

## INTRODUCTION

# Psychotherapies and the Practice of Psychiatry

This supplement on the psychotherapies represents a most important and timely undertaking on the part of the Canadian Psychiatric Association (CPA). The 1985 CPA position paper on psychotherapy established the place of psychotherapy as a skill of a competent psychiatrist. In May 1996, the CPA approved the terms of reference for the Psychotherapies Steering Committee, which in part was to lead to a revised position paper and clinical practice guidelines on the psychotherapies. This supplement includes discussion papers on both subjects, reporting on the work of the Psychotherapies Steering Committee and requesting the input of psychiatrists who are actively involved in providing care to patients. Basic to both papers is the question of the present and future role of psychiatrists in providing care in an environment where the effectiveness of biological treatments is both recognized and sought after, the short-term psychotherapies are gaining recognition as being effective in their own right, and long-term dynamic psychotherapy continues to be an important element of psychiatric treatment, as it has been for decades throughout the world.

These papers begin to address policy questions that arise among psychiatrists, the popular press, third-party payers, and governments who are interested in providing psychiatric care in a cost-effective manner. Is the goal of treatment to control symptoms or to return individuals to their highest possible level of functioning, which includes having quality relationships, self-esteem, and, where possible, employment? What is the appropriate place of the psychotherapies and pharmacotherapies in the treatment of individuals with mental illnesses running the full spectrum, and who should provide the treatment deemed necessary? Who should prescribe the treatment, and who should deliver same? Is split treatment, when delivered in an uncoordinated fashion by multiple professionals (commonly seen in the managed-care environment of the United States), cost-effective, and is this the path Canadian psychiatry should follow? Is

psychotherapy an essential part of psychopharmacology? Is integrated treatment the way of the future? Should psychiatrists be trained to deliver the short-term psychotherapies, or should they leave these treatments to other professionals? Who are the seriously mentally ill, and do they require and deserve the full complement of psychiatric treatments? Are the goals and objectives of postgraduate education such that the psychiatrist of the future will be trained to provide integrated care that spans the range of psychiatric therapy?

There is no longer any question as to the effectiveness of psychiatric treatments, and I believe that they are immeasurably enhanced by the biological treatments now available, but only if psychiatrists continue to provide the psychotherapies when indicated. Psychiatrists must speak out against a growing lobby that sees psychiatry as limited to pharmacotherapy and, at best, supplemented by psychotherapy provided by other professionals. This role, recommended in the name of a more cost-effective health care system, overlooks the offset costs that patients and families continue to pay when patients are not returned to their highest possible level of productivity.

These discussion papers will serve their intended purpose only if they receive the attention of Canadian psychiatrists. Read the papers carefully. The CPA welcomes your comments to enhance the future development of a position paper and clinical practice guidelines on the psychotherapies. It is hoped that the CPA Annual Meeting in Toronto in September 1999 will provide an opportunity to obtain the views of all attendees.

Your written comments may be addressed to the Psychotherapies Steering Committee, c/o CPA, 441 MacLaren Street, Suite 260, Ottawa, ON K2P 2H3, or emailed to [cpa@medical.org](mailto:cpa@medical.org).

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# Guidelines for the Psychotherapies in Comprehensive Psychiatric Care: A Discussion Paper

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This discussion paper concerning guidelines on the practice of the psychotherapies by psychiatrists has been developed by a working group of the Steering Committee on the Psychotherapies formed in 1996 by the Canadian Psychiatric Association (CPA) to address the practice of psychotherapy by Canadian psychiatrists. This paper provides the profession with guidelines for clinical care related to the practice of the psychotherapies that reflect best practices based on the available evidence, with the aim of improving standards of practice within the profession. Such guidelines are intended to be linked to emerging strategies for medical education, as well as continuing medical education (CME) and clinical quality assurance (CQA) initiatives within the CPA. This paper reviews the literature, synthesizing theoretical and research contributions and available empirical data. This Working Group has attempted to reflect the clinical experience of Canadian psychiatrists and to report only material that could reasonably be applied to the various models of psychotherapy.

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## Introduction

There has been professional and public concern about the contemporary standards of psychotherapeutic practice and professional licensure. These have focused on 2 areas:

1. Service-use issues concerning the application of appropriate criteria regarding duration and intensity of psychotherapy based on empirical findings and the cost-effective use of psychiatric resources: these issues deal with accountability to the public.
2. Ethical issues involving boundary violations, particularly of a sexual or manipulative nature: these issues highlight the need for psychiatrists to be accountable to patients for their professional conduct.

The psychiatrist is also accountable to the medical profession through such bodies as the provincial colleges of physicians and surgeons and the Royal College of Physicians and Surgeons of Canada (RCPSC) and through the framework of medical responsibility embodied in common law. Professional accountability in domains concerning children, adolescents, people with medical illnesses, and the geriatric population may require special additional areas of emphasis. Indications of organic impairment must be evaluated carefully, including an evaluation of the patient's legal competence (affected by mental retardation, dementia, or delirium) and the possible need for substitute decision-makers.

This discussion paper is written as a step toward the possible development of clinical practice guidelines (CPGs), not standards of care. CPGs represent general aspects of clinical practice that are accepted as principles of management within the profession. They are designed to improve the overall quality of clinical practice. In contrast, standards of care define the minimum levels of acceptable performance or results that are always expected and are determined by examining all clinical data available for an individual case.

This first phase of CPG development addresses overarching considerations and factors that are common to all the psychotherapies. This paper incorporates ideas and techniques from existing CPGs and related documents prepared by other psychiatric educational and practice sources including the "Guidelines for Canadian Practice Guidelines" published by the Canadian Medical Association (CMA) (1).

The integration of the psychotherapies with biological and social therapies as a hallmark of psychotherapy as actually practised by psychiatrists is underscored. The capacity of psychiatrists to employ comprehensively both biological and psychological treatments provides a unique contribution to mental health care. The American Psychiatric Association in its "Position Statement on Medical Psychotherapy" has articulated the central role of the psychotherapies in the practice of contemporary psychiatry (2). The Coordinators of Postgraduate Education in Psychiatry (COPE) guidelines offer a comprehensive statement regarding psychotherapy training as a skill set central to the identity of the psychiatrist (3). Similar position statements have been developed in a joint publication by the Association of Academic Psychiatry and the American Association of Directors of Psychiatric Residency Training (4). The Royal College of Psychiatrists (United Kingdom) (5) and the German Council of Physicians (6) have also developed detailed documents concerning the importance of a broad orientation to psychotherapy. The report of the Joint Task Force on "The Definition, Guidelines and Standards for Medical (Psychiatric) Psychotherapy" (7) to the Ontario Medical Association has recently been published (8) and is an important background resource for this discussion paper.

In Canada, the RCPSC has articulated "Objectives of Training and Specialty Training Requirements in Psychiatry" (9), which notes the following:

The resident will be proficient in the use of all currently available psychiatric and relevant medical diagnostic techniques and treatment modalities including psychotherapies, (including but not limited to psychodynamic, behavioural, cognitive and interpersonal therapies for families, groups and individuals) and physical means of treatment including psychopharmacotherapies and ECT.

The fourth edition of the *Handbook of Psychotherapy and Behavior Change* (10) summarizes controlled studies of treatment outcome that establish beyond reasonable doubt the effectiveness of psychotherapy (11). The overall effect size, a statistical measure of change, is in the range of 0.85, indicating that the average treated person is significantly more improved than 80% of the untreated sample (12). This response rate is in the same range as that reported for most psychopharmacological treatments. These positive results have led to a surge of interest in understanding how psychotherapy works. In particular, the research focus is increasingly shifting from simple outcome studies to more complex process–outcome

studies and applying these to specific diagnostic conditions and specific theoretical models of psychotherapy. It is no longer appropriate to speak of psychotherapy as a single global entity but rather to consider a range of empirically validated models of psychotherapy.

There is a growing body of literature dealing with the connections between process events and outcome change, with a doubling of the available studies over the last 7 years. The psychotherapy research field can now be said to be entering a mature phase. Psychiatrists are increasingly expected to follow generally accepted criteria for providing clinical services based on empirical data. The development of CPGs by professional organizations is one manifestation of this process.

Contemporary psychiatrists employ a range of psychotherapeutic approaches in a range of clinical settings and with a broad range of patients, rather than restricting practice to a single, narrowly applied approach. Like any other medical treatment, psychotherapy requires a proper assessment and diagnosis (formulation–focus) prior to initiating treatment. It requires identifying indications, contraindications, and side effects, along with informed consent. This includes estimating length of treatment, acknowledging that most patients respond within a few months and that lengthy interventions require proper justification. Many of the general principles of psychotherapy are incorporated into the practice of psychiatric medical management, where serious mental illness may require extended continuous care with episodes of intensive care.

It has been estimated that there are several hundred varieties of psychotherapy. Many claim unique and powerful clinical techniques related to their theoretical position. Yet virtually all comparative studies of psychotherapy find a large common effect mediated through active ingredients, in all reasonable and planned therapeutic endeavours. These findings have been consolidated under the term "common factors" (13,14) and incorporated into an integrating framework known as the "generic model" (15). This should not be mistaken for a "lowest common denominator." It identifies powerful mechanisms that underlie all types of psychotherapy by targeting pathogenic beliefs and behaviours and testing them in the therapeutic process. This includes special emphasis on the concept of the therapist–patient alliance and, similarly, on an informed clinical decision concerning the patient's capacity to effectively use more or less structure and to tolerate anxiety within the psychotherapeutic setting.

These common mechanisms are found to be correlated with outcome for behavioural, cognitive, interpersonal, psychodynamic, and psychoanalytic psychotherapy. They apply equally to primarily supportive or primarily interpretive psychotherapy and to individual, group, and family modalities. These mechanisms are now considered to be established facts and should be taken into account when exploring ways to

make psychotherapy most effective. While many other clinical techniques are reported to have positive evidence, there is not enough replication data to justify including them in the model. In many cases, these additional techniques may help some patient populations but not others. Some simply have not been adequately studied. Acknowledging nonspecific and specific factors recognizes that techniques might appear inert in large-scale analyses yet be powerful in the hands of a given clinician or in treating a specific condition or situation.

An estimated 20% of the general population uses psychiatric services (16). This subgroup represents a cohort of patients who are vulnerable to psychological decompensation. This may be related to the fact that the major psychiatric and personality traits associated with the major diagnostic categories have significant heritability (17–19). However, in all of these disorders much of the variance is found elsewhere. The social-psychiatry literature has established that attachment issues and chronic stress may predispose individuals to psychiatric disorders (20,21). Similarly, much literature indicates that acute stress, particularly that involving close relationships, also predisposes individuals to decompensation (22). Theories of predisposition for and reactivity of psychiatric illness suggest that the goal of cure, in many if not most cases, is unrealistic. Psychiatric treatment, both biological and psychological, is effective in acute episodes and may improve adaptation during future episodes. For some severe and persistent conditions, long-term maintenance treatment has been advocated, often at reduced frequency. More than 15 years of data indicate that approximately 80% of patients seeing a psychiatrist receive 12 or fewer sessions in a given episode (23–25). These figures are based on large service-delivery systems, but specific psychiatrists may have unique practice profiles within these systems. From this empirical perspective, most patients can expect effective treatment of specific episodes with the possibility of future episodes.

