

## Can a ‘return-to-work’ agenda fit within the theory and practice of CBT for depression and anxiety disorders?

Matthew Wesson\* and Matthew Gould

*Ministry of Defence, Department of Community Mental Health Portsmouth, Hampshire, UK*

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**Abstract.** Helping service users to return to work has emerged as a key therapeutic objective of the Improving Access to Psychological Therapies (IAPT) initiative. IAPT programmes implement National Institute for Health and Clinical Excellence (NICE) guidelines, especially cognitive behaviour therapy (CBT), for people suffering from anxiety and depression. However, relatively little research has been conducted to date into whether, or how, cognitive behavioural interventions can help individuals return to work. This paper reviews literature and research into CBT and occupational outcomes and considers whether a return-to-work agenda may jeopardize the therapeutic alliance which is suggested to be necessary for effective CBT. Moreover, through the use of clinical examples from our practice, we suggest ways in which employment issues might be integrated into CBT for depression and anxiety disorders. We conclude that a return-to-work agenda can be utilized during therapy while maintaining a collaborative and secure therapeutic relationship, especially, perhaps if work issues are embedded within the formulation. However, further research is needed, not only to determine whether CBT can help individuals return to work but also how CBT might best integrate a return-to-work agenda.

**Key words:** CBT, employment, IAPT, occupational mental health, outcomes.

### Introduction

In recent years, the cost of mental health problems to the UK economy has been a significant focus of the UK government, advisors and clinicians among others [e.g. Department for Work & Pensions (DWP), 2002; Sainsbury Centre for Mental Health (SCMH), 2003; Social Exclusion Unit (SEU), 2004; Layard, 2005; Black, 2008; PricewaterhouseCoopers, 2008]. The Layard report (2005) was instrumental in shaping the UK government’s recent thinking on mental healthcare and recommended increasing the provision of talking therapies such as cognitive behaviour therapy (CBT) to address this economic issue, which, in part, led to the Improving Access to Psychological Therapies (IAPT) [Department of Health (DoH), 2007] programme. IAPT programmes implement National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from anxiety and depression. Although

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\* Author for correspondence: Mr M. Wesson, Department of Community Mental Health, PP6 Sunny Walk, HMNB Portsmouth, Portsmouth, Hampshire PO1 3LT, UK. (email: matthew.wesson776@mod.uk)

IAPT has not been without its critics, some of whom consider it to have over-emphasized CBT while others consider it to be based on a flawed economic analysis (Marzillier & Hall, 2009), it has been suggested that the running costs of IAPT services can be recovered as some of those users accessing services would come off their incapacity benefits and return to work (RtW) following a course of CBT (Layard *et al.* 2007). Specifically, the Depression Report [Centre for Economic Performance (CEP), 2006], which followed on from the Layard report (2005), estimated that a successful course of CBT would lead to 1 year free from depression and result in nearly 2 months of work. This paper explores whether and how employment goals can be included within CBT for anxiety disorders and depression. First, this paper examines the economic arguments in favour of increasing the provision of CBT, in particular the current evidence base of CBT and employment. Second, an exploration of the clinical and ethical difficulties which may be caused by a RtW agenda. Last, a discussion of ways in which employment goals could be embedded more into CBT with examples from our own clinical experience.

### **The economic cost of depression and anxiety disorders**

SCMH estimated that the economic cost of mental health problems to society in England in 2002/2003 amounted to approximately £77 billion (SCMH, 2003). Output losses, such as non-employment, unpaid work, sickness absence and premature mortality, equated to over £23 billion of these costs. Furthermore, when these costs were adjusted to include only depression and chronic anxiety they totalled £12 billion a year – 1% of the total national income (CEP, 2006). The direct cost to UK employers of mental health problems (the majority of which constituted depression and anxiety disorders) has been estimated at approximately £26 billion (SCMH, 2007). This amount includes not only absenteeism but also ‘presenteeism’ which accounts for staff turnover and reduced productivity at work. In addition, the UK psychiatric morbidity survey (Office for National Statistics, 2000) showed that 42% of working-age adults suffering from depression and 40% suffering from an anxiety disorder were on incapacity benefit or income support compared to only 8% with no mental health disorder.

