

## In debate

## Proposals for massive expansion of psychological therapies would be counterproductive across society†

Derek Summerfield/David Veale

**Summary**

In 2007 the UK Government announced a substantial expansion of funding for psychological therapies in England to provide better support for people with conditions such as anxiety and depression. Will these services result in the medicalisation of normal distress? Or are they simply an evidenced-based solution for a previously unmet need? In

this debate Derek Summerfield and David Veale discuss the issues raised by these controversial proposals

**Declaration of interest**

D.S.: none / D.V.: none.

**For**

Layard's proposals for 10 000 more therapists in new psychological treatment centres trades on a naively mechanistic concept of 'mental illness' and would be counterproductive across society.

Lord Layard, an economist at the London School of Economics, has made these remarkable proposals to tackle what he describes as the 'massive suffering' accruing from untreated 'mental illness' (chiefly depression and anxiety disorders) across Britain.<sup>1</sup> Two pilots are underway.

First, I would argue that the advice he has received from the mental health field amounts to disease-mongering. Layard states that nearly 1 in 6 of the entire population has depressive or anxiety disorders, rather as the Royal College of Psychiatrists claimed during its anti-stigma campaign that 1 in 4 families in Britain contains a mentally ill member. He says the 800 000 people per year require (mostly) cognitive-behavioural therapy (CBT). Where do these figures come from? If on average 1 in 4 or 6 of the people going about their ordinary business on the street outside my house as I write are diagnosable as 'cases' of mental illness, we need to re-examine our models before we examine the people. It is time that the profession reviewed its touching faith in the capacity of screening instruments (e.g. the General Health Questionnaire) to generate hard data on prevalence within a population. Such instruments, with their demand characteristics and tendency to reify subjective consciousness through a mechanistic focus on 'symptoms', produce ridiculous overestimates. Structurally unable to assess the whole person immersed in the dynamic complexity of a life, they re-cast the physiology of normal distress as pathology. Categories such as 'depression' or 'anxiety disorder' are facile when applied across a population in these ways.

Layard writes that 'psychological help is what thousands or millions of patients want'. Is this true? We are in an age of the medicalisation and professionalisation of everyday life, and of the industrialisation of health, yet lay opinion can still run against the tide. In 1996, just before the Royal Colleges of Psychiatrists and General Practitioners began their 'Defeat Depression' campaign, they surveyed lay people's attitudes to depression and its treatment. What they found was broadly subversive to the basic assumptions driving the campaign (though they didn't let this put them off): most people did not subscribe to a

depression-as-disease model, and saw things in terms of situational problems which were not something to take to the doctor.<sup>2,3</sup> A similar preference for psychosocial explanations rather than terms like 'illness' and 'disease' came through a recent study of public attitudes to anti-stigma programmes that deployed the 'mental illness is an illness like any other' approach.<sup>4</sup>

In Britain more than 2.5 million people of working age (7.5% of the working-age population) are now claiming doctor-attested disability benefits, treble the number in the 1970s. Only 20% of people receiving incapacity benefit for more than 6 months will return to work in the following 5 years.<sup>5</sup> The contribution of mental disorders to overall sickness absence has increased markedly, and doctor-attested 'stress' is now epidemic, the number one cause of sickness absence nationally.<sup>6</sup> In the age of the 'doctor-patient relationship' and a 'patient-led NHS' (National Health Service), general practitioners frequently feel unable to police the sick role and its entitlements. Moreover, political attitudes – notably in the Thatcher era when job centre managers were advised to recommend the benefits systems to job seekers as an alternative route to a living – have at times been in collusion with these trends, since they improve the look of the unemployment statistics.

My 3 years as consultant psychiatrist in occupational health to the Metropolitan Police Service, where extended sickness absence constituted a significant proportion of referrals, brought home how hard it is to remove a diagnostic label once it has been applied. There was little evidence that a pro-rehabilitation approach was being taken by NHS psychiatrists or psychologists with the officers in follow-up with them, and as time passed the negative effects of a chronic sick role – the erosion of a sense of agency and competence – became ever more salient as obstacles to recovery. Sitting at home between out-patient appointments, waiting for an elusive 'cure', they languished. This was compounded by the perverse incentives attached to open-ended disability benefits, which can take on a life of their own. Indeed, being in receipt of disability benefits seems to be an independent risk factor for a poor outcome.