Articles 31 and 32 of the CMA Code of Ethics (26) read as follows:

31. Recognize the responsibility of physicians to promote fair access to health care resources.

32. Use health care resources prudently.

The discipline of psychiatry has a responsibility to develop guidelines concerning length of treatment. Service-use curves suggest that 2 categories of patients be considered: 1) most patients seeking psychiatric care, who require or desire relatively brief treatment, and 2) a smaller group requiring longer-term care, characterized by patients with comorbid conditions, severe and persistent major mental illness, and severe characterologic disorders. Recently, the effectiveness of longer-term maintenance therapy has been highlighted (27,28).

One concern in preparing this document was the question of how, indeed whether or not, to differentiate between

psychiatric management, which inevitably includes a talking component, and the formal psychotherapies. We have agreed that this distinction needs to be made. All physicians, psychiatrists and nonpsychiatrists alike, have the responsibility of making a diagnosis, selecting an indicated treatment, and delivering that treatment within the context of a positive and supportive doctor–patient relationship. Within this general medical framework, the physician is expected to attend specifically to the syndrome being treated and also to the broader context in which it occurs. For example, the treatment of diabetes mellitus must concern not just blood-sugar levels but also diet, the effects of stress, exercise, and the education of patients regarding their individual responsibilities in managing the illness. Most psychiatric disorders have similar features; they are recurrent, and situational factors often contribute to triggering or maintaining an acute episode. We suggest that, in regard to standard psychiatric management, psychiatry is no different from the field of medicine in general. Such psychiatric management is, of course, influenced by the general principles of psychotherapy relating to skillful management of interactional processes and purposeful use of supportive techniques. For this reason, advanced training in psychotherapy should be part of the training for all psychiatrists. However, within this general aspect of psychiatric management usually enacted through brief sessions (that is, 15–30-minute sessions at time intervals corresponding to the acuity of the disorder), specific psychotherapy may be indicated and prescribed for a diagnosed condition. This document is concerned with the particular characteristics of these psychotherapeutic treatments.

### **Ethical Guidelines for the Psychotherapies**

This section applies to all activities of the psychiatrist and not solely to psychotherapy. We provide it here because many ethical issues are specifically brought into focus within the intense interpersonal environment of psychotherapy. The CMA has developed a comprehensive Code of Ethics (26). The following comments expand on and apply that document to the practice of psychotherapy. It is recommended that this material be read in conjunction with the CMA Code of Ethics.

#### *Patient Access to Medical Records*

Although medical records are the property of the psychiatrists who compile them or of the institution or agency in which they work, patients have the right to examine their records and to copy information that is contained in them. Psychiatrists must accommodate their patients' access to their psychotherapy records in a timely manner. At the same time, the psychiatrist should be alert to the impact of this information on the patient or any other third party and be available to the patient to review the material.

### *Confidentiality*

Confidentiality forms the foundation for a trusting therapeutic relationship that is the cornerstone of effective psychotherapy. It has also been recognized that there are limits to confidentiality, as when the safety of the patient or others is at stake.

The CMA Code of Ethics (26) states:

respect the patient's right to confidentiality except when this right conflicts with your responsibility to the law, or when the maintenance of confidentiality would result in the significant risk of substantial harm to others, or to the patient if the patient is incompetent; in such cases, take all reasonable steps to inform the patient that confidentiality will be breached.

Although the confidentiality of patient information is affirmed in provincial law (29), legal requirements to reveal certain kinds of information without patient consent are defined in both statutory and common law. The most notable legislative requirements are civil commitment regarding danger to self or others and mandatory reporting of designated diseases, suspected incompetence to operate road vehicles, and suspected child abuse. It is ethically essential for psychiatrists to familiarize themselves with the precise legal requirements for the jurisdiction in which they work.

When harm is threatened to others and no legislated requirement to report is specified, a duty to warn may, nevertheless, override the duty to respect patient confidentiality. When the anticipated harm is believed to be imminent, serious, possibly irreversible, and unavoidable except by unauthorized disclosure, the harm averted by the breach of confidentiality must be weighed against the harm associated with the breach (29–31). A patient whom a psychiatrist believes to be potentially dangerous at any point in treatment should be informed of the possibility of a breach of confidentiality. Psychiatrists must tell patients under what circumstances this would occur. Any proposed breach of confidentiality should be discussed with the patient before it is implemented and the patient's assent obtained whenever possible. It is recommended that psychiatrists consult with knowledgeable others, such as the Canadian Medical Protective Association (CMPA), before breaching confidentiality under any circumstance.

### *Boundaries*

The concept of boundaries is crucial to developing an effective therapeutic relationship. Gutheil and Gabbard define a boundary violation as the crossing of a boundary that leads to harm (32). Minor boundary violations may seem benign but can lead to potential harm or, at the least, an undermining of the therapeutic process. Circumstances may arise in which alterations of the frame may be indicated, such as intervening on a patient's behalf with an employer to provide time for treatment or accompanying a phobic patient in situations that cause severe anxiety. Hence, context is key to understanding boundaries, and disregard for context may lead to misuse of

these principles (33). It is important for psychiatrists to discuss possibly problematic boundary issues with colleagues while maintaining patient confidentiality. A patient's records should include a note of the circumstances and purposes of formal collegial consultation.

Any deviation from the normal standard of practice that is initiated by the psychiatrist must have a clear therapeutic rationale and be able to withstand objective scrutiny regarding its therapeutic justification. This underscores the importance of obtaining a second consultation opinion if problematic boundary issues emerge in ongoing psychotherapy (32).

### *Home Offices*

Treating patients in a home office requires serious consideration of the patient's best interests because of the increased risk of boundary issues, especially when treating patients with poor reality-testing or those with the potential for forming unrealistic views of the therapeutic relationship.

### *Inappropriate Patients*

It is inappropriate to engage in dual relationships with patients or to treat one's own family members or patients with whom one has a current social, business, or professional relationship. It is potentially problematic for a psychiatrist to treat a patient and the patient's close relative, close friend, or lover contemporaneously, unless a planned conjoint approach is used. Long-lasting idealization of the psychiatrist may potentially undermine free choice, making it unethical to enter into a business arrangement with a patient or former patient. It is similarly unethical for a psychiatrist to lend, borrow, or solicit money from a patient or former patient.

In underserved areas, there may be no alternative to some of the above situations, requiring careful attention to context. In such instances, a note in the patient's chart should specify what the options are and why a course of action is taken that would ordinarily be contraindicated. In such instances, clear principles and guidelines about confidentiality and neutrality must be articulated to the patient, within the limits of confidentiality as outlined above.

### *Sexual Exploitation*

The CMA defines psychiatric abuse (sexual or otherwise) of patients as "any behavior that transgresses the patient–physician relationship in an exploitative manner by . . . words or actions" (34). Exploitation implies that psychiatrists are acting in their own interests with relative disregard for the interests of their patients (35,36). Sexual involvement with patients is prohibited. The prohibition against sexual involvement with patients extends to the relationship between psychiatrists and any family members involved in the welfare of a patient; for example, a mother consulting about her child's treatment. Explicitly: flirtation, romance, or sexual expression is not ethically defensible within or outside the psychotherapy session,

whether with the patient or with the patient's significant others.

Verbal communication with patients about sexual issues is an appropriate part of quality medical and psychiatric practice. Asking patients about their sexual behaviour, concerns, and history is an important component of clinical interviewing and decision-making. Sexual feelings may arise in the context of psychotherapy and may be appropriately discussed. This makes it imperative that psychiatrists be aware at all times of the potential for misinterpretation and the need to govern themselves in such a manner as to avoid undue provocation of such issues.

There is no clinical justification for any physical contact between a psychiatrist and a patient beyond usual social custom such as a handshake. Touching intended to convey solace and sympathy should be used with caution, given its potential for misinterpretation and potential distortion. Providing emergency medical treatment is a legitimate exception to the prohibition against touching. Every reasonable effort should be made to have a colleague perform required physical examinations on one's own psychotherapy patients.

Some jurisdictions have recommended a lifetime ban on romantic and sexual involvement between psychiatrists and former patients (37). Given the complexity of the psychotherapeutic relationship and the sometimes persistent idealization of the therapist that follows psychotherapy, there is a subsequent risk for a continuing interpersonal power imbalance and nonautonomous choice on the part of the patient. The recommended lifetime ban in some jurisdictions on romantic or sexual involvement has generated controversy regarding autonomy and independent choice. In our view, it is a potentially destructive situation, and every caution should be applied, including consultation with a colleague.

#### *Competence*

It is not ethical to practice psychotherapy when significantly impaired as a result of illness, pain, substance abuse, or personal preoccupation. Consultation with colleagues when one's judgement is felt to be impaired is imperative. Psychiatrists whose judgement may be biased by strong personal subjective reactions (countertransference) are encouraged to obtain consultation while maintaining patient confidentiality. Signs of such difficulty include intense preoccupation with a specific patient, recurrent dreams involving a specific patient, intense positive or negative emotions with regard to a specific patient, and uncharacteristic anticipation or dread of a specific patient's visits.

#### *Terminating Treatment*

The psychiatrist is obliged to ensure appropriate alternative care for patients should he or she fall ill or be away for an extended period or when the psychiatrist and patient mutually decide that the current treatment is no longer effective. A

sudden unilateral decision to terminate treatment is a warning sign that there is difficulty in the relationship (38). Such decisions are indications for seeking a second opinion.

#### *Reporting Unethical Behaviour*

Psychiatrists may learn of the apparent unethical behaviour of a colleague. The response to this situation will depend on many variables, such as the nature of the unethical conduct, the potential harm to the patient, the certainty of the facts, and the nature of the relationship between the physician and the offending colleague. The response options range from initiating a serious discussion with the colleague to reporting him or her to the appropriate licensing and regulatory body. The psychiatrist should be familiar with provincial regulations regarding such situations and should consider consulting the CMPA.

#### **Pretherapy Factors**

This section addresses several core features surrounding the initial contact with the patient. These focus on various aspects of the assessment process and the decisions required regarding the initiation of treatment.

#### *Assessment*

A comprehensive assessment is required to determine whether psychotherapeutic treatment is required and, if so, to determine the merits of medical, psychological, and social therapies. If psychological therapy is indicated, further decisions must be made regarding the model and the degree of intensity and depth preferred (39). Assessment requires evaluating the patient's presenting problem; history of therapy, with clear definitions of previous treatment; personal history of relationships, occupation, and achievements; and current life context. The experience of the interpersonal contact made in the evaluation, the patient's defences, and the therapist's objective reactions to the patient complete the assessment. The role of medication must always be ascertained as part of a coherent, integrative practice of psychotherapy (40). Indications for a thorough medical work-up must also be assessed. Formulating an understanding of the patient and his or her difficulties, in collaboration with the patient, is a bridge between the assessment and the treatment. This helps the patient feel understood, supported, and engaged in the treatment as a partner, prepares the patient for the prescribed model of psychotherapy, and sets the stage for proper informed consent.

#### *Developing a Focus*

Most contemporary psychotherapeutic models establish a focus for treatment by identifying a core pattern emerging from the patient's narrative during treatment. This pattern identification is critical, since there is substantial evidence that consistent focusing on the core pattern is correlated with positive outcome in treatment. In addition, this process helps build the

therapeutic alliance through the patient's experience of being understood (41–45).

Coherent models of understanding emerge from various theoretical conceptualizations and will be influenced by a clinician's training and orientation. Patterns that will serve to focus the treatment may be identified at various levels of functional integration including behavioural, cognitive, interpersonal, and intrapsychic. Representative examples include the following:

1. Specific behavioural patterns and associated beliefs; for example, obsessive–compulsive disorder (46).
2. Negative thought patterns associated with low self-esteem; for example, depression (47).
3. Interpersonal schema (for example, 48,49).
4. Interpersonal problem categories (for example, 50).
5. Intrapsychic patterns such as the core conflictual relationship theme model (for example, 51), the plan formulation model (for example, 44), and other psychodynamically informed models (for example 52,53).

