Good Practice in Action 048
Research Overview

Mental health literature within the counselling professions

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Context

This resource is one of a suite prepared by BACP to enable members to engage with the current BACP E*thical Framework for the Counselling Professions* in respect of mental health.

Purpose

The purpose of this resource is to provide an overview of research and literature relating to mental health for practitioners working in the counselling professions.

Using the research overviews

BACP has developed the *Good Practice in Action* series, these are free for BACP members to download. It is hoped these will support good practice in the counselling related professions. They are all reviewed both by member-led focus groups and experts in the field and are based on current research and evidence.

BACP members have a contractual commitment to work in accordance with the current *Ethical Framework for the Counselling Professions*. The *Good Practice in Action* resources are not contractually binding on members but are intended to support practitioners by providing general information on principles and policy applicable at the time of publication, in the context of the core ethical principles, values and personal moral qualities of BACP.

Specific issues in practice will vary depending on clients, particular models of working, the context of the work and the kind of therapeutic intervention provided. As specific issues arising from work with clients are often complex, BACP always recommends that you discuss practice dilemmas with a supervisor and/or consult with a suitably qualified and experienced legal or other relevant practitioner.

The studies included in this overview use different terms to differentiate counsellors from psychotherapists and other professionals who provide counselling-related services. However, when this overview was written, care was taken to refer specifically to psychotherapists and counsellors as 'therapists', and to refer to social workers, coaches and those engaged in pastoral care as 'practitioners'. Whether the term 'therapy', 'counselling', or 'psychotherapy' is used depends on how it was referred to within the reviewed study; however, all pertain to counselling-related services.

1 Introduction

This resource was compiled with the goal of providing helpful information about mental health for therapists and practitioners in respect of therapy and other counselling-related services. In particular, key definitions associated with mental health, common disorders of mental health, and the law associated with mental health are presented. This resource is purely informative and should be used in conjunction with BACP's E*thical Framework for the Counselling Professions* (2018).

2 What are mental health and mental illness under the law?

The law in respect of mental health and mental illness is complex. Barbara Mitchels informs readers within Good Practice in Action Legal Resource 029: *Mental Health Law within the Counselling Professions in England and Wales*:

> *The main statutory provisions in this field are the Mental Health Act 1983 (MHA 1983) as amended by further subsidiary legislation, the Mental Health Act 2007 (MHA 2007), the Mental Capacity Act 2005 (MCA 2005) and the Care Standards legislation.*
>
> *Other statutes are relevant to specific care issues, police matters, criminal offences and procedures, and are mentioned in the body of this resource where relevant. There have been regular calls to update law and practice in the area of mental health, and with increasing scrutiny of our law under the Human Rights Act 1998 by the European Commission for Human Rights (ECHR), the increasing awareness of disability rights, the impact of the United Nations Convention on the Rights of Persons with Disabilities, which came into effect in 2008, and the recurring disclosures of abuse in care systems, we might anticipate further reforms, so stay alert for changes in law and guidance which are relevant to your therapy practice.*

Any reference to the MHA within this resource will refer to the MHA 2007, as amended unless otherwise noted. Readers wanting to know more about the legal aspects of mental health in the context of the counselling professions can download it from: https://www.bacp.co.uk/events-and-resources/ethics-and-standards/good-practice-in-action

2.1 Defining mental health

The World Health Organisation (WHO, 2016) defines 'mental health' as:

> *'Mental health is a state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. Mental health and well-being are fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life.'*

This definition informs and underpins this resource.

2.2 Defining mental disorder

Under S.1 (2) of the MHA, a 'mental disorder' means any disorder or disability of the mind. This definition relies heavily upon professional and medical definitions of certain known or documented types of mental disorders.

'Mental illness' is not specifically defined in the MHA. This is because courts of law still generally rely upon case law, and medical and psychiatric practice for definitions of specific mental illnesses (Pilgrim, 2014). Courts of law apply definitions of mental illness as these are expressed in psychiatric manuals.

2.3 Differentiating learning disabilities from mental disorders

'Mental disorder' is differentiated from a 'learning disability' under S. 1(4) of the MHA in that it refers to 'a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning.' Under S.1(2A) of the MHA, a person with a learning disability is not considered to be suffering from a mental disorder for many purposes of mental health law, 'unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part'. In practical terms, this may mean, for instance, that a person with a learning disability is presumed to have mental capacity and can give or withhold consent to medical procedures despite having a learning disability.

2.4 Defining mental capacity

Barbara Mitchels tells us that:

> *'The MCA [Mental Capacity Act 2005] empowers individuals to make their own decisions where possible, and protects the rights of those who lack capacity. Where an individual lacks capacity to make a specific decision at a particular time, the MCA provides a legal framework for others to act and make that decision on their behalf, in their best interests, including where the decision is about care and/or treatment'*
> (Mental Health Act 1983 Code of Practice, Department of Health 2017 5:97).

2.5 Defining 'therapists' and 'practitioners'

Under the NHS, counselling may be provided as part of local community healthcare services, most private counselling occurs within a paid professional practice (Mitchels, 2015). If a prospective client lacks mental capacity to understand and enter into some or all of the terms of a therapeutic contract, then it might not be ethical or appropriate to provide private therapy services for that person.

Providers of services informed by therapeutic theory and practice that are delivered with sufficient expertise to satisfy professional standards and ethics. These professions include coaching, counselling, pastoral care and psychotherapy.

3 Context of mental health in counselling and psychotherapy

Alongside the *Ethical Framework for the Counselling Professions* and the development of sector-specific and core competence frameworks, showing skills needed for practitioners working within the counselling professions, other organisations also offer the following: The Open University's Counselling and Psychotherapy Central Awarding Body (CPCAB) provides a Service Levels Framework, where mild to moderate common mental health problems are assigned Service Level B and more severe mental health problems are assigned Service Level C. These service levels provide practitioners with a framework for the level of therapeutic change likely, the degree of mental health and wellbeing likely in clients, and the CPCAB qualifications required to work with this client group.

The management of risk as part of a therapist's duty of self-care must necessarily be balanced with the therapist's professional duty of care towards clients with mental health problems. Working with clients who have mental health disorders or mental illnesses may expose therapists to increased risk of violence (Bond, 2015).

BACP members are committed to show respect by 'protecting client confidentiality and privacy' (Commitment 3b). There are times, however, when the duty of confidentiality, may be breached, for example when complying with requirements of statutes, when complying with lawful orders of a court, or when public interest or safety justifies it. In cases where clients express serious threats of harm against themselves or other identifiable persons, and the therapist holds a reasonable belief that the risk is real and imminent, the duty of maintaining confidentiality may be breached (Bond and Mitchels, 2014). Members can access Good Practice in Action Legal Resource 014 *Managing Confidentiality* for further information at: http://www.bacp.co.uk/ethics/newGPG.php

4 How the literature was identified

This literature review was undertaken by utilising electronic databases and search engines such as Google Scholar, PsycInfo and PubMed. Search term stems such as 'Counselling' and 'Psychotherapy' were used in conjunction (AND) with other search terms such as: 'Mental Health', 'Mental Health Professionals', 'Psychiatry', 'Clinical Psychology', 'Counselling Psychology', 'Psychological Therapies', 'Psychological Interventions', 'Primary Care', 'Psychopathology', 'DSM-V', 'ICD-10', 'Diagnosis', 'Formulation', 'Assessment and Referral', 'Depression', 'Anxiety Disorders', 'Suicide', 'Legal Framework', 'Ethical Issues', 'De-Medicalisation'.

To provide relevant and up-to-date information, only studies published in English from 2009 until 2015 were included. The focus of the literature search was to identify studies and articles that pertained to the counselling professions in the UK. However, as countries such as the US, Australia, Canada and Scandinavian countries all use definitions under DSM-V and the ICD-10, and have healthcare systems where private and paid counselling and psychotherapy practice are allowed, studies and articles from these countries were also included. Studies published in English from countries such as China, Iran, Uganda and Tanzania, where it is not known whether private counselling and psychotherapy practice exists, were excluded.

Also excluded were books and chapters of books, studies involving children, and studies and articles involving genetic counselling. Genetic counselling is part of medical practice and not counselling practice. However, there are studies regarding genetic counselling for mental illnesses (such as schizophrenia) or neurodegenerative diseases (such as dementia), which were included where the focus of such studies is in dealing with stigma or emotional and relationship conflicts created by the results of genetic tests (Gershon and Alliey-Rodriguez, 2013).

As this resource is a mere overview of studies on the broad topic of mental health, specific treatments and therapies were not included. There may be mention of some types of treatment such as Cognitive Behavioural Therapy (CBT), Interpersonal Therapy (IPT) and other therapies but these refer only to the types of therapies which were utilised in the studies included in this overview. This overview does not aim or attempt to study these specific treatments and therapies, or even to recommend them as best treatments. These treatments and therapies are only mentioned in this overview as these were the very treatments utilised in the studies included in the overview.

