Treatment Choice in Psychological Therapies and Counselling

Evidence Based
Clinical Practice Guideline

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Development of the Guideline was led by the British Psychological Society Centre for Outcomes Research and Effectiveness, with the support and participation of the following organisations:

British Association for Counselling and Psychotherapy
British Confederation of Psychotherapists
British Psychological Society
Depression Alliance
Mind
Royal College of General Practitioners
Royal College of Psychiatrists
UK Advocacy Network
UK Council for Psychotherapy

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PREFACE

These clinical practice guidelines were developed to aid decisions about which forms of psychological therapy are most appropriate for which patients. Those who refer patients to psychological therapists include General Practitioners, psychiatrists and, often, other therapists. This is a complex field and in making referrals, these professionals may find it useful to have the relevant research evidence appraised and summarised, together with current expert consensus. Many General Practitioners, having decided a psychological therapy is indicated, will refer to local mental health specialists for 'brokerage assessment'. It is anticipated that these guidelines will also be of value to people in local mental health teams and departments of psychology or psychotherapy undertaking this role.

Psychological therapies have an important role to play in helping people with mental health problems, who should have access to effective treatment, both physical and psychological (National Service Framework for Mental Health, Department of Health, 1999). There is no doubt that these therapies can have demonstrable benefit, for example in reducing distress, symptoms, risk of harm to self or others, health related quality of life and return to work. However, not all are effective for all patients, and practitioners will wish to consider which factors are important in considering a referral. All too often, access to therapy is determined by irrelevant demographic factors, such as place of residence or age, rather than evidence about benefit.

The guidelines address who is likely to benefit from psychological treatment, and which of the main therapies currently available in the NHS is most appropriate for which patients. They also consider which other factors need to be taken into consideration. The guidelines have been produced by a multi-disciplinary guideline development group, led by the British Psychological Society, and they have undergone extensive independent scientific review.

The guidelines are based on the extensive body of international psychotherapy research, systematically reviewed and appraised. Implications of this evidence for practice are rarely straightforward, so in addition, with the help of a large multi-disciplinary panel who had read the evidence review, we used structured methods to ascertain expert consensus on treatment choice. Where there was a strong consensus we used it to inform recommendations, but we have indicated the type and strength of evidence on which each recommendation is based.

The methods used to develop the guideline are described in Chapter 1, and the evidence is summarised in Chapter 2. The principal recommendations are linked to evidence in Chapter 3. There has been considerable controversy over the role of guidelines in this field, and the best way of implementing recommendations. These issues are addressed in Chapter 4.

Throughout, we have tried to adopt best practice in guidelines development by adhering to the criteria recommended by Cluzeau and colleagues (1997). These guidelines have used national resources to gather, sift and weigh a wide range of evidence. As such they are inevitably generalisations, and will apply to a greater or lesser extent to individuals. The recommendations are therefore an aid to informed collaborative decision-making. They cannot and should not replace professional judgement in assessing the individual case, and, of course, a generalisation, however well based, is no substitute for a specialist assessment following referral.

Having said this, many clinicians will find it valuable to have a succinct summary of up-to-date research evidence in psychological therapies. Local availability of these therapies and local arrangements for assessment vary enormously, and we are aware that the guidelines will be used and adapted in many different ways. For the individual patient, these guidelines may help to prevent inappropriate referral, delay, and wrong treatment allocation, multiple assessments and false starts in therapy. Adapted locally, they could form the basis for agreement between primary and secondary care professionals on referral pathways. They also have an educational function. They contribute to an evidence based approach to psychological therapies that will benefit patients by clarifying how much (and how little) we currently know from research, or can agree between experts. Finally, they may help to empower and inform service users in a field that is often confusing or mystifying.

Nowhere is the gap between research and practice wider than in this field. Most psychological therapy in the NHS is pragmatic and eclectic, where therapists use a judicious mix of techniques drawn from varying theoretical frameworks. Most psychotherapy research, on the other hand, is on standardised interventions of 'pure' types of therapy, e.g. cognitive, behavioural or psychoanalytic. The most prevalent interventions are paradoxically the least researched. These and other gaps in research coverage do not mean these interventions are ineffective, but they do point to the need for systematic work to improve this evidence base. By confronting this divide within these guidelines, we hope to promote better research as well as less variable practice.

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Methods

1.1 Scope of the guidelines

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

- depression, including suicidal behaviour
- anxiety, panic disorder, social anxiety & phobias,
- post traumatic disorders,
- eating disorders,
- obsessive compulsive disorders,
- personality disorders, including repetitive self harm

In addition, we were aware of the importance of psychosomatic presentations in primary care, and of indications for psychological treatment. However, as all physical illnesses (e.g. cancer, heart disease, asthma) may have psychological aspects or complications, we decided on the scope of this guideline by surveying a small opportunity sample of General Practitioners (n=49). There was a high degree of consensus on four physical conditions for which they would welcome guidance. The following are therefore included in the scope of the guideline.

- chronic pain,
- chronic fatigue,
- gastrointestinal disorders (e.g. irritable bowel syndrome)
- gynaecological presentations (e.g. pre-menstrual syndrome, pelvic pain, menopausal vasomotor symptoms)

The task of the Development Group, already difficult, would become impossible unless the scope of the guideline were limited. The guideline therefore does not address the use of psychological therapies in the following situations:

- disorders in childhood and adolescence,
- psychoses including schizophrenia,
- mania and bipolar disorder,
- alcohol and other drug addictions,

- sexual dysfunction & paraphilias,
- organic brain syndromes and acquired brain injury
- learning disability

Decisions about these exclusions were made on pragmatic grounds, to focus on common mental health problems in adults. Exclusion from the guideline does not imply that psychological therapies are unhelpful or inappropriate in these conditions, simply that they are beyond the scope of this particular guideline. For example, psychological therapies have been developed specifically to help people with schizophrenia or alcohol problems. Guidance on psychological interventions for schizophrenia is being developed as part of the National Institute for Clinical Excellence guidelines on schizophrenia. We acknowledge that, in the case of people with learning difficulties, there is no clear boundary to identify where this guideline ceases to apply. It should not be assumed that people who have mild to moderate cognitive impairments fail to benefit from the mainstream therapies described here. Where research on the impact of factors such as intelligence and educational attainment is available, it has been reviewed. This and other topics excluded from this guideline would be appropriate for separate guideline development.

The guideline only considers the choice of psychological therapy and does not consider pharmacological treatments. No evidence has been reviewed on their effectiveness or the comparative effectiveness of medication and psychological therapy. This means that recommendations for a psychological therapy do not imply that a pharmacological treatment is not indicated. In general, prescribed medication is not a contra-indication for psychological therapy (or vice versa), and separate consideration will need to be given to pharmacological treatments. Nor is the combination of psychological and pharmacological treatments considered here. The research evidence on the relative merits of either form of therapy or combination therapies will be most appropriately considered in condition-specific guidelines, such as the forthcoming NICE guideline on treatments for depression.

Cost effectiveness of psychological therapies is clearly an important element of treatment choice decisions. However, true economic appraisal in this field is extremely sparse and basic methodological issues are only now being addressed by researchers and health economists (Miller & McGruder, 1999). We address the evidence, in section 2.2 and consider cost issues in implementing this Guideline in section 4.2.

1.2 Types of psychological therapies

There are many types of psychological treatment and the range of 'brand name' therapies can be confusing for the non-specialist. Whilst it is not practicable to give a working definition of every separate therapy, we have listed the main types of psychological therapies widely used in the NHS. In addition, there are some therapies which, whilst not yet widely available, have been the subject of research, and appear in the evidence review in Chapter 2. These are also listed separately. Provision of psychological therapies in the NHS varies considerably in different parts of the country. Each of these can be practised with individuals, couples, families or groups.

Within the NHS, psychological therapies are provided by members of different professional disciplines, including clinical psychologists and psychiatrists, specially trained mental health nurses, occupational therapists, art and drama therapists, counsellors and psychotherapists. Some therapists have generic roles, providing therapy as an integral part of care programmes within mental health teams. Others provide stand-alone services. There is a wide range of training routes to competence as a psychological therapist.

Terminology in this field is also confusing. We adopt the usage that 'psychological therapy', 'psychological treatments', 'talking therapies' and 'talking treatments' are interchangeable, representing the most generic terms. Within this broad family of therapies, there are two main traditions, psychotherapy and counselling. The distinction between the two is blurred, as they lie on a continuum, such that for each type of psychological therapy there is a corresponding form of counselling (psychodynamic psychotherapy – psychodynamic counselling, cognitive behaviour therapy – cognitive behavioural counselling, etc.). In essence, different forms of psychotherapy have evolved to offer remediation of mental health problems and symptoms by structured interventions. Different forms of counselling emphasise the individual's resources rather than psychopathology, with a focus on a reflective, experiential process. Here the patient's concerns are rephrased and clarified in order that he or she may develop a greater sense of well being and cope with life difficulties differently. There is emphasis on mental health promotion rather than 'treating disorders'. Historically, as this approach developed outside the NHS, and it was applied later in medical settings, counselling tended to be briefer and counsellors worked with patients who were less ill.

The terminological confusion is exacerbated by the common practice of denoting all psychological therapy delivered in primary care as 'counselling'. In fact, a number of 'counsellors' employed in primary care are qualified psychotherapists.

1.2.1 Psychotherapies commonly practised in the NHS

Cognitive behaviour therapy (CBT)

This refers to the pragmatic combination of concepts and techniques from cognitive and behaviour therapies, common in clinical practice. *Behaviour therapy* is a structured therapy originally derived from learning theory, which seeks to solve problems and relieve symptoms by changing behaviour and the environmental factors which control behaviour. Graded exposure to feared situations is one of the commonest behavioural treatment methods and is used in a range of anxiety disorders. *Cognitive therapy* is a structured treatment approach derived from cognitive theories. Cognitive techniques (such as challenging negative automatic thoughts) and behavioural techniques (such as activity scheduling and behavioural experiments) are used with the main aim of relieving symptoms by changing maladaptive thoughts and beliefs.

Psychoanalytic therapies

A number of different therapies draw on psychoanalytic theories, although they differ in terms of technique. *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. This form of therapy is often time-limited, with anxiety aroused by the ending of therapy being used to illustrate how re-awakened feelings about earlier losses, separations and disappointments may be experienced differently. *Psychoanalytic psychotherapy* is a longer-term process (usually a year or more) of allowing unconscious conflicts opportunity to be re-enacted in the relationship with the therapist and, through interpretation, worked through in a developmental process.

Systemic therapy

Systemic and family therapists understand individual problems by considering the relevance of family relationships and the impact of the wider social and economic context on people's lives, their wellbeing and their mental health. Therapeutic work is undertaken with individuals, couples, or families and may include consultation to wider networks such as other professionals working with the individual or the family. Therapy aims to identify and explore patterns of belief and behaviour in roles and relationships

and therapists actively intervene to enable people to decide where change would be desirable and to facilitate the process of establishing new, more fulfilling and useful patterns. Therapists may work in teams using live consultation or as sole practitioners using retrospective consultation. Therapy is often relatively short term.

Eclectic therapies

Many NHS therapists formulate the patient's difficulties using more than one theoretical framework and choose a mix of techniques from more than one therapy approach. The resulting therapy is pragmatic, tailored to the individual. These generic therapies often emphasise important non-specific factors (such as building the therapeutic alliance and engendering hope). By their nature, they are more idiosyncratic and difficult to standardise for the purposes of randomised controlled trials research.

Integrative therapy

An integrative therapy differs from eclectic approaches, as it is a formal theoretical and methodological integration of, for example, behavioural, cognitive, humanistic or psychodynamic approaches. These therapies are therefore amenable to research. One such approach is cognitive analytic therapy.

Other psychotherapies

The above list is by no means comprehensive. Other types of therapy practised in the NHS include existential, humanistic, process-experiential (client-centred), feminist, personal construct, art therapy, drama therapy, transactional analysis and group analysis. Further information about psychotherapy types can be obtained from the UK Council for Psychotherapy.