Patients may be selected for a specific therapeutic model based on the established indications for its use. Therapists must ensure that they have the capacity (skills and training) to work with the patient and his or her identified problems within the model selected.

#### *Assessing Patient Requirements and Vulnerabilities*

While it is evident that psychotherapy is broadly and generally effective, the proper fit between patient, therapist, and treatment can influence outcome. One dimension of this has been described as the supportive–expressive continuum. The psychiatrist can choose where on this continuum to concentrate therapeutic efforts in order to match the patient's needs (54), recognizing that effective psychotherapy can be achieved on both ends of the continuum (55). Unfortunately, both of these terms are open to misunderstanding, because the words are used idiosyncratically.

Psychotherapy at the supportive end of the continuum can be defined as a treatment in which the psychiatrist's activities promote the patient's adaptive function, both within and outside of the therapy setting; the psychiatrist employs an open, direct and active stance (56) in order to provide emotional support and affirm the patient's adaptive behaviour. Additionally, the psychiatrist functions as a model of more adaptive functioning (54). This psychotherapy builds on the patient's strengths and supports defences, fostering a strong therapeutic alliance. It examines transference and the treatment relationship only if they are negative. The psychiatrist's approach is conversational rather than abstinent, and direct measures are used to enhance self-esteem (57). At the same time, supportive techniques emphasize maintaining a clear focus and titrating expectations for change over time to

modulate anxiety. Addressing obstructions to the therapeutic process and encouraging emotional expression are expected, just as they are at the expressive end of the continuum. These supportive techniques, tied to expectations of change, are sometimes confused with the term "supportive therapy," which may refer to simple support measures.

Psychotherapy at the expressive end of the continuum emphasizes exploring, uncovering, and interpreting covert schema-related material reflecting psychodynamic, interpersonal, or cognitive perspectives. The strategy is to make conscious and overt what is outside of patient awareness, often by exploring underlying difficulties in relationships, most notably within the patient–therapist relationship itself.

Pine notes the importance of linking the 2 ends of this continuum, such that interpretation is given to patients within the context of support rather than within the context of abstinence, and advocates a shift from an either/or approach to a both/and approach (58). This avoids a polarizing stance in favour of a constant recalibration of position on the continuum. Interpretations in this context are made empathically, in a nonblaming fashion, cognizant of the adaptive efforts being made by the patient. This perspective suggests that the continuum might be better understood as 2 independent dimensions: supportive techniques and interpretive techniques concerning internal states that may be mixed in various combinations. Throughout psychotherapy it is important to focus on the joint creation of the therapy by both patient and psychiatrist, each impacting the other, either positively toward growth or negatively toward regression (59).

Proper assessment of the patient is hence critical to facilitating a good start that leads to effective involvement in treatment, which correlates with better outcome (43). The psychiatrist's failure to recognize the severity of ego impairment, insufficient capacity for introspection or frustration tolerance, and significant patient hostility that is not sufficiently contained by the treatment process may result in a negative therapeutic interaction and termination before maximum benefit is received (60–62). Mays and Frank note that underdiagnosis of patient vulnerability or coping capacities resulting in an overemphasis on expressive techniques without adequate support or limit-setting contributes significantly to negative therapeutic outcomes (63). These considerations become more crucial as the level of characterologic disturbance increases, indicated by the following features (54):

1. Developmental factors:
  - a) Early deprivation and loss of parental figures.
  - b) A history of abuse or sexual trauma.
  - c) Neurological dysfunction that may impair impulse control and diminish psychological mindedness and abstraction.
2. Psychological factors:
  - a) Ineffective reality-testing.

- b) Poor impulse control and a tendency to act out tensions.
- c) Low frustration tolerance.
- d) Low capacity for perseverance to task without demanding enactments.
- e) Low capacity to tolerate and distinguish fantasy from reality.
- f) Low tolerance of affect.
- g) Proneness to externalization of tension. Patients who make strong use of a projective style do poorly in the expressive or confronting psychotherapies.
- h) Low psychological mindedness (64).

### 3. Relationship factors:

- a) Severe self-esteem vulnerability.
- b) High use of mirroring and idealizing. Substantial support prior to interpretation may be required, since such patients may experience interpretation as criticism.
- c) High levels of attacking behaviour that may potentially require active containment and a therapeutic contract.

### *Other Patient Factors*

There is evidence that the following patient factors correlate with better outcome (43):

1. General level of psychological health as reflected by the Global Assessment of Functioning Scale (*Diagnostic and Statistical Manual of Mental Disorders* [DSM-IV] Axis V) (65).
2. Motivation and positive expectations of change.
3. Positive attitude toward self, therapist, and therapy (65).
4. High psychological mindedness (66,67). This may be an important intervening variable in that patients who are able to complete therapy do well regardless of initial psychological mindedness (64). Psychological mindedness can be defined as "an attribute of an individual that presupposes a degree of access to one's feelings; a willingness to try and understand oneself and others, a belief in the benefit of discussing one's problems, an interest in the meaning and motivation of one's own and others' thoughts, feeling, and behavior and a capacity for change" (67). The role of preparation is particularly important for patients with low psychological mindedness.
5. Presence of strong affect, either anxiety or depression, is linked to motivation and is a positive prognosticator (43).

The severity of initial symptoms is not a prognostic indicator (68). Age, sex, and demographics do not appear to be reliable predictors of outcome.

Patients with a better quality of relationships do better in interactive and less-structured treatments, and patients with poorer human relationships struggle in establishing a therapeutic alliance and may need more active supportive

techniques (69). Piper and others report that patients with poor quality of relationships may experience accurate transference interpretations as threats or blaming, in contrast to patients with a high quality of object relatedness, who are able to make use of such interventions (45).

### *Pretherapy Preparation*

Therapy is initiated most effectively when the patient is prepared with information regarding how to make best use of the treatment process. Preparation has been used most broadly in group psychotherapy (70–72) and has been presented in various ways, including verbal communication, written outlines, and simulated treatments. Preparation has been associated with enhanced tenure in treatment, reduced drop-out rate, enhanced task adherence, and increased self-disclosure (71). It is not directly correlated with outcome but, like psychological mindedness, may facilitate a better start and enhanced tenure (51). Preparation helps demystify therapy and establish a preliminary base for a therapeutic alliance (43). Synchronizing patient and therapist expectancies regarding the treatment is another advantage, enhancing tenure of treatment and outcome (73). The therapist and the patient collaboratively establishing clear goals and objectives for treatment regarding symptomatic improvement and broader functioning is important in elective treatment and facilitates the monitoring of therapy progress (74).

### *Frequency of Sessions and Duration of Treatment*

Decisions regarding the frequency and duration of treatment also are based on the initial assessment. Service-use data for general mental health service systems show consistent patterns, often termed the dose-response curve. This information is useful in predicting overall use and in designing treatment programs. The course of an individual patient may vary considerably from the standard patterns, and some diagnostic subgroups tend to have unique patterns. A large North American database, much of it antedating managed care programs, indicates that about 50% of patients will terminate treatment by the eighth session (75).

Howard and others reported that 50% of patients improve symptomatically within the first 8 sessions, reflecting a process of remoralization (76). However, more recent studies suggest that this is an overly positive view of the dose-response curve (24,77). The available current evidence does indicate a positive response rate for 75% of patients after 6 months of psychotherapy. This clear evidence for the early effectiveness of the psychotherapies includes psychodynamic, interpersonal, cognitive-behavioural, and supportive models (25,78,79). The more focal and acute the disturbance or conflict and the more evidence of an acute precipitant, the more likely a shorter-term approach will be successful. One of the tasks of careful assessment is to determine which patients fall into the approximately 25% of patients who may require psychotherapy longer than 6 months and may benefit by going

directly to a longer-term format. The substantial majority of patients attend for a relatively brief course of treatment in any particular treatment episode. Therefore, one of the brief or time-limited psychotherapies may provide an opportunity to assess the patient's motivation and capacity to use therapy and to evaluate or establish the need for a longer-term approach (80). The assessment of patient strengths and vulnerabilities has been discussed at length in a preceding section. Patients assessed as having cumulative higher loadings on these features are less likely to respond adequately to briefer interventions and may have difficulty benefiting from longer-term psychotherapy. A history of failed treatment and previous hospitalization may indicate the need for longer-term treatment. Severity of depression itself is less of a predictor than is comorbidity with other Axis I or II disorders (68). The presence of particular characterological traits, such as perfectionism, also predicts requirements for longer treatment (28,81,82).

The psychiatrist may carefully review therapeutic strategies at the 6-month point if further regular formal psychotherapy is being considered. The review would attempt to understand why the patient was not responding within the usual time frame and whether a therapeutic impasse had been reached. Another theoretical model or modality (including pharmacotherapy) may be considered or a second consultation opinion requested. A different therapist might be considered, since slow progress may be related to the therapist-patient match. Satisfactory justification may be found for continuing longer on the same course of treatment. Such a review reflects the accountability of the psychiatrist for use of medical resources.

Major characterologic disturbance appears to respond much more slowly (11). There is empirical support that the longer individuals stay in treatment, the better their outcome (15,83). Longer-term psychotherapies may be of an intensive nature with an intended endpoint or may be designed for intermittent maintenance to prevent regression or the need for hospitalization (as with schizophrenia [84] or depression [27]).

There is little empirical data to establish guidelines regarding frequency. Clinical experience underscores the importance of frequency being sufficient to contain patients' distress and to provide sufficient support for patient containment or to facilitate expressive therapy. With behavioural interventions, some evidence supports the early intensification of treatment when there is a particular focus on a behavioural disturbance, such as in bulimia nervosa (85).

#### *Therapeutic Contract*

Establishing a therapeutic contract that incorporates mutual understanding by the patient and the psychiatrist of the nature and format of treatment is the next step after assessment (74). The contract is generally limited to verbal discussion during

the initial sessions. However, in situations where interactional problems are anticipated or appear to have contributed to prior unsuccessful treatment, it may be noted in the chart or given in writing to the patient. Aspects of the contract that need to be addressed include the frequency and schedule of treatment, the duration of appointments, the fee, the nature of the office setting, and the role of medication. Establishing the contract helps to initiate the therapeutic frame (32). It sets the obligations of the psychiatrist and the trust of the patient. Any potential deviation from the therapeutic frame or the treatment boundaries by the psychiatrist must be able to withstand external and objective scrutiny as being in the interest of the patient, and accordingly, the psychiatrist is advised to document the therapeutic rationale for any such deviation. Smith and others note the importance of psychotherapy contracts as potentially mitigating premature termination of therapy and sabotage of treatment (61). The contract defines the special characteristics of the specific psychotherapy and begins the process of role induction as it shapes both patient and psychiatrist roles and expectancies (61). The psychotherapy contract should be rooted in a recognized model of human development and adaptation; it should employ a formal psychodiagnostic schema; it should note the repertoire of interventions to be employed; and it is embedded in a psychotherapeutic style that promotes safe and effective involvement of the patient and psychiatrist (74).

The contract is particularly important for patients who have a history of therapy-defeating behaviours and is most clearly articulated for patients with character pathology (86). The contract should identify the limits of psychotherapy and the patient's responsibility for collaboration in psychotherapy, delimiting the potential for patient acting-out or sabotage of treatment and setting clear guidelines for the termination of psychotherapy. It may address frame-threatening behaviours, sexualization of the treatment, failure to progress or deterioration, or increased suicidal risk.

