Psychological Therapy and Counseling

Dr. Michael Pare, MD MSc, OCFP, Representing the OMA Section on GP-Psychotherapy and Dr. Barry Gilbert, MD, CCFP, FRCP (C), Representing the OMA Section on Psychiatry on behalf of The Guidelines Advisory Committee (GAC)

When is psychological therapy warranted for patients with mental health problems?

Scope:
Psychological therapies are provided by mental health professionals from a range of disciplines. This guideline is intended for primary care physicians, psychiatrists and psychologists and others involved in the treatment and or referral of patients with mental illnesses.

Background:
Mental illnesses are common conditions in current practice. Psychological therapy and counseling have demonstrable benefits for many patients in reducing distress, symptoms, risk of harm to self or others, health related quality of life and return to work. However, not all therapies are effective for all patients, and practitioners need to consider many factors before considering referral for a specific therapy.

Method:
GAC librarians searched Medline and Embase databases and guideline web sites for guidelines on psychological therapy and counseling. Each guideline was sent to a minimum of three trained Ontario physicians for assessment using a standard evaluation instrument (Cluzeau et al, 1999). Guideline assessment scores were aggregated, and GAC members considered the highest scoring guidelines for endorsement. The Committee used the scores and the qualitative feedback from assessors, as well as its own knowledge of implementation barriers, to determine the best available evidence in this clinical area. Nonetheless, the guideline selected is limited by its exclusion of patients with substance abuse problems and by not including patients with comorbidity, which may make up at least half of patients in psychiatric practice. The GAC initially produced a summary document to enable quick decision-making on the part of practitioners. This summary, however, was considered inadequate by two OMA sections – Psychiatry and GP Psychotherapy, and the following summary was produced.

The Summary below has been extracted from Treatment Choice in Psychological Therapies and Counseling: Evidence Based Clinical Practice Guideline, The UK Department of Health, 2001 The full guideline is available at: www.doh.gov.uk

Introduction
The recommendations in this guideline are relevant to the following presenting problems:

- depression, including suicidal behavior,
- anxiety, panic disorder, social anxiety and phobias,
- post traumatic disorders,
- eating disorders,
- obsessive compulsive disorders,

1 It is important to clarify a significant terminology difference between the UK study being discussed and the Ontario context. In the original UK article it was decided that the terms “psychological therapy” and “counseling” are both useful words for what in Ontario – at least as defined by OHIP – is called “psychotherapy”. Within OHIP “counseling” is defined as an educational intervention and should not be confused with “counseling” as a form of psychotherapy as some may use the term in other contexts (such as in the UK).
• personality disorders, including repetitive self harm, and
• some somatic complaints (e.g. chronic pain, chronic fatigue).

The following conditions for which psychological therapies may be helpful are excluded from this guideline: Disorders in childhood and adolescence, psychoses including schizophrenia, mania and bipolar disorder, alcohol and other drug addictions, sexual dysfunction and paraphilias, organic brain syndromes, and learning disabilities. The guideline does not consider pharmacological treatments, but in general, there is no reason why medication and psychotherapy should not be used together. This document may be photocopied freely.

The recommendations are weighted as follows:

A. Based on a consistent finding in a majority of studies in high quality systematic reviews or evidence from high quality studies.
B. Based on at least one high quality trial, a weak or inconsistent finding in high quality reviews or a consistent finding in reviews that do not meet all the criteria of 'high quality'.
C. Based on evidence from individual studies that do not meet all the criteria of 'high quality'.
D. Based on evidence from structured expert consensus.

Recommendations

The strength of each recommendation or guiding principle is indicated, linked to the evidence review. Further explanatory text is included to clarify recommendations and give appropriate caveats, but this is kept to a minimum. The strength of each recommendation depends on the quality of evidence supporting it, and is graded from A to D.

As pharmacological treatments were beyond the scope of this guideline, the following recommendations should not be taken to imply that a psychological therapy is indicated over and above medication. The value of a pharmacological treatment, whether as an alternative to, or additional to, psychological therapy, should be considered separately.

• Initial Assessment

Psychological therapy should be routinely considered as a treatment option when assessing mental health programs (B).

