into the effects of psychotherapy on absenteeism are discussed in 4.2.

From the above, it is evident that the various types of data required to calculate the direct and indirect costs of psychotherapy are either inadequate or non-existent.

4.2 Research into cost-effectiveness

Various techniques can be used for economic evaluations, such as cost-minimization studies, cost-effectiveness analysis, cost-utility analysis and cost-benefit analysis. Cost-minimization studies are used in situations where there is no difference between the effects of the treatments being compared, and so the only issue of importance is the difference in cost. In an analysis of cost-effectiveness, various treatment outcomes can be used, but the end points must be directly comparable. In this situation, the costs are related to the effectiveness of the alternatives. An analysis of the cost utility is a special type of cost-effectiveness analysis in which the results are expressed as an effect on survival and on quality of life. To this end, quality adjusted life years (or Qalys) are used. If the benefits are also expressed in monetary terms, then the approach is described as a cost-benefit analysis. Since it is often difficult to express all of the benefits in financial terms, analyses of this type are seldom performed.

A survey of research into the relationship between costs and benefits in the field of psychotherapy examined 18 publications that appeared between 1984 and 1994, eight of which described studies that incorporated control groups (Gab97). The researchers' general conclusion was that the use of psychotherapy reduces the direct cost of treatment. This conclusion was mainly based on estimates of the costs involved in admitting patients to hospitals or other institutions. Since the costs are much higher than those involved in outpatient treatments, even a slight reduction in the duration of admission results in a marked reduction in total costs. The study dealt with a variety of psychiatric problems, including schizophrenia, affective disorders, borderline personality disorder and drug abuse (Gab97). However, this study failed to make clear what percentage of the cost reductions could be attributed to psychotherapy. For example, the treatment of schizophrenic patients referred to in the survey is, in addition to pharmacotherapy with antipsychotic drugs, the counselling for the families involved (Hog91). In the case of affective disorders, it was unclear whether the use of psychotherapy resulted in any reduction of costs, even if it did result in a reduced number of hospital admissions. Researchers in Scotland have concluded that, in the case of disorders of this type, the treatment costs are all about the same, regardless of whether treatment was administered by social workers, GPs, psychotherapists or psychiatrists (Sco92).

A reduction of hospital admissions in a group of patients with a borderline personality disorder may well have resulted from the use of psychotherapy (Lin91, Lin93). Researchers had previously reported that intensive treatment reduced the period of admission (Tuc87). Other studies produced less clear results, however, partly as a result of the wide variation in hospital admissions (Ste92, Bat99). Some researchers have concluded that there was a considerable reduction in absenteeism (Ste92, Gab97). It is possible that there is also a reduction in the number of contacts with the law (Dol96). In these studies also, no distinction was made between the effect of psychotherapy and that of other elements of the treatment. In the United Kingdom, studies have recently been carried out into the effect of short-term psychotherapy on the costs of treating non-psychotic patients who often made use of mental health facilities. After a period of six months, it was found that there had been a significant reduction in overall costs (Gut99).

For patients who had received inpatient psychotherapy in the Netherlands, an estimate was made of the medical costs involved both before and after treatment. The patients were admitted for an average of ten months. There was a wide distribution in terms of the duration of clinical treatment (almost half of the patients were discharged within six months, but in more than 15 per cent of cases the period of treatment exceeded 18 months). Following the treatment, the services of professional practitioners were called upon less often. However, there was no significant

improvement in the work situation (Har99). More details are required in order to calculate the relationship of costs to benefits, including the extent and nature of assistance given before and after treatment, and the duration of the effect of inpatient psychotherapy. Nor is it known what effect another type of intervention might have had.

Relatively few analyses concerned the cost-effectiveness of psychotherapy. Two examples are the calculations of the relationship between the costs and the results of treatment given to patients suffering from depression and those suffering from bulimia nervosa (Kam95, Kor95). In both cases, statistical modelling was used to compare pharmacotherapy, psychotherapy and a combination of the two. In both cases, the analysis was based on the results of previous efficacy studies.