1.2.2 Counselling in the NHS

Counselling is a systematic process which gives individuals an opportunity to explore, discover and clarify ways of living more resourcefully, with a greater sense of well being. Counselling may be concerned with addressing and resolving specific problems, making decisions, coping with crises, working through conflict, or improving relationships with others.

Counsellors may practice within any of the therapeutic approaches listed above, using psychodynamic counselling, cognitive behavioural counselling, systemic counselling and so on. However, most are influenced by humanistic, process-experiential and psychodynamic principles.

The work of most counsellors is generalist (analogous to general practice) and is not necessarily linked to diagnostic categories. Many counsellors work in primary care, but they are increasingly found in secondary care settings. A broad distinction can be made between generic and specific counselling. The latter may be specific to a therapeutic model (for example, psychodynamic counselling) or a life crisis (for example, bereavement counselling).

In relation to specific life crisis issues, there are many voluntary sector counselling agencies (Relate, bereavement agencies, sexual abuse survivor groups etc) to whom GPs commonly refer patients with mental health problems. For example, one such service, Cruse Bereavement Care, currently receives more than one third of its referrals from GPs.

1.2.3 Other therapies in research review

A number of forms of psychological therapy have been mentioned in the research review (Chapter 2), although they are not necessarily widely practised within the NHS. These are listed here for reference, descriptions are given in Annex 1.

Applied relaxation therapy
Autogenic training
Cognitive analytic therapy (CAT)
Dialectical behaviour therapy (DBT)
Eye movement desensitisation & reprocessing (EMDR)
Hypnotherapy
Interpersonal therapy (IPT)
Problem-solving therapy
Psychoanalytically informed day hospital treatment
Psychodynamic-interpersonal therapy
Rational emotive therapy
Schema-focused cognitive therapy
Social skills training
Stress inoculation therapy
Supportive psychotherapy
Therapeutic community

1.3 Responsibility and support for guideline development

This guideline was commissioned and funded by the Department of Health. During its development the National Institute of Clinical Excellence was established, which contributed to its development costs. The British Psychological Society commissioned the guideline development through its Centre for Outcomes Research and Effectiveness at University College London. This Centre, as similar Royal College Research and Clinical Effectiveness Units, is operationally independent of the BPS, but is responsible to the BPS for clinical effectiveness and research initiatives funded from the Department of Health and other sources.

The guideline development group (Annex 5) met 13 times over 2½ years, reporting to a separate steering group (Annex 9). The Royal College of Psychiatrists, the Royal College of General Practitioners and the British Association for Counselling and Psychotherapy participated in both groups. These organisations, together with the United Kingdom Council for Psychotherapy and the British Confederation of Psychotherapists, also nominated expert panellists for the consensus generating work. Depression Alliance, Mind (Diverse Minds, Mind Links) and the UK Advocacy Network (UKAN) nominated members for a user consultation group. Members of these groups are listed in the appendices – the professional expert panel (Annex 6), the user consultation group (Annex 7), and independent scientific reviewers (Annex 8).

1.4 Evidence identification and synthesis

The development group took a stepwise, hierarchical approach to identifying and interpreting evidence. First, the best quality evidence from systematic meta-analytic reviews was identified, in relation to therapies for the main presenting problems covered in the guideline. From this review dataset, secondary evidence on other factors was analysed, and since these factors are rarely themselves the subject of experimental manipulation, a slightly lower standard of evidence was used. Gaps in the resulting evidence base were then addressed by supplementary searches, both for missed reviews and for individual high quality trials that were either too recent to be reviewed or too sparse for meta-analytic review. Finally, expert and user consensus was used in three ways – first, where no research evidence was applicable, second to interpret the practical implications of evidence and finally, to confirm the clinical appropriateness of recommendations. An overview of the guideline development process is given in Figure 1.

Dr Hannah Mackay and Dr Michael Barkham from the Psychological Therapies Research Centre at the University of Leeds undertook the main systematic review of research evidence. They were assisted in rating reviews on quality criteria by Ms Saskia Duckmanton at CORE.

Their task was to review systematically the research evidence regarding outcomes of psychological therapies (psychotherapies and counselling). This may be divided into two main areas:

1. Evidence of the effectiveness of psychotherapy and counselling for people with particular diagnoses, including the differential effectiveness of specific types of therapy. The diagnostic areas/presenting problems considered were:

    - depression including postnatal depression;
    - anxiety disorders including generalised anxiety, panic and agoraphobia, social phobia, post-traumatic stress disorder, and obsessive compulsive disorder;
    - eating disorders;
    - personality disorders;
    - Somatic presentations including chronic pain, chronic fatigue, gastrointestinal problems and gynaecological problems.

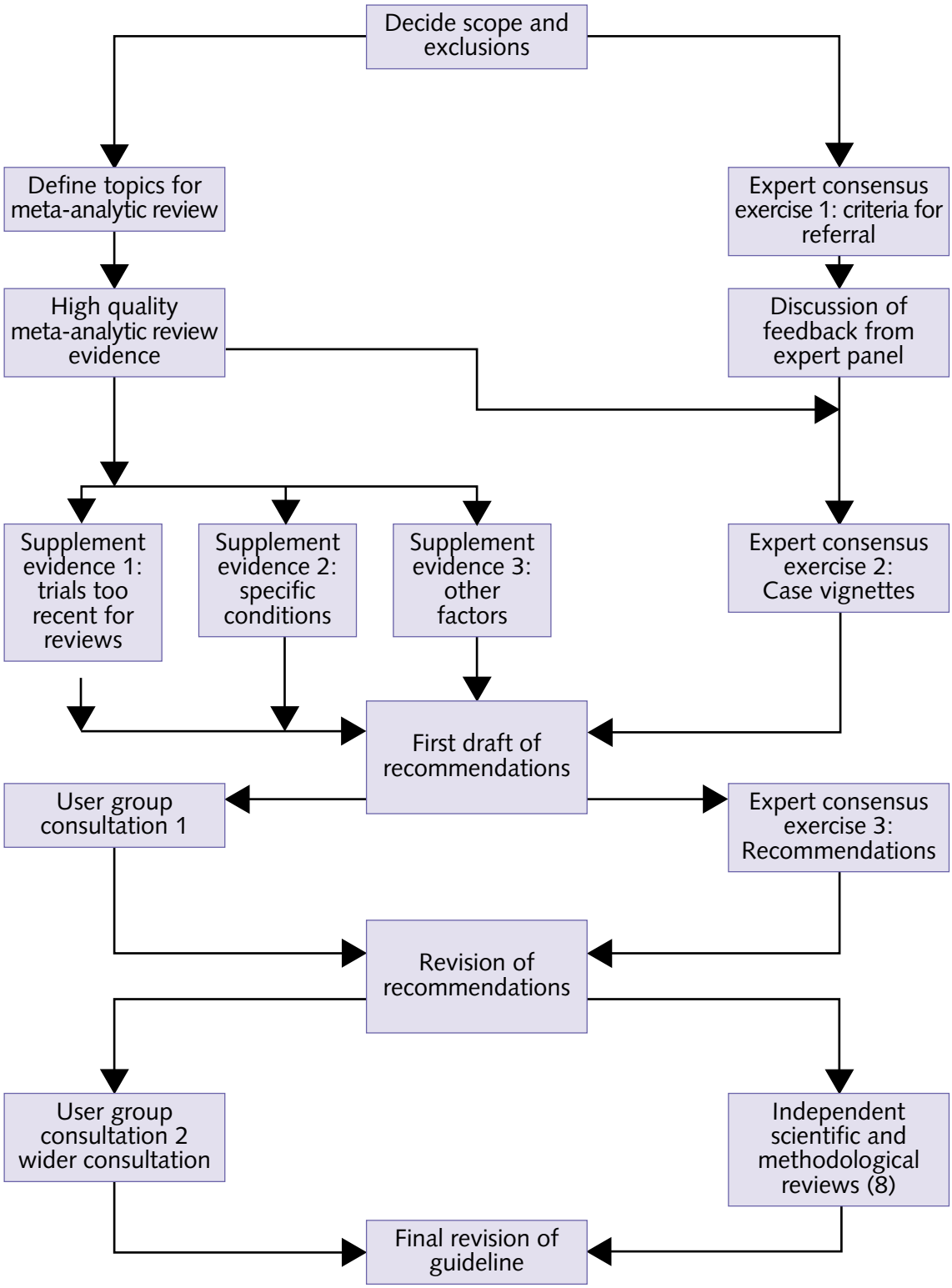
2. Evidence about the impact of other factors on therapy outcome. Other factors include: co-morbidity, chronicity, severity and features of the presenting problem; demographics, family situation, psychological characteristics, therapeutic alliance, attitude to therapy and treatment history of the client; length, setting and process of the therapy.

Evidence was compiled from two main sources:

- Cochrane-registered reviews
- High-quality published reviews, 1990-1998

Drawing on these reviews allowed a larger quantity of research evidence to be utilised in the present report than would otherwise be possible.

Figure 1: Overview of guidelines development process



1.4.1 Location of evidence

Text box 1: Search strategies

PsycLit: (June 1998 issue)

1. explode "psychotherapy" or explode "counseling" or explode "behavior-therapy" or explode "cognitive-therapy" or explode "psychotherapeutic-counseling "or explode "family-therapy "or explode "marriage-counseling "or explode "couples-therapy" = 20737
2. "literature-review "in de or "meta-analysis" in de = 6004
3. 1 and 2 = 477
4. (child in ag or adolescent in ag) not adult in ag = 36286
5. not 4 = 415
6. 5 and: depression (45) or (depressive or depressed (18)) or anxiety (32) or personality disorder* (11) or social phobia (2) or panic (13) or agoraphobia (10) or ptsd (7) or obsessive compulsive (15) or anorexia (5) or bulimia (18) or binge (2) or psychosomatic (2) or fatigue (2) or ("client-treatment-matching" in de or explode "client-characteristics" (11)) or comorbidity (1) or severity (5) or chronic* (16) or obesity (8) or dysthymia (0) = 118

MedLine/Embase/Cochrane DAN database:

1. 341484 REVIEW in PT
2. 9007 "Randomized-Controlled-Trials"/all subheadings
3. 2979 META-ANALY* in PT
4. 344463 #1 or #3
5. 3394 #2 and #4
6. 18917 explode "Psychotherapy"/all subheadings

*7. 59 #5 and #6

A further search of MedLine and PsycLit was then made using the terms 'psychotherapy' and 'review', in order to ensure that reviews which had been inadequately labelled were identified. A further 175 papers (after initial exclusions) were identified. The total number of papers located from electronic searches was 503.

Cochrane-registered reviews were identified from the Cochrane Collaboration database (Issue 3, 1998). Completed reviews concerning psychological therapies and counselling were downloaded from the database (n = 3). Relevant registered protocols, for which results were not yet available from the database, were identified (n = 7). Authors of completed reviews and registered protocols were contacted, and asked to provide any further results, which might not yet be available through the Cochrane database. Results of a registered protocol were provided by one author, and preliminary results were provided by a further author.

Review articles and meta-analyses were located primarily by searching the computerised databases MedLine, Embase and PsycLit, and the database held by the Cochrane Depression, Anxiety and Neurosis group. References to further reviews and meta-analyses were identified in Roth and Fonagy (1996), in recent issues of the Journal of Consulting and Clinical Psychology, and by members of the Guidelines Development Group.

1.4.2 Exclusion criteria

Papers were excluded at this stage, on the basis of reading the abstract or article, if they:

a) were not literature reviews or meta analyses; or

b) specifically concerned types of diagnosis not relevant to the current review, e.g. schizophrenia, drug abuse, bipolar disorder; or

c) concerned only children and adolescents; or

d) did not review more than one psychotherapy study.

After applying these criteria, 217 reviews remained to be assessed for quality (see reference list).