Data from other countries confirm the significant negative impact of depression and anxiety on the economy. For example, a North American study put the work-loss costs for those in employment with mood disorders (the vast majority of which were depressive disorders) at \$11.5 billion (Druss *et al.* 2001). Another USA study found that people with a pure affective disorder (i.e. excluding comorbid problems) had 10 times more work-loss days and work cutback days compared to those with no disorder (Kessler & Frank, 1997). An Australian mental health survey (Andrews *et al.* 2001) found that people suffering from affective or anxiety disorder were between 2.1 and 2.8 times more likely to be unemployed compared to the general population.

There is a plethora of research documenting the psychological sequelae of unemployment. For example, Warr *et al.* (1988) found that unemployed people experience higher levels of depression and anxiety together with lower self-esteem and wellbeing. Graetz (1993) found that employed people report significantly higher levels of psychological health and wellbeing than the unemployed and students although, as Graetz recognizes, the benefits of employment are confined to those who have or find a satisfying job. This is an important point in the RtW agenda. Although the relationship between work and health can be complex, a recent

review of over 400 pieces of scientific evidence concluded that work is beneficial to health and wellbeing and 'outweighs the risks associated with it and by the negative consequences of unemployment and sickness absence' (Waddell & Burton, 2006, p. 24). Waddell & Burton's recommendations included that 'those with common health problems, including anxiety and depression, should be encouraged and supported to remain in, enter or re-enter work as soon as possible because it is therapeutic, helps to promote recovery, leads to better health outcomes, minimizes the harmful effects of long-term absence and incapacity, and promotes inclusion' (Waddell & Burton, 2006, p. viii).

When these statistics and findings are considered in conjunction with the substantial evidence base for CBT for depression and anxiety (as evidenced by NICE) it is perhaps unsurprising that the Layard report (2005) highlighted the potential economic benefits that may follow from increasing the provision of CBT for people with depression and anxiety disorders in the UK. This was reflected in the IAPT health and wellbeing framework which explicitly incorporated 'inclusion (including employment)' as one of its four main outcome measures (DoH, 2007, p. 15); helping long-term incapacity benefit claimants back to work and helping people who have mental health problems remain at work. It is important then to review the evidence that CBT can assist individuals in either remaining or returning to work.

### **CBT and employment**

Typically, many healthcare professionals do not consider employment to be a key objective for people with mental health problems (SEU, 2004). Indeed, as Black comments in a recent review, historically there has been poor coordination between the UK National Health Service (NHS) and employment and skills programmes leading to care that is symptom-focused with little regard to RtW or workplace adjustments (Black, 2008). Unsurprisingly, therefore, there is limited UK (and international) research to date examining the occupational outcomes of mental health treatment. A review of the NICE guidelines for depression and anxiety disorders did not reveal a single RtW recommendation (Hashtroudi & Paterson, 2009); while NICE (2009) reported a lack of evidence for the effectiveness of healthcare interventions that help people RtW.

There is some evidence that CBT can help non-clinical groups who are on long-term unemployment RtW. For example, Proudfoot *et al.* (1997) found that a CBT group-training programme led to statistically significant improvements in mental health and employment rates compared to a non-CBT-based control programme. The CBT group involved many aspects seen in standard CBT including goal-setting, challenging of automatic thoughts, relapse prevention as well as specific application of techniques for work situations. However, any mental health gains during training had been lost at 3 months for those who had not found employment which suggests the need for 'booster' CBT sessions. Della-Posta & Drummond (2006) compared the effects of offering 4 hours of CBT and job search assistance training to standard training alone for worker's seeking employment following a work-related injury. The CBT group showed statistically significant improvements in mental health scores and secured employment more rapidly than participants in the standard job search group. Creed *et al.* (1999) reported improvements in mental health and coping behaviours in a group of unemployed people following a CBT-based programme but there was no difference in employment rates between

the CBT and control group, although the numbers at follow-up were small. Similarly, Harris *et al.* (2002) found no differences in job-seeking behaviours following a group CBT training programme compared with a non-CBT-based skills programme. However, as the authors acknowledge, their population had very substantial barriers to returning to work (e.g. limited education or training, very long periods of unemployment) while their CBT programme also de-emphasized behavioural components such as activity scheduling and experiments which may be critical ingredients in successful job-seeking.