The search terms did not include the names of specific therapies as it was not the purpose of the overview to provide resources on discrete forms of treatments and therapies. This overview merely seeks to provide an overview of research trends and developments regarding common mental health illnesses and problems. A future review may explore specific therapy modalities.

This review does not include the guidelines from the National Institute for Health and Care Excellence (NICE) because BACP is a professional body that provides non-statutory guidance that can be used independently from other resources. BACP has its own standards based on contractual commitments of members to the *Ethical Framework for the Counselling Professions* and its members are not precluded from using NICE guidelines in addition to the standards and resources of BACP. The former can be found at: https://www.nice.org.uk/standards-and-indicators

A total of 105 publications were included in this review of mental health research.

5 Synopsis of research related to mental health

The aim of this research overview is to group similar studies in order to show new developments in the field of counselling and psychotherapy, as well as counselling related professions such as coaching and pastoral care.

The developments in research cover the debate between the advantages of psychotherapy over pharmacotherapy. One interesting finding from this overview is that within recent research it is shown that a combined approach using both psychotherapy and pharmacotherapy may produce better symptom reduction and faster remission.

The literature also included findings on the variables that confound studies investigating the efficacy of psychotherapeutic interventions. These are: age, ethnicity, gender, adverse experiences, therapeutic alliance, therapist competence, type of therapy received, number of sessions and the site at which interventions are provided. Findings of co-morbid illnesses or medical conditions suggest that mental health conditions may result in undiagnosed mental illness, especially in older people.

There was also an emphasis on late life depression. This comes with the recognition that the number of persons aged 60 and above is growing. Often, older people suffer from disability, which prevents them from seeking help for mental problems, despite their susceptibility to mental problems as a result of co-morbid conditions such as Parkinson's Disease or chronic pain.

There are studies included in this overview that suggest client perceptions as to the type of treatment, as well as client expectations, impact outcome. Some studies correlate ethnicity and the under-utilisation of treatment modalities, under-treatment of mental illnesses, and lack of access to mental healthcare.

Non-pharmacological interventions, which may be complementary to either pharmacotherapy or psychotherapy, are also included, specifically: mindfulness and meditation, acupuncture, and body psychotherapy through dance and movement.

A significant number of the studies examine the development and provision of psychotherapy via the internet. In this regard, research has kept pace with technology and has adapted technology to provide psychotherapy to under-served populations through a cost-effective modality. Indeed, this overview of the research suggests that psychotherapy via the internet may complement traditional face-to-face psychotherapy.

6 Why is research important for our professional group?

The BACP *Ethical Framework for the Counselling Professions* 2016 states:

> '*We value research and systematic inquiry by practitioners as enhancing our professional knowledge and providing an evidence-base for practice in ways that benefit our clients'* (Good Practice, Point 68).

Specifically, research on definitions of concepts in counselling is important because definitions change over time. Also, emerging areas and modalities of practice, especially with the prevalence of information and communication technology, create new practice contexts where accepted and traditional definitions and concepts may or may not quite apply.

It is also important to note that the rationale for research is provided by the changing professional frameworks and codes. Professional manuals, which provide definitions of common mental disorders, are periodically reviewed and updated. Thus, literature, such as that provided in this resource, is invaluable in updating practitioner knowledge and providing an evidence-base for the counselling professions.

According to the NHS England *Five Year Forward View For Mental Health* (www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf), mental illness is the single largest cause of disability in the UK. The cost to the economy is estimated to be around £100 billion annually (roughly the cost of the entire NHS). Formed in 2015, the Mental Health Taskforce aims to improve mental health outcomes by ensuring that those with mental health problems are accessing quality care, and by 2021 the NHS intends to have moved towards an equal response to mental and physical health. With government devolution of NHS resources (as seen in Manchester in 2015 when NHS England and Greater Manchester announced a shared plan for £6 billion health and social care funding), it is increasingly likely that psychological therapies' (including Improving Access to Psychological Therapies (IAPT)) services will be independently commissioned by GP-led clinical commissioning groups (CCGs). This is also partly driven by the government ambition to achieve parity of esteem between mental and physical health as outlined in the Government's response to the Mental Health Taskforce's *Five Year Forward View for Mental Health* report (HM Government, 2017). Whatever the outcomes of these far-reaching and ambitious projects, there is likely to be an increase in referrals for patients who need treatment of some form for psychological/mental illness.

7 Why is it important to engage with research?

It is important to engage with research because new social phenomena occur every day that give rise to new modalities of practice and new means of delivering traditional modes of practice. This is particularly true when it comes to diagnosed mental illness or risk of mental illness. For example, genetic counselling is expanding the role of the counselling professions. Therapy is not only important to those with mental disorders or those at risk of mental disorders. The counselling profession becomes relevant when results of genetic marker tests for mental disorders or neuro-degenerative conditions impact on family relationships and marital choice; or when families have to make decisions regarding whether to undergo genetic testing, abortion, or implantation procedures.

8 The ethical imperative of engaging with research related to mental health

According to BACP's *Ethical Framework for the Counselling Professions* (BACP 2018), our commitment to clients includes a commitment to 'work to professional standards by keeping our skills and knowledge up to date' (commitment 2b) and in the good practice section, 'we value research and systematic inquiry by practitioners as enhancing our professional knowledge and providing an evidence-base for practice in ways that benefit our clients' (Good Practice, Point 68). Professional competence will only be achieved and maintained by engagement at some level with clinical research.

Furthermore, there is a definite trend towards the development of 'embedded' clinical/psychotherapeutic practice into the domain of social work, charity or aid and rescue work, educational services and even religious practice. Indeed, counselling via the internet is a trend where ethical issues presented may be unprecedented.

BACP members who offer and provide counselling in these areas are included in the definition of 'practitioners' who are required to be accountable under BACP's *Ethical Framework* and thus, need to be informed and made aware of the developments in mental health research.

9 Research for mental health in counselling and psychotherapy

9.1 Depression (including Bipolar Disorder)

9.1.1 Psychotherapy versus pharmacotherapy

Traditionally, therapy has competed with pharmacology. However, research suggests that therapy changes the circuitry of the brain just as drugs do. When therapy reduces symptoms, the brain increases its efficiency at processing information, improving the malfunctioning brain circuits (Stahl, 2012).

Cuijpers et al. (2014b) suggest that the effects of antidepressants in treating depressive orders may be overestimated because of publication bias; that is, that there is selective publication of positive trials. Reanalyses, including unpublished trials, yield reduced effect sizes (i.e. lower effectiveness). This has led to claims that psychotherapy is more effective than antidepressants, the latter having insignificant advantages over placebos. This study suggests that the debate over whether antidepressants or psychotherapy is more effective, is still open.

Craighead and Dunlop (2014) assert that effective psychotherapy and antidepressant medication have been developed for major depressive disorder, and 66% of depressed clients respond to either psychotherapy or medication. However, only 33% of these achieve remission when receiving just one or the other treatment. They suggest a combination of treatments and recommend that neurobiological considerations inform treatment decisions.

Treatment guidelines (in the US) suggest combined treatments that include both psychotherapy and pharmacotherapy, except in mild to moderate depression. Cuijpers (2014a) asserts that combined treatment is significantly more effective than either treatment alone; moreover, patients with mild to moderate depression may receive pharmacotherapy when they may prefer psychotherapy.

Dekker et al. (2013) ask which the best treatment combination is, proposing that clients with mild or moderate depression may begin with pharmacological interventions such as antidepressants; then, if there is no response, combined therapy could be helpful. Dekker refers to this as a 'sequential strategy' and cautions that it may not be acceptable for all clients with this condition.

MacDonald et al. (2013) examined the effects of administering intranasal oxytocin (the attachment hormone) which may benefit males with depression. Oxytocin was found to increase anxiety symptoms in males with depression and it did not increase eye contact with the therapist. Instead, it decreased non-verbal behaviours that cut off social contact. The results of this study put into question any potential antidepressant benefits of oxytocin administration.

9.1.2 Variables in assessing outcomes in treating depression

Most of the studies exploring the efficacy of treatment, measure changes in depressive symptoms, but Renner et al. (2014) proposed that improvements in social functioning may be an important outcome when assessing psychotherapy for depression. They also asserted that although improvements in social functioning are strongly associated with improvements in depressive symptoms, mere reduction in depressive symptoms doesn't explain improvements in social functioning.

Gaudiano et al. (2013) suggested that clients' treatment expectancies also play a role in the effectiveness of treatments. They found that the majority of clients accept psychotherapeutic treatments more readily than antidepressants, because they believe they will reduce their symptoms. This increases their willingness to participate in psychotherapy rather than in medication trials. These findings may lead researchers to purposively select participants in clinical trials based on their treatment expectations and consider treatment expectation as a variable that may contribute to treatment response.