Furthermore, and this is fundamental, psychiatric formulations by definition do not capture the active meaning-making and appraisal of interests that the patient engages in, and yet for cases of sickness absence above 6 months or so the major prognostic factor regarding a return to post and career was whether the officer *wanted* to do so.

Mental health models have historically failed to properly acknowledge the central role of social capital and engagement –

†See invited commentary pp. 331–332, this issue

notably employment – in buttressing personal adjustment and competent citizenship. Clinic follow-up by psychiatrists and psychologists has allowed a passive role for patients, failing to put graded normalisation back to customary social roles at the heart of therapeutic objectives from the start. I have soberly concluded that large numbers of patients would have been better off if they had not got caught up in mental health services.

Layard wants to treat huge numbers of people, promoting CBT as a kind of population panacea. There would be those with no history of contact with mental health services, some working, some not. But a technical fix cannot solve problems whose locus is not in the body but in a particular situation in life. Moreover, once a psychiatric formulation is deployed as the explanation for a person's problems, the moral economy of the situation alters. Attention shifts to a diagnosed condition for which the patient is not responsible, and from which they are not expected to recover without professional help. Agency passes from patient to therapist in expectation of an expert cure. The danger is that this unnecessary brush with a mental illness label may leave a taint: as the Read *et al*<sup>4</sup> study noted, it may be that the general public prefer psychosocial explanations because once a disease model is applied to the brain, something definitive appears to have been said about the patient's core qualities as a person: 'The assumption is that the person is incapable of judgements, reason, autonomy – that their personhood is negated'. How might this affect the way they see themselves, and how others see them, from then on? They might well give up sooner in the future, be more likely to see themselves not as normally stressed but as ill (for which they are not responsible), and in general play out the role of a limited person assigned to them by a medical authority.

There would also be those with a history of contact with the mental health field, many of whom have taken up chronic sick roles and receive ongoing disability benefits. Although in principle CBT does lend itself to the graded steps of a pro-rehabilitation approach, it is a kind of kitsch to assume that 16 sessions will magically restore these people to productive citizenship in isolation from any other initiative. The bitter experience of the occupational health field is that many, if not most, of those who have been on disability benefits for more than 6–12 months have been 'lost'.

I am with Layard in his concern about what sickness absence costs the nation, but his starting point is naive and simplistic in its broad characterisation of mental illness as a naturalistic phenomenon, as concrete and quantifiable as, say, hips needing replacement – a swimming pool's worth so to speak, which can be baled out, and that this would be paid for by the productivity of those thus restored to 'health'. It was such assumptions that in part launched the NHS itself in 1948: by this reasoning the figures above would suggest that the NHS has been a miserable failure!

What is the cultural background to this debate? To coin an aphorism, citizens are on average as tough as the culture they are living in expects them to be. Yet over the past 40 years in particular, the concept of a person in Western culture has come to emphasise not resilience but vulnerability, and with 'emotion' as its currency. This momentous shift has its roots in the way that medico-therapeutic ways of seeing have come to dominate everyday explanations for the vicissitudes of life, and the vocabulary of distress. What has been described as a culture of therapeutics invites citizens to see a widening range of experiences in life as inherently risky and liable to make them ill. This involves a blurring between unpleasant but everyday mental states and those suggesting a clinical syndrome. The mental health field has played its part in promoting the idea that the trials of life reflect noxious influences easily able to penetrate the average citizen, not just to hurt but to disable. This is to endorse a much thinner-skinned

version of a person than previous generations – encouraged to be emotionally continent and self-sufficient ('stiff upper lip', 'bulldog Britain') – would have recognised. In line with this, there have been steady increases in all categories of mental health professionals, for example, a doubling in consultant psychiatrist numbers in 20 years, and a trebling in 10 years of membership of the British Association of Counselling.<sup>7</sup> Other markers include a veritable epidemic of antidepressant prescribing – nearly 3 times higher than in 1990.