1.4.3 Appraisal of quality

Text box 2. Quality criteria for assessing research reviews (Oxman & Guyatt, 1988)

1. Were the questions and methods clearly stated?
2. Were comprehensive search methods used to locate relevant studies?
3. Were explicit methods used to determine which articles to include in the review?
4. Was the validity of the primary studies assessed?
5. Was the assessment of the primary studies reproducible and free from bias?
6. Was variation in the findings of the relevant studies analysed?
7. Were the findings of the primary studies combined appropriately?
8. Were the reviewers' conclusions supported by the data cited?

Cochrane reviews are known to be methodologically sound, as they are produced using procedures explicitly specified to achieve this and peer reviewed against methodological criteria. Review articles and meta-analyses which were not registered with the Cochrane Collaboration were evaluated using quality criteria suggested by Oxman and Guyatt (1988, see text box 2 above).

Each review or meta-analysis was assigned to one of three bands; high quality (meeting all eight criteria); medium quality (six or seven criteria) and low quality (fewer than six criteria). A sample of 20% of the papers was rated independently by another researcher. Inter-rater reliability of the quality bands was acceptable (intraclass correlation ICC (1, 2) = .70).

The numbers of papers in each quality band are shown in Table 1.

Table 1

Quality (number of criteria achieved)	High (8)	medium (6/7)	low (0 to 5)
Number of reviews	42	43	132

For review of evidence on the effectiveness of psychological treatments for particular diagnoses, only papers of the highest quality (eight points) were included. For review of evidence on other factors influencing outcome, both high and medium quality reviews were used, as these factors were dealt with less frequently and there was not sufficient evidence from the 42 high quality reviews alone. The high and medium quality reviews on which recommendations are based are referenced in Annex 2. Reviews that did not meet either criterion (scoring fewer than six points) are listed in Annex 3.

1.5 Supplementary evidence collection

After receipt of the main evidence review, preliminary results from two Cochrane reviews, on depression and on primary care counselling, became available. Results from these are summarised separately.

The Development Group undertook supplementary searches of PsycLit and Medline for individual trials that had a publication date too recent to be included in the meta-analytic reviews. In this way, it was possible to examine whether the conclusions of the evidence review required revision in the light of new evidence.

Following discussion of the main review report, the Development Group also undertook supplementary search for evidence on further topics where evidence was very sparse from meta-analytic review. These concerned patient characteristics such as ethnicity, psychological mindedness, motivation and capacity to sustain personal relationships and characteristics of the therapeutic relationship i.e.'therapeutic alliance'. Full details of the search strategy are given in Annex 4.

There were two topics (specifically, gynaecological and gastrointestinal problems) where the search strategy outlined here yielded no systematic review evidence. In these cases, a structured enquiry was made of subject experts identified by the development group to find supplementary sources of evidence, both missed reviews and individual high quality trials.

1.6 Expert consensus methods

Formal consensus development methods (Murphy et al., 1998) were used to complement the research review. A panel of experts in psychological therapies was assembled by inviting five nominations from each of the participating professional organisations. The criteria were that each nominee should have had clinical experience in the NHS, be acknowledged by peers to have expertise in their field and have a genuine desire to seek consensus on best practice. In addition, it was requested that one of the five people nominated should also have had experience of managing a service within the NHS.

Thirty-eight experts were nominated of whom 36 participated in one or more stage of the expert consensus process. Two consensus meetings used a nominal group technique, and finally a postal Delphi exercise was held. Members of the panel are listed in Annex 6.

The first conference considered important issues for referral practice where good scientific evidence is lacking. Small groups met to generate criteria on which people presenting with mental health problems

in primary care were likely to benefit from secondary referral, and of those, which were most likely to benefit from a formal psychological therapy. Lists of criteria were generated and then formal private voting and feedback of consensus was used prior to re-iteration of voting.

Panel members before the second meeting received the Mackay and Barkham evidence review. This meeting considered the appropriateness of each form of psychological therapy, for different types of mental health problem. The panel's feedback from the first conference suggested that making treatment choice decisions on the basis of lists of patient characteristics and presenting problems was not a good simulation of the clinical realities of decision making. For the second meeting, a more realistic clinical vignette was prepared for each of type of presenting problem. Eight vignettes were considered.

Panellists were first asked to rate privately whether any type of psychological treatment was appropriate. If so, response alternatives were provided for 'highly appropriate; treatment of choice', 'fairly appropriate', 'neither appropriate nor inappropriate', 'probably inappropriate' or 'highly inappropriate; not recommended.' Consensus was pre-defined as an 85% agreement between participants across two 'appropriate' or two 'inappropriate' categories

Panellists were asked to make the following assumptions in rating appropriateness of each form of therapy:

a) there is equal access to all therapies, e.g. waiting time before treatment is not a factor.

b) all therapies are delivered by competent therapists to a reasonable clinical standard for their level of experience.

c) the medical management of the case is optimal.

The allegiance to one particular 'school' of therapy of each panellist was also ascertained, to allow *post hoc* analysis of the effect of allegiance upon judgements of appropriateness. (See 1.7 below.)

After reading the evidence review and studying the questionnaire, each panellist made his or her judgements in private, before any discussion of the cases. The results were calculated and fed back to the group. The conference divided to discuss cases where consensus was not achieved. The syndicate groups reported their conclusions to the full panel and a structured discussion of the whole panel was facilitated. Following this procedure, a second round of voting was carried out. After the second round, the consensus criterion was met for all cases on therapy modality, seven cases on therapy duration, seven cases for level of therapist experience, but only two cases on therapy type.

The final expert consensus exercise did not use a nominal group method, but a postal Delphi technique (Jones & Hunter, 1995). The main recommendations, based on the evidence review and consensus workshops, were circulated to the panel, who were asked to vote on the extent to which they agreed or disagreed with each of the recommendations. After collation of votes, and panellists' comments, the results were sent out to all panellists, including those who had not responded to the first request. A second iteration of voting was undertaken. Consensus was achieved on all but one recommendation. This recommendation was discarded by the Development Group because more than 15% of respondents disagreed with it.

1.7 Allegiance

Allegiance to one particular form of therapy is an important variable in psychotherapy outcome research. Similarly, the preference that an 'expert' may hold for one therapy over another may influence clinical decision making. In an attempt to see if psychotherapeutic orientation was influencing clinical decision making within the expert consensus panel each member, with the exception of the general practitioners

(3), was asked to describe his or her psychotherapeutic orientation. Four categories were used, namely psychodynamic (7), cognitive behavioural (5), humanistic (1), and eclectic/integrative (2). Details of the method used to monitor the allegiance effects of the expert panel are described in 1.6. If allegiance effects were at work, it was predicted that a privately-made choice of therapy would be concordant with orientation and that this decision would not change after clinical discussion within the expert panel. Conversely, if allegiance effects were minimal it was expected that personal recommendations of therapy and declared orientation would show some variation and that some change after clinical discussion between experts would occur.

Whilst numbers are small the data suggested that allegiance effects were present. Before group discussion experts showed a trend towards recommending their own therapy whilst suggesting other orientations were inappropriate. The cognitive-behavioural group uniformly recommended a cognitive or behavioural treatment in all cases whilst commonly rating other treatment as inappropriate. The small numbers of humanistic and integrative practitioners all recommended their own therapy too although they thought that others may also be appropriate. In contrast the psychoanalytic practitioners were more varied in their personal recommendations and in only one case did all practitioners agree in recommending focal psychoanalytic therapy.

Following group discussion cognitive-behavioural, integrative/eclectic, and humanistic practitioners continued to rate their own treatment as appropriate in all cases although alternative therapies were more strongly supported in some cases in the second iteration. Psychoanalytic practitioners on the other hand showed greater variation in the second round of voting.

1.8 User consultation

A panel of mental health service users within the scope of the guideline was assembled by inviting the following organisations to nominate individuals:

- UK Advocacy Network
- Depression Alliance
- Mind; Diverse Minds and Mind Links.
- Centre for Health Information Quality

Service user representatives received an early draft of the principal recommendations and they were then invited to a meeting to discuss them. Changes in content and format were made in response to each of the points made by user representatives. Following this, the user panel received a copy of the draft full guideline. Users were invited to a further meeting and following detailed and extensive discussion, written comments were received. On this basis, further changes were incorporated.

The final draft guideline was sent to 30 national mental health service user organisations for comment.

The user group consultation identified the need for an information resource based on the guideline development work, specifically designed by and for service users. This resource is being developed and will be separately available following the publication of this guideline.

1.9 Linking evidence to recommendations

We used Eccles et alia's (1998) adaptation of the classification of grading the strength of recommendations (see text boxes 3 and 4).

Text box 3: Categories of Evidence

Ia Evidence from meta-analysis of randomised controlled trials

Ib Evidence from at least one randomised controlled trial

IIa Evidence from at least one controlled study without randomisation

IIb Evidence from at least one other type of quasi-experimental study

III Evidence from descriptive studies, such as comparative studies, correlation studies and case-control studies

IV Evidence from expert committee reports or opinions, or clinical experience of respected authority or both.

Text box 4: Strength of recommendations

A. Directly based on category I evidence

B. Directly based on category II evidence or extrapolated from category I evidence

C. Directly based on category III evidence or extrapolated from category II evidence.

D. Directly based on category IV evidence or extrapolated from category III evidence.

Recommendations were based on the best available evidence, for example, if a recommendation could be made based on high quality reviews of research evidence, weaker forms of evidence (e.g. descriptive studies, expert consensus) were not used.

The best available level of evidence was considered in relation to diagnosis, therapy type, therapy duration, socio-demographic factors, patient characteristics, therapy relationship factors, co-morbidity, patient preference, and therapist factors. The sequence of evidence appraisal and recommendation development is summarised in Figure 1. Table 4 (located between Chapters 2 and 3) gives the sources of evidence for recommendations.

In the brief version of the guideline, space did not permit both evidence and recommendation gradings to be given separately. We therefore used only grades for strength of recommendations, explaining the links to quality of evidence.

1.10 External scientific review

The Guidelines Steering Group approached eight external scientific reviewers who had not been involved in the Guidelines Development process. Each reviewer received the full guideline, the evidence review and the summary of recommendations. They were asked to comment on whether the conclusions were justified by the evidence and represented an accurate appraisal of the field. One of these reviewers with experience of guideline development used the Cluzeau et al. (1997) instrument to appraise formally the quality of guideline development. Further corrections and amendments were based on these reviews.

1.11 Piloting/pre-testing

Early implementation projects will be used to pre-test the guideline, in terms of its perceived usefulness, acceptability to users and impact on local referral pathways. Subsequent revisions of the guideline will incorporate improvements based on results from these pilot studies.

1.12 Scheduled review and updating

This guideline is likely to represent best current evidence for 18 months but not longer than three years after being written. The recommendations should be reviewed and updated no later than three years after publication, or earlier in the light of major new evidence.