Dysfunctional attitudes may moderate both pharmacotherapy and therapy for clients with chronic depression. Shankman et al. (2013) examined whether levels of dysfunctional attitudes correlate with response to treatment for chronic depression. The study concludes that the correlation between dysfunctional attitudes and treatment response is complex but that dysfunctional attitudes may be associated with better responses to pharmacotherapy than to psychotherapy in chronic depression.

9.1.3 Therapeutic alliance

Altenstein, et al. (2013) considered the behaviours of both the therapist and the client and how their behaviours complemented or interplayed during a session, they were investigating whether these behaviours predicted emotional arousal in the client. They analysed one session per each of 20 depressed clients included in the study (a more accurate result may well have been gained if all or a higher percentage of client sessions had been analysed however). The impact of the interplay between the therapist and client was measured only by self-reports. It was found that affiliative behaviours were associated with a positive therapeutic alliance, but clashing behaviours of therapist and client predicted more emotional arousal in clients. One interesting finding was that when a therapist refrained from answering outbursts of client hostility, it predicted a positive therapeutic alliance.

Arnow et al. (2013) investigated whether or not a positive therapeutic alliance early in treatment predicted symptom reduction in chronically depressed clients, and whether there was a difference in response to treatment between cognitive behavioural analysis system of psychotherapy and brief supportive psychotherapy.

Cognitive Behavioural Analysis System Psychotherapy is a synthesis of Cognitive Therapy and Cognitive Behavioural Therapy specifically designed for chronic depression. It was found that a positive working alliance was associated with lower symptom ratings.

These findings were directly contradicted by Hendriksen et al. (2014), who analysed the data from a randomised clinical trial investigating whether therapeutic alliance directly accounts for symptom change. It was found that the therapeutic alliance did not predict subsequent symptom change. Other factors such as therapeutic technique, transference phenomena, therapist competences, and client characteristics may influence symptom change.

While it is recognised that stigma is a barrier to seeking help in mental health treatment, there are few studies that examine whether stigma also influences treatment experiences. Kendra et al. (2014) examined self-stigma and perceived public stigma. They found that self-stigma was negatively associated with the initial working alliance; and perceived public stigma was unrelated to engagement and the working alliance; suggesting that self-stigma and perceived public stigma were generally unrelated to changes in the outcomes over the initial phase of counselling.

However, the study also found that while perceived public stigma decreased over the first few sessions, self-stigma remained constant, thus, the role of stigma in clinical work cannot be overlooked.

9.1.4 Ethnicity

Ince et al. (2014) examined whether a sample's racial-ethnic minority proportion moderated the effect size of psychotherapy among 56 randomised control trials (RCTs) on the psychological treatment of depression. No moderating effect of race-ethnicity was found, suggesting that psychotherapy is equally effective regardless of the client's ethnicity.

Quinones et al. (2014), however, asserted that ethnicity and membership in minority groups may predict differences in receipt of treatment. They found that, in the population of veterans of the US armed forces, those veterans who were non-White and members of ethnic minority groups had lower odds of adequately using and receiving a prescription for antidepressants. This may be due to patient preferences or system factors, or inequitable quality of care that interact to generate differences in provision of care.

9.1.5 Gender and sex as variables in susceptibility to depression and treatment outcome

The study by Vigod and Taylor (2013) focused on determining the reason for the preponderance of depressive illness in women. They pointed to biological factors, which include the brain structure and function, as well as the impact of reproductive life stages. However, they also asserted that women are differentially disadvantaged by environmental stressors, which include interpersonal violence, socioeconomic instability, and caregiving burden. The study notes that not all women develop depression and not all who experience adverse life events suffer from depression. This led them to focus, instead on how sex, genetics and environmental factors interact and influence the development of depression. This study rationalises investigations into this area by stating that those who practice psychodynamic psychotherapy can benefit from understanding the complexities that determine risk and resilience.

da Rosa Silva et al. (2013) investigated the effect of the participation of fathers in psychological interventions within the context of Post-Partum Depression in women.

Two families were studied. The families participated in parent-infant psychotherapy for 12 sessions. This study asserted that the presence of fathers reduces the feeling of mothers that they are solely responsible for the process of change in the family. From the point of view of the therapist, the presence of fathers allows parenthood issues to be addressed.

9.1.6 Age as predictor of depressive symptoms

Older people, particularly those aged 60 and over are prone to depression as well as anxiety (Laidlaw, 2013). Late-life depression occurs in the context of cognitive impairment, medical burden and disability, and must be assessed with the broader clinical context (McGovern et al., 2014). Measures such as the Geriatric Depression Scale is useful in determining symptoms and levels of depression among the elderly (Cody and Drysdale, 2013). One problem in diagnosing depression in this population is that some patients suffer from conditions or diseases to which anxiety and depression are marked co-morbid conditions (Hall, 2012).

Research regarding the mental health of the elderly is important as there is a global demographic change in lifespan often referred to as the 'greying' of the population (Hall, 2013). Cohorts of elderly people are living beyond the expected lifespans of the previous generation (Laidlaw, 2013). Research, as Laidlaw points out has overlooked anxiety and focused more on late-life depression; yet, recognition and reduction of anxiety and depressive symptoms prevent major mental health problems.

One important contribution of research is the understanding of the physical characteristics of late life depression. Mackin et al. (2013) studied 22 individuals with late life depression in two groups. All of them underwent magnetic resonance imaging (MRI) of the brain and cortical mapping of grey matter; tissue thickness was also calculated. After 12 weeks of psychotherapy, they again underwent MRI. Those who manifested at least 50% reduction in depressive symptoms had greater cortical thickness than those who did not respond.

The study correlated cortical thickness with the likelihood of response to psychotherapy. Cortical atrophy in those aged 60 and over is an important marker of individuals at higher risk of poor response to psychotherapy.

Therapy is seen to be effective in treating depression, but there is a dearth of studies that probe the effectiveness of therapy in older people and the specific components of therapy that will be effective for this population. A Delphi group, consisting of 24 Dutch experts, confirmed that effective psychotherapy among the elderly consists of age-related characteristics and must respond to negative life experiences, physical illness, cognitive disorders, personality characteristics, grief, sleep disorders, previous depression and functional changes. They also expressed that factors such as values and norms, feelings of shame and guilt regarding problems, and changing life perspectives are important variables in therapy (Cloosterman et al., 2013).

A qualitative study by Dakin and Arean (2013) sought to establish the views and perspectives of the elderly as to: what they expect from psychotherapy; what they feel are the most and least effective aspects of treatment, and their recommendations to improve treatments; more importantly, the study sought to determine the needs of this population so that future psychotherapy and interventions may be designed to meet those needs. Dakin and Arean (2013) established that the participating people aged 60 and over, sought treatment for depression relating to interpersonal relationships, health conditions, grief, finances, housing, and challenges due to loss of 'executive function' (a set of mental skills which enable people to get things done such as managing time). They found the focus on interpersonal relationships to be the most helpful process of treatment, also found helpful was, suggesting increasing the number of sessions, discussing problems in a more proactive way and considering their choice of treatment.

9.1.7 Adverse childhood experiences and treatment response

A systematic review and meta analysis by Norman et al. (2013) confirmed that adverse childhood experiences, such as parental neglect and abuse, are recognised risk factors for developing adult psychopathology. Johnstone et al. (2013) examined whether these can also predict treatment response in adults with depression. In this RCT of 177 outpatients receiving CBT or Interpersonal Psychotherapy for depression, clients reporting high levels of maternal care during childhood showed better responsiveness to treatment. In Interpersonal Psychotherapy, clients who received high levels of paternal protection and maternal care during childhood had significant positive response to treatment. However, the study was limited by two factors: adverse childhood experiences other than parental neglect and abuse were not investigated, and clients who were included in the study had already completed CBT, which may have weakened the findings.

9.1.8 Number of sessions, site of treatment provision

Braun et al. (2013) conducted a meta-analysis of 53 studies involving 3,965 clients and found that CBT, Behaviour Activation Therapy, Psychodynamic Therapy, Interpersonal Psychotherapy and supportive therapies may all be equally effective.

However, client self-ratings and clinical significance suggest that supportive therapies are less effective. One important finding is that the length of therapy sessions seems to be a determinant of effectiveness as assessed by the treatment response and reduction in depressive symptoms.

Cuijpers et al. (2013) asked the question of how much psychotherapy is required to treat depression. They assert that while psychotherapy has been shown to be effective in the treatment of adult depression, it is not clear how the number of sessions, the frequency of sessions and the intensity of the therapy involved relates to the treatment effect and treatment response.

Dinger et al. (2014) explores whether day-clinic (outpatient) or inpatient psychotherapy is most effective for depression. They found that despite clients' strong preference for one or the other treatment modality, there was a significant and large symptom decrease in both outpatient and inpatient groups. The findings support the integration of therapeutic evaluation in routine clinical settings, and also highlights that different levels of care and the settings in which care is received may impact the benefits derived from psychotherapy.

