

Changing the topic does not change the facts

In a Comment published in *The Lancet Psychiatry*, Scott Lilienfeld and colleagues¹ wrote that I encouraged psychotherapists to ignore new practice guidelines for post-traumatic stress disorder (PTSD) because they relied inordinately on randomised controlled trials (RCTs). I did not urge therapists to ignore the guidelines because they relied on RCTs; I urged them to ignore the guidelines because research studies—the same RCTs they laud—show that the recommended therapies do not work for most patients.

The only therapies considered for the guidelines were brief (eight to 12 sessions), one-size-fits-all forms of cognitive behaviour therapy, which are conducted by following step-by-step instruction manuals. Research shows that few patients who receive these treatments get well.²

The largest and arguably best RCT behind the PTSD guidelines showed that the interventions failed most patients. This RCT studied 255 female veterans with PTSD who received a so-called highly recommended form of cognitive behaviour therapy (prolonged exposure therapy) or a control treatment that did not attempt to address trauma.³ Nearly 40% of the patients who started cognitive behaviour therapy dropped out, voting with their feet about its value; 60% of the patients still had PTSD when treatment ended; and 100% of the patients were clinically depressed when treatment ended.³ At 6-month follow-up, there were no significant differences between the cognitive behaviour therapy and control groups. Results for other RCTs of brief, manual-driven cognitive behaviour therapy are even poorer: overall, approximately two-thirds of patients who receive these so-called highly recommended treatments

still have PTSD after completing treatment.⁴

The issue comes down to truth in advertising. Proponents of these brief treatments promote them to practitioners, the public, and policy makers as “best” therapies, “evidence based”, “scientifically proven”, “empirically supported”, and “gold standards”. It is remarkable that investigators who beat the drum so loudly for science seem so unconcerned with the actual findings of the studies they extol. They promote therapies as evidence based merely because they were studied with an RCT design—not because they offer meaningful help to meaningful numbers of patients. This practice ensures continued funding for researchers, at the expense of false hopes for patients and their loved ones.

A foolish hypothesis does not magically become a sound hypothesis because it is studied with an RCT design. One foolish hypothesis is that long-standing, engrained mental health conditions can be treated in just eight to 12 sessions. A scientific study of more than 10 000 therapy cases showed that therapy follows a dose-response curve.⁵ It takes more than 20 sessions for 50% of patients to show clinically meaningful improvement, and 40 sessions for 75% of patients to show improvement. Diverting attention from these facts benefits no one.

I declare no competing interests.

Jonathan Shedler
jonathan@shedler.com

Department of Psychiatry, University of Colorado School of Medicine, Aurora, CO, USA

- Lilienfeld SO, McKay D, Hollon SD. Why randomised controlled trials of psychological treatments are still essential. *Lancet Psychiatry* 2018; published online March 27. [http://dx.doi.org/10.1016/S2215-0366\(18\)30045-2](http://dx.doi.org/10.1016/S2215-0366(18)30045-2).
- Shedler J. Where is the evidence for “evidence-based” therapy? *Psychiatr Clin N Am* (in press).
- Schnurr PP, Friedman MJ, Engel CC, et al. Cognitive behavioral therapy for posttraumatic stress disorder in women: a randomized controlled trial. *JAMA* 2007; **297**: 820–30.

- Steenkamp MM, Litz BT, Hoge CW, Martmar CR. Psychotherapy for military related PTSD: a review of randomized clinical trials. *JAMA* 2015; **314**: 489–500.
- Lambert MJ, Hansen NB, Finch AE. Patient-focused research: using patient outcome data to enhance treatment effects. *J Consult Clin Psychol* 2001; **69**: 159–72.

Authors' reply

In keeping with Rapoport's Rules of Argumentation,¹ we acknowledge several points of agreement with Jonathan Shedler regarding our Comment.² We concur that the treatments recommended in the post-traumatic stress disorder (PTSD) practice guidelines are not panaceas: even the best PTSD treatments leave many patients with clinically significant symptoms. Development of better interventions or improvement of existing ones to reach these remaining individuals is needed.

Still, Shedler's appraisal of these treatments is unduly negative. He cites one study³ that reported about a 40% dropout rate in patients with PTSD who received prolonged exposure therapy, an intervention recommended in the PTSD guidelines. Nevertheless, a meta-analysis of PTSD treatments, including prolonged exposure therapy, reported an average dropout rate of 18%, with no significant differences among active treatments.⁴

Shedler maintains that, contrary to our claim, he did not urge practitioners to ignore the guidelines on the grounds that they relied on randomised controlled trials (RCTs). Yet, in his original 2017 blog post, Shedler wrote that the guidelines “ignore all scientific evidence except one kind of study, called randomized controlled trials” and that the American Psychological Association, which endorsed the guidelines, was “blinded by RCT ideology”. We stand by our assertion.

Shedler implies erroneously that the practice guidelines for PTSD call for brief treatments (eg, eight to 12 sessions). The guidelines were derived largely from investigations of brief treatments, but they did not



Published Online
March 27, 2018
[http://dx.doi.org/10.1016/S2215-0366\(18\)30093-2](http://dx.doi.org/10.1016/S2215-0366(18)30093-2)



Published Online
March 27, 2018
[http://dx.doi.org/10.1016/S2215-0366\(18\)30102-0](http://dx.doi.org/10.1016/S2215-0366(18)30102-0)

For the clinical practice guideline for the treatment of PTSD see <https://www.apa.org/ptsd-guideline/ptsd.pdf>

For more on the 2017 blog post by Jonathan Shedler see <https://www.psychologytoday.com/blog/psychologically-minded/201711/selling-bad-therapy-trauma-victims>

recommend that interventions be limited to a small number of sessions.