There is strong research evidence of the potential benefit of psychological treatments to individuals with a wide range of mental health problems. For this reason, they should not be overlooked in assessing treatment options. Medication may be the treatment of choice in an individual case, but it should not be the only option considered. Pharmacological treatments are not within the scope of this guideline. The evidence on whether the combined effects of medication and psychological treatment are greater than singly is complex, but in general, drugs are not a contraindication to psychological therapy, or vice versa.

In considering psychological therapies, more severe or complex mental health problems should receive secondary, specialist assessment (D).

There was a consensus in the expert panel that when considering psychological treatments, specialist psychological or psychotherapeutic assessment should be provided for patients with more severe or complex mental health problems. These guidelines are not intended to take the place of systematic assessment for the suitability of psychotherapy for individual patients.
Effectiveness of all types of therapy depends on the patient and the therapist forming a good working relationship (B).

This principle is important in decisions by GPs and their patients about the option of psychological therapy, because ‘therapeutic alliance’ is the single best predictor of benefit. A good working relationship in therapy does not necessarily mean the absence of conflict or difficulty, but a fundamental agreement on the goals and tasks of therapy and some level of commitment to the relationship. If this is lacking, the therapy is less likely to be helpful, whatever other research evidence may recommend it in general terms. If this occurs, a second opportunity to establish a working relationship is advisable.

Therapies of fewer than eight sessions are unlikely to be optimally effective for most moderate to severe mental health problems (B).

Often 16 sessions or more are required for symptomatic relief, and longer therapies may be required to achieve lasting change in social and personality functioning (C).

Specific phobias and uncomplicated panic disorder (without agoraphobic symptoms) can respond to brief interventions (B).

The issue of optimal treatment length is complex, but referrers and patients often ask for guidance on what to expect. Some service commissioners have only been prepared to fund very brief therapies (e.g. six sessions), although there is no research evidence to suggest that this is an adequate trial of therapy for most moderate to severe problems. Exceptions may be uncomplicated phobias and panic disorder without agoraphobia. A common therapy length in the UK National Health Service – (NHS) is from eight to 20 sessions, although some therapies may need to be longer, for example, where there are complications of personality disorder or chronic relapsing depression. While there is little research evidence about the most effective pattern of delivery, there is some limited evidence of the benefit of extended follow up or ‘booster’ sessions for chronic disorders.

The patient’s age, sex, social class or ethnic group are generally not important factors in choice of therapy and should not determine access to therapies (C).

Ethnic and cultural identity should be respected by referral to culturally-sensitive therapists (C).

There is a risk of unwarranted and stereotypical assumptions being made about which types of people are most likely to benefit from psychological therapy, e.g. middle-class or well-educated people, or women, or people under 50. There is generally no consistent research evidence for these assumptions. Reviews on ethnicity show mixed results for ethnic matching of therapist and client, but do suggest the importance of cultural sensitivity, and therapists not imposing their own cultural values on clients.
Patient preference should inform treatment choice, particularly where the research evidence does not indicate a clear choice of therapy (D).

There is little research evidence on the effect of patient preference, although this research is now being commissioned. This recommendation is therefore extrapolated from research evidence on therapeutic alliance and supported by expert professional and user consensus. Failure to take account of patient preferences on treatment type, length and therapist may damage commitment to the therapy. The recommendation assumes that relevant information about therapy options has been made available and that there will be a subsequent opportunity to explore the meaning of the preference in the assessment discussions between therapist and client. It also raises the issue of how to proceed when a patient’s initial response is to reject the therapy option most strongly supported by research evidence. After discussion with their GP, many people are willing to attend for initial consultation and to give the approach a fair trial. Other therapies may be offered if the first recommended treatment is unacceptable.

- **Skill level of therapist**

The skill and experience of the therapist should also be taken into account. More complex problems, and those where patients are poorly motivated, require the more skilful therapist (D).

This principle is relatively weakly supported by research evidence, possibly for methodological reasons, but achieved a strong expert consensus. Many therapies in the NHS are necessarily delivered by novice therapists or those with minimal training. The clinical consensus was that, while not necessarily problematic for straightforward presentations, it is safer practice for people in severe and complex difficulties and with greater risk of self-harm to be treated by therapists who are more skilful.