9.1.9 Type of therapy received as a variable in treatment response and efficacy

a) Internet-based psychotherapy:

One of the major areas of research in mental health is the effectiveness of telephone or internet-based psychotherapy and the types of clients it could prove most beneficial for. Most of these studies are still in the recruitment stage, and the published study protocols centre upon the significant burden of a major depressive disorder on individuals and societies as the rationale for research: web-based interventions address the burden of depression.

Krieger et al. (2014) suggest that web-based psychotherapy for major depressive disorders can be effective either as a stand-alone mode of psychotherapy or as an addition to traditional psychotherapy.

Lopez-del-Hoyo, et al. (2013) explored web-based CBT and found it can also be an efficacious and cost-effective treatment option. Their protocol proposes a low-intensity and self-guided internet-delivered psychotherapy which will be integrated into primary care.

Under the NHS, clients are often put on a waiting list to receive inpatient psychotherapy. Internet-based psychotherapy for major depression may reduce the waiting time for clients, reduce prolonged suffering and impairment brought about by waiting for treatment, and avoid the risk of making depression a chronic condition (Reins et al., 2013).

Sheldon et al. (2014) focused on a telephonic assessment, support and counselling program (TASC) to deliver psychotherapy to primary care medical clinics, an underserved population in the public health system. Primary care clinics deliver medical care to low-income, culturally-diverse populations where clients don't have much contact with mental health providers.

The lack of immediate access to mental health care is also a rationale for research on internet-based interventions for depression. Osenbac et al. (2013) conducted a meta-analysis of literature on 'telehealth' interventions which are delivered remotely. No evidence was found to suggest that telehealth modalities are less effective than traditional face-to-face modalities for reducing symptoms of depression.

Donker et al. (2013) investigated the predictors and moderators of responses to internet-delivered Interpersonal Psychotherapy, CBT, and an active control intervention. The study was conducted over four weeks and participants were spontaneous visitors to a therapy website. At baseline and at six-month follow-up, predictors and moderators such as age, gender, marital status, education level, depression/anxiety symptoms, disability, quality of life, medication use, mastery, dysfunctional attitudes, and treatment preferences were assessed using self-report measures. Female gender, lower mastery and lower dysfunctional attitudes were

found to predict better outcomes regardless of the type of internet-delivered intervention. Younger people preferred internet-delivered Interpersonal Psychotherapy, while older participants derived more benefits from internet-delivered CBT programmes.

b) Interpersonal psychotherapy (IPT):

Miniati et al. (2014) asserted that IPT is a dynamically informed and present-focused psychotherapy originally conceived for patients with unipolar depression. It was subsequently modified for other disorders. While IPT has been known to be effective for depression, Bernecker et al. (2014) suggested that little is known about the components that promote change when this particular therapy is used. In their study, 95 depressed clients received manualised IPT, and multi-level modelling was used to assess the relationship between the change in each interpersonal and cognitive domain and outcome. Reduced romantic relationship adjustment was found to be related with post-treatment reduction in depressive symptoms. However, in other domains, change was not significantly associated with outcome.

Constantino et al. (2013) focused on client characteristics as predictors of remission from depression in IPT, examined 95 participants for four characteristic domains: socio-demographic, clinical/diagnostic, interpersonal and cognitive. For the purposes of the study, participants were considered in remission if at post-treatment their scores on the Beck Depression Inventory Scale were less than 10. They found:

- participants with fearful attachment dimensions in their Relationship Scales Questionnaire (between <3.75 and <3.25) were more likely to go into remission.

- age also seems to be a factor as it was found that those under 25 years of age who were more fearfully attached were more likely to remit.

Jackson (2013) studied 56 clients who were diagnosed with major depression and already receiving emotion-focused therapy (EFT) or IPT. Self-relevant transcripts from two early phase and working phase sessions were extracted for each client.

These were rated using Levels of Client Perceptual Processing, the Experiencing Scale (the quality of an individual's experiencing of the self as revealed in verbal communications), and the Working Alliance Inventory (a measure of the success of the therapeutic alliance). The objective was to determine whether EFT or IPT was more effective in reducing symptoms of depression over time, improving depth of experiencing, the manner of perceptual processing, and the working alliance. Both treatment groups showed similar patterns of high working alliance scores in the early phase, which were maintained as therapy progressed to the working phase. The EFT treatment group showed significant increases in depth of experiencing and manner of perceptual processing over the course of therapy. The increase in level of experiencing in the EFT group predicted

decreased depressive symptoms, and an increase in levels of experiencing and perceptual processing predicted decreases in depression. These clients were found to engage in more analytical and internally focused differentiation in the working phase of treatment, unlike the IPT group. Early working alliance predicted treatment outcome in IPT; this group showed significant increase only in the depth of experiencing and not in levels of perceptual processing.

A nine-centre study in Australia investigated whether clients with mild to moderate depression who attended primary care would achieve remission of a depressive episode with IPT or with antidepressants (selective serotonin re-uptake inhibitors) (Menchetti et al., 2014). Remission was defined as a score of less than seven at two months on the Hamilton Rating Scale for Depression, and daily functioning assessed using the Work and Social Adjustment Scale. The percentage of clients who achieved remission at two months was significantly higher for the counselling group when compared with the antidepressant group. More importantly, moderators of treatment outcome were identified as: depression severity, functional impairment, anxiety comorbidity, previous depressive episodes, and smoking habit. Client characteristics predicted a different outcome with pharmacological and psychological interventions.

An American study found significantly high levels of depression among war veterans (Stewart et al., 2014). This study then recruited 241 veterans and 124 therapists from a veterans' affairs hospital system to investigate whether competence training of therapists in IPT can be associated with general reductions in depression and improvements in quality of life among veterans. As therapist competence in IPT increased, so did improvements in the quality of life among the veterans. The levels of depression decreased and the study concluded that their results support the feasibility and effectiveness of broad dissemination of IPT in routine clinical settings in the Veterans' Affairs healthcare system.

Fourteen female clients suffering from alcohol dependency and major depression were recruited in an uncontrolled pilot study testing the feasibility, acceptability and initial effects of IPT (Gamble et al., 2013). Clients attended eight sessions of IPT in addition to routine addiction care. They were measured for treatment satisfaction, drinking behaviour, depressive symptoms, and interpersonal functioning at baseline, eight, 16, 24 and 32 weeks. Significant improvements were found during the treatment period and these improvements were sustained at follow-up. Thus, there is evidence to suggest that IPT is a feasible and highly acceptable behavioural intervention for women with depression and alcohol dependency.

Depression in low-income mothers of infants and toddlers was the focus of a randomised control trial by Beeber et al. (2013). IPT and parenting enhancement were tested and compared with an equal attention control condition, with 226 mothers recruited and randomised to an intervention delivered in their homes by psychiatric mental health advanced practice nurses or to a control group where equal attention was delivered by generalist nurses. Both intervention and control groups had significantly

reduced depression scores at 14, 22 and 26 weeks post-intervention measures. However, only the mothers in the intervention groups showed an increase in positive involvement with their child, as measured by closeness, positive effect, affection, and warm touch.

Toth et al. (2013) investigated the efficacy of IPT for depression among 128 ethnically diverse mothers who were economically disadvantaged (living at or below the poverty level) and dwelling in an urban community who don't seek treatment. The participants were randomised to either the IPT group or to the group who received community standard treatment. Their depressive symptoms were assessed before, after and eight months post-treatment. Depressive symptoms significantly decreased among the mothers in the IPT group when compared with the group receiving enhanced community standard treatment.

Miniati et al. (2014), conducted a systematic review to investigate the efficacy of IPT for postpartum depression. The use of IPT in post-partum depression was found to be effective as it showed improvement using commonly-used depression scales in women. When it is used alone or in combination with antidepressants, IPT may shorten the time to recovery and prolong the time spent in remission.

Claridge (2014) investigated through meta-analysis, the efficacy of IPT or relational psychotherapy studies as treatments for depression in pregnancy and postpartum.

The study showed that treatment had a medium, or large, positive effect on reduction of depressive symptoms. However, the treatment type, the severity of the depression and the method by which the depression was assessed moderated the effect sizes. Meta-regression analyses revealed that treatment effects were largest when IPT was delivered with IPT adherence fidelity checks (or when therapists were trained or retrained in IPT) and when there were more sessions. These findings, then, justify more research examination of IPT for pregnancy and postpartum depression.

c) Relational Constructivist Psychotherapy:

Pinheiro et al. (2014) recruited 320 women from maternity wards in Brazil. Using Beck's Depression Inventory Scale, 115 women who showed symptoms of depression were recruited. Sixty were eligible to join, and randomly assigned to either a CBT group or a Relational Constructivist Therapy group for seven sessions.