Quality of life was taken into account when evaluating the results of treatment given to depressive patients. To this end, a factor is used with values between 0 and 1, the former corresponding to patients who have died and the latter value to completely healthy patients. The estimated quality factor for depression is 0.45 (a lower factor than for tuberculosis or hemodialysis for example, which serves to illustrate the severity of this disorder). In order to adjust for the side effects of medication, the quality factor was set at a value of between 0.7 and 1 during periods of pharmacotherapy, when patients suffered no bouts of depression. The calculation was performed using the results of a previous study (the Pittsburgh Study of Maintenance Therapies in Recurrent Depression; Hir94b). In that study, the results obtained using combination therapy and pharmacotherapy were roughly equivalent. It follows from the analysis that psychotherapy generates five Qalys, and pharmacotherapy also generates five, if the quality factor is set at 0.7. The total direct costs of psychotherapy and therefore also the costs per Qaly, are higher than for pharmacotherapy. It should be noted, however, that recent studies of combination therapy have achieved better results than have separate treatments (as stated in 2.2; Kel00).

The second example concerns the cost-effectiveness of the treatment of patients with bulimia nervosa. A comparison of the costs and results of pharmacotherapy and psychotherapy shows pharmacotherapy to be the more efficient of the two (since a given result was achieved at the lowest cost). However, from the efficacy study it can be concluded that a much better result can be achieved with a combination of the two therapies, even though this is associated with higher unit costs (Kor95).

A major objection to these analyses is that the two sample calculations referred to took no account of possible differences in the duration of treatment results. In the case of depression, the researchers assumed that the patients received continual treatment, whereas in the case of bulimia nervosa they worked on the basis of results achieved

within one year. When evaluating the cost-benefit ratio, however, the question of long-term differences in the treatment results is extremely important (Don99). If complete recovery is not achieved, then the frequency and duration of relapses are substantial determinants of cost-effectiveness. Many studies into the results of psychotherapy are restricted to short periods of time, which poses problems for any analysis of efficiency. Depressions are generally studied for three to six months, while anxiety disorders are usually studied for even shorter periods (Rot96).

One of the subjects for research into the duration of treatment results was the treatment of patients suffering from panic disorders (Bro95, Mil96). These disorders are chronic in many patients if left untreated. The researchers found that only twenty per cent of patients remained free of attacks during the first year following cognitive therapy. After two years, approximately half of the patients had received a new course of therapy (Bro95). It was suggested that slightly better results would have been obtained if combination therapy had been used (Bak98). Studies have also been carried out into the long-term results obtained in patients with depressive disorders. In many cases, depression is not restricted to a single episode. Studies into the 'natural course' of the disorder revealed that 28 per cent of patients suffered a relapse within one year, and 75 per cent within ten years. In only 18 per cent of patients was there no recurrence (Hir94a). Some researchers feel that, for recurrent depressions, psychotherapy can be a useful supplement to antidepressant drug therapy. The results of an American study (the Pittsburgh Study of Maintenance Therapies in Recurrent Depression) supported the conclusion that psychotherapy lengthened the intervals between episodes of depression (Hir94b). Pharmacotherapy, however, appeared to produce superior results. During a 3-year course of therapy with imipramine, with or without interpersonal psychotherapy, 20 per cent of patients suffered a relapse. Where psychotherapy was used with or without a placebo, the equivalent figure was 60 per cent (Fra90, Hir94a). A follow-up study supports the conclusion that patients who had previously obtained beneficial effects through the use of imipramine suffered significantly fewer relapses when pharmacotherapy was continued. Interpersonal psychotherapy had no significant effect (Kup92). In another group of patients, who were treated using antidepressants, it was found that follow-up treatment using cognitive behavioural therapy (targeted at residual symptoms) considerably reduced the rate of relapse in the subsequent four-year period (Fav96).

A study of the results of psychotherapy in bulimia nervosa patients six years after their treatment found that about half of the patients had recovered (Fai95). The course of this disorder is often chronic in nature, but it is not known how many patients recover without therapy (Rot96).

From the above it is clear that further data is required before the efficiency of treatments in patients with recurrent disorders can be established. For each of the

therapies in question, both the incidence of relapse and the length of the intervals must be determined. If psychotherapy has a lasting result while pharmacotherapy does not, as is the case in most patients with a specific phobia, then psychotherapy can be said to be efficient. However, the requisite data is not available for many psychological disorders. Although some published research makes mention of the number of relapses that occur, relatively large numbers of subjects withdraw from these studies. As a result, it is not clear whether these figures are representative of the patient population. As stated, there has been virtually no research into the efficacy of long-term psychotherapy (2.3), while there is no data at all regarding efficiency. It is reasonable to assume that, in some cases, the use of psychotherapy can achieve considerable cost savings. In specific terms, this would be achieved by avoiding the need to hospitalize a patient or, if a patient does need to be admitted, by reducing the period of admission. In some cases, however, it may be the case that the number of sessions given is unnecessarily large. As mentioned before, it is usually the case that efficacy has only been demonstrated for a limited number of sessions (2.2) whereas the positive relationship between number of sessions and the improvement achieved tends to level out at higher numbers of sessions (2.3.2).