CBT may also have a role in helping people suffering from comorbid physical and mental health problems RtW. Programmes based on cognitive behavioural techniques have been shown to be effective in treating such conditions as chronic low back pain (Guzman *et al.* 2001) and arthritis (Keefe *et al.* 2002) by addressing unhelpful beliefs around pain and recovery. However, even though pain and depression have been shown to be the most significant variables for predicting RtW (Corbiere *et al.* 2007) there has been limited research into vocational outcomes for patients with chronic pain following CBT programmes. A randomized control trial by Li *et al.* (2006) found that a 'work readiness' programme, which incorporated CBT techniques, improved injured workers' motivation and employment readiness and reduced their anxiety levels; however, Li *et al.* did not measure long-term occupational outcomes. A small study by White *et al.* (2008) found that group CBT for chronic pain led to improvements in psychological and physical health and occupational functioning. Other studies have also shown that CBT interventions for pain-related work disability can improve RtW rates (e.g. Kendall & Thompson, 1998; Ektor-Anderson *et al.* 2008; Sullivan *et al.* 2006).

There has been some interesting recent research on workplace CBT interventions. For example, Seymour & Grove (2005) report that brief individual therapeutic interventions, including CBT, are effective for employees with job-related distress. However, the positive effects of CBT were mainly found in occupations where there was a high degree of control over the work environment which seems to suggest that CBT might not be beneficial if the work environment is both low in control and high in demand (Grove, 2006). Mino *et al.* (2006) found that a stress-management programme based on a CBT approach reduced symptoms of depression in workers at a highly stressful workplace but unfortunately the study did not investigate the impact of absenteeism or 'presenteeism'. Wang *et al.* (2007) compared telephone outreach and a care management programme, which included CBT, to treatment as usual (TAU) for workers with depression. The enhanced care included a comprehensive assessment of needs, facilitated entry to treatment [both CBT (either in-person or telephone), and antidepressant medication] and supported treatment compliance. At 6- and 12-month follow-up the intervention group showed improved clinical and workplace outcomes including higher job retention rates and an annual effect of 2 weeks more work than the usual care workers. However, there was little detail as to how much CBT was utilized in the treatment group and what this involved.

In contrast to these two studies, de Vente *et al.* (2008) found no differences in symptoms or absenteeism between CBT-based stress management training (SMT), whether group or individually delivered, for work-related stress complaints compared to TAU. However, as the authors acknowledge, individuals in the SMT group were not urged to resume work as soon as possible, instead only encouraged to at least partly resume work if their symptoms reduced to acceptable levels based on their own judgement. De Vente *et al.* (2008) suggest that a more explicit RtW agenda may have led to enhanced outcomes for the intervention group. An

interesting study by Blonk *et al.* (2006) examined interventions for self-employed people on sick leave owing to work-related psychological complaints. They compared CBT delivered by psychotherapists with a brief CBT informed intervention which included workplace and individual interventions delivered by labour experts. They found the combined individual and workplace intervention achieved significantly higher levels of both partial and full RtW over the standard CBT group. The results lead the authors to recommend that RtW should be addressed earlier on in CBT. Finally, findings have recently been released on the occupational outcomes achieved by the two IAPT demonstration sites (Clark *et al.* 2008). When combined the sites showed that CBT correlated to a net increase in employment of 5% which is in line with the forecasts made by Layard *et al.* (2007). However, the re-employment rates varied considerably across the two sites with one site achieving a 10% increase in employment and the other a 4% increase. It should be noted that although disturbance in occupational functioning was captured using psychometric tools there was no mention of whether or how RtW was addressed in therapy.

In summary, even though research is somewhat limited and the relationship between mental health and RtW is a complex phenomenon, there is evidence to suggest that CBT can be effective at reducing absenteeism and in helping people RtW. CBT is a generic term for a multitude of approaches, therefore it is difficult to identify which particular aspects may lead to improved RtW rates. However, as Blonk *et al.* (2006) suggest, incorporating workplace interventions and making RtW more explicit in treatment may improve outcomes. Therefore, it is important to consider how CBT can maximize both positive clinical and occupational outcomes, while maintaining the core components of CBT such as the collaborative relationship. Key questions which we will now explore are: What are the likely challenges of incorporating RtW explicitly into treatment? Will it cause problems in the therapeutic relationship? Can RtW be formulated and treated as a form of avoidance to be identified, challenged and overcome?