Beck's Depression Inventory Scale was used at three points: first within 30-60 days after childbirth, at the end of treatment and at 12-months' follow-up. The depression inventory scores were compared and while there was a significant reduction in postpartum depression symptoms, there was no difference in effectiveness between the two interventions.

d) Short-term psychodynamic therapy:

Abbass et al. (2012) published comments on a study by Barber et al., noting the study's failure to find an overall effect of psychodynamic therapy treatment relative to the patient receiving a concurrent placebo treatment. Barber et al. (2013) however had found that psychodynamic therapies yielded impressive pre-treatment versus post-treatment effect sizes in clients with major depression. However, as Abbass et al. point out the clients included within the study were often struggling with their basic life needs; they also assert that the medication and placebo may have become confused with the psychotherapy interventions they were also receiving.

e) Body Psychotherapy (BPT):

Rohricht et al. (2013) proposed that new and more effective treatments for depression are required. They conducted an exploratory randomised controlled trial of Body Psychotherapy for clients with chronic depression. Body Psychotherapy, which includes dance and movement, was delivered in small groups in 20 sessions over 10 weeks, but in addition to treatment as usual (psychotherapy and antidepressants). Assessment using the Hamilton Rating Scale for Depression showed that patients in the Body Psychotherapy group had significantly lower depressive symptom scores than those in the control group, suggesting that Body Psychotherapy may be an effective treatment for chronic depression.

f) Group Cognitive Behavioural Therapy (CBT):

According to a systematic review and meta-analysis conducted by Krishna et al. (2013), group CBT is effective for reducing depressive symptoms, but the benefit is not maintained at follow up; further group psychotherapy was not found to reduce the incidence of major depressive disorders. However, the authors point out that the methodological quality of studies found, and their reporting, may be sub-optimal for this population.

g) Non-directive therapy:

King et al. (2014) studied patients of a general practice who were diagnosed to be suffering from an International Classification of Diseases–10 (ICD-10) depressive episode or mixed anxiety and depression. Participants were randomly assigned into groups: 134 participants received CBT, while 126 received non-directive counselling based on a Carl R. Rogers' counselling handbook, 67 patients received the usual care from their GP. King et al. (2014) found that both types of counselling were superior to GP care in reducing depressive symptoms and there was no significant difference in effectiveness. They recommend that national clinical guidelines recommend non-directive counselling as equally effective as CBT.

h) Cognitive Behavioural Analysis System of Psychotherapy (CBASP):

Secondary care is specialist care and under the NHS, patients are referred to secondary care when treatments in primary care do not provide remission. Patients with depressive symptoms that do not reduce after the end of treatment in primary care are considered patients with chronic depression. According to Swan et al. (2014), patients with chronic depression are a difficult to treat group. Cognitive Behavioural Analysis System of Psychotherapy (CBASP) is proposed by Swan et al. (2014) as a novel, yet acceptable and effective treatment for chronic depression. This was an open study design with a moderate sample size of 115 referred patients and no control group.

Only 39% of the cohort showed no change after six months of CBASP. Quality of life, social functioning and interpersonal functioning improved. Thus, CBASP is proposed as an acceptable therapy for patients with chronic depression as it was associated with clinically significant change.

Arnow et al. (2013) focused on 395 adults who were chronically depressed and who were randomised to receive 16-20 sessions of CBASP or Brief Supportive Psychotherapy in addition to antidepressants. Depressive symptoms were assessed every two weeks. It was found that a positive early working alliance was associated with lower symptom ratings. Also, findings suggest that for those clients in the CBASP treatment group, the interaction between a positive treatment alliance and symptom ratings was more significant. While the results of the study support the role of the therapeutic alliance as a predictor of outcomes for chronic depression, therapeutic alliance as a predictor of outcome was more pronounced in CBASP, which is more directive than Brief Supportive Psychotherapy.

9.1.10 Co-morbidity of chronic illnesses as a variable in treatment response

a) Depression and breast cancer

Barrera and Spiegel (2014) asserted that mild to severe depression is the most frequent psychological symptom in patients with cancer. Treating depression symptoms mitigates emotional distress and improves quality of life, medication or treatment adherence and overall outcomes. On the other hand, untreated depression has been associated with impaired immune response and poorer survival. They also assert that psychotherapeutic interventions are effective in reducing depressive symptoms.

Gawrysiak et al. (2013) investigated the efficacy of short psychodynamic psychotherapy for a client with major depression and breast cancer who received eight sessions of pragmatic psychodynamic psychotherapy. Pre- to post-treatment assessment was performed weekly using functional magnetic resonance imaging (fMRI) in order to track the neurobiological indicators of depression attenuation. The fMRI was piloted in this study and it was proposed as an alternative means of evaluating treatment responsiveness. The results of the fMRI showed the client having significant reductions in depressive symptoms.

b) Depression and pain

Depression and pain often occur together; pain often disrupts sleep, brings fatigue, drains the internal and external resources to manage pain, as well as bringing depressive symptoms; and thus, impacting outcomes of treatment for depression (Hopton et al., 2014). Patients often communicate interest in non-pharmacological therapies for treating pain but there is limited evidence of their efficacy (MacPherson et al., 2013).

An RCT investigating the outcomes of acupuncture or counselling or usual pharmacological treatment was conducted by Hopton et al. (2014). In this RCT, 52 participants were selected purposively for a qualitative study regarding their experiences of depression with co-morbid pain, which were compared with their experiences of depression alone. Those who received counselling found that they gained a better understanding of themselves and their situation. Participants in both the acupuncture and counselling groups received support to focus on relevant lifestyle and behaviour changes. The researchers concluded that the therapeutic relationship and active engagement in recovery may play distinct roles in driving long-term change.

MacPherson et al. (2014) interviewed 19 therapists and 17 acupuncturists to gain insight into achieving long-term benefits for depression with co-morbid pain. The qualitative analysis found that both groups adapted individual approaches to their patients; they encouraged patients to gain insight into the root causes of their depression. They also found that learning to relax and sleep better makes patients more receptive to change. The therapists emphasised the importance of a therapeutic relationship. Acupuncturists used the approach of traditional Chinese medicine while the therapists used a humanistic, non-directive, patient-centred approach.

The question of the efficacy of brief psychodynamic psychotherapy in treating primary fibromyalgia with depression was central to this RCT. It evaluated an adapted form of individual short-term psychodynamic psychotherapy and compared it with primary care management treatment as usual (Scheidt et al., 2013). A total of 46 female clients were randomised to receive short-term psychodynamic psychotherapy for 25 weeks and treatment as usual for six months. Both treatments were effective in reducing the scores on the Fibromyalgia Impact Questionnaire, and it was concluded that when routine treatment for fibromyalgia is of a high standard (meaning it focuses on the improvement of health behaviour coupled with antidepressant and analgesic medication), this is equally as effective as short-term individual psychodynamic psychotherapy in improving symptoms of fibromyalgia.

c) Depression and Parkinson's Disease

Fifty percent of people with Parkinson's Disease also suffer from major depressive symptoms. There is very little research on psychosocial interventions for the treatment of depression in this population. Three people with Parkinson's Disease and major depressive disorder participated in this study with their caregivers. All participants received six to15 sessions of Interpersonal Psychotherapy focused on resolving the interpersonal problem of role transition. Two of the participants experienced improvement in depressive symptoms and the gains were maintained at the one-month follow-up. This suggests that Interpersonal Psychotherapy may be effective in this particular population but controlled trials are needed to further evaluate its efficacy (Rubino, 2014).

d) Depression and diabetes

Depression and diabetes are co-morbid problems and yet, there is very little research regarding Latino diabetics with depression, particularly, into which depression interventions would be acceptable to them. This study by Herrera (2014) sought to educate 32 Latino participants by presenting them with study aims and with three scripts, which were empirically supportive of CBT, Interpersonal Psychotherapy and Behavioural Activation. After the presentation, the participants were then asked to choose their preferred intervention. Both Interpersonal Psychotherapy and Behavioural Activation were preferred over CBT. Further studies were recommended to determine the role of culture and other variables in treatment choice.

e) Depression and HIV

Depression is co-morbid in HIV-positive patients on anti-retroviral drug treatment. Depression may compromise medication adherence which, in turn, may accelerate disease progression. The randomised controlled study by Petersen et al. (2014) recruited 76 HIV-positive patients with co-morbid depression. Only 34 were eligible. They received a group-based counselling intervention based on Interpersonal Psychotherapy from therapists working with HIV clients. Assessments were made using the Patient Health Questionnaire (PHQ9), the Hopkins Symptom Checklist and Multidimensional Scale of Perceived Social Support, first at baseline and then at three-month follow-up. Depression scores showed improvement in the intervention group. The study recommended a larger trial be held to confirm the results.

