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Cognitive Behaviour Therapy Treatment Failures in Practice: The Neglected Role of Diagnostic Inaccuracy

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Abstract. Cognitive behaviour therapy (CBT) treatments have been developed and validated with respect to specific diagnoses. In routine clinical practice diagnostic accuracy is poor, making for poorly targeted treatment. The problems posed by lack of diagnostic rigour, including non-detection of co-morbidity, are rarely the subject of supervision sessions and treatment failures may be inappropriately attributed to other factors such as lack of therapeutic skill or an unmotivated client. It is argued that a false dichotomy exists between diagnosis and case formulation fuelled by professional territorial disputes. We suggest that diagnosis acts as a lens, focusing attention on the range of cognitions salient to a case formulation and also highlights psychosocial and environmental factors that may affect treatment outcome. It is recommended that practitioners enhance their effectiveness by using structured interviews routinely as a part of their ongoing assessment of clients.

Keywords: Treatment failures, diagnosis, CBT, case formulation.

Introduction

Cognitive behaviour therapy has been found to be efficacious (DoH, 2001), albeit more efficacious with some disorders than others. Experts on the Department of Health panel have expressed their consensus view as the relative weight of evidence supporting interventions for different disorders using three categories A, B and C from most to least evidence. They concluded that an “A” rating should be given for CBT with depression, PTSD and anxiety disorders, whilst a “B” rating should be given for CBT for eating disorders and a “C” rating to all structured therapies delivered by skilled practitioners for the long-term treatment of personality disorders. In reaching their conclusions the experts were reviewing predominantly outcome studies conducted in research centres, in which the researchers used structured interviews. A structured interview such as the Structured Clinical Interview for DSM-IV Axis 1 Disorders (SCID; First, Spitzer, Gibbons and Williams, 1997) formulates questions to be asked, with

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regard to each symptom or criteria in a DSM-IV criteria set, together with supplementary questions depending on the patient's response. The accompanying User's Guide indicates the type of information that would rule in or rule out the presence of a particular symptom. Healthcare professionals can be trained in its reliable administration.

Reliability and cognitive content

Reliability refers to the consistency with which a diagnosis is made. Poor reliability gravely impairs research. The work of Beck and colleagues (Beck, Ward, Mendelson, Mock and Erbaugh, 1962) on the reliability of psychiatric interviews predates his first writings on cognitive therapy. They reported that the level of agreement between different assessors varied between 32 and 54%. The clinicians in Beck et al.'s study were operating with their own understanding of a) what constituted the key elements of a disorder, i.e. there was variation in the information considered important (information variance); and b) as to how severe a symptom had to be in order to be considered present, i.e. there was variation in the threshold considered necessary for the presence of a symptom (criterion variance). Beck et al. (1962) suggested that steps needed to be taken to reduce both information and criterion variance for meaningful research. This led to the development of structured interviews with inter-rater reliabilities of 80–90% for anxiety and depressive disorders. DSM–IV-TR (APA, 2000) has itself tried to reduce information variance by stating that "valid application of the diagnostic criteria ... necessitates an evaluation that directly accesses the information in the criteria sets." Unfortunately, there is no evidence that present day CBT practitioners are taking steps to minimize either of the two sources of variance and it is unlikely that their interviews are any more reliable than those of the clinicians in Beck et al.'s study.

A fundamental postulate of Alford and Beck's cognitive theory (1997) is that emotional disorders are distinguished by their differing cognitive content. His theory makes a link between diagnosis and case formulation. For example, in anxiety the self is seen as inadequate (because of deficient resources), the context is thought to be dangerous and their future appears uncertain. Whilst in paranoid disorders, the self is interpreted as mistreated or abused by others, and the world is seen as unfair and opposing one's interests. Without accurate diagnosis, a practitioner is likely to be less alert for relevant cognitions and thereby miss therapeutic targets.

Missed diagnoses and co-morbidity

In a comparison of routine psychiatric assessment and the SCID, Zimmerman and Mattia (1999) assessed a cohort of 500 patients attending psychiatric outpatients, using routine unstructured clinical interviews and the next cohort of 500 patients were interviewed with the Structured Clinical Interview for DSM-IV Axis 1 disorders (SCID; First et al., 1997). Fifteen disorders were more frequently diagnosed in the SCID sample and the differences occurred across mood, anxiety, eating, somataform and impulse disorder categories. The rate of detection of post-traumatic stress disorder, using an unstructured interview, was 50% of that using structured interview. CBT practitioners are for the most part non-medics and arguably less likely than their psychiatric colleagues to be driven by a quest for diagnosis. Thus inter-rater reliabilities of practitioners' assessments may be even less than that of psychiatrists conducting a traditional interview.