Chapter 5

Recommendations concerning long-term psychotherapy

5.1 Recommendations concerning research

As explained in the previous chapters, the amount of research into long-term psychotherapy is insufficient to draw conclusions regarding its efficiency. Given the severity and the incidence of certain psychiatric disorders, the Committee feels that research of this kind should be carried out.

Such research should primarily be targeted at the clinical effects of long-term psychotherapy. In the past, research into long-term treatments such as psychoanalysis dealt with the therapeutic process or the patient-therapist relationship, but little consideration was given to clinical effects. In particular, the question of whether these effects can indeed be attributed to the therapy remains to be answered. To this end, a controlled study with patient randomization would be required, since it is not possible to determine the natural course of the disorder with sufficient accuracy.

The most eligible patient groups for a study of this kind would appear to be depressive patients for whom other therapies have failed, and patients with personality disorders, in particular borderline personality disorders.

The use of both pharmacotherapy and short-term psychotherapy in the treatment of depressions has been extensively studied (chapter 2). In some patients, however, these therapies do not appear to achieve a lasting effect (Bir00). No scientific effect-studies, nor indeed any efficiency studies, have been carried out into long-term psychotherapy in such patients (Are97). The Committee feels that it would be useful to conduct research into intensive, long-term psychotherapy in these cases. Additional factors to

be taken into account are that individual patients experience a substantial burden of illness and that periods of depression occur relatively frequently. There are also considerable medical expenses involved, particularly due to frequent admissions to clinics. The recommendation that this particular group of patients be studied does not imply that other clinical syndromes would fail to produce positive results, nor indeed that a positive result is guaranteed for this group. The study could be carried out on outpatients and, as stated, it would have to be randomized. This could then be compared to the 'usual' treatment. In order to avoid subsequent confusion as to what exactly constitutes 'usual' treatment, both this and the long-term psychotherapy used would need to be clearly defined. The psychotherapies to be studied could consist of long-term cognitive therapy or interpersonal therapy, once or twice a week, on the one hand and a psychoanalytically-oriented therapy given one to five times a week on the other. If the patient's suitability for a given treatment is an inclusion criterion then randomization should take place after inclusion, to make the result independent of the selection. The effects should be analysed both on the basis of 'intention to treat' and on 'completers'. Records should be kept of the costs involved for both groups of patients, in connection with the planned efficiency analysis.

Another group of patients that, in the Committee's view, should be the subject of a study into the possible beneficial effects of long-term psychotherapy are those with borderline personality disorders. This type of personality disorder is generally chronic in nature and is often associated with comorbidity (Sto00). The problem is characterized by recurring crises, periods of admission, self-mutilation, suicide, addiction and episodes of depression, anxiety or aggression. The problems sometimes tend to ease in the forties and fifties. Various short-term treatments appear to have little effect. The cost of treatment is very high. A reduction in the number of periods of admission could achieve considerable cost savings (see for example Gab00). Although comorbidity makes it more difficult to study the efficacy of a given therapy, the exclusion of patients with comorbidity would detract from the clinical relevance of the study (Bat00). The experimental design adopted can be analogous to that used for depressive patients. Moreover, a comparison could be made between a psychoanalytically oriented treatment and a long-term form of cognitive therapy. Here also, a comparison with the 'usual' treatment requires a definition of that treatment. It should be noted that no such comparison has been included in a study currently being carried out in the Netherlands into psychotherapy, with a grant from 'Ontwikkelingsgeneeskunde' (Development of cost-effective treatments in medicine; research project Outpatient treatment of borderline personality disorders: cognitive behavioural therapy versus analytical psychotherapy). The randomization and analysis of the results are subject to the same conditions as those that apply to research into depression.