- **Patient characteristics**

Interest in self-exploration and capacity to tolerate frustration in relationship may be particularly important for success in interpretative (psychoanalytic and psychodynamic) therapies, compared with supportive therapy. (C).

This principle is extrapolated from evidence from controlled trials that suggest patients who lacked these characteristics did less well in interpretative, psychoanalytic therapy compared with supportive, noninterpretive therapy.

- **Adjustment to life events**

Patients who are having difficulty adjusting to life events, illnesses, disabilities or losses (including Childbirth and bereavement) may benefit from brief therapies, such as counseling (B).

The evidence base for counseling, whilst improving, suffers from methodological shortcomings. There is evidence of effectiveness with mixed anxiety/depression and generic psychological distress presenting in primary care. Specific client groups (e.g. bereavement reactions, mild post-natal depression) may also benefit from counseling and other brief therapies.
• **Post traumatic stress**

Where post-traumatic stress disorder (PTSD) is present, psychological therapy is indicated, with best evidence of cognitive behavioral methods. (A)

Patients with PTSD can expect to receive substantial help from psychological therapy even in the absence of a complete cure. The differential effectiveness of different types of treatment has not been established, with best evidence for the benefit of systematic desensitization (graded exposure) and related approaches (stress inoculation therapy, and eye movement desensitization). Psychodynamic therapy and hypnotherapy have also shown benefit. Prolonged re-exposure (flooding) may exacerbate some symptoms (depression, anger, alcohol use), and graded re-exposure is generally more acceptable to patients.

• **Depressive disorders**

Depressive disorders may be treated effectively with psychological therapy, with best evidence for cognitive behavior therapy and interpersonal therapy, and some evidence for a number of other structured therapies, including short-term psychodynamic therapy (A).

This recommendation reflects a large body of research, considered in eight high quality reviews and two Cochrane reviews. Psychological therapy has been shown effective in the treatment of depression in general adult and older adult populations, including inpatient care and depression after childbirth. The best evidence is for cognitive behavior therapy and interpersonal therapy. However, direct concurrent comparisons show few significant differences between orientations and a number of other approaches have shown some evidence of effectiveness. These include behavioral therapy, problem-solving therapy, group therapy, systemic therapy, non-directive counseling in primary care and psychodynamic interpersonal therapy.

• **Anxiety disorders**

Anxiety disorders with marked symptomatic anxiety (panic disorder, agoraphobia, social phobia, obsessive compulsive disorders, simple phobias and generalized anxiety disorders) are likely to benefit from cognitive behavior therapy (A).

There is a wide evidence base from meta-analytic reviews supporting exposure-based behavioral treatments and cognitive behavior therapy, including panic control therapy. The demonstrated effectiveness of exposure based methods for a variety of anxiety disorders suggests they should be tried first for patients who can tolerate them, and this was also the expert consensus. However, the lack of evidence on other therapies does not mean they are ineffective.

• **Eating disorders**

Bulimia nervosa can be treated with psychological therapy; best evidence is for interpersonal therapy and cognitive behavior therapy (A).

Individual psychological therapy for anorexia nervosa may be of benefit, there is little strong evidence on therapy type (B).
In bulimia, a recent Cochrane review found most evidence for cognitive behavior therapy. Other reviews have found evidence of efficacy for interpersonal therapy and family therapy, the latter particularly where the patient is under 18. There is less high-quality evidence on anorexia; individual therapies have shown some benefit, with little to distinguish treatment types. Family therapy may be indicated for early onset of anorexia; broadly-based individual therapy may be more appropriate for later onset.

- Personality disorder

A co-existing diagnosis of personality disorder may make treatment of the presenting mental health problem more difficult and possibly less effective; indications of personality disorder include forensic history, severe relationship difficulties, and recurrent complex problems (D).

Mental health problems such as depression, anxiety, panic, eating disorders and self-harm often co-exist with severe difficulties in relationships and self-management. The latter problems sometimes begin in childhood and are severe and repetitive enough to meet diagnostic criteria for personality disorder. In such situations, recommended psychological therapies for common mental health problems such as depression may still be worthwhile. In particular, there is evidence that anxiety disorders can be treated successfully in this group. However, other evidence and a strong clinical consensus indicates that for many patients, therapy for common mental health problems in this group are likely to take longer and the outcome may be attenuated.