Illich<sup>8</sup> in his seminal text *Medical Nemesis* describes the pervasive but largely unrecognised consequences of what he calls social and cultural iatrogenesis. Healthcare consumes an ever growing proportion of the national budget, but with increasingly unclear benefits for patients or society as a whole. The more people are exposed to healthcare, the sicker they can feel; medicalising the problems of living can become part of their perpetuation. Illich points to the longer-term implications of the erosion of time-honoured ways of dealing with pain, sickness and death. The more the mental health field promotes its technologies as necessary interventions in almost all areas of life, and the more that people pick up that they are not expected to cope through their own resources and networks, the more we may see socially constructed ways of enduring and coping wither. Thus, it will be ever harder to reconcile to the everyday hardship of life, the vale of tears that is our common lot. As more resources are provided for mental health services, more are perceived to be needed – an apparently circular process, a dog chasing its own tail. Has an expansive mental health industry become as much a part of the problem as of the solution? In the interests of cultural endorsement of a view of personhood as basically robust (surely a collective imperative, given the state of the world) the mental health industry arguably needs to contract, not expand.<sup>9</sup>

Finally, it is noteworthy that Layard's proposals arose from a commission by the Prime Minister's Strategy Unit, and, as with his work on 'happiness', reflect the rise of modes of governance deploying modern psychological discourse as an instrument of policy to help manage subjectivity across society. The UK government's commitment to the 'therapeutic state' comes through not just in health, but in education, social services and law enforcement. Consider Layard's extraordinary statement that 'in Britain mental illness has now taken over from unemployment as our greatest social problem'. We should beware: the political and economic order benefits when distress or dysfunction that may connect to its policies and practices is relocated from socio-political space, a public and collective problem, to mental space, a private and individual problem.<sup>10</sup>

Derek Summerfield

### Against

I wonder which papers you [D.S.] have read, as Lord Layard has cited all his sources. The epidemiological data are taken from the widely respected Psychiatric Morbidity Survey in the UK.<sup>11</sup> A total of 8800 randomly selected individuals were assessed with the Clinical Interview Schedule (CIS), which is based on ICD-10. About 1 in 6 adults (16.4%) were assessed as having a depressive or anxiety disorder in the week before their interview, the most prevalent being mixed anxiety and depressive disorder (8.8%). The others were generalised anxiety disorder (4.4%), depressive episode (2.6%), phobia (1.8%), obsessive-compulsive disorder (1.1%) and panic (0.7%). The findings are in line with other international surveys. Do structured diagnostic interviews overdiagnose normal distress as pathology? A comparison of clinical interviews conducted by you and by your peers, and the CIS

should determine whether you underdiagnose mental disorder as normal human suffering. I will discuss later how one can differentiate the two.

The Layard proposals cover the provision of evidence-based psychological therapies for the 800 000 people per year (or 1.5% of the population in the UK) who have chronic and disabling depression and anxiety disorders. They can hardly be accused of trading on a naively mechanistic concept of mental disorder when they focus on such a small proportion of those identified in the Psychiatric Morbidity Survey.<sup>11</sup> The pilot centres have found the mean duration of the presenting problem to be 6 years, so they are certainly not transitory life stresses.

The next issue you raise is whether people actually want psychological help. Targeting 1.5% of the population acknowledges that not everyone wants help. However, about a quarter of the people assessed as having depression or anxiety in the Psychiatric Morbidity Survey were already receiving treatment (or roughly 4% of the population in the UK). Close to 20% were taking medications, 9% were having counselling or psychotherapy and 4% were receiving both therapy and medication. We do not know how much non-evidence-based psychotherapy and counselling is currently being delivered. Cognitive-behavioural therapy is the dominant evidence-based psychological therapy but waiting lists in the NHS are often a year or longer. In primary care, patients with depression or anxiety disorders tend to be offered either counselling (which incorporates a range of modalities) or medication. These approaches are usually less effective in the long term especially for anxiety disorders and recurrent depression. Medication may have unacceptable side-effects or lead to a higher rate of relapse when discontinued. You appear to want to deny patients already in treatment the choice of an evidence-based psychological therapy. The suggestion that an individual may obtain direct access to treatment without necessarily obtaining a referral from their general practitioner (GP) arises from the common reluctance to seek help from GPs, whether that arises from factors such as stigma, lack of information on the treatability of their condition or disillusionment with medication alone. When given the choice, patients commonly prefer an effective psychological therapy, yet many people who may potentially benefit are either simply not referred, because of the long waiting lists, or opt for the private sector. The proposals are therefore an attempt to offer patients the choice of evidence-based psychological therapies by reconfiguring services so that they are more consistent with the National Institute for Health and Clinical Excellence (NICE) guidelines.

Further evidence that the Layard proposals find favour with the public comes from a report published by five leading mental health charities (Mental Health Foundation, Mind, Rethink, The Sainsbury Centre for Mental Health, Young Minds),<sup>12</sup> from cross-party political support and from approval by a wide range of user groups such as OCD Action and the National Phobias Society. They know what users want.