#### *Limit-Setting*

The contract establishes the foundation for more active limit-setting, which may be required of the psychiatrist to protect the patient, the psychiatrist, and the integrity of the treatment (87). Limit-setting may include verbal challenge, behavioural limits, medication, changes in the frequency of treatment, the enlisting of auxiliary help, and hospitalization if necessary. It is protective and alliance-building, rather than power-driven, and must always be respectful of the patient. The psychiatrist, in maintaining the frame, must be particularly alert to the potential for strong reciprocal subjective therapist reactions (countertransference) that may perpetuate and amplify the patient's maladaptive transaction cycles (49,52). Green and others note a sequence of 1) initially identifying a problematic behaviour, 2) delineating what behaviour can be tolerated in the psychotherapy context, and 3)

identifying the consequences if that behaviour continues (87).

### *Informed Consent*

Informed consent, although commonly viewed as a legal concept, is essentially an ethical imperative designed to promote the values of both self-determination and personal well-being. Two cases heard before the Supreme Court of Canada (*Hopp vs. Lepp* and *Reibel vs. Hughes*) introduced significant changes into Canadian law with respect to the physician's duty to disclose information to a patient. The nature of any proposed treatment should be fully explained to the patient to ensure informed decision-making. This includes the benefits and risks of the treatment and the benefits and risks of the alternatives, including the option of no treatment at all.

The current standard of disclosure is to provide patients with all the information that a reasonable person in the patient's situation would want or need to make an informed decision (88). In applying this standard to the psychotherapies, the ethical psychiatrist must explain the benefits and risks of the psychotherapeutic model and modality being considered and must contrast it to the benefits and risks of other psychotherapeutic models, modalities, and/or psychopharmacological approaches. Informed consent emerges from a detailed assessment of the patient (89).

Key elements of informed consent are as follows:

1. The consent relates to the specific therapy.
2. The consent is informed and voluntary.
3. The patient is capable and competent in terms of the domains involved in the specific decision-making and for the specific time frame.
4. Potential tasks are identified; for example, exacerbation of anxiety or unsettling of other interpersonal relationships.
5. Potential limits of confidentiality are discussed as appropriate.
6. Alternative courses of therapy are outlined.
7. The consequences to the patient of not proceeding with therapy are reviewed as appropriate.

Informed consent shows respect for the individual's right to self-determination and recognizes that individuals are important judges of their own requirements. The process of arriving at informed consent establishes mutual respect and facilitates the development of a working alliance. The information exchange and acquisition of knowledge may be therapeutic in itself. It protects the therapist from legal liability. Informed consent is a process and a dialogue rather than a single event, which, once established, continues throughout therapy. It forms part of the treatment record and should be recorded as a formal written statement of informed consent or as a chart notation that the discussion has taken place. Implied consent is

not a waiver of consent. It can be assumed or inferred from the patient's conduct only after the patient has been adequately informed of information relevant to the decision.

Psychotherapy is a powerful medical intervention with inherent risks, work, pain, and benefits that has reasonable alternatives. At no time should the patient feel coerced to engage in any process. A patient's passive agreement is not a reason in itself to proceed with an intervention, since for various reasons, a mutually agreed upon intervention may be initiated that is of no proven benefit or, frankly, damaging to one or both participants. Informed consent is especially important in any psychotherapy where therapist activity is prominent.

### **The Alliance**

The quality of the relationship that develops between the patient and the psychiatrist has been intensively studied over the last 2 decades (15,62,90). The alliance consistently accounts for the largest single share of the variance regarding prediction of positive outcome. This literature has emphasized the contributions of both the patient and the therapist to the development of the alliance (91).

The global term "alliance" is used here. Various aspects of the literature refer to this as the "therapeutic bond" (74), the "helping alliance" (68), or the "therapeutic alliance" (92). The alliance comprises 3 components:

1. The bond between the participants; that is, the real relationship or the emotional connection, based on mutual human responses, trust, and respect (93).
2. Agreement about the goals of therapy.
3. The "working alliance" (94), based on the agreement that therapy is focused on the proper targets and that patient and psychiatrist can work purposefully together on therapeutic tasks.

The working alliance is considered to be the strongest single predictor of outcome. Measures of the alliance from the patient, therapist, and observer perspectives all predict outcome, but the patient's view is clearly the best predictor. Measures of the alliance at a relatively early point in treatment (session 3 or 4) appear to be most predictive. This presumably reflects the establishment of a constructive working environment (15).

A comprehensive assessment followed by selection of an appropriate treatment model for which the patient is prepared and gives informed consent contribute to establishing the alliance. Positive outcome in therapy is significantly correlated with mutual affirmation and collaboration in the treatment, patient-therapist empathic resonance (90), and personal investment on the parts of both the patient and psychiatrist, in contrast to psychotherapies that are marked by mistrust, superficiality, or misunderstanding. As a robust contributor to positive outcome, any misalignments in the alliance should

be identified and addressed as early as possible. Although a positive alliance is associated with positive outcome (43), an initial negative alliance does not preclude a positive outcome if it is repaired promptly and perhaps repeatedly. The effective repair of threatened ruptures or empathic failures in the alliance correlates with better outcome (13,48).

#### *Patient–Therapist Interactive Factors*

One should strive for optimal collaboration in the therapeutic relationship. This is monitored by attending to the balance between patient autonomy and therapeutic guidance as demonstrated by frequency, type, and quality of therapist intervention (neither too permissive nor too controlling); patient initiative in discussing relevant issues (neither too dependent nor too unreceptive); and emotional tone of therapist interventions.

A related goal is optimal communication (communicative attunement) in therapy as demonstrated by the degree of openness, clarity of communication, mutual sense of understanding, and ability to resolve miscommunications.

The patient–psychiatrist relationship and the idea of “fit” acknowledges that psychotherapy is a complex multivariant relationship that subsumes common therapeutic factors, the psychiatrist’s natural attributes, personal characteristics (56), technical skill, and the therapeutic alliance. Demographic factors do not appear to be significant. Conte and others report that therapeutic outcome is correlated with patient satisfaction as reflected by patients’ perceptions of therapists as being respectful, understanding, trustworthy, likeable, encouraging, technically competent, and “not too quiet” (95). Alexander and others report that patients choose their therapist on the basis of likeability and mutual attraction as well as on a sense of the therapist being helpful toward them (96). There is evidence that the opportunity for patients to select a therapist and for the therapist to select the patient is significantly related to positive outcome.

#### *Patient Factors*

The patient’s motivation must be assessed initially and monitored throughout the therapy to ascertain whether engagement is sufficient for maintaining an effective therapeutic bond (97). This is assessed by noting the patient’s attendance at sessions, contribution of significant issues and materials to sessions, and activity level on issues both within and between sessions. It should be noted that many seriously dysfunctional patients present with poor or inconsistent motivation. This should not be taken as a contraindication for psychotherapy but rather be seen as the first priority in treatment. For these patients, instilling motivation may be the single most important goal of treatment.

Patient expressiveness is also important for maintaining an effective therapeutic bond. This should be monitored by noting the patient’s participation in sessions, the patient’s

sharing of personal information, and the degree of his or her emotional expression.

#### *Therapist Factors*

Unconditional positive regard, warmth, empathy, openness, and absence of hostility or dogmatism correlate significantly with better outcome (73,98). The psychiatrist’s ability to recognize, process, and use personal reactions (countertransference) is an important component of effective therapy. It helps retain the frame of therapy, maintain boundaries, and lessen the likelihood of amplifying negative interpersonal spirals with patients (99,100). Lambert has underscored the critical role of the person of the psychiatrist and his or her psychological health and well-being in improved treatment outcomes (98). These characteristics facilitate an enhanced therapeutic bond between patient and psychiatrist (74). The skill of the psychiatrist is important, but experience is less clearly so (43), and psychiatrists must employ a range of skills that reflect both the supportive and exploratory components of treatment.

1. The psychiatrist should possess an appropriate level of training, skills, and experience in practising psychotherapy. This may be assessed through type of training program, peer supervision, peer review, case consultation, participation in continuing education programs, and competent recording of therapy in patient medical records.
2. The psychiatrist should be appropriately engaged in the therapy, as demonstrated by committed availability, attendance to sessions, attentiveness, interest and participation in the therapy, and an activity level in the sessions appropriate to the technique of therapy being used.
3. The psychiatrist should use empathic understanding in the practice of psychotherapy. This is achieved with an accepting and sensitive attitude, demonstrable through the words, tone, and behaviour of the therapist, to understand the patient’s subjective experience.

#### *Sociocultural Factors*

Particular attention must be paid to issues surrounding power and control. These involve possibly subtle interactional phenomena involving gender issues; it is necessary to recognize different developmental emphases between the sexes, particularly in areas of autonomy from and identification with parental figures. Similarly, cultural patterns may influence significantly the nature of the alliance expected by the patient from clinicians, often emphasizing the role of advice and direction and prohibiting the sharing of family issues with outsiders.

#### **Quality and Nature of Therapist Activity**

Each model of psychotherapy has a unique set of therapist techniques. In addition to their technical impact, these interventions may impact the quality of the alliance. This section

highlights several aspects regarding therapist activity, which are supported in both the empirical and clinical literature.

#### *Education in the Psychotherapies*

The last 30 years have seen the emergence and validation of specific models of psychotherapy (101). However, many educational programs have not provided training in these models. Given the present state of knowledge in the field of psychotherapy, it is increasingly expected that psychiatrists follow specific therapeutic models that have demonstrated efficacy and indications for use. Psychiatrists should be trained to a reasonable level of competence in the specific psychotherapeutic technique with which they are working.

It is imperative for every psychiatrist to maintain competence in general psychiatry by participating in continuing medical education activity. For the psychiatrist who employs specific psychotherapy models, this includes updating and continually monitoring assessment and psychotherapy skills. Consulting appropriate specialists or subspecialists as necessary is encouraged.

Some of these models employ active intervention techniques that carry a risk of misalliance and other negative effects for the patient. Acceptable models provide well-defined techniques, goals, selection criteria, and training protocols. For self-monitoring, supervision, and the teaching of these techniques, electronic recordings or direct observation by a third party, with the informed consent of the patient, may be of value. Peer review and ongoing training groups are recommended, particularly for psychiatrists using more active psychotherapeutic interventions.

#### *Technical Strategies*

Several core strategies for the psychotherapist that enhance the effectiveness of the psychotherapies have been identified in the "common factors" (13) literature and should be knowledgeably developed and supported throughout the course of psychotherapy:

1. Encouraging the open expression of thoughts and feelings.
2. Encouraging thoughtful self-examination.
3. Promoting realistic hopeful expectation.
4. Encouraging mastery over self and circumstances.
5. Providing a rationale that explains the patient's problems and thus promoting a sense of cognitive mastery.

#### *Level of Psychiatrist Responsiveness*

The therapist should have an optimal level of emotional engagement tailored to the individual patient and the patient's self-regulatory capacities. Excessive emotional engagement may be harmful to severely fragile patients, including those with schizophrenia (102). Conversely, excessive detachment and intellectualization may slow the process of emotional experience and working through in expressive therapy.

#### *Degree of Support of Coping Mechanisms or Defences*

While a supportive relationship is the basis for any course of therapy, the use of supportive techniques (103) may or may not be indicated in specific situations during a course of therapy. Patients with poor anxiety tolerance may benefit from therapist efforts to augment defences by using a more structured and cognitive approach. Conversely, clarification of defences may be warranted for a patient who wishes to experience and work through feelings about a recent loss but, at the same time, intellectualizes excessively. The goal of any form of therapy is always to support optimal coping mechanisms; however, the form this support should take depends on the patient, therapist, and treatment technique.