### **Collaboration and the therapeutic relationship**

‘Collaborative empiricism’ is seen as a cornerstone of effective cognitive therapy (Beck *et al.* 1979). Although faced with common symptoms and diagnoses, the cognitive therapist should view each client’s problems as idiosyncratic and should actively work ‘shoulder-to-shoulder’ with the client to develop a shared understanding of the client’s problems which facilitates learning in therapy (Durham *et al.* 2000). There has been an increasing interest in the role of the therapeutic alliance in CBT over the last two decades and more recently its relationship to therapy outcomes. For example, Trepka *et al.* (2004) found a clear positive association between alliance and outcome in cognitive therapy for depression and this association was stronger than therapist competence. A collaborative approach is regarded as an important factor in developing a strong therapeutic alliance (Ledley *et al.* 2005). Martin *et al.*’s (2000) review of the theoretical definitions of the therapeutic relationship found three main themes of the alliance; the collaborative nature of the relationship, the affective bond between the patient and therapist, and the ability to agree on treatment goals and tasks.

It seems natural that the cognitive therapist might shy away from bringing the RtW issue into treatment as it clearly introduces a therapist-/service-driven goal and therefore seems to go against the collaborative nature of CBT which could be a clear bias towards the therapist

taking the lead. It could be perceived as taking an authoritative or autocratic stance which is against the principles of a good cognitive behaviour therapist (Curwin *et al.* 2000). It could also be a potential barrier in the development of a good therapeutic alliance, which in turn could lead to poorer therapy outcomes, or it could make the therapist appear overly controlling leading to clients dropping-out of treatment. However, from our own experience this has not necessarily been the case. Avoidance of the RtW issue by the therapist may have more to do with their assumptions and beliefs that it will automatically damage the therapy. Certainly, keeping the RtW issue as a hidden agenda item would go against the explicit collaborative nature of CBT (Sanders & Wills, 2005), especially where an objective of the service is to help clients return to, or stay in work.

One of the potential problems with bringing the RtW agenda into therapy is that it might be seen by the client as a preconceived idea of the therapist or that the therapist is prioritizing the goals of the service over the clients, which could then create a significant barrier to the therapy becoming a collaborative venture. Therefore, a RtW agenda that is delivered as a therapist-driven goal may not only effect collaboration but the whole therapeutic relationship. Further consideration is needed on how to balance the goals of the therapist and service, and respect and respond to the preferences of individual patients. Imposing or subtly coercing a RtW agenda on a client who does not wish to establish RtW as a treatment goal raises significant ethical issues. However, in our experience, at an in-house occupational mental health service, we have mostly found that a RtW agenda facilitates both therapy and the therapeutic relationship and that once prompted the client is often keen to have it incorporated within their therapy goals. Potential ways of balancing these issues can be illustrated through two short examples from our own clinical practice.

### **Clinical example 1**

Mike was a 45-year-old senior communications manager for a large organization. He had suffered from chronic fatigue syndrome for several years and had been signed-off work for the last 6 months. He had been referred by a consultant psychiatrist after his condition had not improved through self-management strategies such as 'pacing' and medication. Initially the therapeutic relationship was somewhat tense; Mike felt that being referred for CBT meant that 'all my symptoms are in my head'. Early on in treatment a problem list was developed which in itself can be viewed as the beginnings of the formulation (Persons, 1989). Mike placed being signed-off sick near the top of his problem list as for him it highlighted his lack of progress in his condition and left him without an important aspect of his social identity. Setting goals can help to increase hope and a sense of control for the client (Charlesworth & Greenfield, 2004), and this was particularly important in engaging Mike to the therapy.

For Mike returning to work was a key feature of his medium- and long-term goals, and demonstrated that RtW was made explicit early on in therapy, which accords with the recommendations of Blonk *et al.* (2006). Setting goals and generating a problem list is a collaborative process (Josefowitz & Myran, 2005) and helped Mike overcome some of his initial scepticism as well as instilling some hope in the therapy and the future. It also helped forge the beginnings of a therapeutic relationship. By session 8 he had been able to start on a graduated RtW programme.