You focused your argument on depression, though anxiety disorders are just as distressing and disabling. I would like to know whether you follow the various NICE guidelines, which have involved the meta-analysis of hundreds of randomised controlled trials as well as widespread consultation with researchers, clinicians, professional and voluntary organisations and users. For example, you have previously argued that post-traumatic stress disorder is a manufactured diagnosis. However, CBT for post-traumatic stress disorder can demonstrate significant effect size, enabling individuals to process a trauma emotionally and return to their normal roles in life much earlier than they would have done without treatment.<sup>13</sup> For example, if following assault and rape a woman in the UK experiences flashbacks and nightmares over an extended period, and is avoiding thoughts and situations

that remind her of the trauma so that she is disabled in her everyday life and relationships, will you discuss with her the evidence for CBT and refer her to an appropriate service? If you do, you'll know how difficult it is to secure a quality service quickly. Or will you inform her that her symptoms are simply those of normal human suffering which she might reduce over time with the right support? To extend the period of distress and handicap unnecessarily strikes me as immoral and possibly negligent.

Your next argument is that providing evidence-based psychological therapies would be 'counterproductive across society'. You provide no evidence that these proposals would maintain unemployment and loss of social roles. You state that psychiatric formulations lack active meaning-making and do not focus on an individual's valued directions in life. I do believe you have taken a shot at the wrong target! A model of 'disease' and passivity is just irrelevant to CBT. From the outset, a cognitive-behavioural therapist develops a shared formulation that emphasises both the meaning the patient places on internal or external experiences and the way in which that person has responded with avoidance and safety behaviours or ways of attempting to control their inner world. Psychopathology is therefore differentiated from normal human suffering when it results in the individual coping in ways that make their suffering worse and means that they can no longer follow their valued directions in life. Once a patient has a good psychological understanding of how they are exacerbating their distress and handicap, then during therapy they have the responsibility to change. This might include testing out whether a belief is true, whether a cognitive process (e.g. ruminating or self-focused attention) is helpful or whether behaviour such as avoidance or substance use maintains their symptoms in the long term. The homework and goals of therapy are focused on the patient's valued directions in life with an expectation of graded normalisation for a return to employment and social roles. Cognitive-behavioural therapy does not ignore the social context of mental disorder. Competent therapists are aware of the effects of, for example, poverty, continuing abuse or the lack of social support. They take care to facilitate the process by which the person becomes their own agent of change in a hostile environment, including interactions with relatives or friends who are critical or overprotective. Practitioners address these issues and work collaboratively on solutions that might be helpful in overcoming these obstacles.

You seem to lack awareness of current best practice in CBT and your personal experience as an occupational psychiatrist seems to me to lend weight to the Layard proposals. They are not just about increasing access but are also designed to improve the *quality* of the service. The efficacy of CBT differs according to who delivers it and how it is delivered. You (and readers) might like to audit your local psychology or psychotherapy service with the following questions.

- (a) Are the therapists delivering CBT accredited (or accreditable) by the British Association of Behavioral and Cognitive Psychotherapies as reaching a minimum standard for training? Qualification as a clinical psychologist is not adequate as CBT is a postgraduate qualification.
- (b) Do the therapists follow empirically driven written protocols for a disorder derived from randomised controlled trials?
- (c) Do the patients have a formulation shared with them that identifies the meaning they attach to events or internal experiences and the avoidance and safety behaviours that are maintaining their symptoms?

- (d) Do the patients have agreed goals which include a return to their valued directions in life such as employment or social roles?
- (e) Do patients participate in the setting of relevant homework between sessions and is this monitored at the beginning of each new session?
- (f) Are the therapy sessions audio- or video-taped and a copy given to the patient to enhance learning and to the therapist to ensure quality control in supervision?
- (g) Do the therapists work in teams specialising in a particular disorder or group of disorders for supervision by a senior therapist or by their peers?
- (h) Do the staff receive continuing professional development and attend workshops and conferences in CBT to maintain their accreditation?
- (i) Do the staff use standardised outcome scales and employment data that can be audited and is the effect size compared against clinical trials for a particular disorder?
- (j) Can a service offer CBT promptly and in a stepped care model so that those with more severe problems and comorbid disorders can be routed to more experienced therapists?

