Psychotherapy should be subject to rigorous regulation just like drug treatments, say academics

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Psychotherapies such as cognitive behaviour therapy (CBT) are under-regulated in the UK and should be subject to the same standards of evidence as drugs, assert two experts in psychological medicine writing in the *Journal of Psychopharmacology* (January issue published today by SAGE).

They say the largely unrecognized potential for serious adverse effects resulting from talking therapies means rules should be tightened, particularly in light of the UK Government's recent £150m investment in psychotherapy services for depression and anxiety, which will result in many more therapists practising in the UK.

"While welcoming the increased profile that mental health problems have been given by the Government and the expansion of scientifically validated psychological treatment…we wish to urge a note of caution," says Professor Michael Sharpe, Psychological Medicine & Symptoms Research Group, School of Molecular & Clinical Medicine, University of Edinburgh, UK, who co-authored the editorial with Professor David Nutt of the Psychopharmacology Unit, Department of Community Based Medicine, University of Bristol, UK.

"Our concern is about the tendency to consider psychological treatments less critically than pharmacological ones. It is important that both are seen as having a place in treating depression and that both are subject to

the same standards of scrutiny and regulation."

According to Nutt, few psychotherapy trials meet the requirements demanded of drug tests, and even those that do frequently show that psychotherapy performs no better—and often worse—than pharmacological interventions. What is more, he points out, many psychotherapy trials do not even consider the possibility that their treatment could harm. Yet all therapists should be aware that therapy can have adverse effects on some patients and a major part of psychotherapy training is how to deal with issues such as counter-transference that can mediate these negative effects.

"We need a much more sophisticated view than 'psychotherapy good; drug treatment bad' if we are to effectively and safely improve the mental health of the population," says Sharpe.

Potential adverse effects of psychotherapy include worsening of the patient's condition, the development of psychological dependency on the therapist, and wastage of patient and therapist time when the treatment is ineffective. In addition, the editorial cites evidence that a small minority of therapists take advantage of vulnerable patients and exploit them emotionally, financially, and sexually.

"Given that psychotherapy is not necessarily always the benign yet efficacious therapy that seems to be generally assumed, patients should be made aware of the risks as well as the benefits especially now we have a government initiative to improve psychotherapy provision on the NHS," write the authors. They suggest that patients should be able to alert authorities to problems with psychotherapies they receive by use of a similar scheme to the one through which adverse drug events are reported which Sharpe and Nutt suggest could be administered by the Medicines and Healthcare Regulatory Agency, the body responsible for dealing with drug reports.

Nutt and Sharpe urge therapists to ensure patients are aware of the risks as well as the benefits of psychotherapy. In addition, they suggest that therapists should to commit to performance and practise standards and agree to be monitored or audited on their professional records.

“Up-scaling the provision of psychological therapy to the degree [proposed by the UK Government] is a major challenge for quality assurance. Bad therapy will not work and may harm. It will be essential therefore that the increase in number of therapists is done incrementally with (a) rigorous monitoring of the quality of the therapy given and (b) professional regulation of therapists to minimise the risk of exploitation of patients,” concludes Sharpe.

Source: SAGE Publications UK