Table 2: Odds ratio results from Cochrane reviews

Reference	Focus	Treatment	control	n	Odds ratio	95% confidence interval	
Ray & Hodnett (1998)	Caregiver support for postpartum depression	Additional support	TU	2	0.34	0.17	0.69
Hawton et al (1998)	Treatment of deliberate self-harm	Problem-Solving therapy	TU	4	0.73	0.45	1.18
		Intensive intervention + outreach	TU	<6	0.86	0.60	1.23
		Emergency card	TU	2	0.45	0.19	1.07
		DBT	TU	1	0.24	0.06	0.93
Wessely, Rose & Bisson (1998)	Debriefing in adults exposed to trauma	Debriefing	TU	2	2.90	1.10	1.75

Table 3: Effect size results from high quality reviews

Reference	Focus	Within group (pre-post)			Between group (treatment vs control)			
		treatment	n	mean ES	treatment	control	n	mean ES
Depression								
Gaffan, Tsaousis & Kemp Wheeler (1995)	Cognitive therapy for depression; BDI outcomes	CT[1] CT[2]	28 37	>2.25 >1.81	CT[1] CT[2]	NT NT	7 11	1.56 0.89
Gorey & Cryns (1991)	Group work for depressed older persons	Group therapy	19	0.98	Group therapy	NT	8?	0.62
Robinson et al (1990)	Psychotherapy for depression, controlled research	n/a			all therapy CT BT CBT other therapy	NT NT NT NT NT	37 8 12 13 6	0.73 0.96 1.02 0.85 0.49
Scogin & McElreath (1994)	Psychological treatments for geriatric depression; controlled research	n/a			all therapy CT reminiscence therapy	NT/P NT/P NT/P	23 7 8	0.78 0.85 1.05
Stuart & Bowers (1995)	CBT for depression; inpatients	CBT	8	4.34	CBT + med.	med	4	1.13
Panic/agoraphobia								
Clum, Clum, & Surls (1993)	Psychological vs. pharmacological treatments for panic disorder	n/a			psych. coping psych. coping flooding combination	NT P P P	6 4 3 8	0.83 1.41 1.36 1.09
Gould, Otto & Pollack (1995)	Pharmacological vs. cognitive-behavioural vs. combined treatments for panic disorder.	CBT, CT or BT[3] medication[3] combination[3]	8 4 2	0.06 -0.46 -0.07	CBT, CT or BT medication	NT/P P	22? 16	0.68 0.47

Table 3: Continued

Reference	Focus	Within group (pre-post)			Between group (treatment vs control)			
		treatment	n	mean ES	treatment	control	n	mean ES
Van-Balkom et al. (1997)	Benzodiazepines, antidepressants, psychological panic management (CBT), exposure in vivo and combination treatments in panic disorder with or without agoraphobia; short-term efficacy	CBT (panic) CBT (agoraphobia) exposure (panic) exposure (agor.) combination (panic) combination (agor.)	23 26 12 52 5 8	1.25 0.91 0.79 1.38 1.79 1.22		n/a		
Social phobia								
Feske & Chambless (1995)	CBT vs. exposure for the treatment of social phobia	CBT exposure	12 9	0.90 0.99	CBT exposure	NT/P NT	7 7	0.77[4] 0.94[4]
Taylor (1996)	Cognitive-behavioural therapies for social phobia	waiting list placebo exposure CT CT + exposure social skills training	6 6 8 5 12 5	-0.13 0.48 0.82 0.63 1.06 0.65		n/a		
Generalised anxiety disorder								
Gould, Otto, Pollack & Yap (1997).	Pharmacological vs. CBT for GAD		n/a		CBT medication	NT/P P	22 39	0.70 0.60
Obsessive Compulsive Disorder								
Abramowitz (1996)	Variants of exposure and response prevention (ERP) for OCD	ERP	29	1.16		n/a		
Abramowitz (1997)	Behavioural and pharmacological treatment for OCD; controlled outcome literature		n/a		ERP SRI medication non-SRI med.	relax P P	2 5 2	1.18 0.71 0.14
Cox, Swinson, Morrison & Lee (1993)	Clomipramine, fluoxetine and exposure for OCD	ERP cloripramine fluoxetine	9 12 7	2.56 3.24 3.45		n/a		
Van Balkom, Van Oppen, Vermuelen, Van Dyck, Nauta & Vorst (1994)	Behaviour therapy and antidepressants for OCD	all treatments BT CT CT + BT placebo + BT placebo	100 45 3 4 4 8	1.15 1.46 1.09 1.30 1.69 0.20		n/a		
Bulimia								
Hartmann, Herzog, & Drinkmann (1992)	Psychotherapy of bulimia	all psychotherapy 'control groups'	24 6	1.04 0.12		n/a		

Table 3: Continued

Reference	Focus	Within group (pre-post)			Between group (treatment vs control)			
		treatment	n	mean ES	treatment	control	n	mean ES
Lewandowski, Gebing, Anthony & O'Brien (1997)	Cognitive-behavioural treatment of bulimia	CBT (cog measure)	?	0.69	CBT (cog meas.)	NY/T	?	0.64
		CBT (beh measure)	?	0.74	CBT (beh meas.)	NT/T	?	0.64
Chronic pain								
Morley, Eccleston & Williams (1998)	Cognitive-behavioural treatments (including behaviour therapy (BT) and biofeedback (BFB)) for chronic pain		n/a		CBT, BT, BFB (all outcomes)	NT	>28	0.50
					CBT, BT, BFB (pain experience)	NT	28	0.40
					CBT (pain)	NT	16	0.33
					BT (pain)	NT	5	0.32
					BFB (pain)	NT	7	0.74
Other								
Corrigan (1991)	Social skills training; symptom/adjustment outcomes	social skills training[4]	35	0.99		n/a		
Anderson & Lambert (1995)	Short-term dynamically oriented psychotherapy (STPP)		n/a		STPP[4]	NT	11	0.57
					STPP	P	5	0.30
Crits Cristoph (1992)	Short-term dynamic therapy (STPP)		n/a		STPP (symptoms)	NT	5	1.10
					STPP (general psych)	NT	5	0.82
					STPP (social adj)	NT	5	0.81
Svartberg, & Stiles (1993)	Short-term psychodynamic psychotherapy (STPP)		n/a		STPP	NT	7	0.20
Engels, Garnefski & Diekstra (1993)	RET		n/a		RET	NT	31	1.62
					RET	P	12	0.90
Lyons & Woods (1991)	RET	RET	88	1.37	RET	NT	31	0.98
					RET	WL	28	1.02
Linden (1994).	Autogenic training (AT); controlled outcome research	AT (bio. measure)	17	0.43	AT (bio measure)	NT	8	0.36
					AT (psych meas.)	NT	6	0.67
		(beh/psych measure)	16	0.58	AT (bio measure)	P	7	0.51
					AT (psych meas.)	P	5	0.24
Shadish, Montgomery, Wilson, Wilson, Bright & Okwumbua (1993).	Marital and family therapy (MFT)		n/a		MFT (all)	NT	71	0.51
					MFT (beh)	NT	40	0.56
					MFT (systemic)	NT	14	0.28
					MFT(humanistic)	NT	8	0.23
					MFT (dynamic)	NT	1	0.63
					MFT (eclectic)	NT	15	0.58

1. pre-1987.
2. 1987–1994.
3. post-treatment to follow-up.
4. These figures were changed in meta-analysis to reflect heterogeneity

Evidence Review

The full systematic meta-review of high quality reviews (Mackay and Barkham, 1998) is available from the Psychological Therapies Research Centre, 17 Blenheim Terrace, University of Leeds, LS2 9JT. Tables 2 and 3 summarise effect sizes from Cochrane Reviews and other high quality reviews respectively.

The narrative summaries of research evidence from that meta-review are reproduced here, with references. Supplementary sources of evidence with their implications for the findings of the Mackay & Barkham meta-review, are added as appropriate in a different font.

Evidence statements are graded from I to IV for the strength of the scientific evidence provided, described on p18, text box 3.

2.1 Diagnosis

2.1.1 Depressive disorders

Psychological treatment has been found effective in the treatment of depression in general adult and older adult populations, including in inpatient care (Ia). Cognitive behaviour therapy and interpersonal therapy in particular have been found efficacious in the treatment of depression, with best evidence for cognitive behaviour therapy. (Ia). Behavioural therapy, problem-solving therapy, group therapy and marital and family interventions have all shown some evidence of efficacy (Ib). Direct concurrent comparisons have indicated few significant differences between types of therapy, although some have insufficient statistical power to do so. (Ia) (DeRubeis & Crits-Christoph, 1998; Gaffan, Tsaousis, Kemp Wheeler, 1995; Gorey & Cryns, 1991; Markowitz, 1996; Ray & Hodnett, 1998; Robinson et al, 1990; Sandberg, Johnson, Dermer et al, 1997; Scogin & McElreath, 1994; Stuart & Bowers, 1995). A recent Cochrane review, (Hunot & Churchill, personal communication, 1999) found that for brief psychotherapy, cognitive behaviour therapy variants were most efficacious compared with other therapies, in terms of calculated odds ratios in meta-analysis.

(Supplementary evidence) Psychodynamic-interpersonal therapy has also shown evidence of effectiveness (Ib) (Shapiro et al, 1994). Time-limited depression-targeted psychotherapies are efficacious when transferred from psychiatric to primary care settings (Ia) (Schulberg, Katon, Simon & Rush, 1998). King et al (2000) reported results of a pragmatic controlled trial of 464 patients (of whom 197 were randomised between usual GP care, non-directive counselling and cognitive behaviour therapy, 137 chose a specific therapy and 130 were randomised between the two psychological therapy conditions). They found counselling and cognitive behaviour therapy were equally effective and superior to usual GP treatment for both depression and mixed anxiety/depression at 4 months. By one year, the control group had improved to be equivalent to the psychological therapy groups. At 12 months, the patients who had received non-directive counselling expressed higher levels of satisfaction than the other two groups. (Ib)

2.1.2 Panic disorder and/or agoraphobia

Exposure-based treatment and CBT have shown efficacy in the treatment of agoraphobia, although exposure may be less effective on measures of panic (Ia). Applied relaxation may also be effective (Ia). Other psychotherapeutic approaches have not been systematically reviewed. (Clum, Clum & Surls, 1993; DeRubeis & Crits-Christoph, 1998, Dewey & Hunsley, 1990; Emmelkamp & Gerlsma, 1994; Gould, Otto & Pollack, 1995; Hoffart, 1993; Milrod & Busch, 1996; Van-Balkom et al, 1997).

2.1.3 Social phobia

Exposure and cognitive therapy are effective for the treatment of social phobia (Ia)(DeRubeis & Crits-Christoph, 1998; Feske & Chambless, 1995; Taylor, 1996.) Other psychotherapeutic modalities have not been systematically reviewed/evaluated.

2.1.4 Generalised anxiety disorder

Cognitive and behavioural therapies are effective in treating GAD (Ia). (DeRubeis & Crits-Christoph, 1998; Gould, Otto, Pollack & Yap, 1997). Other psychotherapeutic approaches have not been systematically reviewed/evaluated.

2.1.5 Post traumatic stress disorder

Psychological treatment may have an impact on PTSD; review evidence suggests that this may be limited, and may reduce symptoms of depression and anxiety more than primary PTSD symptoms (Ia). Differential efficacy of particular treatments has not been established; relatively little research evidence is available. Best evidence of efficacy was reported for exposure and other cognitive behavioural methods (stress inoculation and eye movement desensitisation and reprocessing) (Ib), with some evidence for hypnotherapy and psychodynamic therapy (II). The efficacy of critical incident debriefing as a preventative intervention is not supported by current research evidence (Ia) (DeRubeis & Crits-Christoph, 1998; Shalev, Bonne & Eth, 1996; Solomon, Gerrity & Muff, 1992; Wessely, Rose & Bisson, 1998).

(Supplementary evidence) Many of the published studies showing negative results for critical incident de-briefing do not assure the quality of the intervention (II) (Dyregrov, 1998). Two more recent studies confirm the value of cognitive and behavioural techniques in the treatment of post-traumatic stress symptoms (Ib) (Tarrier et al, 1999, Marks et al, 1998).

2.1.6 Obsessive Compulsive Disorder

Behaviour therapy (or exposure with response prevention) and cognitive therapy appear to be efficacious in the treatment of OCD (Ia), although there is disagreement over which is more effective according to the available evidence. These psychological treatments appear to produce results similar to those achieved by drug treatments (Ia). Behavioural treatment may be less effective in treating depressive symptoms than anxiety symptoms in OCD (Ia). (Abramowitz, 1996; Abramowitz, 1997; Cox, Swinson, Morrison & Lee, 1993; DeRubeis & Crits-Christoph, 1998; Van Balkom, Van Oppen, Vermuelen, Van Dyck, Nauta & Vorst, 1994).