#### *Maintaining Focus*

Therapeutic focus is a common therapeutic factor throughout many models of psychotherapy (see *Developing a Focus*). Focusing requires a high level of therapist activity and therefore has the potential to mobilize anxiety or to create misalliance. Hence, focus must be an informed, collaborative process applied by a therapist trained in the specific technique. Further, the patient should be monitored at all times for evidence of misalliance during the course of focused therapy (13,104). Maintaining a focus is an important therapeutic strategy with inherent risks and benefits.

#### *Managing Anxiety*

Excessive anxiety refers to anxiety that either interferes with therapy or produces a significant rupture in the alliance or other untoward effect such as poorly contained anxiety between sessions. The degree to which anxiety is simply managed or actively explored depends on the specific therapeutic technique selected for a specific patient. In a course of exposure therapy for phobic disorders, for example, a graded exposure to anxiety-provoking stimuli is considered optimal. Conversely, models of therapy using supportive techniques may seek to minimize the level of anxiety throughout the course of therapy.

#### *Negative Factors*

Follow-up studies suggest that negative effects are found in 5% to 10% of patients (63). These tend to be associated with specific therapist factors and technical factors. Therapist factors include general tendencies involving hostility, criticism or blame, exploitativeness, eroticism, and excessive need to make people change. Technical problems include technical rigidity, unclarified attacks on defences, destructive interpretations, and misplaced (therapist-driven) foci (105).

#### **The Clinical Record**

The medical record must conform to the standards and regulations of the relevant professional jurisdiction (that is, the provincial college of physicians and surgeons) governing the records of all medical acts, whether or not there is a major

psychotherapeutic component. There must be an entry for each treatment service provided. Information regarding the patient should be released to a third party only with the consent of the patient or with proper legal documentation. The nature of information released is best restricted to the purpose for which it is intended, that is, selected to address specific circumstances such as professional competence suits, coroners' investigations, college investigations, custody suits, compensation cases, or Revenue Canada investigations. Particular care must be taken regarding the integrity of records stored in an electronic computer system. The record is also written with the knowledge that review by the patient may be requested.

#### *Content of the Medical Record*

Since psychotherapy notes can be subpoenaed and may be used to the patient's possible detriment, the goals of detailed notes and the usefulness of the note-keeping format deserve serious thought. Necessary chart notes are those that clearly depict the patient's initial problems, the psychotherapy contract, and the plan by which the patient's goals are to be met.

An initial consultation should be provided to the physician, clinician, agency, or other body to whom a patient is being referred in a timely manner. The contents of the communication will be based on the purpose of the consultation. For example, providing a detailed personal history obtained for intensive psychodynamic psychotherapy to an agency might be inappropriate, while such information could be useful to a psychiatric colleague. Some referring physicians will have an informed understanding of the patient and their family, others may see their role in more restrictive terms. Judgement needs to be exercised in regard to the depth of factual material to be provided beyond a diagnostic and management opinion. If in doubt regarding the uses to which the information may be put or the level of confidentiality available, it would be preferable to err on the side of less-detailed information.

Progress notes must be written for each visit, preferably noting the session number. These will vary in length and detail depending on the complexity of the point in treatment. The goal of charting is to monitor progress and, should it prove necessary, to allow another clinician to assume responsibility with minimum disruption to the patient. Significant shifts in status or major problems will be monitored in regard to tracking the target areas being addressed, key or problematic interventions, evidence of a negative course of treatment, evidence of the patient's intent to harm him- or herself or others, and evidence of progress. In situations formally supervised, note should be made of the consultant's recommendations and the clinician's response to these. Laboratory investigations, medical interventions, and consultations should be recorded. There must be a detailed record of medications prescribed and the rationale for these, preferably on a separate face sheet in the chart.

Intimate personal content, details of fantasies, sensitive information about other individuals in the patient's life, and the psychiatrist's speculations about clinical material do not belong in a formal medical record unless they are essential to support crucial diagnostic changes or treatment decisions. Overall, the notes should demonstrate a meaningful relationship between the goals of treatment, established at the beginning of therapy or readjusted during therapy, and the specific therapeutic strategies being delivered.

The use of formal assessment measures is encouraged. Clinical judgement of psychological status can be augmented with the use of standard assessment measures. These may take the form of self-report questionnaires (such as the Beck Depression Inventory [106]) or of structured assessment techniques (the Hamilton Rating Scale for Depression [107]). A measure of patient satisfaction may also be included, though satisfaction measures do not necessarily correlate with symptom measures (95,108). Satisfaction measures are perhaps more useful in regard to clinical-service program development.

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# The Practice and Roles of the Psychotherapies: A Discussion Paper

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### Purpose

The 7 main objectives of this paper are as follows:

- To comprehensively detail the efficacy of the psychotherapies.
- To detail why skills in the psychotherapies are essential to the effective and competent functioning of contemporary psychiatrists.
- To establish a balance between the practice and use of both short-term and long-term therapies.
- To establish definitively that the psychotherapies must be included as a central component of core psychiatric services.

To document some of the deficits in our knowledge and to suggest areas for future research.

To be a resource for a future Canadian Psychiatric Association (CPA) position paper on current psychotherapies.

To state the limitations of psychotherapy in a responsible manner.

Skills in the psychotherapies are considered essential in the repertoire of a competent psychiatrist. This position has been articulated by many of the world's leading psychiatric associations, including in the United States (US) (1), Britain (2), Germany (3), and Canada (4,5).

The CPA (6) approved a position paper in 1986 that stated: "A psychiatrist must be competent in both psychotherapy and pharmacotherapy." The paper argued for a new research paradigm that would put aside some of the unanswered questions about effectiveness but which would lead to useful hypotheses about what is widely known—mainly, that the psychotherapies are helpful with certain patients and that certain psychotherapies are helpful in specific populations of patients.

During the past decade, the documentation for the efficacy of the psychotherapies has accumulated. Also, the official educational bodies in psychiatry are arguing for the need to strengthen the role of the psychotherapies. This paper summarizes the evidence-based literature and recommends how best practices should derive from the new knowledge.

### The Role of Psychiatry

How do the psychotherapies fit into the role of psychiatry in medicine? The Ontario Medical Association–Ontario Psychiatric Association Task Force on Psychotherapy Standards (4) suggested the following role for psychotherapy within psychiatry. "Psychiatry is a medical specialty that is grounded in biological knowledge about human nature. North American psychiatrists generally endorse a 'biopsychosocial model' that recognizes the interplay of biological,

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psychological and social factors in the development of psychiatric disorders and in their treatment.”

The Task Force strongly endorsed the need “to continue to support medical (psychiatric) psychotherapy within the health care system. Psychiatrists have a broad knowledge base and a systematic approach to diagnosis, prognosis and treatment planning. Psychiatrists receive a detailed education in the complex interaction between mind, brain and body so they are aware of the way that medical disorders, developmental and physical changes and bodily states influence the mind, and how the mind influences the body. Throughout their training, psychiatrists learn to carry the ultimate clinical responsibility for the management of very ill patients. Psychiatrists have experience with a wide range of mental illnesses, from the minor to the most severe. Psychiatrists can use biological treatments, such as electroconvulsive therapy and pharmacological agents. The literature demonstrates that combined use of medications and psychotherapy is frequently the most appropriate and effective treatment for a significant number of psychiatric disorders.”

Psychiatrists have a special role within the field of medicine as the interpreters of social and psychological phenomena for their colleagues and their patients. Psychiatry is the only specialty that can act as a specific reference point for the practice of medical psychotherapy.

The Ontario Task Force (4) proposed the following definition:

Psychotherapy is any form of psychological treatment for psychiatric disorders, behavioural maladaptions, and/or other problems [This would include problems associated with medical, surgical and obstetric disorders; reactions to the illness; and psychological contributions to the pathogenesis or perpetuation of the illness.] in which a physician deliberately establishes a professional relationship with a patient for the purpose of removing, modifying or retarding existing symptoms, or attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development.

Treatment should be based on general standards of practice developed from 1) professional standards and practice guidelines generally endorsed by peer-reviewed professional literature and/or taught in university departments of psychiatry and 2) ethical standards of practice maintained by professional licensing bodies.

### Psychotherapy Skills for a General Psychiatrist

Should all psychiatrists require basic psychotherapeutic skills? Copus has suggested that basic skills include being able to form a therapeutic alliance, being competent to assess psychological issues, monitoring the therapist's own feelings, creating a safe milieu, and having specific intervention skills (7).

Cameron describes therapeutic alliance, comprehensive assessment, the ability to construct formulations leading to

tailored treatment, the ability to understand quality of attachments, the need to terminate treatment effectively, an understanding of countertransference, the importance of avoiding boundary violations, and the importance of supervision and consultation skills (8). All of these functions require psychotherapeutic sophistication. It is likely true that forming a good therapeutic alliance will improve compliance with other aspects of psychiatric treatment.

## Summary of Evidence-Based Psychotherapies Literature

### 1. Cognitive-Behavioural Therapies

Hundreds of studies have examined the efficacy of cognitive and behavioural interventions for a broad range of disorders including anxiety disorders, mood disorders, schizophrenia, eating disorders, substance abuse, sexual disorders, and stress-related medical conditions. For most of these disorders, cognitive-behavioural therapy (CBT) has been shown to be of some benefit and, for many disorders, may be the treatment of choice. In addition to the huge number of published outcome studies, there are now numerous metaanalytic studies (9,10) demonstrating the efficacy of CBT for various disorders relative to other treatment modalities (for example, pharmacological treatments).

#### *Depression*

Several literature reviews (11,12) have found that CBT is an effective treatment for depression. However, there is little evidence that CBT is more effective than certain alternative treatments such as pharmacotherapy and interpersonal psychotherapy (IPT).

#### *Panic Disorder and Agoraphobia*

Panic disorder has been successfully treated with various cognitive and behavioural interventions including cognitive restructuring, interoceptive and *in vivo* exposure, and applied relaxation. Across a wide range of studies, an average of 85% of patients treated with CBT are panic-free at posttreatment, and 88% are panic-free at follow-up (13).

#### *Social and Specific Phobias*

There now exist over 25 studies examining the efficacy of CBT for social phobia and dozens more examining the use of CBT for specific fears and phobias. Heimberg and Juster reviewed the literature on CBT for social phobia and concluded that various treatment strategies appear to be effective for social phobia, including social-skills training, exposure, applied relaxation, and cognitive therapy (14). CBT for social phobia appears to be equally as effective as phenelzine, and its effects last longer.

#### *Obsessive-Compulsive Disorder*

Three recent literature reviews (10,15,16) concluded that CBT (usually in the form of “exposure and response

prevention”) is an effective treatment for obsessive–compulsive disorder (OCD). Although there was no consistent difference in efficacy between CBT and various pharmacological interventions (such as clomipramine and fluoxetine) on most measures, Abel concluded that CBT may be most beneficial for compulsive rituals, whereas pharmacotherapy may be especially helpful for patients with prominent obsessions, overvalued ideation, and depression (15).

#### *Generalized Anxiety Disorder*

Cognitive-behavioural treatment of generalized anxiety disorder (GAD) primarily comprises cognitive therapy and various relaxation-based interventions. Recent reviews (for example, 13,17) of more than 10 studies examining the efficacy of CBT for GAD suggest that CBT is effective.

#### *Posttraumatic Stress Disorder*

Few controlled studies exist of CBT for treating posttraumatic stress disorder (PTSD). However, the few studies of individuals who have experienced traumas related to combat or rape suggest that CBT strategies (such as imaginal exposure or stress management) are effective for overcoming and preventing PTSD (18–20).

