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A storm in a teacup: a commentary on the 'Consensus conference on psychological therapies for anxiety and depression'

Silvia Paola Papini,* *Fabio Vanni***

Abstract. – This work is intended as a critical interpretation of the Consensus conference on psychological therapies for anxiety and depression which today comprises a document that is officially adopted by the Ministry of Health and is therefore the reference for operators in the sector. This formal authority makes it advisable for the document to be understood and assessed in depth. The main areas covered in the document are analyzed here, distinguishing between the report for the jury and the recommendations made by the jury itself. As we will see, there is a great difference between the two aspects and, therefore, the document itself contains some issues which the members of the jury themselves have already mentioned. However, others deserve attention: the insufficient examination of childhood and adolescence, the narrow perspective held on the types of studies considered useful, and the recommendations regarding training. These are serious limitations, which make the document in appearance anyway (albeit with the best intentions), an unconvincing text which needs extensive revision in order to reach acceptable standards.

Key words: psychotherapy, anxiety and depression, scientific research, public-private, efficacy.

Introduction

In 2022, at the end of a process started a few years earlier, the document 'Consensus conference on psychological therapies for anxiety and depression' was published by the Italian Higher Health Institute (*Istituto Superiore di Sanità*). Originating from the initiative of the University of Padua – The Department of General Psychology – with the aim of 'promoting knowledge and application of psychological therapies of proven efficacy for anxiety and depression and facilitating the accessibility of the population to

*Psicologa, Psicoterapeuta, Responsabile scientifico 'Gruppo Zoe. Per lo studio e la formazione sulla qualità e l'efficacia delle cure psichiche', Coordinatore Italiano OPD-3, Socio Ordinario SIPRe. E-mail: sppapini@yahoo.it

**Psicologo, psicoterapeuta, Dirigente AUSL Parma, Direttore RP, Direttore Scientifico 'Progetto Sum'. E-mail: fabiovanni@progettosum.org

appropriate care, particularly psychological care, in order to reduce the current treatment gap' (Gruppo di lavoro "*Consensus* sulle terapie psicologiche per ansia e depressione" - di seguito "Gruppo di lavoro Consensus", 2022, p. 3). The intention, in our opinion is acceptable and commendable and arises from the finding that, among other things, in the National Health Service the therapies that are most frequently provided are mainly pharmacological, often not taking into consideration the person that requires them, the impact that discomfort can have on his/her life and the personal and psychosocial resources he/she has. At present, we have sufficient data, which is also well described within the Consensus Conference (Bandelow *et al.,* 2017; Barkowski *et al.*, 2020; Cuijpers *et al.*, 2020; Fava, 2002; Furukawa *et al.*, 2017, 2021), to say that in many cases these are not the treatment of choice, despite national and international data showing that over 80% of people seeking care receive prescriptions for antidepressant drugs. A reasoned *review* of studies for the treatment of depression is also found in Chapter IV of 'The Competence to Cure. The contribution of empirical research' (Fava & Gruppo Zoe, 2016).

Specifically, the objective of promoting psychological therapies is articulated in a number of areas in which the state of the art, strengths, and challenges can be identified, and actions to make real changes in favor of this promotion can be taken. Brusaferro, President of the Higher Health Institute, describes them well in his premise to the Consensus:

1. Recognition of disorders and treatment plans;
2. Access to services and more generally to treatment;
3. Academic training and graduate schools;
4. Promotion of research.

For us, in more detail, this means:

1. Knowing how to identify that this type of suffering is involved, understanding its severity and impact on the life of the individual, understanding the milder forms, and catching them early – in short, knowing more about what is being discussed. It is estimated that people with different forms of anxiety and depression which become debilitating and impacting to them, where suffering does not become an opportunity for growth and self-appropriation, but a trap that limits and confines the person in dysfunctional spirals are about 7% of the population in a year, and up to about 20% of the population experiences this malaise within their lifetime;
2. It is estimated that people with these types of symptoms, which are called 'common emotional disorders' or 'common mental disorders', account for about 50% of the demand for the Italian national health service (NHS) and that there is a shortcoming in the corresponding services offered. This is probably due to the fact that over the years, given the limited resources available, the NHS has concentrated more on taking

care of serious disorders (personality or psychotic disorders) and has neglected all the requests that are the subject of this document. Meanwhile, this problem has been oriented towards the private sector with problems of accessibility for a large part of the population (linked primarily to the economic aspect), and therefore of the risk of being undiscovered and becoming chronic for those who do not find adequate and timely answers;
3. Giving psychotherapists (but not only) more tools in the training phase to learn about these issues, to know how to identify critical situations, to have the skills on how to accompany people in a treatment course, but also giving them tools to understand the results of scientific research and to be guided by them;
4. Supporting research, taking a greater interest in it, increasing studies on the evaluation of treatment outcomes, on the process, making them an integral part of the service we provide to patients.