5.2 Recommendations concerning the practical situation

5.2.1 National guidelines

Various professional societies and institutes in the area of mental health care have developed treatment guidelines (in the Netherlands; Coh00, Spi98). If psychotherapy is to be used efficiently, it is essential that these guidelines are both multidisciplinary and national (Coh00). Patients with psychological disorders seek help from a variety of professionals. It is therefore important that various professional groups be involved in drawing up the guidelines. Multidisciplinary guidelines are presently being drawn up within the mental health care services. These will apply to the treatment of patients with disorders such as anxiety disorders, mood disorders, psychotic disorders and schizophrenia. To this end, working groups have been set up (or will be set up in the near future) within the mental health care service under the auspices of a Steering Committee for the Development of Multidisciplinary Guidelines. Those participating in the steering committee will include representatives of various professional groups, such as: the Netherlands Society of General Medical Practitioners, the Netherlands Psychiatric Society, the Netherlands Psychotherapy Society, the Netherlands Institute of Psychologists and the Nurses Federation within the mental health care service (being established). As explained in 2.1, efficiency also implies efficacy. Accordingly, the results of research into efficacy are vital for such guidelines. Partly on the basis of data referred to in 4.1 and 4.2, consideration should also be given to criteria for determining the duration and frequency of psychotherapeutic treatment.

5.2.2 Monitoring long-term psychotherapy

Until there is clear evidence to support the efficacy and efficiency of long-term psychotherapy, restraint must be practised in the use of such therapy. In the same vein, restraint should also be practised in the use of short-term psychotherapy that has not been studied by means of RCTs. In some cases, psychotherapeutic treatment can be deemed necessary, even though no adequate research has been carried out into the effect of psychotherapy. These might include cases involving a newly developed or unusual form of psychotherapy, and of its use in association with relatively rare disorders.

Experts may also take the view that long-term psychotherapy is essential. Given the burden placed on the mental health care service in terms of time, money and the use of human resources, the indication of long-term psychotherapy should be well supported. Some examples of situations in which the indication can be considered are

complex psychological problems (including comorbidity, or pathology of a family system), a previous history of failed treatments, and long-term psychiatric problems for which the patient has received no previous psychotherapeutic treatment. In the above-mentioned cases, psychotherapy can be used in accordance with the rules of good clinical practice.

In addition, the results of treatments must be carefully observed and evaluated. To this end, the Committee feels that a monitoring system should be developed, to be implemented as soon as possible. Examples of such systems are the quality system of the Netherlands Institute for Psychoanalysis (Bee98) and the evaluation system developed by the Menninger Clinic (Cli99, Fon99, Gra99). The results of treatments described with the aid of such systems do not, of course, provide any definitive answers concerning the effectiveness of long-term psychotherapy. However, systems such as these can be used in the context of naturalistic studies. These can provide the information that is required when setting up RCTs. If a monitoring system is to be developed, it should at least meet the following requirements:

1 the system should contain decision rules for establishing the indication, and continuing or terminating a course of treatment
2 the objectives of a given treatment should be clearly formulated
3 there should be a clear relationship between objectives, measurements of progress and therapeutic interventions
4 the system should generate relevant information and should be easy to use
5 it should be usable in a variety of settings and for various diagnostic categories.

With regard to the decision rules, criteria should be established for the indication of long-term psychotherapy. In addition, criteria should be established to facilitate evaluations of the quality of treatments, as should norms for good clinical practice and standards for their evaluation.

The Hague, 28 February 2001,
for the committee

(signed)

dr PA Bolhuis,	dr RW Trijsburg,
secretary	chairman

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A The request for advice

B The Committee

Annexes

Annex **A**

The request for advice

The limits of care

On 11 September 1989, the President of the Health Council received a request from the State Secretary for Welfare, Health and Cultural Affairs to produce an advisory document relating to the limits of care (letter reference DGVGZ/Stabo/JM/U-00136). The following is an extract from the State Secretary's letter:

As set out in the Statement of the Government's Views on the Limits to Health Care, the current insurance package will be rationalized where possible and where necessary. This procedure is needed to remove unnecessary, marginally effective and/or inefficient parts of the package. In this connection, I would refer you to policy objectives no. 3, as described on page 24 of the Statement of the Government's Views on the Limits to Health Care (Parliamentary Document II, 1987-1988, 206620 no. 1-2).

The first question to be dealt with is 'which procedures might be eligible for further evaluation?'. On 8 February 1989, I formally requested the Health Insurance Funds Council to chart this area and to arrange for testing (either in-house or elsewhere). I also asked that the types of assistance for which testing is deemed appropriate should be ranked in a given order. For the record, I have enclosed a copy of this request for advice. I trust that you will consult the Council's secretariat, with a view to aligning your approach with the recommendations produced by the Health Insurance Funds Council.

Next, the scientific situation pertaining to each of the items on the list of interventions must be indicated. I look forward to receiving the Health Council's recommendations in this matter. In that context, you may arrive at the conclusion that for some topics the scientific situation does not provide sufficient basis for reaching a verdict and that further testing is required. In that event, I would be grateful if you

could inform me of the relevant topics and questions, and indicate which approach you consider to be most appropriate. With regard to the latter, I have the following in mind.