2.1.7 Eating disorders

For the treatment of bulimia, evidence suggests that psychological therapy is efficacious (Ia). The efficacy of cognitive/cognitive-behavioural therapy has been established (Ia); less research has been carried out on other forms of therapy, but there are indications that family therapy and interpersonal approaches may be effective (II). Focus on relationships in therapy has been associated with good outcome (II). (Compas, Haaga, Keefe, Leitenberg & Williams, 1998; Hartmann, Herzog & Drinkmann, 1992; Lewandowski, Gebing, Anthony & O'Brien, 1997; Sandberg, Johnson, Dermer et al (1997).

There was little evidence available from high-quality research reviews on the effectiveness of treatments for anorexia nervosa.

(Supplementary evidence) In the absence of grade I evidence, best evidence for anorexia nervosa is for family therapy and broadly based individual therapy for patients with early onset and late onset of illness respectively (II) (Crisp et al, 1991; Russell et al, 1987; LeGrange et al, 1992; Treasure, 1995).

2.1.8 Somatic complaints

General. There is some evidence of the efficacy of family and marital therapies in the treatment of psychosomatic disorders and physical illness (II). Patients with functional somatic symptoms, in the initial acute phase may respond to individual therapy if they are willing to participate (II). (Guthrie, 1996; Sandberg, Johnson & Dermer, 1997).

Gastrointestinal. Research evidence of the efficacy of psychological treatments for IBS is not yet conclusive, but suggests that such treatments may be useful (Ib). (Talley, Owen, Boyce & Paterson, 1996; Compas, Haaga, Keefe, Leitenberg & Williams, 1998)

(Supplementary evidence) Little research has been conducted in primary care settings. In secondary care, several small studies of multi-component CBT have been carried out with mixed results, some finding benefit (Greene & Blanchard, 1994; Neff & Blanchard, 1987; Shaw, Srivista, Sadlier et al., 1991; Payne & Blanchard, 1995) others not (Bennett & Wilkinson 1985, Corney, Stanton, Newell et al, 1991; Blanchard, Scwarz, Suls et al., 1992): one large study of psychodynamic therapy and one smaller study of group hypnotherapy showed positive results (Svedlund, Sjodin, Ottoson et al. 1983; Harvey, Hinton, Gunary et al, 1989). In treatment resistant GI disorders, psychodynamic-interpersonal therapy and hypnosis showed effectiveness (Guthrie, Creed, Dawson & Tomenson, 1991; Whorwell, Prior & Farragher 1984) (Ib).

Chronic fatigue. There is little high quality research on treatment of chronic fatigue syndrome. One Cochrane review indicates that CBT is more effective than controls in improving physical functioning and experience of fatigue (Ia) (based on a small number of patients; Price & Couper, 1998). Other psychological treatments have not been reviewed.

(Supplementary evidence) Randomised controlled trial evidence shows benefits of behaviour therapy (including graded exercise therapy) and some evidence for cognitive therapy (Ib). (Wearden et al, 1998; Fulcher & White, 1997) Other modalities have not been subject to outcome research.

Chronic pain. Cognitive and behavioural therapies, including biofeedback, show evidence of being effective in the treatment of chronic pain (Ib). There is little evidence of effectiveness on vocationally relevant outcomes. (Compas, Haaga, Keefe, Leitenberg & Williams, 1998; Morley, Eccleston & Williams, 1998; Scheer, Watanabe & Radack, 1997).

Gynaecological. No high quality review evidence was identified.

(Supplementary evidence) There is growing evidence from recent RCTs that psychological approaches have utility. Cognitive behaviour therapy and Rational Emotive Therapy were found effective for pre-menstrual syndrome (Ib)(Blake et al, 1998; Morse et al., 1991). Pelvic pain benefited from a cognitive behavioural approach (Pearce, Knight and Beard, 1982, Peters et al, 1991). Vasomotor symptoms in menopause were reduced by applied relaxation therapy (Hunter et al, 1998).

2.1.9 Personality Disorders

There is little comparative outcome research on the treatment of personality disorders with psychotherapy, and no high quality reviews were identified.

One medium quality review suggested that behaviour therapy in avoidant and borderline disorders and psychodynamic approaches in a variety of personality disorders may be useful (II) (Shea, 1993).

(Supplementary evidence) There are promising developments in psychotherapeutic treatment in this field, but most results are from cohort studies. A recent medium quality review found that these patients do improve their mental health and social functioning, whether measured by self-report or observer ratings, for a range of psychotherapeutic methods. Comparison with natural history data suggests a substantial effect of therapy (Perry, Banon & Ianni, 1999) (III). Another review suggests the potential value of longer term, integrated, theoretically coherent approaches which focus on compliance and target problems in relationships, (III) (Bateman & Fonagy, in press; Sanislow & McGlashan, 1998). Good results for reducing parasuicidal behaviour in borderline personality were obtained in two RCTs (Ib); one of a psycho-analytically informed day hospital programme (Bateman & Fonagy, 1999) and one of dialectical behaviour therapy (Linehan, Armstrong, Suarez, Allmon & Heard, 1991, Linehan, Heard & Armstrong, 1993, Linehan, Tutek, Heard & Armstrong, 1994). A meta-analysis of therapeutic community treatment in either residential or day unit setting) included eight randomised controlled trials among 29 studies. The quality of studies was variable and diagnostic criteria for inclusion mixed, including a very high proportion of patients with personality disorder. Pooled odds ratios suggested these approaches are effective. (Ia) (NHS Centre for Reviews and Dissemination, 1999).

2.1.10 Deliberate self-harm

A Cochrane review found some evidence of efficacy in reducing self-harm for problem-solving therapy, for the provision of an emergency card, and from a single study of dialectical behaviour therapy (Ib). However, the authors concluded that there were too few studies to make firm recommendations. (Hawton et al, 1998).

(Supplementary evidence) A trial of psychoanalytically informed partial hospitalisation compared with standard psychiatric care showed reduction in self harm and suicide attempts in patients with personality disorder after 6 months treatment, maintained until the end of treatment at 18 months (Ib) (Bateman & Fonagy,1999)

2.2 Other factors

Evidence grading for factors other than diagnosis was problematic, where high quality reviews of randomised trials considered factors which were not themselves the subject of experimental manipulation. For many of factors considered in 2.2.2 to 2.2.8 (such as the impact of treatment length, sociodemographic factors and severity of presenting problem) the evidence is therefore graded III.

2.2.1 Therapy type, irrespective of diagnosis

Two of three high quality reviews of the efficacy of *short-term psychodynamic psychotherapy* found it to be of similar effectiveness to other modalities, but this finding was disputed by a third review. These reviews included mixed patient groups, including many patients considered difficult to treat. Differences in findings may relate to different inclusion criteria (Anderson & Lambert, 1995; Crits-Christoph, 1992; Svartberg & Stiles, 1993).

There is some evidence for the efficacy of *Rational Emotive Therapy, social skills training, autogenic training* (although this was not more effective than alternative treatments), and *marital and family therapies* (II) (Engels, Garnefski & Diekstra, 1993; Lyons & Woods, 1991; Linden, 1994; Sandberg, Johnson, Dermer et al, 1997; Shadish, Montgomery, Wilson, Wilson, Bright & Okwumbua, 1993.)

Psychosocial treatments in primary care were most often found effective when manualised treatments were used with specified client groups (II) (Brown & Schulberg, 1995). Ray and Hodnett (1998; Cochrane review) found that additional support in the postpartum period reduced depression at 25 weeks; however, this finding was based on very small numbers of participants.

(Supplementary evidence) Four studies of counselling in primary care met inclusion criteria in a recent Cochrane review (Rowland, Bower, Mellor Clark, Heywood, Hardy & Godfrey, 2000). Pooled outcome data showed statistically significant reduction in psychological symptoms for the counselled group compared with controls, in a combined sample of 487 patients with non-specified anxiety/depression and psychological distress. Patient satisfaction levels with counselling were high. (Ia) King et al (2000) (study described in 2.1.1 above)reported that counselling and cognitive behaviour therapy were equally effective and superior to usual GP treatment for both depression and mixed anxiety/depression in the short term, although the patients who had received non-directive counselling expressed higher levels of satisfaction at one year follow up. (Ib) Simpson et al (2000) found no significant differences between psychodynamic counselling, cognitive behaviour therapy and usual GP treatment in a trial of 181 patients who had been depressed for over six months, although an analysis of 'caseness' at 12 months follow up favoured both psychological treatments over the usual care. (Ib)

A medium quality meta-analytic review (Greenberg, Elliott & Lietaer, 1994) of experiential therapies (closely related to counselling methods) found non-significant effect size differences between these compared with cognitive and behavioural treatments (II). The authors note that when only those studies of directive experiential treatments (process-experiential and Gestalt) were included, the effect size difference was favourable to these therapies.

A randomised controlled trial of counselling by health visitors trained in an eight session intervention for postnatal depression (5-13 weeks post partum), found it to be of benefit in reducing depression at 25 weeks (Ib) (Holden, Sagovsky & Cox, 1989).

Cost-effectiveness evidence for psychological therapies seemed strongest for more severe mental disorders (II) (Gabbard, Lazar, Hornberger & Spiegel, 1997).

(Supplementary evidence) A Cochrane review (Hunot, Churchill et al. 1999) examined economic outcomes for brief psychological treatments for depression. For most comparisons, there was no economic evidence, or insufficient data for analysis. Two well-conducted economic evaluations (VonKorff et al, 1998; Lave et al 1998) gave tentative support for the hypothesis that psychological therapy is more efficient than usual care (Ia). Both these evaluations were conducted in the USA, and it is difficult to know whether these results transfer to the UK health system. One UK study (Scott & Freeman, 1992) employed a less robust methodology but came to similar conclusions (Ib). One analysis (VonKorff et al., 1998) concluded that cognitive-behavioural therapy offered within a collaborative care model for major depression was more costly but achieved greater success than treatment as usual, giving a modest cost-effectiveness advantage (Ib). CBT for minor depression was less cost-effective in this study.

A review of cost effectiveness was commissioned for the NHS Executive review of strategic policy in psychotherapy (Healy & Knapp 1995 for Department of Health, 1996). They identified only 10 UK studies between 1974 and 1994 which incorporated an economic component, few of which could be interpreted as true economic appraisals, because of methodological drawbacks, including inadequate cost estimation, inadequate follow up and incomplete cost estimates. Three early UK studies reported cost data and found improvements in clinical outcome and achievement of overall cost savings for psychological therapy in primary care settings. However, these were not full cost-effectiveness analyses. (II) (Ginsberg & Marks, 1977; Ginsberg, Marks, & Waters, 1984; Robson, France, & Bland, 1984). A better cost analysis in a recent Cochrane review of counselling in primary care (Rowland et al, 2000) based on one randomised controlled trial (Harvey et al,) concluded that counselling was cost neutral. King et al (2000) found no differences in costs between counselling, cognitive behaviour therapy and usual GP care, but warned that this may have been due to insufficient power to detect cost differences important to decision makers.

A recent UK randomised controlled trial (Guthrie et al, 1999) suggested that brief psychodynamic-interpersonal therapy may be cost-effective relative to usual care for patients with enduring non-psychotic symptoms who were not helped by six months of conventional psychiatric treatment (Ib).

2.2.2 Co-morbidity

Few reviews systematically considered the effects of co-morbidity. Most evidence is gained from post-hoc analysis rather than planned experiment and is therefore graded III. One high-quality review suggests that flooding for PTSD may exacerbate co-morbid symptoms of anger, depression and alcohol abuse (Solomon, Gerrity & Muff, 1992). Two medium quality reviews suggest that therapy for mental health problems may have poorer outcomes when they co-exist with personality disorders. However, avoidant and dependent personality disorders were positive indicators for supportive therapy for obsessive compulsive clients in one review; and one review suggests that personality disorders are associated with more impairment overall, but not with a differentially poorer response to treatment. (Juster & Heimberg, 1995; Reich & Vasile, 1993, Whisman, 1993).

(Supplementary evidence) One research group has consistently found that patients with both anxiety disorder and personality disorder show as much improvement with cognitive behaviour therapy for their anxiety as those without a personality disorder (Dreessen & Arntz, 1998).