#### *Schizophrenia*

Evidence shows that CBT may help to improve social skills, self-care, and independent living skills and decrease aggressive behaviour among patients with schizophrenia (21). Peris and Skagerlind (22) and Alford and Correia (23) offer promising approaches to modify delusions and effect the patient’s view of self. In addition, behavioural treatments may help to decrease the amount of medication needed by patients as well as to increase the time between relapses. For example, Hogarty and others compared 4 treatment conditions with respect to relapse rate in the first year following treatment with 1) social-skills training, 2) family psychoeducation, 3) social-skills training plus family psychoeducation, and 4) no psychological intervention (24). All patients received fluphenazine. The 1-year relapse rates for the 4 groups were 20%, 19%, 0%, and 41% respectively. A cognitive approach to hallucinations was developed by Bentall and others (25).

There is a continuing need to develop nonpharmacological treatments that target resistant symptoms, cognitive deficits, and other psychological aspects of the illness (26).

#### *Sexual Dysfunction*

Various cognitive and behavioural strategies have been used successfully to treat sexual dysfunction in men and women. These include systematic desensitization, cognitive therapy, masturbation training, and assertiveness training (18,27).

#### *Behavioural Medicine*

Recent reviews concluded that CBT can help reduce distress in patients undergoing surgery and patients diagnosed with serious illnesses such as AIDS and cancer (28,29). In

addition, CBT has been used effectively to decrease high-risk sexual behaviour in adolescents. Finally, CBT strategies are effective for managing various psychophysiological disorders, including chronic pain, tension headaches, irritable bowel syndrome, obesity, arthritis, and insomnia, and for decreasing type A (coronary prone) behaviour. CBT may be effective (although evidence is mixed) for treating hypertension and migraine headaches as well.

#### *Alcohol Abuse*

Several cognitive and behavioural strategies have been attempted with patients who abuse alcohol. Some of these include social-skills training, communication training, contingency-management training, and cue exposure (18).

#### *Bulimia Nervosa*

CBT tended to be equally as effective as other nonbehavioural interventions, including supportive psychotherapy, IPT, and group therapy. In some cases, CBT was more effective than other approaches when improvement was measured immediately following treatment.

#### *Personality Disorders*

Controlled studies of CBT for personality disorders are limited. Among these, Linehan and others (30) found that their version of CBT, “dialectical behaviour therapy” (including skills training, contingency management, cognitive therapy, exposure to emotional cues), was more effective than traditional psychotherapy for decreasing parasuicidal behaviour, hospitalization time, and premature termination of treatment among patients with borderline personality disorder (BPD).

## **2. Group Psychotherapy**

The original psychotherapy-outcome metaanalysis by Smith and others concluded that group therapy is an effective model of intervention (31), with an average effect size of 0.83, finding that the average treated person was more improved after psychotherapy than were 80% of wait-list control subjects (32). An identical finding was noted by Robinson and others in a metaanalysis of group-psychotherapy studies of the treatment of depression (33). Subsequent reviews (34,35) and metaanalytic reviews (36–38) further document the general effectiveness of group therapy as significantly superior to nontreatment.

Group therapy plays an important role in treating elderly persons, and significant and durable treatment effects have been shown for the treatment of geriatric depression (39–41).

Behavioural and cognitive-behavioural group therapies have been effectively employed for a range of anxiety disorders (42). Significant and durable improvements have been shown in treating agoraphobia and panic disorder (43,44), social phobia (45), and OCD (46).

Group therapy has been effective in treating eating disorders, particularly bulimia nervosa (47) and bingeing without purging (48).

Group therapy has long been recognized as useful in treating patients with personality disorders, as documented in qualitative reviews (49,50), and this clinical impression was recently substantiated by research documenting the effective use of group therapy in the homogeneous treatment of BPD (51–53) and a heterogeneous range of personality disorders (54).

Group therapy has been effective in treating patients with PTSD (55–57) and substance abuse and alcoholism (58).

Group therapy approaches have been effective with nonpsychiatric patient populations as well, with significant effectiveness, notably for patients with HIV and malignancies (59), both primary and secondary, using both cognitive-behavioural approaches and interactive approaches emphasizing social supports.

### 3. Couple Therapy

A good outcome in couple therapy is defined as a lessening of relational conflict and distress and a redefinition of ways to resolve conflicts. Alternatively, the realization that the relationship is unworkable and that both partners' well-being can only be achieved through separation or divorce also constitutes a positive outcome.

In a critical review of marital-therapy outcome research, Wesley and Waring (60) concluded that no single approach (behavioural marital therapy, cognitive marital therapy, emotion-focused marital therapy, or insight-oriented marital therapy) proved to be superior to the others. These authors propose a standard for efficacy studies, in which a positive outcome for a form of marital therapy would produce subjective and objective improvement in 50% of eligible couples and would be maintained for 1 year. They argue that a wait-list control group is not appropriate for ethical reasons. Further, they suggest that no marital-therapy outcome study has included enough couples (63 in each treatment group) to offer a suitable standard for determining an effect size.

Alexander and others reviewed outcome research in couple therapy through its impact on symptoms and couple satisfaction (61). Studies included self-report of couples and observational scales. Improvement rates varied from 50% to 83%.

Alexander and others report also that most couples who receive standard marital-therapy interventions show more improvement than do the control couples (61). Johnson and Greenberg in a study of 45 couples reported significant improvement in couples receiving emotion-focused treatment at 2-month follow-up, compared with couples treated with a problem-solving approach and a wait-list control group (62).

Couple therapy has been studied in various clinical conditions. It has been shown to be an effective adjunctive treatment for depression (63–65) and for agoraphobia (66,67). Among alcoholic patients, couples receiving marital therapy do better than controls on both marital and drinking measures (68,69). In a study of couples where one partner experienced a disorder of sexual desire, Hawton and others reported an 84% improvement (70).

In studying unsatisfactory outcomes in couple therapy, Anderson and others (71) showed that therapies which maintain high intensity, encourage conflict escalation, and emphasize advice-giving produce the highest drop-out rate. Allgood and Crane found that treatment dropouts from marital therapy had fewer children and tended to present with problems related to individual or family-of-origin issues, rather than with problems related to the interaction between the partners (72).

### 4. Family Therapy

Alexander and others suggest that the complexities in marital therapy are magnified in family therapy (61). The treatment unit is more variable, and because of the resistance and affects of multiple individuals, most conflicts are intensified. Many families presenting for therapy have multiple problems.

#### *Outcome and Efficacy*

1. *Schizophrenia*. Family psychoeducational programs and family therapy integrated with pharmacotherapy offer a delay in relapse and improved social functioning (73).

2. *Affective Disorder*. Keitner and others found that family therapy plus pharmacotherapy results in improved family functioning and recovery from an adolescent depressive episode (74). Clarkin and others showed that inpatient family interventions were effective for bipolar patients but not for unipolar patients (75). They suggested that patients who are too depressed cannot benefit from family psychotherapy. Waring and Patton reported that depressed women can be helped with marital therapy and that those who rate intimacy in their marriage as low remain more depressed than do women who rate intimacy in their marriage as high (76).

3. *Anorexia Nervosa*. Family therapy can be helpful for adolescent females with anorexia, provided the duration of the disorder is less than 3 years (77,78).

4. *Conduct Disorder*. Family therapy can play a positive role in adolescent conduct disorder and adolescent suicide (79,80). In treating adolescents, Henggeler and others reported that a flexible, individual, community-based intervention was effective in a large group of delinquent adolescents (81). Social, learning-based parent-training approaches for parents of aggressive children and preadolescents have proven effective (61,82).

5. *Suicide*. Family therapy may prove helpful to a family following the suicide of one of its members (83,84).

Alexander and others' metaanalysis of 20 years of family therapy showed positive effects, compared with no treatment or placebo treatment (61). However, these authors concluded that the superiority of family therapy to other modalities has not been substantiated. Gurman and others concluded that 73% of family cases improved during treatment (82). Recent reviews of the positive impact of couple and family therapy on a clinical population have been published (79,85,86).

#### *Negative Outcomes*

Gurman and Kniskern report that poor outcomes of family therapy are associated with therapists who have poor relationship skills and confront patients directly about loaded issues and with therapists who fail to intervene when there is serious confrontation between family members (87). Coleman and others edited a multiauthored volume entitled "Failures in Family Therapy" (88). It is commendable to publish negative results; therapists could otherwise obtain a false sense of security, unaware that therapy may harm some patients.

### **5. Psychotherapy With Children and Adolescents**

Several methodological improvements have occurred over the past 15 years. Assessment tools have become much more standardized. Diagnostic interviews for children (89,90) and symptom rating scales for depression, anxiety, tics, eating disorders, obsessions and compulsions, and hyperactivity are now available.

Treatment approaches for children have been operationalized. Therapy manuals exist for psychoanalytically oriented treatments (91), family therapy (92), cognitive therapy (93), parent training (94), social-skills training (95), mother-infant interventions (96), and brief psychotherapy of varied modalities (97), to name but a few.

Behaviour modification and cognitive-behavioural techniques account for about one-half of all treatment studies over the past 20 years (98).

Fonagy and Target undertook a retrospective chart review of more than 750 cases of child psychoanalysis and psychotherapy at the Anna Freud Centre (99). The authors found that long-term (longer than 6 months), intensive (4–5 times weekly) therapy was significantly more effective than short-term (less than 6 months), nonintensive (1–3 times weekly) therapy for preadolescent patients, while the reverse was true for teenagers. Children with internalizing disorders did better than those with externalizing disorders, but the difference disappeared when intensity and duration of treatment were controlled for. Intensive treatment was especially beneficial when the disorder was severe. When the disorder was less severe, there was no difference between intensive and nonintensive therapy. The study findings may not be generalizable because of a selection bias of the clinical population, the lack

of control subjects, and the retrospective nature of measuring improvement.

Does child therapy work? If one takes a broad-based metaanalytic approach, then the answer is "Yes." Studies that include age ranges 2–18 years and cut across modalities and types of problem as recently as 1995 show mean effect sizes ranging from 0.71 to 0.84 (100–104), which is similar to outcomes in metaanalytic studies of adult psychotherapy. The average child after treatment functioned better than did 78% of control-group children.

Nevertheless, a specific treatment is likely to vary in effectiveness as a function of child, parent, family, community, therapist, therapy, and temporal or developmental factors.

Aggressive and antisocial behaviour (conduct disorder) is one of the most extensively studied problem domains. Patterson and others have demonstrated improved behaviour at home and school (105). Long-term improvement has been difficult to document.

CBT for depressed children and adolescents has resulted in significantly reduced functional impairment and depressive symptomatology, compared with placebo discussion groups, waiting list only, and no treatment (106).

Metaanalytic studies of family therapy show effect sizes ranging from 0.45 (107) to 0.70 (108). Diagnostically, the greatest family-therapy successes have appeared for children with schizophrenia, for which psychoeducation to reduce "expressed emotion" reduces the probability of relapse (109) and rehospitalization (110); family members with anorexia nervosa and bulimia, in which weight gain and normal menstrual functioning are better maintained than with individual therapy (111); and children with conduct disorder, where parent management training (112,113), functional family therapy (114), and multisystemic family therapy (115) have all resulted in lower recidivism rates among delinquents and improved family functioning.

A metaanalysis of child and adolescent psychotherapy effectiveness concluded that research evidence for efficacy is clearer for behavioural than for nonbehavioural therapy (102,116).