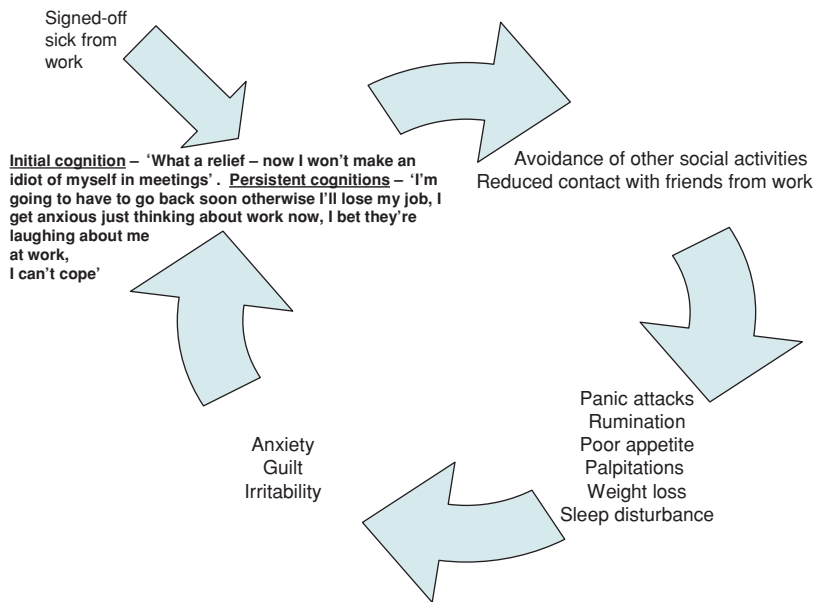


Fig. 1. Maintenance cycle for clinical example 2.

### Clinical example 2

Simon described a 2-year history of panic attacks that were initially brought on during large work meetings but his difficulties had now generalized to most places where large crowds were present and he had recently been signed-off work by his GP (see Fig. 1). With regard to his problem list, Simon was particularly concerned that the problems might have a long-term negative impact on his new career as an engineer. This together with some of his work-related therapy goals, proved strong motivating factors for Simon in his recovery. Simon used his motivation to good effect in designing challenging experiments between sessions. These included behavioural experiments around his attendance at work meetings. There was time spent during therapy to overcome specific cognitions he had around the potential embarrassment of fainting in front of work colleagues. Role-play was used in sessions to practice discussions with his manager around his fears.

### Lessons learned

These clinical examples offer guidance on how an RtW agenda can be incorporated early on in therapy through strategies such as goal setting. Engaging clients early on in their sickness absence is crucial; 90% of new claimants of incapacity benefit initially expect to RtW (Green *et al.* 2000). If identified and made explicit early on in therapy this RtW motivation can help with engagement and commitment to between-session tasks. However, not all clients will be explicit in making RtW a therapy goal or be as motivated to RtW, so it is worth investigating whether this issue can still be addressed in CBT while maintaining a collaborative relationship. We suggest another possible way is to incorporate occupational issues and RtW within the social domain of a client's formulation. Although some might suggest that we are coercing

the client towards addressing this issue we propose that the role of the cognitive behaviour therapist is often to draw the client's attention to issues outside of their current awareness (Kennerley, 2007).

### **Formulation**

Formulations are based on the principles of scientific investigation and are used in many therapeutic approaches (Tarrow & Calam, 2002). Although there is limited evidence linking formulation with outcomes (Bieling & Kuyken, 2003) they are nevertheless a central feature of CBT and form the relationship between theory and practice (Persons & Davidson, 2001). Eells (2007) describes a formulation as a set of hypotheses around the causes, triggers and maintaining factors of the client's problem which help to make predictions about which treatment strategies are most appropriate. Formulations are 'living' documents which allow the therapist to empathically see issues from the patient's point of view, which helps the client feel valued and understood (Beck, 1995) while promoting the collaborative nature of CBT (Sanders & Wills, 2005). When working occupationally there is clearly a need to incorporate social factors into the formulation. Work plays an intrinsic part in a person's past, present and future (Cooper & Baglioni, 1988) and so it seems appropriate that employment issues need to be factored into the conceptualization. In the following case examples we seek to demonstrate how we incorporated an RtW agenda into the cognitive formulation and how this informed therapy.