The document was divided into two parts. In the first part, a group of experts asks questions and puts forward topics and data to support them. In this case, we are dealing with twelve questions organized into four areas. The second part of the document was formulated by a jury that answers the questions and makes the actual recommendations.

Firstly, what is clear is that there is a large gap between the first and second parts, that is, between what is proposed and what is accepted, and for us, too, certain aspects of the proposed document appear to be very ambiguous, as we will try to demonstrate below.

The final report for the jury

Let us now explain and comment on some aspects of the first part of the document.

In this section, they refer to and consider some of the most important international guidelines [such as the National Institute for Health and Care Excellence (NICE) guidelines and the American Psychological Association (APA) guidelines] and the Improving Access to Psychological Therapies (IAPT) model. This model has been active in the United Kingdom since 2006 and was developed by David Clark to increase the offering of psychotherapy and facilitate access to treatment. This model is contemplated in detail, and one of its main points is the importance of a stepped care approach, that is, to provide different levels of care depending on the outcome of the initial assessment, to collect outcome variables, and to provide therapists with regular supervision. Important aspects and services on which we believe it is essential to improve in our country as well.

However, it should be noted here that the initial assessment should be

made by expert staff who understand the problems that arise, the opportunities for treatment, the outcomes, and not by gatekeepers – usually due to a lack of resources – with economically oriented selection functions. The appropriateness of the treatment is the guide to be inspired by and requires competence, the ability to coordinate with professionals who have other skills, which must also be identified, *etc*. Otherwise*, stepped care* is an economic selection that also opens up other opportunities for those who can afford it and leaves those who cannot in the dark.

However, there are other points that are critical in our opinion, such as the choice of the type of psychotherapy offered, which is based on efficacy studies according to the Randomized Controlled Trials (RCT) methodology, and also the training of therapists on specific protocols, which refer to therapy manuals. It is also striking that these points are highlighted in the experts' report for the jury, as standards to follow rather than partial aspects to be taken into account together alongside others.

Furthermore, while the recommendations of the jury highlight important deficiencies in research related to childhood and adolescence (Gruppo di lavoro Consensus, 2022, p. 91), it is not possible to refrain from including subjects of this age group among the subjects of these recommendations.

Among the criticalities, we cannot fail to mention that Silvio Garattini, Founder and President of the Mario Negri Institute and President of the Jury, in the presentation of the final report of the Consensus Conference to the jury itself declared that 'The variety of forms of psychotherapy must be evaluated in relation to the effectiveness of cognitive psychotherapy, the most studied therapy from a scientific point of view' (Gruppo di lavoro Consensus, 2022, p. ix). A statement that deserves to be commented on.

It seems that we are still paying the price of an ancient legacy, the one for which psychotherapy has made its way to find itself a legitimate place alongside the longest and most consolidated form of care, medicine. It also seems that this path to legitimacy has been found by trying to highlight what might be closer to medicine itself at the expense of what could be differentiated, and not through integrating common aspects to build a shared project. In short, starting from the first objections (Eysenck, 1952, 1961, 1966; Rachman, 1971 *vs.* Bergin, 1971; Luborsky *et al.*, 1975; Rosenzweig, 1954; *etc*.) in the 1950s, 'The great psychotherapy debate,' as it was called by Wampold and Imel in their contributions on this subject (Wampold & Imel, 2015), has not ended despite the birth and development of research in psychotherapy, and has brought with it, along with opportunities for growth and greater legitimacy, also this disruptive aspect so that in order to assert itself it is necessary to discredit others [*mors tua vita mea (their loss is our gain*)]. However, as the two authors point out quite dramatically, the same debates are being held where over the years some empirical evidence has been gathered to support different points of view.

As for the scientific aspects, Garattini's sentence refers to the fact that the whole document refers to 'effective' treatments, where efficacy is understood as statistical efficacy since the studies used to evaluate efficacy are those that follow the RCT model.

'RCTs are the gold standards for research into the effectiveness of psychotherapy', which are not limited to randomly assigning patients to different groups but have a differing sophisticated methodological apparatus. Regarding psychotherapies in our country, no randomized controlled clinical trials have been conducted so far that have been replicated by independent teams. Nor are they expected to be replicated in the near future, as size, complexity, and costs go beyond the scientific resources of the country's system. Based on the quality and quantity of research, a hierarchy of 'efficacy tests' is established for a certain psychotherapeutic treatment for different disorders […] the highest level is that of 'well-established treatments' (among the requirements are at least two RCTs, carried out by two separate research groups, attesting superiority over placebo or an alternative treatment that is superior to the placebo' (Gruppo di lavoro Consensus, 2022, p. 44).