### **6. Brief Therapy**

#### *Outcome Studies*

Howard and others examined the "dose-effect" relationship in psychotherapy (117). They reported a metaanalysis of 2431 outpatients with varying diagnoses and lengths of treatment over a 30-year period. The results indicate that, by the 8th session, approximately 50% of patients measurably improved and that 75% improved within 26 sessions. Kopta and others analyzed the dose-effect relationship of 854 psychotherapy outpatients by examining differential dose-effect curves in relation to 3 classes of symptoms (118). Acute

distress symptoms showed the highest average percentage of patients recovered, across doses, compared with the other 2 classes. These studies clearly illustrate the large therapeutic gains that patients can acquire in a brief amount of time. Further, this research highlights the importance of selection criteria in determining which patients would be more suitable for long-term treatment. We need more studies of patients with chronic psychiatric symptoms, severe trauma, and characterological disorders, which often require long-term therapy to attain remission and prevent relapse. Other studies, using Mann's time-limited psychotherapy (119) and short-term anxiety-provoking psychotherapy (120) with trained therapists, confirm that symptomatic improvement is stable over follow-ups at 6 months, 12 months, and even 2 years. This is consistent with a general trend in psychotherapy-outcome research that gains achieved during therapy are maintained after therapy (121).

#### *Comparative Outcome Studies*

A comprehensive review by Lambert and Bergin (121) and Robinson and others (122) of comparative outcomes for depressive disorders showed that verbal therapies were inferior to CBTs. However, once treatment allegiance was accounted for through regression analysis, the outcome of all therapies was equivalent (121). Sloane and others randomized 90 outpatients to short-term analytical psychotherapy, behaviour therapy, and minimal-treatment while on a wait list (123). No differences in outcome were found between the 2 treated groups, and this was replicated at the 8-month follow-up. This well-designed study was reinforced by the National Institute of Mental Health (NIMH) collaborative depression study (124), and more recently, Shapiro and others concluded that brief psychodynamic-interpersonal therapy and CBT are equally effective for depression (125).

#### *Metaanalysis and Brief Psychotherapy*

Smith and Glass reviewed 400 controlled psychotherapy outcome studies by metaanalysis (126). Their results include that effective treatment is achieved by a mean 17 sessions and that short-term approaches are significantly effective. Similarly, Crits-Christoph's rigorous metaanalysis of 11 brief dynamic psychotherapy studies provides evidence that brief dynamic therapy is about equal to cognitive and behavioural therapies, as well as to medication (127). Diguier and others confirmed previous studies that various psychotherapies do not differ in effectiveness (128).

#### *Psychotherapy Process Research*

Process-outcome studies identify specific events within psychotherapy sessions and determine whether their occurrence or absence is correlated with or predictive of outcome (129). Significant predictive results of positive outcome have been found for the following factors: severe psychiatric pathology, positive therapeutic alliance, and accurate interpretations

(130–132). Piper and others have also demonstrated that the quality of object relations is a strong predictor of therapeutic alliance and psychotherapy outcome (133). Further, group therapy has been used effectively in a brief format. Many authors are now focusing on measuring interpersonal relationship patterns and their significant impact on outcome (134–137).

#### *Conclusions*

Brief therapy is currently underused in Canada, despite its clear advantages and proven efficacy.

### **7. Long-Term Psychiatric Care**

Although there is general agreement that most serious psychiatric illnesses either endure or frequently return, there is surprisingly little consensus about the need for continuity of psychiatric care. Some advocate the consultation model (ongoing treatment by a family physician with "as-needed" consultations by different psychiatrists). Others advocate the case management model, where continuity is provided by a nonmedical case manager (which position may be filled by different individuals) with the psychiatrist serving as a peripheral member of the treatment team. Others support the role of psychiatrist as long-term primary care provider for seriously ill patients with enduring or relapsing illnesses. This means a long-term commitment to those patients with regular (not necessarily frequent) contact over many years and essentially permanent access to further treatment as needed.

The essence of providing long-term psychiatric care is giving patients access to intermittent but known and trusted caregivers.

### **8. Long-Term Psychotherapy**

#### *Efficacy and Cost-Effectiveness of Long-Term Psychotherapy*

Certain methodological problems are involved in studying long-term therapy. We need more data and better conventions to measure improvement. Banon and others conducted a metaanalysis of the outcome studies of psychotherapy for patients with personality disorder (138). They identified all studies that used systematic means of making the diagnoses, incorporated valid outcome measures, and allowed for the calculation of magnitude of effect. The correlation between the remission and the duration of treatment was investigated. The frequency of sessions varied from once weekly for inpatients to once or twice weekly for ambulatory care. Cognitive-behavioural and psychodynamic orientations were equally represented. The mean magnitude of effect was 1.00–1.04 for the experimental group and 0.25–0.50 for the control group. With treatment, 11.57% of patients remitted each year, so by 8.33 years, no patient had a diagnosis of a personality disorder. This contrasted with 5 natural-history

studies of BPD resulting in a remission rate of 3.7% yearly, necessitating 24 years for 100% total remission (139).

Further, these authors found that once-weekly sessions led to 50% remission after 2.45 years and 100% remission after 8.7 years. With twice-weekly sessions, these figures were halved to 1.22 and 4.3 years respectively.

In another series of studies, patients with a diagnosis of a BPD manifesting self-mutilation, with or without suicidal intent, were conducted by Linehan (140,141). The experimental group received weekly individual and group psychotherapy sessions for 1 year, compared with a control group that received "treatment as usual," averaging 20 sessions yearly on an outpatient basis. The results indicated that the yearly average number of self-mutilation incidents was 1.5 (of less medically severe nature) for the experimental group, compared with 9 for the control group. The number of inpatient days yearly was 8.6 for the experimental group and 38.86 for the control group, a highly statistically significant finding. Further, the experimental population, on average, worked 5 weeks more every year than did the control group. Regarding the cost of psychiatric hospitalization, the experimental group averaged \$6083.00 and the control group \$27 940.00, which constitutes significant savings (142). The gains achieved by the experimental subjects were generally maintained at 1 year follow-up, one-half of them remaining in therapy beyond 1 year. Linehan opines that 1 year of therapy is too short and that 2 years are required for treatment effects to stabilize, at which point 20% will remain stable, while 50% will relapse within 2 years and will require 2 more years of intensive therapy.

A recent prospective study examined the outcome of intensive psychodynamic psychotherapy, an average of 25.4 months, for 23 patients with personality disorder. The findings, beyond symptomatic improvement, indicated that 75% of patients who met Axis I diagnosis criteria and 72% who met Axis II diagnosis criteria no longer fulfilled these diagnostic criteria after therapy. At 5-year follow-up, the findings showed statistically significant improvement on scores for symptoms, characterological defences, and affectivity, while 68% reduction in personality disorder diagnosis was maintained (143).

Luborsky and others recently reviewed all studies that compared psychodynamic treatments with other well-known treatments (such as CBT, behavioural, group, and experiential treatments) (144). To be included in the review, studies had to score well on a list of criteria for good psychotherapy studies. He concluded that outcome was generally quite comparable in many patient populations.

Numerous recent studies on patients with personality disorders show that psychodynamic psychotherapy is effective in ameliorating personality difficulties, even in its early to mid stages of treatment. Stevenson and Meares of Australia

evaluated the effectiveness of a psychodynamic psychotherapy for patients with BPD (145).

In Norway, Monsen and others reported on a prospective study of patients with personality disorders receiving psychodynamic psychotherapy (146). The majority of patients had previously tried less intensive forms of treatment. At treatment completion, 72% of patients no longer qualified as having a personality disorder. These gains were maintained at 5-year follow-up.

*Depression.* There is now evidence that longer-term treatment may be necessary for depression. The NIMH Collaborative Study of Depression, a very highly regarded multicentre control study of 16 weeks of medication, CBT, and IPT treatment for depression, initially showed good results at 16 weeks but had very disappointing results at 18-month follow-up (147). Klerman and Weissman, who developed the short-term interpersonal approach used in the study, wrote: "The percentage of patients who had recovered during acute treatment, but who remained well over the 18-month follow-up, was disappointingly low, ranging from 19% to 30%. The rate of relapse for those who recovered—30% to 50%—was disappointingly high. These rates were not significantly different between [NIMH] treatment groups" (148, p 832). Shea and others conclude that "16 weeks of these specific forms of treatment is insufficient for most patients to achieve full recovery and lasting remission" (147, p 782). Clearly brief psychotherapy or brief medication is not the answer to all depressed patients' needs. It appears that current short-term therapies are more effective at relieving symptom distress than in improving patients' adaptive functioning (149). Certainly we need to study further how to measure improvement and how to maximize improvement with cost-effectiveness.

Blatt and others from Yale University have begun to further separate out subgroups of depressed patients who need long-term treatment (150). Recently they analyzed data from the NIMH study and found, for example, that self-critical patients (who are more likely to attempt suicide) did not improve in any of the treatment conditions, all of which were short-term (medication, IPT, CBT, and clinical management). Blatt and Ford have recently shown that inpatients who are self-critical and receive psychodynamic psychotherapy 4 times weekly do improve after 15 months of treatment (151). "Perfectionistic patients do poorly in brief treatment for depression, they are significantly more responsive to long-term, intensive psychoanalysis and psychoanalytically oriented inpatient treatment" (150).

*Consumer Satisfaction.* Because of important limitations on the methodology of control studies, it is essential that control studies be supplemented by natural studies, which examine patient satisfaction with psychotherapy as it is actually practised. Seligman has reviewed several limitations of control trials (152). For instance, in random clinical trials, therapists

are assigned to patients; in practice, patients actively seek out the kind of therapist they want. In psychodynamic treatments “the patient–therapist match” is shown to be very important. The recent, massive Consumer Reports survey showed that patients are very pleased with their long-term treatments (152). Of 4000 readers surveyed, almost all who sought psychotherapy reported improvement and longer treatment length (which included the psychodynamic treatments), which correlated with better outcomes. Those in managed care had worse outcomes.

#### *The Economic Impact of Psychotherapy*

Cost of treatment defies simplification and involves consideration of the following issues: cost-minimization—for example, psychotherapy is less expensive than alternative methods; cost-effectiveness—that is, the combination of cost analysis with a single endpoint (such as a depression-free episode); cost-utility, where multiple clinical endpoints are summarized into a single measure (such as work performance following psychotherapy-induced relief from BPD diagnostic criteria); cost-benefit analyses, where clinical effectiveness is expressed not in terms of disorder-free episodes or attrition in suicide rate but in monetary terms (153).

A study of the cost-minimization of combining psychotherapy and antidepressants in treating hospitalized depressed patients demonstrated that spending, on average, \$257.50 on psychotherapy saved \$25 405.00 for each hospitalized patient due to shortened length of stay, which represents almost \$100.00 of savings for every dollar spent on psychotherapy (154). The same investigator found that monthly psychotherapy maintained freedom from relapses for almost twice as long as did clinical management and placebo.

The expansion of psychotherapy coverage by the CHAMPUS program, which provides health care insurance for US military personnel and their families, resulted in a net savings of \$200 million during the 4-year study, 1989–1992. The cost-offset was the result of reduced use of inpatient services. For every \$1.00 spent on psychotherapy, \$4.00 was saved in accrued inpatient costs (155).

We report here one finding of an early cost-offset study; its results converge with those of more recent studies, and the effects of psychoanalysis, and not only of intensive psychotherapy, were investigated. In Germany, 845 patients receiving these 2 modalities of therapy required significantly less medical hospitalization during a 5-year period, compared with a sample that did not. Prior to treatment, psychotherapy patients averaged 5.3 days in hospital, compared with 2.5 days for the control sample. However, 5 years posttreatment, the average for the psychotherapy patients was 0.78 days yearly (156). Despite these results, the German health care system years later saw fit to deinsure intensive psychotherapy and psychoanalysis, only subsequently to reinstate them

when it was shown that their cost-benefits were so substantial that even psychoanalysis paid for itself over the years.