2.2.3 Severity of presenting problem

Evidence regarding severity is mainly descriptive rather than experimental (graded III) and results are equivocal. Severity of depression has been found to have a positive relationship with outcome in two reviews of therapy with elderly populations (Gorey & Cryns, 1991; Scogin & McElreath, 1994). Other reviews have found a negative effect of severity on outcome (Thase, Greenhouse, Frank et al 1997;

Whisman, 1993) or no effect (Robinson, Berman & Neimeyer, 1990; Mintz, Mintz, Arruda & Hwang, 1992). One medium quality review suggests that higher severity of bulimia predicts a poor outcome of group work (McKisack & Waller, 1997); one high quality review suggests that therapy was less effective for more severely physically ill patients (Guthrie, 1996).

2.2.4 Chronicity

No consistent effect of chronicity of disorder has been established. It has been found to be a positive, null, and negative predictor of outcome in the reviews described. The one review of panic and the one review of bulimia showed some positive effect of chronicity on outcome (Clum, Clum & Surls, 1993, Fettes & Peters, 1992). Three reviews of depression and the one review of generalised anxiety disorder showed no impact of chronicity (Mintz, Mintz, Arruda & Hwang, 1992, Thase, Greenhouse, Frank et al 1997; Whisman, 1993, Gould, Otto & Pollack, 1995). Three reviews of obsessive compulsive disorder showed mixed results. One study showed no effect (Abramowitz, 1997), or some evidence of negative effects of longer duration of OCD, one on symptoms of depression (Abramowitz, 1996), one on assessor-rated symptoms of OCD (Van Balkom et al, 1994).

2.2.5 Features of disorders

There is little evidence on the effects of features or subtypes of particular disorders. Generalised type social phobia (Juster & Heimberg, 1995), and restrictive type bulimia (McKisack & Waller, 1997) have been associated with poorer outcome. Most research does not indicate an association between endogenous type depression and poorer outcome (Whisman, 1993).

2.2.6 Socio-demographic characteristics

Generally, no effect of *gender* or *age* on outcome has been found (Abramowitz,1996; Engels, Garnefski & Diekstra, 1993; Gorey & Cryns, 1991; Gould, Otto, & Pollack, 1995; Gould, Otto, Pollack & Yap, 1997; Lyons & Woods, 1991; Mintz, Mintz, Arruda & Hwang, 1992; Robinson, Berman & Neimeyer, 1990; Scogin & McElreath, 1994; Van Balkom, Van Oppen, Vermeulen, Van Dyck, Nauta & Vorst, 1994; Whisman, 1993). Exceptions to this general finding of no effect can be listed. One review indicated psycho-educational family therapy for mood disorders is more effective with female clients (Sandberg, Johnson, Dermer, Gfeller-Strouts, Seibold, Stringer-Seibold, Hutchings, Andrews & Miller, 1997). One review indicated recovery from depression was slower for women and older clients, but this was a tentative conclusion (Thase, Greenhouse, Frank et al, 1997). One review indicated that people who drop out of group therapy for bulimia tend to be younger (McKisack & Waller, 1997). One review indicated that rational emotive therapy groups with a higher percentage of women were more effective than groups with a higher percentage of men (Engels, Garnefski & Diekstra, 1993). One review indicated that short-term dynamic therapy tended to be less effective with female clients (Svartberg & Stiles, 1993).

Ethnicity: One review indicates improved outcome in ethnically matched client-therapist pairs in short-term dynamic therapy (Svartberg & Stiles, 1993). One review has linked ethnic minority status with increased risk of dropping out of treatment (Wierzbicki & Pekarik, 1993). Other reviews have not found an effect of ethnicity on outcome (Mintz, Mintz, Arruda & Hwang, 1992).

(Supplementary evidence) Ethnically matched pairs did not have a better outcome in one study of incest survivors and eating disorders (Betz & Fitzgerald, 1993). There was a strong consensus in the service user panel that therapist insensitivity to ethnic identity and cultural issues is unacceptable to ethnic minority patients.

Social-economic status and educational level: One review indicates lower socio-economic and educational levels are risk factors for dropping out of treatment (Wierzbicki & Pekarik, 1993). Three reviews indicate no effect of class, socio-economic status or educational level on outcome (Mintz, Mintz, Arruda & Hwang, 1992; Svartberg & Stiles, 1993; Whisman, 1993).

Family factors: Quality of current family environment may be predictive of therapy outcome, with poorer family environment reducing effectiveness of group/individual treatments, but enhancing effectiveness of couple-based treatments. Three reviews indicate that marital therapy is effective for depressed clients who are also maritally distressed (more so than for maritally non-distressed clients, suggestion of better results than for individual therapy if marital distress preceded the onset of the depression) (Beach, Brooks & Wright, 1996; Baucom, Shoram, Mueser & Daiuto, 1998; Sandberg, Johnson, Dermer, Gfeller-Strouts, Seibold, Stringer-Seibold, Hutchings, Andrews & Miller, 1997). One review suggests higher pre-treatment marital functioning may be associated with better outcome of agoraphobia (Dewey & Hunsley, 1990); another review suggests that methodological problems prevent drawing conclusions on the same question (Emmelkamp & Gerlsma, 1994). One review found 'unhealthy family environment' was a negative predictor of outcome of group therapy for bulimia (McKisack & Waller, 1997).

Other aspects of current family situation: One review indicates that therapy does not have adverse effects on marital satisfaction or mental health of the client's spouse, except possibly among initially hostile couples (Hunsley & Lee, 1995). One review found no effect of marital status on effectiveness of brief psychodynamic therapy (Svartberg & Stiles, 1993). One review found living alone was a positive predictor of outcome of group therapy for depression in older people (Gorey & Cryns, 1991).

2.2.7 Other patient characteristics

Intelligence: Three reviews found no effect of intelligence on outcome (Engels, Garnefski & Diekstra, 1993; Svartberg & Stiles, 1993; Whisman, 1993)

Dysfunctional attitudes: One review indicates that higher dysfunctional attitude scores may be associated with poorer outcome of cognitive therapy for depression (Whisman, 1993).

(Supplementary evidence) *Capacity for interpersonal relating:* Evidence from one series of randomised trials suggests that patients who have poor capacity for interpersonal relationships, finding it hard to tolerate ordinary frustrations in relationships, may have poorer outcomes in psychodynamic therapy compared with supportive therapy (Piper, Joyce, McCallum & Azim, 1998)

Attitude to therapy: There is little formal research evidence on the effects of attitude to therapy or of client expectations on outcome; the evidence has not been assessed systematically.

Treatment history: There is little evidence regarding the predictive value of previous treatment on therapy outcome. Two reviews consider the issue; one found no effect of previous behavioural treatment for OCD (Van Balkom, Van Oppen, Vermeulen, Van Dyck, Nauta & Vorst, 1994); one found poorer outcome for clients with anxiety disorders who had had previous psychological treatment (Durham & Allan, 1993).

Other: One review indicates that low self-esteem predicts poor outcome of group work for bulimia; interpersonal distrust and more emotional disturbance predict dropouts (McKisack & Waller, 1997). One review indicates that RET in groups decreases timidity in fearful clients (Gossette & O'Brien, 1992).

2.2.8 Process of therapy

Effect of treatment length on outcome. The effect of treatment length on outcome is derived from post-hoc analysis rather than experimental manipulation (randomisation). Where effects of longer duration of treatment have been found, they are positive. Longer or more intense treatments were positively associated with outcome in social phobia (Feske & Chambless, 1995); OCD (Abramowitz, 1996; Abramowitz, 1997; Van Balkom, Van Oppen, Vermeulen, Van Dyck, Nauta & Vorst, 1994); bulimia (Fettes & Peters, 1992; Hartmann, Herzog & Drinkmann, 1992; McKisack & Waller, 1997); Rational Emotive Therapy (Lyons & Woods, 1991); marital and family therapy (Shadish, Matt, Navarro, Siegle, Crits-Cristoph, Hazelrigg, Jorm, Lyons, Nietzel, Prout, Robinson, Smith, Svartberg & Weiss, 1997) and focal psychodynamic therapy (Svartberg & Stiles, 1993).

No effect of treatment length was found in depression (Gorey & Cryns, 1991; Robinson, Berman & Neimeyer, 1990; Scogin & McElreath, 1994) generalised anxiety disorder (Gould, Otto, Pollack & Yap, 1997), autogenic training (Linden, 1994).

No negative associations with treatment length were reported. Controlled trials finding positive outcomes in patients meeting diagnostic criteria for mental disorders almost invariably used treatment lengths of eight sessions or more.

(Supplementary evidence) A briefer form of cognitive therapy in panic disorder may be as effective as longer term treatment (Ib) (Clark, Salkovskis, Hackmann, Wells, Ludgate & Gelder, 1999). Dose-response studies have shown differential responsiveness to psychological therapy of different symptoms and syndromes, with longer treatment lengths required for personality disorders (III) (Howard et al, 1993). Follow up of patients recovering from major depressive disorder after cognitive and interpersonal therapy indicated that 16 weeks of these specific forms of treatment is insufficient for most patients to achieve full recovery and lasting remission (Shea et al, 1992) (II). A study of maintenance treatment with chronic depression showed benefit of booster sessions in extended follow-up (Elkin, 1994) (II).

Therapeutic alliance. No high quality review evidence was identified.

(Supplementary evidence) A meta-analytic review, in combination with recently published post-hoc analyses of three high-quality RCTs, suggests that there is good evidence that a positive therapeutic alliance makes a substantial contribution to outcomes in all forms of psychological therapy. (Ib) (Castonguay et al, 1996; DuRubeis & Feeley, 1990; Elkin, 1994; Gaston, 1990; Hollon, DuRubeis, Evans, Weimer, Garvey, Grove & Tuason, 1992; Horvarth & Symonds, 1991; Horvarth, Gaston & Luborsky, 1993; Krupnick et al, 1996; Shapiro, Barkham, Rees, Hardy, Reynolds, Startup, 1994; Stiles, Agnew-Davies, Hardy, Barkham & Shapiro 1998).

Inclusion of spouse in treatment has no effect on outcome of OCD treatment (Emmelkamp & Gerlsma, 1994; Van Balkom, Van Oppen, Vermeulen, Van Dyck, Nauta & Vorst, 1994)

Group vs individual treatment Two reviews found no effect of modality on outcome (Gould, Otto, Pollack & Yap, 1997; Piper & Joyce, 1996).

(Supplementary evidence) A recent Cochrane review found group therapy less efficacious than individual therapy for brief therapy for depression (Hunot & Churchill, personal communication, 1999) although this may be confounded with therapy type.

2.2.9 Treatment setting

There was no high quality research evidence on the influence of primary, secondary or tertiary treatment setting on the outcome of therapy. Such research is difficult to design, and systematic comparisons are rare. For this reason, the expert consensus panel did consider this issue in some detail. A consensus was achieved on the following principles (all graded IV), which should be seen as general considerations rather than specific recommendations.

Patients are treated in primary care if they have mild, stress-related problems or adjustment to life events, or problems with physical health or health behaviours, requiring supportive therapy. Other good reasons for not referring out of primary care include patient choice, a previously good response to primary care treatment or intolerance of psychological treatment. The level of skills, support and supervision available in the primary care setting would also be determining factors. Many patients can be treated in primary care settings if an appropriate therapy is available and if this is acceptable to the patient.

Appropriate referral out of primary care (to either community mental health team [CMHT] or psychotherapy service). Criteria include: history of severe trauma, where previous attempts to treat at primary care level have been unsuccessful, or where the appropriate service is not available in primary care. This is likely to be patients with complex social/family problems, severe depression, anxiety or social dysfunction, and co-morbidity. Patient preference or demand for a secondary service should also be taken into account.

Appropriate referral to a community mental health team (CMHT). In addition to the general criteria for referral to a secondary service, criteria include: known to the CMHT, have had a relapse of a chronic mental health problem, need multi-agency work, are suicidal, self-harming, or pose a risk to others, particularly patients with psychosis, or who are mentally disordered offenders.