Given that widely studied PTSD treatments leave room for improvement, one might be tempted to assume that insufficiently studied treatments, such as psychodynamic therapy, are bound to be more efficacious. As a counterpoint, Dawes⁵ cautioned against the “argument from a vacuum”, in which “what is purported to be true is supported not by direct evidence, but by attacking an alternative possibility”. The treatments recommended in the guidelines are hardly perfect, but they remain the best-supported interventions for PTSD.

We declare no competing interests.

*Scott O Lilienfeld, Dean McKay,
Steven D Hollon
slilien@emory.edu

Department of Psychology, Emory University, Atlanta, GA 30322, USA (SOL); Melbourne School of Psychological Sciences, University of Melbourne, Melbourne VIC, Australia (SOL); Department of Psychology, Fordham University, New York, NY, USA (DM); and Department of Psychology, Vanderbilt University, Nashville, TN, USA (SDH)

- 1 Rapoport A. Three modes of conflict. *Management Sci* 1961; 7: 210–18.
- 2 Lilienfeld SO, McKay D, Hollon SD. Why randomised controlled trials of psychological treatments are still essential. *Lancet Psychiatry* 2018; published online March 27. [http://dx.doi.org/10.1016/S2215-0366\(18\)30045-2](http://dx.doi.org/10.1016/S2215-0366(18)30045-2).
- 3 Schnurr PP, Friedman MJ, Engel CC, et al. Cognitive behavioral therapy for posttraumatic stress disorder in women: a randomized controlled trial. *JAMA* 2007; 297: 820–30.
- 4 Imel ZE, Laska K, Jakupcak M, Simpson TL. Meta-analysis of dropout in treatments for posttraumatic stress disorder. *J Consult Clin Psychol* 2013; 81: 394–404.
- 5 Dawes RM. *House of cards: psychology and psychotherapy built on myth*. New York: Free Press, 1994.

Stand-alone cognitive behavioural therapy is not in clinical equipoise with antipsychotic treatment

I read with concern that a group of help-seeking, young people with first-episode psychosis

were randomly assigned into a group that was not receiving antipsychotic treatment in a study by Anthony Morrison and colleagues,¹ especially in light of another recently reported study by Christy Hui and colleagues,² both published in *The Lancet Psychiatry*, which showed that withholding antipsychotic medication in the early phase of psychosis (even temporarily in remitted patients) might result in poorer long-term clinical outcomes than continued treatment.

Contrary to Morrison and colleagues' assertion,¹ the evidence for cognitive behavioural therapy in treating patients with schizophrenia is hardly convincing,³ and its continued recommendation by practice guidelines is probably unjustified.⁴ A comprehensive evaluation of randomised controlled trials of cognitive behavioural therapy for schizophrenia has shown that masking outcome assessors rendered this therapy ineffective, suggesting that its perceived effectiveness was potentially due to ascertainment bias.³

In view of the inadequate effectiveness of stand-alone cognitive behavioural therapy, and the potential harm from withholding antipsychotic treatment, these two interventions are no longer in clinical equipoise.⁵ Therefore, any further randomised controlled trials would only be ethically justifiable in patients who choose to refuse antipsychotic medication or when cognitive behavioural therapy is offered as an adjunct to pharmacotherapy.

I declare no competing interests.

Feras Ali Mustafa
feras.mustafa@nhft.nhs.uk

Department of Liaison Psychiatry, Northamptonshire Healthcare NHS Foundation Trust, Northampton NN1 3EB, UK

- 1 Morrison AP, Law H, Carter L, et al. Antipsychotic drugs versus cognitive behavioural therapy versus a combination of both in people with psychosis: a randomised controlled pilot and feasibility study. *Lancet Psychiatry* 2018; 5: 411–23.

- 2 Hui CLM, Honer WG, Lee EHM, et al. Long-term effects of discontinuation from antipsychotic maintenance following first-episode schizophrenia and related disorders: a 10 year follow-up of a randomised, double-blind trial. *Lancet Psychiatry* 2018; 5: 432–42.
- 3 Jauhar S, McKenna PJ, Radua J, Fung E, Salvador R, Laws KR. Cognitive-behavioural therapy for the symptoms of schizophrenia: systematic review and meta-analysis with examination of potential bias. *Br J Psychiatry* 2014; 204: 20–29.
- 4 Mustafa FA. On evidence-based medicine. *Lancet* 2017; 390: 2245.
- 5 Freedman B. Equipoise and the ethics of clinical research. *N Engl J Med*. 1987; 317: 141–45.

Authors' reply

Our study,¹ reported in *The Lancet Psychiatry*, compared treatment with antipsychotics, cognitive behavioural therapy, and a combination of both in participants with early psychosis. We disagree with Feras Ali Mustafa that it is unethical to withhold initiating antipsychotics from participants receiving cognitive behavioural monotherapy, and we maintain that there is a case for clinical equipoise. Evidence from blinded trials supports the safety and acceptability of cognitive behavioural monotherapy for psychosis,^{1,2} and all participants in our study were randomly assigned to receive at least one active treatment recommended by the National Institute for Health and Care Excellence.³ These findings are in contrast to the study⁴ cited by Mustafa, in which participants received either antipsychotics or placebo but not cognitive behavioural therapy; in the decade of study participation, the average number of contacts with a clinical psychologist per participant was less than one. Although many people with psychosis respond to and are satisfied with antipsychotics, high rates of switching and non-adherence show that many patients and clinicians are dissatisfied with antipsychotics because of adverse effects or inefficacy, or both,⁵ suggesting the need to evaluate alternatives.

COMPARE¹ was a feasibility study, which received ethical approval, and the study design (eg, exclusion