The method of testing will vary according to the topic. It will sometimes involve the formulation of a consensus regarding the most appropriate/proper use for a given intervention. The indication for the use of a given medicinal product, for example, may sometimes be extended without any corresponding validation. In such cases, further research will be required before there can be any restriction of the indication.

In the case of some interventions, it may be necessary to conduct further patient-based evaluation studies. If this should be the case, then the study could take place in the context of developmental medicine, for example.

I would be grateful if, in the above-mentioned context, you could advise me concerning which existing interventions could be curtailed or cancelled, in view of the scientific situation. I anticipate that, in the course of these activities, you will make use of the information that I have requested from the Health Insurance Funds Council.

Previously, in a letter of 8 February 1989, the State Secretary asked the Health Insurance Funds Council to subject the range of treatments covered by mandatory public health insurance to a critical review (letter reference VTA/VER/VE-407353). The Council was asked to identify which treatments from the insurance package were in need of further evaluation.

Initial recommendations

In response to the first-mentioned request for advice and in anticipation of the Health Insurance Funds Council's report, the Health Council issued the report 'Medical treatment at the cross-roads' in 1991. In 1993 the Health Insurance Funds Council's report 'The cost-effectiveness of existing provision' was published. The report listed 126 areas which were in need of further evaluation for the following reasons:

- probable lack of efficacy
- too low a level of efficiency
- use which cannot be justified in the light of the scientific situation (inappropriate use).

Follow-up

On 23 November 1994 (letter reference VMP/VA-943453) and again on 9 May 1996 (letter reference CSZ/ZT-962171) the Minister of Health, Welfare and Sport requested that the Health Council carry out the further selective evaluation of the list, in consultation with the Health Insurance Funds Council. After seeking expert advice, the

President of the Health Council reported on 10 July 1996 and again on 5 February 1997 stating which of the subjects mentioned in the ‘126 list’ qualified for further investigation by the Council. These subjects were then placed on the Council’s working programme. The MTA Committee (see annex B) was installed in 1997 and given the task of proceeding with the work on these subjects.

Annex **B**

The Committee

The Long-term Psychotherapy Working Group and the MTA Committee jointly fulfilled the role of Committee. The chairperson and secretary of the Working Group also served as the chairperson and secretary of the Committee.

Members of the Long-term Psychotherapy Working Group

- Dr RW Trijsburg, *chairman*
  professor of psychotherapy; Erasmus University, Rotterdam
- Dr F Beenen
  psychoanalyst; Netherlands Institute for Psychoanalysis, Amsterdam
- Dr R van Dyck
  professor of psychiatry; Valeriuskliniek, Vrije Universiteit, Amsterdam
- Dr L Hakkaart-Van Roijen
  economist; Institute for Medical Technology Assessment (iMTA), Erasmus University, Rotterdam
- Dr RC van der Mast
  psychiatrist; Mentrum, Amsterdam
- L de Nobel
  clinical psychologist; Mental Health Board for North Holland-North, Heiloo
- Dr S Schagen
  psychologist; University of Amsterdam
- Dr P Spinhoven
  professor of clinical psychology; University of Leiden

- Dr RJ Takens
  psychologist; Vrije Universiteit, Amsterdam
- Dr PA Bolhuis, *secretary*
  Health Council of the Netherlands

Members of the Committee on Medical Technology Assessment

- Prof. JA Knottnerus, *chairperson*
  Vice-president of the Health Council
- Dr GH Blijham
  professor of internal medicine; University of Utrecht
- A Boer, *advisor*
  Health Insurance Funds Council, Amstelveen
- Dr PMM Bossuyt
  professor of clinical epidemiology; Academic Medical Centre, Amsterdam
- Dr HR Büller
  internist; Academic Medical Centre, Amsterdam
- Dr J Dekker
  professor of paramedic care; Vrije Universiteit, Amsterdam
- Dr MCH Donker, professor of policy and evaluation in mental health care;
  Erasmus University, Rotterdam
- Dr GL Engel, *advisor*
  Association of University Hospitals, Utrecht
- Dr J Kievit
  Professor of medical decision-making; University of Leiden
- Dr FFH Rutten
  professor of health economy; Erasmus University, Rotterdam
- Dr GHM ten Velden, *secretary*
  Health Council of the Netherlands