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In the Zimmerman and Mattia (1999) study, more than one third of the patients examined with the SCID were diagnosed with three or more disorders in contrast to fewer than 10% of the patients assessed with an unstructured interview. There was also evidence that clinicians performing routine assessment tended to stop the diagnostic investigation at the first disorder identified. The likelihood is that CBT practitioners will miss co-morbidity, a major predictor of poor treatment outcome.

Awareness of diagnostic issues amongst CBT practitioners

Diagnostic issues are apparently considered of so little importance by CBT practitioners that they did not merit inclusion as one of the 16 categories used to identify the contents of supervision sessions (Townend, Ianetta and Freeston, 2002). There were, however, two categories that might remotely relate to diagnostic issues: evaluation methods and exclusion criteria. But respondents indicated that of all the 16 categories they most rarely/never discussed these issues together with a category of "safety". Case formulation was the most often discussed subject in supervision in the Townend et al. (2002) study. Flitcroft, James and Blackburn (2004) had seven experienced CBT therapists construct a list of 86 statements capturing concepts considered relevant to a CBT formulation of depression. A further 23 therapists then rated these statements in terms of their importance. One of the least essential features perceived by participating therapists was diagnoses. The lack of interest in diagnosis has been legitimized by Person's (1989) who on p. 12 of her seminal book, *Cognitive Therapy in Practice: a case formulation approach*, wrote "diagnoses are not very helpful in making treatment decisions".

This raises some concerns: without a system of standardized agreed categorisation, i.e. diagnosis, therapists will make a number of errors. In the first instance their clinical practice will consist of the idiosyncratic application of cognitive behavioural techniques that may or may not be appropriate to the client's difficulties. Secondly without categorization there can be no systematic accurate quantification, which means that monitoring treatment progress and outcome is not possible. Such an approach inhibits the development of new efficacious treatments but also suggests that therapists may not be carrying out proven evidence-based treatments.

Diagnosis versus case formulation?

Case formulations arose as an alternative to traditional psychiatric diagnoses. This new conceptual framework helped to establish the identity and independence of psychologically minded therapists. More recently, behavioural case formulations have been replaced by cognitive conceptualizations (see Persons, 1989), but with a retention of a distancing from traditional diagnosis. However, there is no inherent reason why diagnosis and case formulation should be viewed as mutually exclusive. In Beck's writings the case formulation represents a particular case of a general cognitive model; for example, a diagnosis of panic disorder would alert the therapist to the salience of catastrophic threat related cognitions. Thus, in explaining the difficulties of an individual patient, the focus might be on the person's view that their symptoms meant that they were having a brain haemorrhage, whereas for another patient the relevant catastrophic cognition might be that they would faint and embarrass themselves, perhaps suggesting that the principle diagnosis is social phobia

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and not panic. In this way, the diagnosis acts as a lens focusing on the range of salient cognitions.

If more than one disorder is present the cognitive content of the other disorders must also to be taken into account. It is therefore clear that diagnosis helps to flesh out the case formulation. A DSM-IV diagnosis is not restricted to the identification of emotional and personality disorders but also highlights psychosocial and environmental variables that may be pertinent to treatment outcome. Thus diagnosis takes the practitioner beyond the purely intra-psychic concerns of case formulation. We suggest that diagnosis and case-formulation should be regarded as inseparable.

Implications for the assessment of therapists

A major focus in supervision and in CBT training courses is on enhancing therapist competence, on the premise that this will improve treatment outcome. Therapist competence is most usually assessed using the Cognitive Therapy Scale (CTS), which assesses general therapeutic skills, the therapist's ability to structure the session and the therapist's ability to intervene using the most appropriate CBT methods. However, in a major study of therapist competence ratings in relation to outcome for depression Shaw et al. (1999) reported that the total CTS score did not significantly relate to outcome. The component of competence, however, that was most highly related to outcome was the "structure" factor (referring to the pacing and efficient use of time in a session, the setting of an agenda and assignment and review of homework) which accounted for 19% of the variance. Shaw et al. (1999) suggest that aspects that may relate to case formulation appeared to be not as pertinent as one might assume. While other yet to be developed measures of therapist competence may result in differing findings, the Shaw et al. (1999) study raises questions about the weighting that should be given to case formulation.

The CTS is used to assess therapist competence from session two onwards and there is no standardized assessment of the first treatment session. In our view, the first session should include a structured interview, and standardized assessment should be repeated in the middle and at the end of treatment. A comprehensive assessment of therapist competence should include an evaluation of diagnostic skills as well as of the more traditional domains.

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