The exclusion criteria of this overview specifically excludes studies from countries where it is not certain that the modalities of practice, through a public national health system and through private practice similar to that in the UK, exist. During the search for literature, a study from Uganda, which has experienced decades of civil conflict, has been published. Although it is still uncertain whether the practice modality in Uganda is similar to that which exists in the UK, the study findings tackled mental health issues that are also prevalent in the UK, hence, the study by Kaaya et al. (2013) is included.

This study by Kaaya et al. (2013) investigated the effectiveness of group counselling to reduce depressive symptoms and increase prenatal disclosure rates of HIV status. It was a randomised controlled trial among HIV-positive pregnant women and the six-week psychosocial intervention using a problem-solving approach, which was facilitated by a nurse midwife. The participants were split into two groups: one to receive the psychosocial group counselling and the other to receive standard treatment. While there is no significant difference in disclosure rates between the women across the two groups, depressive symptoms were significantly reduced among the participants in the psychosocial group; moreover, the women in this group reported an increased sense of satisfaction with the response from family and friends when they did disclose their HIV-positive status. According to Kaaya et al. (2013), the results were due to the reduced burden of depression, which helped clients better manage the reactions of their partners to their disclosure.

f) Subclinical psychotic and bipolar spectrum features

Wigman et al. (2014) asserted that subthreshold psychotic and bipolar experiences are common in any major depressive disorder. Their study investigated the impact of these subclinical features in assessing the effectiveness of a combination of psychotherapy (CBT or IPT) and pharmacotherapy. They found that these subclinical features and experiences predicted more depression over time, and also predicted non-remission and relapse and thus, they conclude that these negatively impact the course and outcome of psychotherapy.

g) Depression and vision impairment

The link between sight loss and depression is well documented. There are, however, few dedicated therapeutic services for people who are visually impaired (Thurston, 2010) and little evidence of whether counselling or psychotherapy improve psychosocial wellbeing (Nyman, Gosney and Victor, 2009). There is, however, a significant UK-wide randomised controlled trial currently underway evaluating the effect of depression treatment in people with visual impairments based on data from low vision services across the UK (Margrain, 2012 et al.).

9.2 Anxiety (including PTSD, Phobias, OCD)

Anxiety disorders are common mental health problems but these are often expensive to treat. Rosenblatt asserted that treatment of panic disorders is most effective when psychotherapy is combined with medication than when treatment is with psychotherapy alone. This study investigated whether CBT or Brief Dynamic Psychotherapy combined with medication is effective in treating people affected by panic disorders. The study showed that:

- people with obsessive compulsive disorders (OCDs) were responsive to a combination of pharmacotherapy and psychotherapy
- in the context of primary care however, only 60% of patients with a recorded anxiety disorder diagnosis were offered treatment
- under-recognition and under-treatment of anxiety disorders were highlighted as a significant problem, especially when medication is substituted for psychotherapy.

The cost of untreated anxiety disorders is shown to be greater than the cost of effective treatment according to Rosenblatt (2010). Psychotherapy in adult patients with anxiety disorders has been shown to be effective and is associated with a relatively low attrition rate (Smits and Hofmann, 2009).

Gold (2011) considers that anxiety disorders reflect problems in attachment: insecure attachment experiences lead to difficulties and fears about exploring the world. Cheung (2013) asserted that functional neuroimaging findings can have implications and uses in psychotherapy. Neuroimaging, the author considers, can show emotional dysregulation, insecure attachment, the reward-approach system and traumatic memory in patients with anxiety disorders.

Neuroimaging methods help identify neural changes in brain networks associated with emotional regulation after psychotherapy in depression and anxiety (Messina et al., 2013). Thus, neuroimaging can be one of the therapeutic strategies, which may be used to adequately address the neural dysfunctions associated with anxiety disorders.

Life time anxiety disorders may exist alongside other mental health problems such as bipolar disorder. Patients with both bipolar disorder and anxiety disorder experience longer duration of illness, greater severity of symptoms and poorer response to treatment. Thus, Deckersbach (2014) hypothesised that existing conditions may moderate outcomes of psychotherapy treatment.

9.2.1 Computer-based therapy and counselling related services

Anxiety disorders are highly prevalent and the burden of illness associated with anxiety disorders is significant. But the need for intervention is higher than the capacity of specialised mental health service providers. The development of computer-based therapy and counselling-related service programmes for anxiety disorders may be one strategy (Heilman, 2010). Cuijpers (2009) asserted that computer-aided therapy or counselling-related services is as effective as face-to-face therapy but requires less of the therapist's time. It enables speedy access to care and may be delivered using digital devices. The study cautions that the findings of the study were not specific to any type of anxiety disorder or tested against any comparison group. It may be integrated into routine counselling practice.

9.2.2 Interpersonal Psychotherapy (IPT) as possible treatment option

CBT has dominated research and treatment for people with anxiety disorders. IPT, however, has been shown to be effective in treating depression and anxiety disorders and is proposed by Markowitz et al. (2014) as also effective in working with people affected by social anxiety disorder, panic disorder, and post-traumatic stress disorder. One problem is that controlled trials of IPT for anxiety disorders are generally small, underpowered and often, methodically compromised. The study by Markowitz et al. (2014) suggests that while IPT may be effective for anxiety disorders, it has not shown advantages over other therapies.

IPT aims to change the interpersonal behavioural patterns that play a role in the maintenance of social anxiety disorders; while Cognitive Therapy (CT) seeks to modify the dysfunctional beliefs, thought patterns and processing of social anxiety disorders. Stangier et al. (2011) compared the efficacy of CT and IPT with a waiting-list control group in an RCT involving 106 patients diagnosed with social anxiety disorders who were given 16 sessions of either CT or IPT or assigned to the waiting phase. Both CT and IPT led to considerable improvements in anxiety symptoms, which were maintained until one year post-treatment but CT was more efficacious than IPT in reducing social phobia symptoms.

9.2.3 Under-utilisation of relevant treatment techniques

Hipol and Deacon (2013) suggested that despite the well-established effectiveness of exposure-based CBT in the treatment of anxiety disorders, adoption of CBT into clinical practice has been slow. A sample of 51 licensed therapists were recruited and asked to complete a survey assessing their use of various psychotherapeutic techniques with clients diagnosed with OCD, PTSD, panic disorders and social phobias. Nearly all the therapists reported using CBT and techniques such as cognitive restructuring, arousal-reduction strategies and mindfulness. The authors consider that therapist-assisted exposure was underutilised.

9.2.4 Access to psychotherapy for primary care patients

While anxiety disorders are common mental health problems that can be diagnosed and treated in primary care, it has been shown that patients are frequently treated with pharmacotherapy and not with psychotherapy interventions. Roberge et al. (2014) showed that only half of the 740 respondents with panic disorders, generalised anxiety disorders and social anxiety disorders in the study had received a form of psychotherapy. Factors that predicted receipt of psychotherapy in primary care included:

- being female
- being less than 60 years of age
- having a university level education
- having supplementary medical insurance
- and having a panic or anxiety disorder at the same time as a depressive episode.

This study concludes that access to psychotherapy for patients with anxiety disorders in primary care may need to be improved to reduce disparities and boost good patient outcomes.

9.3 Mixed Depression and Anxiety

Mott et al. (2014) reported that the use of psychotherapy for patients with depression, anxiety and PTSD under the Veterans' Health Administration showed heavy expansion. The proportion of patients receiving psychotherapy within 12 months after initial diagnoses increased; the amount of psychotherapy sessions received also increased. But in apparent contradiction, the study also found that newly diagnosed patients received no psychotherapy or only a low-intensity amount of psychotherapy. This puts into question the reach and timeliness of the provision of psychotherapy.

9.3.1 Group therapy

Field et al. (2013) randomly assigned 44 pregnant women to a peer support group or to an IPT psychotherapy group at 22 weeks of their pregnancy. Those in the peer support group participated in 20-minute weekly group sessions for 12 weeks. Those in the IPT group met one hour every week for 12 weeks. At the end of the study period, both groups had lower summary depression and lower anxiety scores.

Cortisol levels for both groups decreased on the last day of the sessions but the decrease was more significant in the peer support group. These findings suggest that peer support groups could be a cost-effective form of treatment for prenatal depression and anxiety.

9.3.2 Mindfulness

Mindfulness encourages people to give deliberate and non-judgmental attention to the present moment and it is a practice adapted from ancient Buddhism. It is also a central component of many therapeutic approaches and has been viewed as a remedy for both mental and physical health problems. Many professionals view mindfulness as a possible alternative or complementary approach to CBT in treating anxiety and depression. Lang (2013) comments however that despite its popularity and the prevalence of mindfulness techniques being incorporated into established therapeutic practice approaches, there is insufficient evidence for its effectiveness and for the mechanisms by which it works.