This line of study is the one historically carried out by the APA Division 12– Society of Clinical Psychology and is called Empirically Supported Treatments. On their website, you can find a regularly updated list of treatments, divided into treatments of proven efficacy, probable efficacy, *etc*. First of all, it is important to note that even within Division 12, proof of efficacy has been added through single-case experimental designs (at least 9) as a criterion of proven efficacy. Not all forms of psychotherapy can be studied through the RCT methodology, which requires defined times and criteria that do not correspond to some forms of treatment, for which different research methodologies, such as that of single cases, must be used.

In addition, the scientific community is very well aware of the limitations that RCT studies entail:

- the very strict selection of patients, which must be homogeneous in terms of diagnosis, for example, excluding all situations where there is a co-morbidity, which is in fact the reality for most people who come to ask for help; let us remember that diagnostic systems serve to give us elements to describe aspects of human complexity and not to create objective realities or truths, since every person is a unique and unrepeatable expression of biological-genetic, experiential, relational, social and life aspects; it goes without saying that co-morbidity is expected, and even the more classic categorical diagnostic systems are increasingly moving towards a dimensional perspective;
- the demand to follow therapy manuals, where literature has shown that following a manual pedantically leads to less effective results than therapies where the clinician takes on the aspect of care first-hand and per-

sonalizes the treatment flexibly and 'self-corrects' it during the process; in fact, we know that the rigidity of interventions is a detrimental factor in the success of therapies, particularly at a time when breaks in the therapeutic alliance are taking place (Henry, 1994; Rennie, 1994; Rhodes *et al.*, 1994; Safran *et al.*, 2001);

- real treatments do not have a fixed duration, but it is often variable because it is closely linked to each specific situation;
- limiting the choice of therapy and therapist harms the alliance, which is the primary outcome factor; while there is little awareness on behalf of users of differences in theories and techniques in the psychotherapy field, every patient has his or her own theory of his or her suffering and the ways one can get out of it; patient preferences are related to successful treatment; the Consensus Conference states this aspect to support the choice of psychotherapy treatment over medication: 'Many people (about half) prefer psychotherapy to drug treatments: if this preference is met there is greater availability and adherence to treatment (Deacon & Abramowitz, 2005; Paris, 2008; Patterson, 2008; Solomon *et al.*, 2008; Vocks *et al.*, 2010)' (Gruppo di lavoro Consensus, 2022, p. 27);
- efficacy studies do not identify the characteristics for which treatment is effective. It is assumed that there are specific aspects that make it effective, but non-specific aspects of treatment that may be transversal to the type of treatment are not taken into account, such as building a relationship of trust with the therapist; the conclusions of the APA Group working on therapeutic Relations (Norcross, 2001) state that: 'Attempts to develop practical guidelines based on evidence of effective psychotherapy while neglecting the therapeutic relationship are entirely incomplete and potentially unsatisfactory in both clinical and experimental settings.'

Stressing the limitations of RCTs does not mean discrediting their value, which remains important in terms of internal validity, but describing their partiality in terms of external validity means the strict criteria necessary to carry out these studies make the results less generalizable. This is the idea of understanding research in a broader perspective, especially regarding respect for clinical practice.

In the text of the Consensus Conference this is only 'hinted at' in some points of the text leaving the reader rather lacking in depth with respect to what can be understood: 'For completeness, it is necessary to mention the fact that over the last decade studies, editorials and meta-analyses have been published which call into question the principle of the efficacy of a psychotherapy based on the traditional RCT approach and the resulting effect sizes (see Shedler, 2018; Wachtel, 2010)' (Gruppo di lavoro Consensus, 2022, p. 15).

And further on: 'Additional caution stems from studies, editorials, and

meta-analytic revisions, published over the last decade, that cast doubt on the principle of the efficacy of psychotherapy based on the traditional RCT approach and the resulting effect sizes. Despite the different methodologies employed, these studies have highlighted some methodological limitations of RCTs in psychotherapy on which the guidelines are based and the substantial non-superiority of some psychotherapies over others in relation to the disorders studied, the follow-up methodologies used, and the outcomes considered. Please refer to the following bibliography: American Psychological Association, 2012; Chambless & Ollendick, 2001; Clark, 2017; Cuijpers *et al.*, 2016, 2020; Flückiger *et al.*, 2014; Guidi *et al.*, 2018; Keefe *et al.*, 2014; Shedler, 2018; Thornton, 2018; Tolin *et al.*, 2015; Watchel, 2010; Westen *et al.*, 2004 (Gruppo di lavoro Consensus, 2022, p. 53).