Structured psychological therapies delivered by skilled practitioners can contribute to the longer-term treatment of personality disorders (C).

Psychological treatment of personality disorders themselves, rather than the co-existing mental health problems, has been the focus of intense development in recent years. A recent meta-analysis found that a number of therapy approaches, both individual, group and milieu show some success with personality disorders. Available therapies include dialectical behavior therapy, psycho-analytic day hospital program, therapeutic communities, cognitive analytic therapy, schema-focused cognitive therapy and psychoanalytic therapy. In a client group that is difficult to research, we located controlled trial evidence to support the first three of these, although research is underway or planned in other approaches. In addition to therapy types, features of service systems are likely to be important in long term management, in terms of structured programs using active methods to enhance engagement, which are well integrated with other services, and have a clear therapeutic focus. The expert consensus was that people in these difficulties are not appropriately seen by novice therapists or in very brief therapies.

- Somatic complaints

Cognitive behavior therapy should be considered as a psychological treatment for chronic fatigue and chronic pain (B).

Psychological intervention should be considered for other somatic complaints with a
psychological component, such as irritable bowel syndrome and gynaecological complaints (pre-menstrual syndrome, pelvic pain) (C).

- **Contraindications**

Routine debriefing shortly after a traumatic event is unlikely to help prevent post traumatic stress disorder and is not recommended (A).

Review of the best-designed studies suggests that routine ‘debriefing’ (a single session intervention soon after the traumatic event) is not helpful in preventing later post-traumatic disorders. These studies have been criticized for the quality of the psychological intervention offered. However, they may be representative of the types of routine debriefing likely to be available in the NHS, and the recommendation was also strongly supported by clinical consensus. Although routine debriefing is not recommended, patient preference may be a guide in individual circumstances.

Generic counseling is not recommended as the main intervention for severe and complex mental health problems or personality disorders (D).

There is evidence of benefit from counseling for mixed anxiety/depression presenting in primary care, but not for more severe disorders. There was consensus in the expert professional panel that counseling is not the main intervention of choice for people with the most severe or complex problems. Other types of psychological therapy may be beneficial. However, panel members believed that for some patients counseling could be helpful in a supportive or adjunctive capacity, as part of a care program, and this view was supported by service users.

**Types of psychological therapy**

- **Cognitive behavior therapy (CBT)** This refers to the pragmatic combination of concepts and techniques from cognitive and behavior therapies, common in clinical practice. Cognitive techniques (such as challenging negative automatic thoughts) and behavioral techniques (such as graded exposure and activity scheduling) are used to relieve symptoms by changing maladaptive thoughts, beliefs and behavior.

- **Psychoanalytic therapies** A number of different therapies draw on psychoanalytic theories. Focal psychodynamic therapy identifies a central conflict arising from early experience that is being re-enacted in adult life producing mental health problems. It aims to resolve this through the vehicle of the relationship with the therapist giving new opportunities for emotional assimilation and insight. Psychoanalytic psychotherapy is a longer-term process (usually a year or more) of allowing unconscious conflicts opportunity to be re-enacted and interpreted in the relationship with the therapist.

- **Systemic and family therapy** (whether treating individuals, couples or families) focuses on the relational context, addresses patterns of interaction and meaning, and aims to facilitate personal and interpersonal resources within a system as a whole. Therapeutic work may include consultation to wider networks such as other professionals working with the individual or the family.

- **Other** This list is not comprehensive. Many other types of therapy are practiced in the UK National Health Service (NHS) including cognitive-analytic, existential, humanistic, feminist, personal construct, art therapy, drama therapy, transactional analysis, group analysis and interpersonal therapy (IPT).
**References:**


**Effective recommendation date:**
June, 2002

**Planned review date**
June, 2005, unless new evidence arises

**Contact information**
Ontario Guidelines Advisory Committee
500 University Avenue, Suite 650
Toronto, Ontario M5G 1V7
Tel. 1-888-512-8173 (ext. 5)
Fax (416) 971-2462
E-mail: yale.drazin@gacguidelines.ca

For more information on the GAC and its guideline review process, please visit the GAC Web site (www.gacguidelines.ca).