These are features of a *quality* service for evidence-based psychological treatment. Thus, CBT is not a 'technical fix' but it is derived from research into cognitive processes and behaviours and is a very pragmatic approach to helping individuals to return to their normal roles in life.

You disparage the assumption in the proposals that 16 sessions of CBT are adequate without any other initiative. First, the proposals aim to integrate CBT with employment advisors in the same service. The 'Pathways to Work' pilots for people on incapacity benefit have shown that eight work-focused interviews plus the return-to-work bonus had no effect on rate of return to work of people with mental disorder but a large effect on those with physical illness.<sup>14</sup> Such individuals were more likely to return to work after CBT and the employment advice.

Second, one needs assumptions for economic modelling. Sixteen is the average number of CBT sessions, from various randomised controlled trials. Cognitive-behavioural therapy can be shorter for some people, especially those who understand the rationale and are able to work on homework consistently. However, factors such as comorbidity, personality and social circumstances can complicate the therapy and extend its time frame. Thus, a clinical service can be flexible and the experience after the Omagh bombing is pertinent. It was found that of 91 patients, 34 (37%) were treated with CBT in 5 or fewer sessions, 59 (64%) in 10 or fewer and 78 (87%) in 20 or fewer. Patients with additional comorbid diagnoses needed more sessions and one individual received 75 sessions.<sup>15</sup> Equally, for many disorders, if a person is not engaged in CBT and starting to do homework by the sixth session, then the obstacles need to be identified and the problem solved. It is otherwise better that a patient is discharged and has the option of returning when they are ready to change.

As far as I am aware, Illich never commented on cognitive-behavioural therapists as a new priesthood nor as a source of power and doctrine which has deprived people of responsibility and caused them to feel alienated from treatment services. Illich, true to his principles, refused all medical treatment administered by doctors and died from cancer in 2002. I would have liked to have discussed CBT with him as he argued that health is a personal task and that self-awareness and self-discipline largely

determine public health. At the heart of CBT is a programme of structured self-help which empowers individuals to make changes; they can build resilience by inoculating themselves against the slings and arrows of misfortune. The goal in CBT is to help people get back to their valued directions in life by helping themselves. The first rung in a stepped care model of several NICE guidelines is self-help guided by bibliotherapy or computers. This will be incorporated into the proposed psychological therapy services, which will offer a range of intensity and expertise provided at all levels from CBT support workers to senior therapists. As the technology progresses, computer programs are likely to become more sophisticated; people will be able to log onto the web and follow a program without needing a therapist. I am sure Illich would have approved.

Of course CBT is not a universal panacea and cannot offer a quick fix. However, after about 30 years of research, it is doing pretty well and is more cost-effective than medication for depression and anxiety disorders in the long term. The effect size and range of disorders it treats increases with every new generation of researchers. For example, we now have evidence suggesting that CBT is superior to psychodynamic transference-based psychotherapy for borderline personality disorder.<sup>16</sup> The proposed therapy services are multidisciplinary and the Royal College of Psychiatrists needs to ensure that all psychiatric trainees are competent to deliver an evidence-based psychological therapy and have a career path so they can become some of the senior therapists and the directors of the new services.

David Veale

#### For: rebuttal

Psychiatric categories are manufactured constellations emerging as DSM or ICD committee decisions. That is indisputable, so why do we treat them as if they were facts of nature identifiable 'out there', as is, say, a tree or a broken leg? Population screening is inherently ludicrous: how many *British Journal of Psychiatry* readers believe that 16% of UK citizens have a mental disorder requiring treatment?

A World Health Organization study in 15 cities around the world found that those whose 'depression' was recognised by doctors did slightly worse than the 'depressed' who were not recognised.<sup>17</sup> In a study of 18 414 patients attending 55 general practitioner practices in Hampshire, 48% of the variance between practices in prevalence of depressive symptoms was accounted for by a measure of socio-economic deprivation.<sup>18</sup> What did these people really need?

The UK is a very multicultural society, yet the detached introspection of talking therapies is grounded in an ineffably Western version of a person. Is this meant to fit everyone?

The psychiatrisation of everyday life may serve to legitimise the marginalisation of people who do not fit. Some issues here are shifts in what is seen as 'economic' work, the individualisation of the workplace, and the widening gap between the 'haves' and 'have nots'. Even the Department of Work and Pensions (DWP) website talks of 'the significant weakening of the labour market for less skilled workers'. The DWP report<sup>14</sup> that Veale cites has nothing specific on mental health, nor any reference to cognitive-behavioural therapy.