Appropriate referral to a psychological therapy/psychotherapy service. In addition to the general criteria for referral to a secondary service, criteria include: have obsessive compulsive disorders, personality disorders or repeated consultations for health anxiety, where patient shows some motivation for a psychological therapy, and desire for change.

The User Consultation Group emphasised the importance of patient preference in choice of setting. If the recommended therapies are available in different locations, this should be a matter of informed patient choice.

Although these principles were reached by structured expert consensus, the research evidence base describes therapies in a mixture of settings, and there is little specific evidence on the impact of location. For these reasons, the recommendations in the following guidelines are made *irrespective of treatment setting*. Local circumstances will dictate where and how the therapies are delivered.

Table 4: Linking evidence to recommendations

Recommendation in Chapter 3	Grade	Evidence (section in Chapter 2)	Grade
1a. Consider psychological treatment as an option	B	2.1.1 to 2.1.10: extrapolated from good evidence of benefit for range of disorders	II/I-extrap
1b. Give severe & complex problems specialist assessment	D	2.1.1 to 2.1.10: extrapolated from good evidence of benefit for range of disorders	IV
2. Consider therapeutic relationship	B	2.2.8 Impact of therapeutic alliance	I
3a. Fewer than 8 sessions unlikely to be optimal	B	2.2.8. Effect of treatment length on outcome.	II
3b. Sixteen sessions or more may been required	C	2.2.8 Effect of treatment length on outcome	III
3c. Simple phobias & panic disorders may respond to brief therapies.	B	2.2.8	I
4a. Age, sex & social class should not affect access	C	2.2.6. Balance of evidence that these factors have little impact on outcome	II
4b. Ethnic identity should be respected and 4c. Disability should not bar access	D	2.2.6. User consensus & professional opinion	IV
5. Patient preference should inform choice	D	Extrapolated from evidence on alliance (2.2.8) supported by user consultation & expert consensus	IV
6. Take account of therapist skill	D	Expert consensus	IV
7. Take account of patient's capacity for interpersonal relating	C	2.2.7: poor interpersonal relating indicates a non-interpretative therapy	III
8. Adjustment to life events	B	2.2.1	II/Iext
9. Post-traumatic stress	A	2.1.5	I
10. Depressive disorders	A	2.1.1	I
11. Anxiety disorders	A	2.1.3, 2.1.4 and 2.1.6	I
12a. Eating disorders: bulimia	A	2.1.7	I
12b. Eating disorders: anorexia	B	2.1.7	II
13a. Mental health problem with personality disorder	D	2.2.2 co-morbidity	III
13b. Treatment of personality disorder	C	2.1.9 extrapolated	II
14a. Chronic pain & chronic fatigue	B	2.1.8	I
14b. Other somatic complaints	C	2.1.8	II
15a. Contraindications: post traumatic debriefing	A	2.1.5 Cochrane review	I
15b. Counselling as main intervention in severe mental illness	D	2.2.9 Expert consensus	IV

Recommendations

The recommendations given below are of two kinds,

a) General principles that we recommend be taken into account when considering psychological therapy options and

b) Specific recommendations about appropriate therapies for presenting problems.

These two types of recommendation reflect the evidence on non-diagnostic and diagnostic criteria respectively.

The strength of each recommendation or guiding principle is indicated, linked to the evidence reviewed in Chapter 2. Table 4 shows the evidence base for each recommendation. 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 (see text box 4 on p. 18).

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.

3.1 Initial assessment

> Psychological therapy should be routinely considered as a treatment option when assessing mental health problems (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.

3.2 Therapeutic relationship

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.

3.3 Treatment length

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

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).

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 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.

3.4 Age, sex, social class and ethnic group

a) 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).

b) 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.

3.5 Patient preference

> 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.

3.6 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.

3.7 Patient characteristics

> Interest in self-exploration and capacity to tolerate frustration in relationships 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, non-interpretive therapy.

3.8 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 counselling (B).

The evidence base for counselling, 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 counselling and other brief therapies.

3.9 Post traumatic stress

> Where post-traumatic stress disorder (PTSD) is present, psychological therapy is indicated, with best evidence for cognitive behavioural 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 desensitisation (graded exposure) and related approaches (stress inoculation therapy, and eye movement desensitisation). 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.

3.10 Depressive disorders

> Depressive disorders may be treated effectively with psychological therapy, with best evidence for cognitive behaviour 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 behaviour 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 behavioural therapy, problem-solving therapy, group therapy, systemic therapy, non-directive counselling in primary care and psychodynamic interpersonal therapy.

3.11 Anxiety disorders

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

There is a wide evidence base from meta-analytic reviews supporting exposure-based behavioural treatments and cognitive behaviour 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.

3.12 Eating disorders

Bulimia nervosa can be treated with psychological therapy; best evidence is for interpersonal therapy and cognitive behaviour 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 behaviour 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.

3.13 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 behaviour therapy, psycho-analytic day hospital programme, 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 programmes 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.

3.14 Somatic complaints

Cognitive behaviour 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).

Many physical illnesses have a psychological component, and patients may respond to individual therapy if they are willing to participate. We considered four conditions in the scope of this guideline; chronic pain, chronic fatigue, gastro-intestinal disorders and gynaecological disorders. The best evidence so far, in a quickly developing field, is for cognitive behaviour therapy in the treatment of chronic pain and chronic fatigue. For irritable bowel syndrome, promising results have been obtained with psychodynamic-interpersonal therapy, cognitive behaviour therapy, psychodynamic psychotherapy and hypnosis. Research undertaken in a range of gynaecological problems (pre-menstrual syndrome, pelvic pain, and vasomotor symptoms in menopause) shows some evidence of benefit.

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

There is evidence of benefit from counselling for mixed anxiety/depression presenting in primary care, but not for more severe disorders. There was consensus in the expert professional panel that counselling 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 counselling could be helpful in a supportive or adjunctive capacity, as part of a care programme, and this view was supported by service users.

Implementation Issues and Audit Criteria

4.1 Limitations and uses of these guidelines

These recommendations are based on best available evidence, using a robust development process that is designed to minimise bias. However, guideline users should be aware that a degree of uncertainty underlies recommendations, because of gaps in scientific evidence, methodological limitations of trials, problems generalising research findings to clinical populations and patient heterogeneity.

Gaps in the research evidence are most apparent for eclectic therapies where the therapist uses a range of techniques and procedures in response to individual patient need. Such approaches, whilst common in the NHS, are not often researched in formal randomised trials, which require the intervention to be standardised to some extent. There are also other forms of therapy where good quality research has not yet been commissioned, and where absence of evidence is not evidence of ineffectiveness. Good examples of this are studies of counselling and psychodynamic therapies, which tend not to use standard research diagnostic criteria to define the patient population. Although some reviewers attempt to extrapolate these results to diagnostically defined populations (e.g. Churchill et al, 1999), the result is rarely satisfactory.

Methodological limitations of randomised controlled trials include the following. Psychological therapy is more difficult to deliver to a set standard compared with a drug treatment. Some negative results may result from poor quality delivery of the intervention (see for example Dyegorev, 1998) and adherence to a treatment manual does not overcome this problem (Waltz et al, 1993). The very act of randomisation may produce systematic between-group differences when patients have strong preferences for one therapy over another (Bradley, 1997). Sometimes high rates of attrition ('drop out') within randomised trials create problems interpreting the results. There are widespread practical difficulties in achieving textbook randomisation in psychotherapy trials. Where samples are small, despite randomisation there often turn out to be unplanned differences between the groups on important variables such as symptom severity. Many of the researchers who conduct comparative outcome trials are not in equipoise but on the contrary are enthusiasts for one therapy approach; this may influence outcome to the extent that removing the effect of allegiance may alter the result of meta-analysis (Robinson et al, 1990). Individual therapists vary in effectiveness, and in most trials such effects are unanalysed or unreported, despite potential impact on the findings (Luborsky et al, 1986).

Most direct comparisons fail to distinguish between the effectiveness of different types of psychological therapy, for reasons that may be methodological, such as insufficient statistical power (Kazdin & Bass, 1989; Norcross, 1995). For this reason, most although not all of the evidence presented in Chapter 2 concerns *absolute* rather than *relative* efficacy. Recommendations are therefore made for therapies for which there is best evidence of efficacy. Other therapies for which there is less or no evidence may or may not be as effective.

Few of these methodological difficulties are unique to psychological treatment trials or psychological therapies clinical guidelines and many are being addressed by improved research designs.

Recommendations are given to inform first treatment choice. Patients may choose not to accept this. GPs and other referrers will wish to consider further treatment options if the first treatment option is unacceptable or ineffective.

The recommendations in this guideline represent generalisations based on research and expert clinical consensus. They are not a substitute for specialist assessment or clinical judgement in the individual case. Clinicians retain clinical freedom to refer for therapies not recommended in this guideline if they believe there are good reasons to do so.

4.2 Implementation issues

Guidelines may be adapted to take account of the availability and organisation of local services, but not at the expense of changing the main recommendations.

These guidelines are designed to contribute to a process of evidence-based psychotherapy practice and service delivery, to be implemented within a context of other initiatives supporting this. Methods of implementation which are targeted for local, individual practice needs are more likely to be effective than methods applied globally. These include educational outreach, peer groups, audit feedback and local facilitators.

Wherever possible, local service users should be involved in implementation and audit of the guideline. This provides the best opportunity for implementation to meet the needs of service users and ensure that service provision is both evidence-based and acceptable to patients.

An important first step in auditing implementation of the recommendations in this guideline is to establish adequate access for patients to the range of evidence-based therapies recommended. After discussion with the patient, first presentations of the disorders within the scope of this guideline should receive an adequate trial of a recommended therapy, before other methods are used.

Those referring for psychological therapies will need to balance local availability of recommended therapies with other factors, such as the quality of the therapeutic relationship (3.2), patient preference (3.2) and skill level of therapist (3.6). Referrals will be influenced by all these factors rather than diagnostic criteria and therapy type alone.

Many General Practitioners, having decided a psychological therapy is indicated, will refer to local mental health specialists for 'brokerage assessment'. It is anticipated that these guidelines will also be of value to people in local mental health teams and departments of psychology or psychotherapy undertaking this role.

Before decisions are taken on psychological treatment options, patients with more complex problems should receive a specialist psychological or psychotherapeutic assessment. These include people with severe mental health problems, those who have failed to respond to initial primary care intervention or those who have a number of different co-existing mental health problems, including people who are at risk of self-harm or harm to others. Suitably qualified specialists include chartered clinical or counselling psychologists, accredited psychotherapists and psychotherapeutically trained psychiatrists.

The guidelines may also be used locally to inform and systematise agreed referral procedures between primary and secondary care, and to stimulate transparency and clarity in information about the range of therapies available locally.

Where a recommended therapy is not available locally, the guidelines may help in assessing local need for such services and in making decisions on priorities for investment. However, in line with NHS Executive advice (Department of Health, 1996) such decisions should not be made solely on the basis of the evidence reviewed in this guideline, but also by attention to evidence of clinical effectiveness of services delivered in localities.

The cost implications of using these guidelines are not straightforward, as there is little evidence on which to base projections. Depending on which assumptions are made, these could vary between:

- cost savings (by efficiencies in service delivery, improved treatment allocation and patient preparation, reducing multiple assessments, inappropriate allocations and false starts in therapy),
- cost neutrality (by offsetting costs of providing recommended treatments in sufficient quantity by efficiencies and cost shifting), and
- cost increases where decisions are made to make new investment in under-provided services.

Beyond the normal constraints set by overall service costs, cost-based commissioning decisions are not feasible in this field, due to insufficient evidence on differential cost-effectiveness. In general terms, levels of disability caused by common mental health problems are considerable and early detection and treatment of depression and anxiety has great potential for health gain and for cost saving. Cost effective intervention should be at the least complex, costly and intrusive level *consistent with effective treatment.* Treatments can be cost-ineffective by being too long (when proving ineffective or when maximum improvement has been obtained) or conversely, by being too short to deliver a therapeutic 'dose' of an otherwise effective treatment. To incorporate economic analysis into future guidelines in this field, we identify economic appraisal in relation to service delivery factors as a priority for future research (see Mason, Eccles, Freemantle & Drummond, 1998).

