

VIEWPOINT

Is Cognitive Behavioral Therapy the Gold Standard for Psychotherapy?

The Need for Plurality in Treatment and Research

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Mental disorders are common and associated with severe impairments and high societal costs, thus representing a significant public health concern. About 75% of patients prefer psychotherapy over medication.¹ For psychotherapy of mental disorders, several approaches are available such as cognitive behavioral therapy (CBT), interpersonal therapy, or psychodynamic therapy. Pointing to the available evidence, CBT is usually considered the gold standard for the psychotherapeutic treatment of many or even most mental disorders.^{2,3} For example, the American Psychological Association's Division 12 Task Force on Psychological Interventions currently lists CBT as the only treatment with "strong research support" in almost 80% of all mental disorders included in its listing.²

For a treatment to be considered the gold standard requires that substantial supporting evidence exists. Recently, however, additional research findings have emerged that question the prominent status of CBT. In this Viewpoint, we review some of the most important findings.

Limited Study Quality

For an evidence-based treatment, the quality of evidence is as important as the quantity of evidence. A recent meta-analysis using criteria of the Cochrane risk of bias tool reported that only 17% (24 of 144) of randomized clinical trials (RCTs) of CBT for anxiety and depressive disorders were of high quality.¹ This is of particular importance because anxiety and depressive disorders are the most common mental disorders.¹

Weak Empirical Tests

When examining efficacy, a treatment may be compared with different comparators, that is, with an established treatment, treatment as usual, a placebo, or a waiting list, with decreasing strictness of the empirical test. CBT was found to have been compared with a waiting list condition in more than 80% of 121 studies in anxiety disorders.¹ In major depression, this was true for 44% of 63 studies.¹ Being more effective than waiting list controls is not a strong proof of efficacy and may lead to overestimating the efficacy of CBT especially because waiting list controls may even represent a nocebo condition.¹

Uncontrolled Researcher Allegiance

Researcher allegiance, which is the researcher's belief in the superiority of a treatment, may influence results in comparative psychotherapy outcome research, repre-

senting an uncontrolled factor in comparisons of treatment efficacy.⁴ For several studies carried out by CBT researchers, high risk of researcher allegiance has recently been identified.⁴ In essence, the treatment conditions against which CBT was compared were designed in a way that essential curative factors were excluded. In one treatment, for example, therapists treating traumatized patients were not allowed to directly address the trauma.^{4(p119-120)} In another study treating social phobia patients, subjects were instructed not to use available coping skills when confronted with the feared situation.^{4(p122-123)} Thus, these treatments did not represent effective therapies, but "intent-to-fail" or strawman treatments leading to enhance the outcome of CBT.⁴

Central Mechanisms of Change Not Corroborated

Cognitive therapy assumes that improvements in symptoms are achieved through changes in key cognitive processes (eg, negative triad, ie, a negative view of self, others, and the future). In a review based on the available evidence, a prominent CBT researcher concluded that this central assumption of CBT is not correct.⁵

Limited Efficacy: CBT Is Not a Panacea

Several meta-analyses reported limited efficacy of CBT.

- In the few high-quality studies available for depressive and anxiety disorders, CBT was found to be less efficacious than in low-quality studies, mostly reducing the efficacy of CBT in panic disorder and social anxiety disorder.^{1(p247)}
- In the high-quality studies, CBT achieved large effect sizes only in comparison with waiting list conditions. Compared with treatment as usual, effect sizes were only small to moderate (0.30-0.45).^{1(p245)} Thus, the additional gain of CBT over treatment as usual is limited and may eventually even be the result of allegiance effects.⁴
- In panic disorder, CBT was not more effective than treatment as usual but only to waiting list.^{1(p250)}
- Publication bias, the tendency to publish only favorable results, was found to reduce the efficacy of CBT in further mental disorders, that is, in major depressive disorder and generalized anxiety disorder.¹
- Rates of response and remission achieved by CBT were found to be only moderate. For depressive disorders, for example, response rates of about 50% were reported. This is true for anxiety disorders as well. Rates for remission are even smaller. Thus, a considerable proportion of patients do not sufficiently benefit from CBT.

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No Clear Evidence of Superior Efficacy

A first-line treatment usually is clearly more effective than other treatments. However, there is no clear evidence that CBT is more effective than other psychotherapies, either for depressive disorders or for anxiety disorders.^{6,7} This is also true for several other mental disorders (eg, personality disorders or specific eating disorders).

Owing to the low number of high-quality studies and the implications for efficacy, the authors of the above cited meta-analysis on study quality and efficacy concluded that the effects of CBT are "uncertain and should be considered with caution."^{1(p245)}

In sum, the few high-quality studies, the numerous tests against waiting list conditions, the limited efficacy, and the missing evidence both on mechanisms of change and on greater effectiveness over other psychotherapies are hardly compatible with a gold-standard status of CBT.

Conclusions

After psychoanalysis had dominated the early years of psychotherapy claiming to be the gold standard, a "CBT-centric" era^{8(p22)} began and some of its proponents succeeded in presenting CBT not only as the empirically best studied treatment,² but also as the most effective psychotherapy: "The most effective contemporary approach is Cognitive Behavior Therapy..."^{9(p36)} While CBT is beneficial for many patients, and CBT researchers developed and tested treatments often long before other approaches, the evidence suggests that CBT should not be considered the gold standard of psychotherapy. Of note, most of the critical results reviewed were reported by CBT proponents or by independent researchers. Thus, the view that the evidence for CBT is limited should not be attributed to a bias against CBT. Furthermore, the

critical results do not stem from arbitrarily selected individual studies but from several meta-analyses or systematic reviews.^{1,5-7} These findings are based on a substantial number of studies, showing a pattern of results. For example, the meta-analysis on study quality and efficacy of CBT in depressive and anxiety disorders included 144 RCTs.¹

While the evidence base for CBT is less strong than often claimed, CBT is probably the best empirically studied type of psychotherapy because for other forms of psychotherapy, such as interpersonal therapy or psychodynamic therapy, fewer high-quality studies are likely to exist. However, this assumption needs to be tested empirically because the risk of bias tool used by Cuijpers et al¹ has not yet been systematically applied to all studies of other psychotherapies while also controlling for researcher allegiance. It is also not clear whether these high-quality studies would yield substantial differences in outcome between the different approaches.⁴ More studies do not necessarily imply that a treatment is more efficacious.

Prematurely declaring one treatment as the gold standard not only has important clinical implications, but also may seriously limit the progress of research because research on other methods of psychotherapy may not be given an equal chance for funding. No form of psychotherapy can presently claim to be the gold standard, suggesting the need for plurality in treatment and research, ie, a variety of different psychotherapeutic approaches. All evidence-based therapies have their strengths, be it a focus on cognitive, emotional, interpersonal, or unconscious processes. Only plurality allows for bridging the gap between the different approaches and for learning from each other to further improve the treatment of patients with mental disorders.⁸

ARTICLE INFORMATION

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