9.3.3 Pharmacology versus psychotherapy

Pharmacotherapy has been relied upon in the management of depression and anxiety but therapy has been gaining popularity and approval from public healthcare professionals. Prajapati (2014) conducted a literature review to determine if there is an evidence-base comparing psychotherapy and pharmacotherapy for depression and anxiety disorders. The literature review found that there is a current evidence-base that suggests that both pharmacotherapy and psychotherapy are effective treatments but further direct comparative studies are necessary.

One area where the debate between which is more effective in anxiety and depression is the enduring efficacy of the treatment effect during follow-up. Fluckiger et al. (2014) comparatively examined evidence-based psychotherapies and treatment as usual (TAU) to determine how long the treatment effects last; they found that psychotherapies have a small superiority in acute depression and anxiety disorders at follow-up assessment.

9.3.4 Patient perceptions on the helpfulness of medication and counselling

As part of a study which aimed to explore the relationship between race and participant perceptions of the helpfulness of counselling and psychotropic medication, 195 adult patients were screened for both depression and anxiety from archival data; and their perceptions (pre-treatment) of the helpfulness of either medication and/or counselling were recorded using a demographics questionnaire. As the researchers suspected, race did not significantly affect participants' reported beliefs about the helpfulness of medication or therapy, however clinically significant, but contrary to the expectation of the researchers, levels of depression and anxiety also did not affect the participants' reported beliefs about whether they considered medication or therapy was helpful (Hricisak, 2014).

Joyce et al., (2009) point out that college students often have problems which are connected to their academic studies, relationships with others and they often report depression and anxiety.

Two hundred and eighteen undergraduate students were examined to determine their preferences to bring about a process of change in these four kinds of problems.

The findings showed that processes of change were seen as more important for problems connected to depression, anxiety and relationships and that these may make college students more receptive to offers of psychotherapy and counselling than offers of pharmacotherapy.

9.4 Eating disorders

An observational study by Compare et al. (2013) tested the effect on psychopathology and quality of life of Emotionally Focused Therapy, Dietary Counselling and Combined Treatment in 189 obese adults with Binge Eating Disorder. Assessments before and at the end-of-treatment, and six-month follow-up determined:

- health-related quality of life
- attitudes toward eating, binge eating
- body uneasiness.

Results show that:

- body weight decreased significantly in all three groups
- clients who received dietary counselling alone had a higher dropout rate and there was no significant decrease in binge eating, body uneasiness, or hunger
- those in the Combined Treatment and EFT groups saw significantly decreased scores on binge eating, body uneasiness, and hunger.

More importantly, at six-month's follow-up, 71% in the Combined Therapy group and 46% in the EFT group had a below-threshold score on the binge eating scale. The authors asserted that these results support the utility of combining EFT and dietary counselling in the treatment of clients with obesity and binge eating disorder.

Poulsen et al. (2014) conducted an RCT of psychoanalytic psychotherapy or CBT for 70 clients with bulimia nervosa who had received at least two years of weekly psychoanalytic psychotherapy or 20 sessions of CBT over five months. The Eating Disorder Examination Interview was administered at baseline, after five months and after two years, with both treatments resulting in improvement. At five months:

- 42% of CBT clients, and
- 6% of the psychoanalytic psychotherapy group stopped binge eating and purging.

At the two-year follow-up review:

- 44% of the CBT groups had stopped binge eating, and
- 15% of the psychoanalytic psychotherapy group had stopped binge eating and purging.

Despite the higher number of sessions and the duration of the treatment, CBT was found to be more effective in relieving the symptoms of binging and purging.

9.5 Personality disorders

Mauck and Moore (2014) reported a single case study of an adult male with a major depressive disorder and intermittent explosive disorder. Treatment consisted of long-term psychodynamic psychotherapy with an emphasis on emotional expression and autonomy. The therapy lasted for 13 months and the client completed daily measures related to his presenting complaint, to his levels of distress, and his episodes of rage. Results indicated improvement in overall distress and rage episodes. However, the client also completed a measure of general psychological function at each month of treatment, which indicated no reliable change. The results were inconclusive.

Rizq (2012) used Interpretative Phenomenological Analysis of the experiences of five primary care therapists who worked with clients who had Borderline Personality Disorders. The primary care therapists experienced feelings of failure and inadequacy as NHS guidelines direct that Borderline Personality Disorders be treated in secondary care and not primary care. The primary care therapists also expressed feelings of ethical responsibility as they adapted the traditional short-term model of counselling to ensure that their clients received ongoing support while they accessed secondary care.

A study by Meneghel et al. (2009) comprised 134 participants who were admitted into hospital for attempted suicide. The study found that patients with personality disorders may have lower suicide intention prior to a suicide attempt but, after the suicide attempt, they maintain higher levels of suicide intention. This partly explains why this four-year study at a hospital found that those who attempted suicide repeatedly were those who were diagnosed with personality disorders.

Gilbert and Gordon (2013) conducted a single-case study of a young woman with avoidant personality disorder, depression, worry, lack of motivation, feelings of inadequacy and non-assertive behaviours in her romantic relationship and professional career. Interpersonal Psychotherapy for depression was used along with assertiveness skills training. Self-reports on levels of self-confidence were tracked daily. Thereafter, a personality and symptom assessment measure was administered.

Results showed that the client experienced improvement in symptoms in self-confidence, somatic complaints, stress, worry, anxiety and depression, suggesting that Interpersonal Psychotherapy techniques may be useful in the treatment of avoidant personality disorder.

9.6 Psychosis (including schizophrenia)

Rohricht et al. (2011) conducted an open trial of Group Body Therapy in addition to the usual treatment for 18 out of 39 eligible clients who were suffering from chronic schizophrenia and had high symptom levels and low psychosocial functioning. The study was based on evidence suggesting that arts or non-verbal therapies may be effective in treating negative symptoms of schizophrenia. The authors also sought to examine the therapeutic processes and clinical outcomes of Body Therapy on symptoms, subjective quality of life, social functioning, and emotional processing. Negative symptoms and general psychopathology significantly reduced during treatment, but positive symptoms and other outcomes did not change. The results of this study by Rohricht et al. (2011) further support the results from an earlier RCT for Body Therapy for clients with chronic schizophrenia.

9.7 Suicide

The findings of a study by Kapusta et al. (2009) suggest that decreasing suicide rates correlate with increasing antidepressant sales and increasing numbers of therapists practising in an area.

9.7.1 Suicide risk assessment

Popadiuk (2013) asserted that therapists who work in the field of career development, human resources or personnel departments need to be made aware of the strong connections between employment and suicide. Events that bring about changes in socioeconomic status, disruption in employment, sudden unemployment, occupational stress, difficulties at work and interpersonal conflicts at work may predict anxiety, depression, isolation or substance misuse, which are all significant risk factors associated with suicide ideation. Walker and Peterson (2012) also suggested that even career therapists in university settings can identify

individuals who may be experiencing emotional distress from life and career stressors. Particularly, dysfunctional career thoughts and career indecision may be related to depression symptoms.

Whisenhunt et al. (2014) collected qualitative data via an online survey with open-ended questions to determine the perceptions of 31 professional therapists in the US who work with those who self-injure, regarding the relationship between suicide and self-injury. Self-injury was seen as any volitional act of hurting oneself that is not socially sanctioned and that does not involve or include a suicidal intent. Self-injury they conclude increases the risk of suicide, however, not all individuals who engage in self-injury attempt suicide. The participants' responses showed that there is a lack of consensus as to the exact causal relationship between self-injury and suicide.

Karver et al. (2010) studied 34 helpline therapists to determine whether they were accurate in predicting risk for suicide-related behaviour. The study found that the helpline therapists had an 80% accuracy in identifying and judging the risk of suicide-related behaviour in youths who called the helpline. The study also recommends that the training procedures of helpline therapists may be used to train other clinicians.

Knudsen et al. (2012) reported a case study of a 57-year-old man with paraplegia who was admitted into hospital due to sepsis. During admission procedures, he told nursing staff that he would rather die. This triggered an assessment of the man's risk for suicide. They found that he had no symptoms for depression, mania, delirium or cognitive dysfunction but an evaluation of his history and mental status revealed that he had significant dysfunctional reliance on narcissistic personality traits. Therapy gave the man space to elaborate on the details of his life. Empathic listening was used by the staff and this appealed to his suffering that enabled a rapid building of trust. Suicide ideation may be a symptom or a manifestation of frustration and rage related to intractable pain and loss of independence.

9.7.2 Reducing suicide risk

The systematic review and meta-analysis of studies by Cuijpers et al. (2013) sought to determine whether psychological treatments for depression can actually reduce suicidal ideation or suicide risk. They focused on 13 studies, which examined the effects of psychotherapy for depression on suicidal ideation and risk and hopelessness, as hopelessness was strongly associated with suicidal behaviour in depression. The researchers found evidence of publication bias. The study concluded by saying that although psychotherapy for depression may have small positive effects on suicidality, the data suggest that psychotherapy for depression cannot be sufficient treatment.