Cognitive-behavioural therapy *per se* is not under attack but it is being peddled as a brightly coloured patent medicine labelled 'cures almost all known ailments!'. Society is not a clinic writ large. This self-aggrandisement of the mental health industry is risking hubris, and perhaps deserves it.

Derek Summerfield

### Against: rebuttal

You have restated your position, barely responding to any of my questions. These proposals are about delivering evidence-based patient choice and a quality service in accordance with the NICE guidelines to the 1.5% of the population currently receiving medication or counselling. The precise percentage of people who have psychiatric disorders is irrelevant to the proposals. With my limited word count, I will simply emphasise that CBT is more of a 'doing' rather than a 'talking' therapy; it is effective, but not a panacea. If you can demonstrate through cost-effectiveness studies that removing relative poverty would significantly improve depression and anxiety disorders, then this debate can be resolved.

David Veale

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### References

- Layard R. The case for psychological treatment centres. *BMJ* 2006; **332**: 1030–2.
- Priest RG, Vize C, Roberts A, Roberts M, Tylee A. Lay people's attitude to treatment of depression: results of opinion poll for Defeat Depression Campaign just before its launch. *BMJ* 1996; **313**: 858–9.
- Summerfield D. Depression: epidemic or pseudo-epidemic? *J R Soc Med* 2006; **99**: 161–2.
- Read J, Haslam N, Sayce L, Davies E. Prejudice and schizophrenia: a review of the 'mental illness is an illness like any other' approach. *Acta Psychiatr Scand* 2006; **114**: 303–18.
- Henderson M, Glozier N, Holland Elliott K. (2005) Long term sickness absence. *BMJ* 2005; **330**: 802–3.
- Wainwright D, Calnan M. *Work Stress: The Making of a Modern Epidemic*. Open University Press, 2002.
- Appleby L. So, are things getting better? *Psychiatr Bull* 2003; **27**: 441–2.
- Illich I. *Limits to Medicine. Medical Nemesis: The Expropriation of Health*. Marion Boyars, 1975.
- Summerfield D. Cross-cultural perspectives on the medicalisation of human suffering. In *Posttraumatic Stress Disorder. Issues and Controversies* (ed G Rosen): 233–45. John Wiley, 2004.
- Summerfield D. The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *BMJ* 2007; **322**: 95–8.
- Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H. *Psychiatric Morbidity among Adults Living in Private Households, 2000*. Office for National Statistics, 2000 ([http://www.statistics.gov.uk/downloads/theme\\_health/psychmorb.pdf](http://www.statistics.gov.uk/downloads/theme_health/psychmorb.pdf)).
- Bird A. *We Need to Talk: The Case for Psychological Therapies on the NHS*. Mental Health Foundation, 2006.
- Ehlers A, Clark DM, Hackmann A, McManus F, Fennell M. Cognitive therapy for post-traumatic stress disorder: development and evaluation. *Behav Res Ther* 2005; **43**: 413–31.
- Adam S, Emmerson C, Frayne C, Goodman A. *Early Quantitative Evidence on the Impact of the Pathways to Work Pilots*. Research Report No 354. TSO (The Stationery Office), 2006 (<http://www.dwp.gov.uk/asd/asd5/rports2005-2006/rrep354.pdf>).
- Gillespie K, Duffy M, Hackmann A, Clark DM. Community based cognitive therapy in the treatment of posttraumatic stress disorder following the Omagh bomb. *Behav Res Ther* 2002; **40**: 345–57.
- Giesen-Bloo J, van Dyck R, Spinhoven P, van Tilburg W, Dirksen C, van Asselt T, Kremers I, Nadort M, Arntz A. Outpatient psychotherapy for borderline personality disorder: a randomized trial of schema focused therapy versus transference focused therapy. *Arch Gen Psychiatry* 2006; **63**: 649–58.
- Goldberg D, Privett M, Ustun B, Simon G, Linden M. The effects of detection and treatment on the outcome of major depression in primary care: a naturalistic study in 15 cities. *Br J Gen Pract* 1998; **48**: 1840–4.
- Ostler K, Thompson C, Kinmonth A-LK, Peveler RC, Stevens L, Stevens A. Influence of socio-economic deprivation on the prevalence and outcome of depression in primary care. The Hampshire Depression Project. *Br J Psychiatry* 2001; **178**: 12–7.