### **Clinical example 3**

Mary was a 25-year-old single healthcare worker who was suffering from depression. Mary reported a great sense of relief when she was originally signed-off work by her GP and during the initial goal-setting did not detail any specific work-related goals. Due to her clear relief at not being at work the therapist did not question whether RtW should be addressed at this stage for fear that it would cause a rupture in the therapeutic alliance. However, as the cross-sectional formulation was developed it became clear to both Mary and her therapist that Mary's absence from work was reinforcing the negative view of herself that she could not cope with life (see Fig. 2).

The formulation helped to illustrate that without her attendance at work her everyday life now lacked structure or goal-directed activity, limiting her ability to experience a sense of mastery from activities which lowered her mood further. The use of Socratic questions at this stage also helped highlight this issue (e.g. 'So Mary, if it now appears to you that being isolated at home and off work is making the problem worse, how might you start to break that pattern?'). Following these observations strategies were developed to address some of her avoidance of activities to both increase her sense of mastery and pleasure along with testing out some of her negative predictions. Behavioural experiments were designed to test her belief that her colleagues would judge her negatively when she contacted them. The RtW plan was informed by the formulation and incorporated testing out key cognition and behaviours. In many ways it followed the principles and benefits of activity scheduling (Beck *et al.* 1979). Openly discussing some of her anxieties and objections to aspects of the RtW plan revealed some cognitive biases that could be either worked through in session or tested out over the following weeks. It also provided opportunities during therapy to learn how she could deal with and overcome potential workplace and other setbacks.

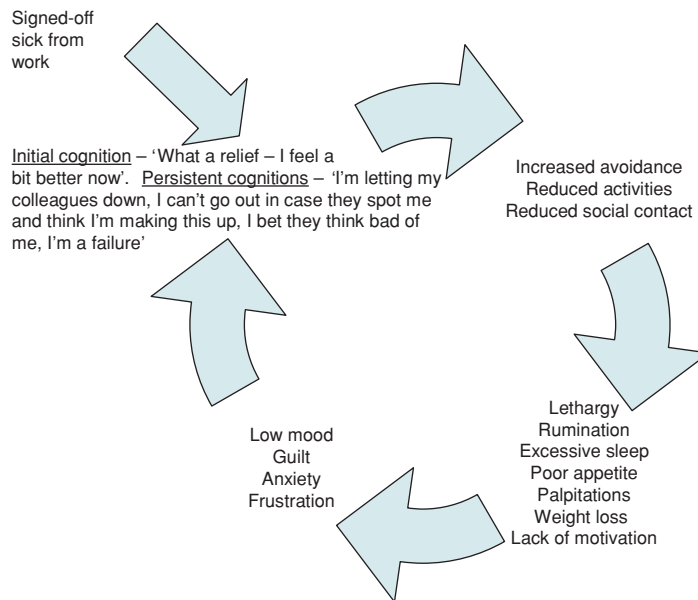


Fig. 2. Maintenance cycle for clinical example 3.

#### Clinical example 4

Stuart, a 28-year-old van driver, was suffering from anxiety and depressive symptoms for the last 6 months. This had been triggered when his wife left him for another man taking their son with her. Stuart was off work which meant he could avoid colleagues asking questions about how he was or his home situation which triggered thoughts such as ‘I’ve lost everything’ and strong feelings of emptiness. However, through the formulation process it became apparent to Stuart and the therapist that his absence from work was playing a part, among others, in maintaining his symptoms (see Fig. 3) and therefore a RtW plan might help him overcome this

Formulating Stuart’s sickness absence helped bring into his awareness the effect it was having on maintaining his anxiety and low mood. Although still anxious about going back to work, this awareness led Stuart to become much more motivated in working towards a return. The RtW plan involved making some contact with his colleagues and managers which were set up in the form of behavioural experiments to test out his negative predictions of what would happen. Stuart, his manager, GP and therapist were all involved in devising a graduated RtW plan in an attempt to make it as likely to succeed as possible. Stuart was prompted to discuss his anxieties about returning to work openly in the session. This helped highlight some of his thinking errors around this issue and allowed opportunities to work with these. There was discussion and problem-solving around how he could deal with the potential reality of negative reactions from colleagues. Carrying out the RtW plan during the therapy allowed Stuart to bring issues from his return to the sessions and for them to be worked through.