A systematic review of literature by Fountoulakis et al. (2009) sought to investigate the efficacy of psychosocial interventions in reducing the risk for attempting suicide among patients with bipolar disorder. It has been found that 25-50% of patients with bipolar attempt suicide at least once in their lives. The findings indicated that therapy which focuses on interpersonal, cognitive and behavioural techniques may be effective in controlling mood shifts, medication compliance, and maintaining morale. The search for literature yielded 17 relevant studies published between 1990-2008 giving definite data on the role of psychotherapy in suicide prevention in bipolar disorder. The systematic review concluded that evidence on how effective psychosocial interventions are in reducing the risk of suicide ideation in bipolar disorder is still emerging.

A systematic review and meta-analyses of literature sought to determine the types of psychosocial interventions that may lower the risk of suicide. The systematic review investigated the effectiveness of dialectical behaviour therapy, CBT and problem-solving therapy. The study concluded that clients at risk of suicide should have access to psychological interventions within the cognitive-behavioural spectrum (Winter, 2013).

The theory of hope and dispositional optimism have been linked to reduced levels of suicide ideation and interpersonal suicide risk. The study by Davidson and Wingate (2013) sought to address the research gap and determine if there are relationships between hope, optimism and suicide risk. Hierarchical regression analyses showed that while hope and optimism predicted lower levels of burdensomeness and thwarted belongingness, they are not significant predictors of suicide ideation in a clinical sample of 107 African American college students.

9.7.3 Suicide risk among young adults

A study by Reis (2010) found that of the college students who carry out suicide, about 20% were clients at university counselling centres. This study found that two factors: depression and attitudes toward help-seeking contributed to the high risk of suicide and participation in counselling. Depression predicts participation in therapy and the level of suicide risk. Thus, those with greater levels of depression would participate in counselling; and college students with positive attitudes toward help-seeking would predict participation in counselling. This explains why about 20% of college suicides were among those who were already participating in counselling.

The study by Mackrill and Hesse (2012) sought to determine if the suicidal behaviour of alcoholic parents can be associated with suicidal behaviour in their offspring. Three hundred and forty-four young adult children of alcoholics who were about to enter a counselling centre in Denmark were surveyed about the threatened, attempted or completed suicide behaviour of their parents. The study found that:

- the suicidal behaviour of the parents was strongly associated with their drinking behaviour
- 46% of the sample had parents who had threatened, attempted or completed suicide
- 13% of the sample had threatened to carry out suicide
- 15% had attempted suicide themselves
- 54% of the sample attempted suicide without threatening to carry out suicide.

The authors conclude therefore that parental suicidal behaviour is strongly associated with suicidal behaviour in their offspring. The study therefore recommended that family suicidal behaviour be addressed among clients whose alcoholic parents threatened, attempted or carried out suicide.

The study by Schicker (2012) asserted that 12% of the 34,000 Americans who carry out suicide each year were young adults belonging to the age group 15-24 years. Factors they considered to contribute to suicide risk for college-aged individuals included:

- depression
- hopelessness
- alcohol and drug use
- relationship problems
- sexual identity issues
- academic concerns and pressures
- social media and the internet
- suicidal history.

This qualitative study used case studies, auto-ethnography and analysis of online survey responses of 64 college campus therapists and what they thought were effective components of their suicide prevention programmes. The study found that among the colleges represented, there was a wide variance in the method of measuring efficacy of their suicide prevention programmes.

9.7.4 Suicide ideation in the elderly

A study by Heisel et al. (2009) tested a 16-week course of IPT for older outpatients who had an elevated risk of suicide. Twelve adults, 60 years or over in age were referred from inpatient and outpatient medicine and mental health services for their current suicide and death ideation as well as self-injurious behaviour. They underwent psychotherapy at a therapist's office at a teaching hospital. They were assessed at baseline, pre-treatment, mid-treatment, post-treatment and at three months' follow-up. Findings support the feasibility, effectiveness and safety of IPT for older adults. Evidence indicates a substantial reduction in suicide and death ideation as well as depressive symptoms. The study recommended controlled trials to further evaluate these findings.

A similar case study of the effectiveness of using the interpersonal theory of suicide to inform IPT on one suicidal older adult was conducted by Van Orden et al. (2012).

Suicide among older adults is at elevated rates when compared with younger adults but there is little evidence of managing and treating suicide risk. The interpersonal theory of suicide proposes that 'thwarted belongingness' and 'perceived burdensomeness' may cause suicidal thoughts among older adults. They recommend therefore that therapists need to focus on four interpersonal stressors that may be present in the client's life such as:

- grief
- role transitions
- interpersonal disputes and interpersonal sensitivity, or
- skills deficits to resolve suicide ideation and prevent recurrence of suicidal crises.

9.7.5 Response to suicide and surviving suicide

Oulanova (2014) defines a suicide survivor as an individual bereaved through suicide i.e. this does not refer to a person who attempted suicide unsuccessfully. A suicide survivor could be bereaved by the loss of a relative, close personal associate, loved one or friend through suicide. The study found that some suicide survivors become peer therapists and do voluntary work. Fifteen such suicide survivors, working as volunteers for at least two years at a counselling centre, participated in this qualitative phenomenological study. The objective of the study was to provide a detailed description of the participants' journey from the experience of suicide of a loved one to the decision to become a peer therapist. The study shows that the suicide survivors view peer counselling as a transformative process whereby they achieve personal growth and acquire new skills. When through their volunteer work, they reach out to other suicide survivors, they counter the loneliness and isolation brought about by suicide bereavement. They also believe that their volunteer

work helps end the silence around suicide and especially offering other survivors a safe place to share their stories.

A study by Anderson (2010) explored the reactions of 75 graduating student therapists and therapists-in-training at master's level to reading a vignette about client suicide. They were then asked to complete the Jones' Clinical Suicide Survivor Survey-Adapted. There were no differences in the perceptions of either group of students as to how they would react to a client suicide. Research evidence suggests that credentialed therapists experience anger, stress, grief, sadness, shock, anxiety, guilt and doubt about their competence over a client's suicide. Therapists often change the way they practise after experiencing a client suicide. This study found that, consistent with evidence from literature, student-therapists and trainee therapists are unaware of the extent of the personal and professional reactions they may experience when a client carries out suicide. The study recommended the development of training programmes to address this issue.

Readers may also be interested in reading Good Practice in Action 042 Fact Sheet: *Working with suicidal clients in the context of the counselling professions*. This can be downloaded at: https://www.bacp.co.uk/events-and-resources/ethics-and-standards/good-practice-in-action

10 Legal aspects of therapeutic work with people who have mental health conditions

Working therapeutically with people affected by mental health conditions is often fraught with ethical concerns and dilemmas that may have legal implications. Indeed, often, therapeutic practice raises questions that bear upon legal rights and duties.

Please see Good Practice in Action Legal Resource 029: *Mental Health Law within the counselling professions in England and Wales* for more information.

11 Implications of research evidence on research and practice

This overview was undertaken to disseminate information to practitioners regarding new developments in the field of the counselling professions: new modalities of practice, new approaches and techniques, and new assimilations of different established models of treatment. The overview was also undertaken to identify new definitions, new concepts and new insights into the relationship between mental health, mental capacity and mental disorder. In this regard, the overview has achieved its aim.

It has highlighted the developments in internet-based psychotherapy, its acceptability and efficacy. It has illuminated the ongoing debate between pharmacotherapy and psychotherapy and how their combination may improve client outcomes.

Interpersonal Psychotherapy is emerging as an equally effective psychotherapeutic technique that may be an alternative to CBT. Mindfulness, Body Psychotherapy, acupuncture and group therapies are also emerging as techniques, which may be assimilated into Interpersonal Psychotherapy and CBT. The importance of the therapeutic alliance and therapeutic engagement is emphasised as a variable factor that impacts treatment response, treatment adherence, and ultimately, treatment efficacy.

12 Conclusion

This overview has shed light on ongoing problems such as the under-recognition of symptoms, under-utilisation of established treatments, inequitable access to effective treatment, and the inadequacy of mental health services to address the prevalence of mental health problems in the community.

It has also shown how lack of resources and information are barriers to seeking help and receiving treatment; for instance, the elderly may not be receiving much-needed psychotherapy treatment.

Overall, the overview was conceptualised to provide a thematic presentation of developments in the field of the counselling professions in order to help practitioners identify potential problems, and to showcase good practice that will ensure better client outcomes.

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Good Practice in Action Resources:
https://www.bacp.co.uk/events-and-resources/ethics-and-standards/good-practice-in-action

BACP (2018) *Ethical Framework for the Counselling Professions*. Lutterworth: BACP
https://www.bacp.co.uk/events-and-resources/ethics-and-standards/ethical-framework-for-the-counselling-professions