A natural experiment of the effects of limiting outpatient psychotherapy coverage in New Zealand compared with that in Australia was published. Australia was found to have twice the number of psychiatrists and one-half the number of psychiatric beds per capita, compared with New Zealand. Further, the population in some areas of Australia enjoys unlimited health insurance coverage of outpatient psychotherapy on a fee-for-service basis. The findings showed increased burden on state-hospital beds and higher per capita mental health expenditure in New Zealand, mainly due to the greater rate of bed use—126 beds per 100 000 costing \$7 million, compared with Australia at the rate of 74 beds per 100 000 at a cost of \$4 to \$5 million. The demographic characteristics of both countries are similar. Treatment options in New Zealand are largely biological, while in Australia, intensive psychotherapy and psychoanalysis are also available (157).

A recent review of the available psychotherapy studies that emphasize the economic effects produced by psychotherapy concluded that 80% of the randomized clinical studies and 100% of the nonrandomized trials indicated that psychotherapy reduces several costs. In combination, 16 of the 18 (88.9%) studies reviewed yielded evidence of a beneficial economic impact in treating severe and chronic psychiatric disorders, including schizophrenia, bipolar affective disorder, and BPD. This impact results from reduced inpatient care and reduced work impairment (153).

#### **9. Continuing Medical Education**

The profession of psychiatry is in a state of substantial ferment. A particularly heated focus relates to the role of psychotherapy in the practice of psychiatry (158–160). This controversy is particularly ironic in light of the fact that “there are now well over 500 studies that attest to the efficacy of psychotherapy . . . ; it seems that psychotherapy is one of the best documented medical interventions in history” (161). At a time of the greatest empirical support for the efficacy of psychotherapy, it is under its greatest threat; this raises the key issue, not of effectiveness, but of accountability.

As the major professional psychiatric organization in Canada, the CPA must assume responsibility for fostering, through continuing education, the accountable and effective practice of psychotherapy. This may begin by performing a detailed needs assessment of practicing psychiatrists, to better shape and guide the necessary retooling and retraining that developments in contemporary psychiatry and psychotherapy demand. Formats to ensure sufficient intensive and extensive exposure are required to actually modify clinician behaviour. We suggest several foci for continuing education in the psychotherapies to reflect the current state of research,

including skill acquisition in the newer therapies such as CBT, IPT, brief dynamic therapy, and integrative psychotherapy. Also, specific training in the functions of consultant and supervisor should be emphasized, anticipating the greater role in the indirect delivery of services that psychiatrists will serve.

This may necessitate addressing certain ideological resistances to the applications of these psychotherapeutic approaches. Although the efficacy of CBT and IPT in the treatment of depression and anxiety disorders is substantial, Persons and others note that traditionally trained psychodynamic therapists experience significant reservations in learning to practice CBT (162). Fundamental misconceptions about CBT include those regarding the nature of the therapeutic relationship in CBT, the focus of CBT interventions, and the depth of change effected. Yet, when these resistances are overcome, psychiatrists are able to employ a broader range of interventions, both as stand-alone and as part of psychotherapy integration (163). It is the integration of psychotherapy and psychopharmacology that is a unique strength of psychiatry and offers particular potency in the treatment of depression, both in the acute and maintenance phases (164,165). Hence, continuing education should include examining models of integration, their strengths and limits, and the potential to misapply integration, looking to common factors, technical eclecticism, and/or an overarching metatheory to guide clinical strategies (166).

In the area of brief dynamic psychotherapy, Barber highlights the fact that dynamic therapists often employ techniques best suited for long-term therapies, although they are compelled both by patient choice and potential coverage restrictions to treat patients over a shorter period of time (167). Continuing education opportunities to enhance the practitioner's ability to identify, collaboratively, a focus of treatment and maintain the proper balance of support and expression for effective treatment are essential. Issues of selection and focus become ever more important in brief dynamic psychotherapies. Recognizing the limits and applications of short-term therapies and the role of long-term dynamic psychotherapy is critical (168,169).

The CPA must foster further rapprochement between research and therapy (170), helping to translate research findings into practical, clinical strategies, dispelling the anachronistic view that laboratory research relates little to actual clinical practice. It is essential in this regard to incorporate the findings of naturalistic studies (161), reflecting what occurs in the real setting of psychotherapy with real patients and real therapists (171), and of randomized control trials of psychotherapy (168).

Howard and others recommend a model of easily employable, critical evaluation to provide clinical feedback regarding the status and progress of ongoing psychotherapies that

can inform both patient and therapist (161). Such evaluation translates the clinical relevance of research from a conceptual issue into one of practical clinical application. This can be achieved through measurements of therapeutic bond, mental health index, and clinical assessment index. This additional form of check and balance may help enhance accountability by identifying, early on, treatments that are not progressing and which may require consultation or alternative treatment approaches.

In addition to specific areas of psychotherapy, continuing education should also address the psychiatrist's role as a consultant to other allied health professionals. Continuing education opportunities should help Canadian psychiatrists to establish effective, collaborative, consultative alliances with individual practitioners or agencies and to develop the capacity to observe, listen, and respond in a way that recognizes patient, therapist, interactive, and systemic contributions to treatment success, stalemate, or negative outcome (172). Related functions include the ability to identify problems that reflect misapplication of technique or countertransference (173) or problems that emerge from an initial inadequate or inaccurate understanding of the patient (174).

## 10. The Cost-Effectiveness of Psychotherapy

The study of the cost-effectiveness of treating medical conditions is a relatively new area of study. This is particularly true for psychiatric conditions and even more so for the area of psychotherapy.

### *Efficacy*

The evidence demonstrating the efficacy of psychotherapy is plentiful and consistent. Compared with wait-list, no-treatment, or minimal-treatment conditions, the psychotherapies have been shown to be effective at reducing symptoms and improving global and social functioning, among other specific effects (175). This is important because if a treatment is not efficacious, it cannot be cost-effective either. Comparative studies of the efficacy of psychotherapy generally have not found robust differences between treatments. Nonetheless, even if 2 treatments are found to be equally effective, compared with, say, a placebo or wait-list condition, one may still be associated with fewer costs and therefore be more cost-effective.

### *The Study of Cost-Effectiveness*

The idea of studying the cost-effectiveness of psychotherapeutic treatments versus no treatment or other active treatments has only recently been raised in the general psychiatric literature. Krupnick and Pincus pointed out the discrepancy between the vast literature demonstrating the efficacy of psychotherapy and the sparseness of literature on its cost-effectiveness (176).

One landmark study examined maintenance treatments for recurrent depression among individuals who recovered from major depression and stayed well for 17 weeks (177). After recovery, these individuals were randomized to 1 of 5 maintenance conditions: placebo, once-monthly maintenance sessions of IPT (IPT-M), IPT-M plus placebo, imipramine, or IPT-M plus imipramine. Using the data on relapse obtained on follow-up and applying several estimates, they modelled the data. Using cost-utility analysis, they first estimated the quality of life for subjects in each condition for the rest of their life. This assumed that the risk for depression associated with each condition was stable over time. They then calculated the different effects for each treatment condition as the costs for each additional quality-of-life year that would be obtained by one condition compared with another over time. Thus they could estimate whether a treatment condition was effective, did or did not reduce medical costs, and was cost-effective compared with another. Much of the data for their estimates, such as the quality of life during depression as opposed to when well and the likelihood that the hazard for recurrence would remain stable until the end of life, were based on other studies, often only one. They demonstrated that both active treatments improved health outcomes in comparison to placebo, but that only the drug-alone condition also reduced health care costs. The drug alone and IPT-M plus drug were more effective and cost-effective than was IPT-M alone. The drug plus IPT-M treatment also improved the quality of life, with costs that are generally within the range of those for "cost-effective treatments," in most medical studies defined as less than US\$50 000 for each additional quality-of-life year. The generalizability of the authors' conclusions is affected by the many conditions and assumptions in the study. For instance, the authors assumed that psychotherapy maintenance would not have a cumulative effect of decreasing the hazard function for relapse over time. Thus, the results would not necessarily generalize to a long-term psychotherapy study that aimed at reducing that hazard by treating (decreasing) the psychological vulnerability to the trigger mechanisms for recurrence. In other words, the treatment model under study limits the conclusions to monthly maintenance treatment situations, which may differ from the real-life treatments offered by psychotherapists treating recurrent depression. Another limit to generalizability is that the study pertains only to patients who had a full recovery from their index episode of depression and remained well for 17 weeks before being accepted into the maintenance study. In fact, psychotherapy might be most likely to be prescribed for patients who do not have a full recovery with or without drug treatment or who relapse quickly or have frequent recurrences despite adequate trial on antidepressant medication.

Gabbard's paper, which demonstrates cost-effectiveness of psychotherapy, may be useful to generate future research (153). He reviewed the literature and stated that the findings

of 8 of the 10 clinical trials with random assignment (80%) and all 8 of the studies without random assignment (100%) suggested that psychotherapy reduces total costs.

#### *Uses and Limits of Cost-Effectiveness Studies*

Richard Frank (178), a health economist specializing in mental health, stated that the challenge for policy research is "to formulate approaches for decision making that balance concerns related to errors such as: (1) paying for ineffective care; (2) excluding effective treatments, and, (3) covering treatments shown to be cost effective that are not used 'cost effectively.'" He notes that "issues of cost-effectiveness are often raised in connection with mental health in a rather cynical manner in order to justify reduced budgets in public programs or to avoid paying for programs that attract 'bad risks' in private insurance." Finally, once decisions are made, they may be vitiated by changes in how things are paid for. For instance, Frank notes that "cost-shifting has long been a pervasive strategy in the mental health sector." A decision that is cost-effective for a funding source may not be so for an agency carrying out the actual treatment, if costs are shifted downward as a result. Thus there are many caveats to how the existing literature might be interpreted, and there is no substitute for developing an empirical literature that addresses questions specific to the health care environment of the Canadian provinces.

#### **Conclusions**

Educational authorities and professional associations in many countries identify the psychotherapies as essential clinical skills for psychiatrists.

Despite this agreement, current teaching in the psychotherapies is deficient. We identified 2 reasons. Faculty members lack expertise in the newer therapies. Also, long-term psychotherapies are underused, which deprives students from developing these skills.

Current research has provided significant evidence for efficacy of most major modalities. Cost-effectiveness studies are promising, but they are a new development.

Psychotherapies are core services to which patients wish and require access.

Improvements are necessary in training, in continuing medical education, and in accountability of the current system.

For a psychiatrist to function effectively as a supervisory consultant or leader of a multidisciplinary team, some psychotherapeutic knowledge and skill is essential.

Balancing short- and long-term as well as newer therapies is desirable.

In research, promising new studies are demonstrating how psychotherapeutic and computerized interventions generate changes in brain metabolism. It may be that an empathic,

nurturing relationship over time changes neural mechanisms. More study will be needed to explore this. Newer techniques, integration of therapies, and combination of psychotherapy with pharmacotherapy are areas for further research.

The combination of pharmacotherapy and psychotherapy can enhance outcome in many psychiatric disorders.

Psychotherapy should be available to all patients, including those with serious illnesses, those with mental and physical disabilities, elderly individuals, and those from other cultures or of different sexual orientation or who are economically disadvantaged.

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