4.3 Suggested audit criteria to improve concordance with this guideline

The following criteria are suggested to audit whether key recommendations in this guideline are being implemented. The criteria can be used at various levels – by individual practices, primary care groups, individual practitioners, secondary mental health care providers and psychological therapy service providers. Patients for whom this guideline is relevant can be identified from practice computer databases, either by disease categories (e.g. depression, anorexia) or from prescriptions issued.

Depending on local information systems, patients to whom these guidelines apply may not be easy to identify retrospectively from existing data. An alternative would be to collect data prospectively, from (for example) the next 30 patients who present with one of the common mental health problems listed in Chapter 1

- depression, including suicidal behaviour
- anxiety, panic disorder, social anxiety & phobias,
- post traumatic disorders,
- eating disorders,
- obsessive compulsive disorders,
- personality disorders, including repetitive self harm,
- chronic pain,
- chronic fatigue,

- gastrointestinal disorders (e.g. irritable bowel syndrome)
- gynaecological presentations (e.g. pre-menstrual syndrome, pelvic pain, menopausal vasomotor symptoms)

It is known that prevalence of these disorders is high, and it can be anticipated that between 25-35% of patients presenting in General Practice will have sufficient psychological symptoms to justify more detailed psychological assessment (Ustun et al, 1999). GPs in the UK spend 30% of their time on mental health problems (MACA, 1999).

The following review criteria for audit are taken from the recommendations in this guideline:

1. There is a record of the available psychological therapy services locally, inside and outside the practice and/or Primary Care Group. The record also indicates where each of the psychological therapies noted in the recommendations of the guideline can be accessed locally.

For all the following criteria, the patient record shows that…

2. Psychological therapy has been considered as one treatment option for all patients with these presenting problems. This includes patients receiving a mental health care programme. If psychological therapy is not offered, the reason is recorded.

3. People with severe or complex presentations (including repetitive self-harm and personality disorder) are referred for specialist psychological or psychotherapeutic assessment.

4. Adequate lengths of psychological therapies are offered patients: at least 8 sessions for moderate mental health problems, 16 sessions or more being available where needed, and longer treatment lengths for patients with personality disorders.

5. If a referral to psychological therapy has been made

   a) the patient's preference and motivation has been assessed

   b) the patient has agreed to referral

   c) the patient's ethnic and cultural identity have been considered

6. For patients presenting with post traumatic stress disorder and patients with anxiety disorders characterised by marked symptomatic anxiety (panic disorder, agoraphobia, social phobia, obsessive compulsive disorders, simple phobias and generalised anxiety disorders), cognitive behaviour therapy is considered as one of the psychological therapy referral options.

7. Cognitive behaviour therapy has been considered as a treatment for patients with chronic fatigue or chronic pain.

8. Patients are followed up to monitor the outcome of the intervention.

Further general information and advice about undertaking audit in primary care on mental health topics and psychological therapies can be obtained from local Clinical Governance leads, Medical Audit Advisory Groups. Other resources which may be found useful include Firth-Cozens (1993), Davenhill & Patrick, (1998) and the Clinical Governance Research and Development Centre, University of Leicester (http://www.le.ac.uk/cgrdu).

Annex 1

Glossary of psychological therapies mentioned in this guideline

Applied relaxation therapy teaches systematic approaches to relaxation, for example, progressive muscle relaxation, often combined with breathing techniques.

Autogenic training is often combined with relaxation methods to create a conditioned relaxation response to an internal stimulus, such as a word or phrase.

Behaviour therapy is a structured therapy originally derived from learning theory, which seeks to solve problems and relieve symptoms by changing behaviour and the environmental factors which control behaviour. Graded exposure to feared situations is one of the commonest behavioural treatment methods and is used in a range of anxiety disorders.

Cognitive analytic therapy (CAT) is a brief (8-25 session) integrative therapy combining elements of cognitive behavioural and psychodynamic therapies in an active, structured and collaborative approach, based on written and diagrammatic reformulations of the presenting difficulty.

Cognitive behaviour therapy (CBT) refers to the pragmatic combination of concepts and techniques from cognitive and behaviour therapies, common in clinical practice.

Cognitive therapy is a structured treatment approach derived from cognitive theories. Cognitive techniques (such as challenging negative automatic thoughts) and behavioural techniques (such as activity scheduling and behavioural experiments) are used with the main aim of relieving symptoms by changing maladaptive thoughts and beliefs.

Dialectical behaviour therapy (DBT) is a longer term cognitive behavioural treatment devised for borderline personality disorder which teaches patients skills for regulating and accepting emotions and increasing interpersonal effectiveness.

Eclectic therapies. Many NHS therapists formulate the patient's difficulties using more than one theoretical framework and choose a mix of techniques from more than one therapy approach. The resulting therapy is pragmatic, tailored to the individual. These generic therapies often emphasise important non-specific factors (such as building the therapeutic alliance and engendering hope). By their nature, they are more idiosyncratic and difficult to standardise for the purposes of randomised controlled trials research.

Eye movement desensitisation and reprocessing (EMDR) is a form of imaginal exposure treatment for post-traumatic conditions where the traumatic event is recalled whilst the client makes specific voluntary eye movements.

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. This form of therapy may be offered in a time-limited format, with anxiety aroused by the ending of therapy being used to illustrate how re-awakened feelings about earlier losses, separations and disappointments may be experienced differently.

Hypnotherapy refers to any therapeutic approach using hypnosis as a main technique, for example, to promote imaginal re-exposure or relaxation.

Integrative therapy refers to a formal theoretical and methodological integration of, for example, behavioural, cognitive, humanistic or psychodynamic approaches.

Interpersonal therapy (IPT). A structured, supportive therapy linking recent interpersonal events to mood or other problems, paying systematic attention to current personal relationships, life transitions, role conflicts and losses.

Problem-solving therapy systematically teaches generic skills in active problem-solving, helping individuals to clarify and formulate their life difficulties and apply principles of problem solving to reduce stress and enhance self-efficacy.

Psychoanalytic psychotherapy is a longer-term process (usually a year or more) of allowing unconscious conflicts opportunity to be re-enacted in the relationship with the therapist and, through interpretation, worked through in a developmental process.

Psychoanalytically informed day hospital treatment is designed to help patients understand their unconscious conflicts as they are enacted in their relationships with other patients and staff in the groups and activities of the day hospital programme.

Psychodynamic-interpersonal therapy (formerly known as the Conversational Model of Therapy) assumes that symptoms and problems arise from, or are exacerbated by, disturbances of significant personal relationships. It explores feelings using cue-based responses and metaphor; links distress to specific interpersonal problems and uses the therapeutic relationship to test out solutions in the 'here and now'.

Rational emotive therapy is a form of cognitive therapy that identifies underlying assumptions and patterns of thinking linked to negative unwanted emotions and challenges these.

Schema-focused cognitive therapy is an integrative, long-term form of cognitive therapy, which addresses the deeply held, enduring beliefs (*schemas*) found in personality disorders.

Social skills training is a form of behaviour therapy in which patients are taught skills in social and interpersonal relationships.

Stress inoculation therapy is a type of behaviour therapy that involves exposure to increasing levels of stress to enhance ability to cope with stress.

Supportive psychotherapy refers to any psychotherapeutic approach that supports existing ways of coping with problems rather than challenges and attempts to change ways of thinking and responding.

Systemic therapy. Systemic 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. Therapy aims to identify and explore patterns of belief and behaviour in roles and relationships. Therapists actively intervene to enable people to decide where change would be desirable and to facilitate the process of establishing new, more fulfilling and useful patterns.

Therapeutic community refers to a residential treatment in which patients learn to understand their problems and to change through their interactions with other patients and staff throughout the 24 hours of community life.

Counselling is a systematic process which gives individuals an opportunity to explore, discover and clarify ways of living more resourcefully, with a greater sense of well being. Counselling may be concerned with addressing and resolving specific problems, making decisions, coping with crises, working through conflict, or improving relationships with others. Counsellors therefore focus on client choices in their life circumstances, as a basis for their work. Counsellors may practice within any of the therapeutic approaches listed here, using psychodynamic counselling, cognitive behavioural counselling, systemic counselling and so on. However, most are influenced by humanistic, process-experiential and psychodynamic principles.

Other psychotherapies. The above list is by no means comprehensive. Other types of therapy practised in the NHS include bibliotherapy, existential therapy, functional analytic therapy, humanistic therapy, process-experiential (client-centred) therapy, feminist therapy, personal construct therapy, art therapy, drama therapy, neuro-linguistic programming, solution-focused therapy, transactional analysis and group analysis. Further information about psychotherapy types can be obtained from the UK Council for Psychotherapy.

Annex 2

Systematic reviews on which recommendations were based

Cochrane reviews

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Annex 4

Supplementary search strategies

1. PsychLit

The search strategy used in the original Psychological Therapies Research Centre (PTRC) review was used as a basis for the following search, searching for specific terms from the original scoping paper of the guideline concerned with patient characteristics, patient choice and treatment factors.

1. explode "psychotherapy" or explode "counseling" or explode "behavior-therapy" or explode "cognitive-therapy" or explode "psychotherapeutic-counseling" or explode "family-therapy" or explode "marriage-counseling" or explode "couples-therapy"

2. "literature-review" in de or "meta-analysis" in de

3. 1 and 2

4. (child in ag or adolescent in ag) not adult in ag

5. not 4

6. 5 and: "psychological mindedness", "treatment-compliance", motivation, ethnic*, "patient history", "early loss", "early experience", depriv*, abuse, neglect, "previous treatment", hered*, "patient history", "life events", "social difficulties", "social deprivation", "patient preference", "patient choice", "client satisfaction", preferences, attrition, take up rates, preparation, treatment length, setting

2. PsychLit

The following searches were done with the intention to identify randomised control trials (RCTs) in the areas where evidence was lacking. Search item 1 was taken from the PTRC review, search item 2 was taken from Cochrane Handbook for RCTs.

1. explode "psychotherapy" or explode "counseling" or explode "behavior-therapy" or explode "cognitive-therapy" or explode "psychotherapeutic-counseling" or explode "family-therapy" or explode "marriage-counseling" or explode "couples-therapy"

2. randomized controlled trial or controlled clinical trial or randomized controlled trials or double blind method or single blind method or random allocation

3. animal not human

4. 2 not 3

5. 4 and 1

6. 5 and: "gynaecological-disorders", "self-inflicted-wounds", "personality-disorders" in de, chronic fatigue, "gastrointestinal-disorders" in de

3. Embase/Medline

1. Explode "psychotherapy" or explode "counseling" or explode "behavior-therapy" or explode "cognitive-therapy" or explode "family-therapy" or explode "marriage-counseling" or explode "couples-therapy"

2. 1 and review

3. 2 and: gynaecol*, self harm, personality disorder, chronic fatigue, gastrointestinal disorders, anxiety-disorders

Exclusion criteria

Papers were excluded if they had already been referenced in the PTRC review, not in English, not a journal article, concerned only children and adolescents or not topic related.

After exclusion, the above search yielded 14 journal articles: 13 reviews and 1 RCT.

Quality evaluation

The review articles were evaluated for quality using Oxman & Guyatt's (1988) criteria. These were rated by Hannah Mackay (PTRC). The RCT identified in the search was not rated for quality.

The articles identified in this search all achieved quality ratings of 5 or below. In the PTRC review, papers which achieved a quality rating of 5 or less were not included in the evidence. Therefore, the reviews will not change the results in the PTRC review, however, it may be important to consider the findings of lower quality reviews where good quality evidence is lacking, and for it to be noted as such. The results of the papers which were identified are summarised in tables 1 to 3.

Annex 5

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