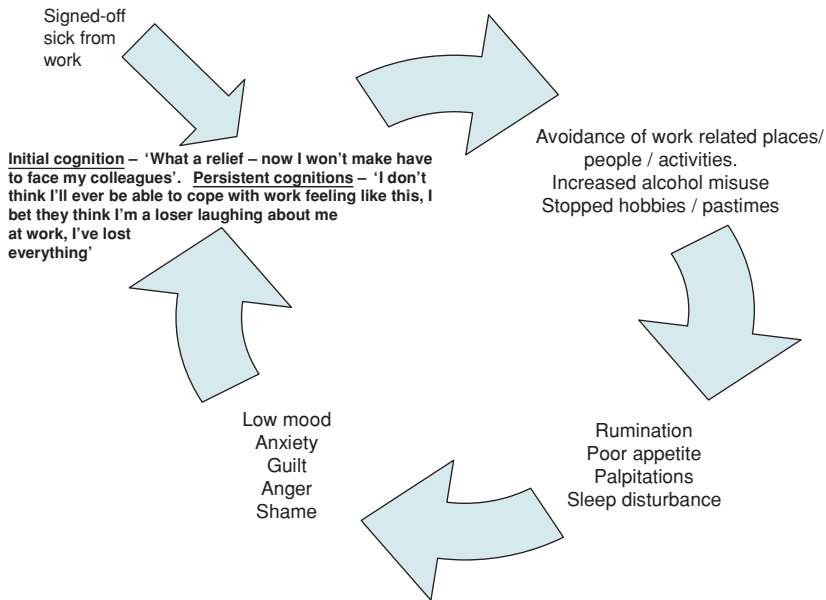


Fig. 3. Maintenance cycle for clinical example 4.

### Lessons learned

Formulations are a mechanism in which work-related avoidant behaviours and unhelpful beliefs can be gently explored which can help prevent the clients from blaming themselves for the situation (Grant *et al.* 2004) while keeping the work collaborative. These clinical examples illustrate that the absence of work typically leads to a maintenance process of reduced activity leading to a lack of positive rewards which in turn can maintain the mood disorder. People not at work tend not to use the extra time for leisure or social pursuits (Royal College of Psychiatrists, 2008) which might be due to society's negative perception of sickness absence. Similarly, there is evidence that employees returning to work after sick leave as a result of a mental health problem are likely to be more closely questioned, demoted or placed under greater levels of supervision (Manning & White, 1995). Herman & Smith (1989) found that colleagues tended to view mental illness as a personal failure. However, it is worth noting that these factors are less prevalent for people suffering from anxiety disorders and depression compared to psychotic illness. Formulations help bring such workplace problems into awareness. Including work issues in the formulation, where appropriate, also ensures that they addressed early within the treatment which has been shown to lead to improved outcomes (Blonk *et al.* 2006). It is also worth noting that once occupational issues are brought into the social domain of the formulation, then 'traditional' CBT interventions were used in these case studies to help the clients overcome the difficulties. This is in line with the Proudfoot *et al.* (1997) training programme which included techniques such as thought records, behavioural experiments and relapse management.

When considering RtW behavioural experiments we often found that a gradual approach was helpful. This accords with NICE (2009) guidance on managing long-term sickness absence,

although a return to some of the duties of the original job or a move to another job within the organization either temporarily or permanently might be appropriate. In doing so, coordination with relevant 'stakeholders' is crucial which requires discussions about therapeutic boundaries and that the therapist's involvement is not on behalf of the client's efforts but alongside them. The therapist's involvement at this point can help alleviate some of the employer's (or employers') concerns about how best they could support the individual; employers often believe that employees should be free of symptoms in order to RtW (Nieuwenhuijsen *et al.* 2004). Although linkage to external organizations is often seen more as function of case management than therapy (Hromco *et al.* 2000), it has the potential to improve overall outcomes. Merging the boundaries between therapy and case management can help counter the arguments that there is not enough consideration of occupational factors by clinicians (Black, 2008) and also that case management rarely provides clients with evidence-based therapy such as CBT (Reinhard, 2000).

## Conclusions

This paper has reviewed evidence of the economic burden that depression and anxiety disorders place on society in terms of benefit payments, lost output to the economy and personal distress. Individuals suffering from these disorders are much more likely to be out of regular employment. This lack of employment may then play a considerable part in the maintenance of the depression or anxiety, particularly in terms of social exclusion. As with the vast majority of mental health treatment research, most of the evidence supporting the use of CBT with depression and anxiety is based on symptom reduction rather than occupational outcomes. There is some, albeit limited, evidence that CBT can assist clients in returning to work but even less research and advice on how to incorporate a RtW agenda. This paper has explored some of the potential challenges with incorporating RtW within CBT such that it may jeopardize the collaborative nature of CBT, which is seen as a vital aspect of the therapeutic relationship. Consideration should also be given to clear work-related goal-setting and taking a more systemic approach when developing a formulation. Formulating avoidance or safety-seeking behaviours that have resulted from sickness absence may help direct future therapeutic work. If explored in a curious and gentle way, we suggest that a collaborative approach can still be maintained and therapy can then be utilized to support the client in developing a graduated RtW plan successfully and to help them to overcome the significant challenges this may present.

There are many factors which may influence a RtW plan and interventions might be required on an individual, team and organizational level (Hill *et al.* 2007). Moreover, there are likely to be specific issues facing certain groups such as those on long-term sickness absence. NICE (2009) defines long-term sickness absence as  $\geq 4$  weeks but in reality people are often on sick leave for much longer periods before help is available. Protracted work absences are likely to be much more difficult to overcome in part because beliefs around the illness and illness behaviour may have become far more entrenched. Although alarming, it is perhaps not surprising then to find statistics that show someone who has been off sick for 6 months has an 80% chance of being off work for 5 years (Waddell & Burton, 2006) while those claiming incapacity benefits for  $\geq 12$  months for work absence (including both physical and mental health problems) will, on average, continue to claim for 8 years (HM Government, 2005). The UK Government's Pathways to Work (DWP, 2002) initiative aims to help this group back into

employment. Although its results have been promising, the evidence shows that the impact for those with mental health problems is much more limited (Blyth, 2006).

There can be complex and varied reasons why people get stuck in the ‘benefits trap’ including the availability of jobs and financial considerations, and these may be best tackled by other agencies recommended in the Pathways to Work scheme such as Jobcentre plus. However, the NHS, including cognitive therapists, may have a part to play in assisting the client overcome other common obstacles. These may include beliefs around their illness or that they are unlikely to get work because of their health problems and reduced confidence about working (Green *et al.* 2000).

### **Future research**

There is a pressing need for further research into the efficacy and effectiveness of CBT in helping people with depression and anxiety disorders RtW. IAPT is one service model which may achieve this but it is important not to become blinkered by this model but to continue to explore other ways in which mental health treatment might take responsibility for promoting vocational outcomes or for integrating itself with employment issues (SEU, 2004; Black, 2008). This may then highlight whether or not CBT can have a specific role as an ‘early intervention to either replace or complement sickness absence’ for those suffering from depression or anxiety disorders (Wilday & Dovey, 2005).

Further investigation is also needed into how the therapist can best incorporate RtW into the collaborative relationship which is at the heart of effective CBT. This may then give cognitive therapists more confidence that a RtW agenda can be explicitly addressed ‘shoulder-to-shoulder’ with the client instead of being directed at them. Work forms a fundamental part of most people’s lives and of their self-concepts. Those people not in employment due to depression or anxiety disorders not only suffer from their symptoms but also suffer from their exclusion from society. Cognitive therapists can have an important role in helping those excluded to become engaged again (Richards & Suckling, 2008).

### **Acknowledgements**

Up-to-date information on IAPT is available at: [www.iapt.nhs.uk](http://www.iapt.nhs.uk)

### **Declaration of Interest**

None.

### **Recommended follow-up reading**

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### **Learning objectives**

- (1) To review some of the economic arguments in favour of increasing the provision of CBT and review key research on CBT and occupational outcomes.
- (2) To consider potential difficulties and ethical issues which might result from introducing a return-to-work agenda into CBT.
- (3) To identify ways in which employment issues might be integrated into CBT.