In fact, shortly after talking about experimental efficacy, we find this written: 'What has been said so far constitutes only one side of the coin. It concerns a relatively abstract meaning of the term 'efficacy', as it is obtained under optimal conditions of advanced research: this type of efficacy is usually called 'theoretical efficacy'. The other side of the coin is occupied by questions of practical effectiveness and efficiency (Gruppo di lavoro Consensus, 2022, p. 45).

We believe it makes sense to talk about the other side too, in a text that aims to promote culture and the provision of psychological treatments alongside or as an elective treatment to pharmacological therapies, but also independently of them.

Therefore, we will go into some more detail.

It is certainly important to mention the entire area of studies carried out by APA's Division 29, Society for the Advancement of Psychotherapy, which focuses on so-called non-specific factors, those factors that are transversal to the type of orientation but that are linked to its efficacy. Examples of this are the therapeutic alliance (which has proven to be the strongest predictor of outcomes in studies in recent decades, for both individual, couple, family, and group therapies), consensus on objectives, empathy, positive consideration, and the collection of feedback from the patient are just some of the proven efficacy factors, and there are others that are likely to be effective, such as authenticity, a real relationship, and repair of breakdowns. The group coordinated by Norcross publishes an update of the results of these studies approximately every 10 years (Norcross, 2002, 2011; Norcross & Lambert, 2019; Norcross e Wampold 2019). Lambert and colleagues (Asay & Lambert, 1999; Lambert 2013; Wampold, 2001) estimated that the influence of common or non-specific factors on a variance of treatment results is 30% (compared to 15% for specific techniques).

This outlook could already lead to a broadening of the view, in a more integrative perspective, towards different forms of psychotherapies. The importance of finding treatments, and forms of psychotherapy that are

based on efficacy is not in pursuit of the illusory idea that there is a single form of therapy that is effective and resolute for all but consists in the possibility of offering various serious and solid courses of treatment, given the fact that each person can find correspondence in different courses. 'No treatment has come close to being effective in 100% of cases treated. The demonstration of efficacy of treatment does not tell us whether that treatment will be effective in the case we are treating, even if the patient belongs to a diagnostic category for which that type of therapy has been proven effective' (Fava & Gruppo Zoe, 2016, pg. 21).

Other examples are mentioned in the same report in certain paragraphs or footnotes:

- 'It should be noted that many guidelines favor cognitive behavioral therapy (CBT) over psychodynamic therapy (PDT) because of the greater number of studies that have historically been conducted on CBT, but in recent times, several research and meta-analyses have shown that PDT is often not inferior to CBT (see, among others, Cuijpers *et al.*, 2014; Gerber *et al.*, 2011; Keefe *et al.*, 2014; Leichsenring & Steinert, 2017; Shedler, 2010; Steinert *et al.,* 2017; Steinert & Leichsenring, 2017; Thoma *et al.*, 2012; Tolin, 2015)' (Gruppo di lavoro Consensus, 2022, p. 54);
- 'In partial contradiction with some of the guidelines that have just been reviewed, in particular the NICE guidelines, a recent meta-analysis has shown the substantial equivalence of effectiveness of CBT and psychodynamic therapies in the treatment of anxiety disorders considered so far (Keefe *et al.,* 2014)' (Gruppo di lavoro Consensus, 2022, p. 62).

Jury recommendations

These additional elements are considered further in the part of the jury's recommendations that points to quite a different scenario compared to the proposals, as we have mentioned:

> 'It is advisable to promote the development of a system for monitoring the outcomes of interventions carried out in public and private structures, even those that are non-affiliated with the healthcare system. This recommendation […] also allows for the assessment of subjective acceptance, from the therapeutic alliance and satisfaction of psychological treatment that is so strongly related to the patient's consent and reciprocity, in order to observe and manage, including in terms of psychological options, the difference between theoretical efficacy and practical efficacy which are also observed in this field' (Gruppo di lavoro Consensus, 2022, p. 91).

Let us clarify that when we talk about treatments based on efficacy tests, we talk about clinical efficacy too. In fact, it goes on to say:

> 'Within psychotherapies supported by efficacy evidence, as there are no clinically relevant differences in efficacy between individual interventions, it is recommended that careful consideration be given to the offer of a variety of structured psychotherapies, provided that their outcome is systematically assessed and monitored' (Gruppo di lavoro Consensus, 2022, p. 92).

It is also noted that 'The Consensus Conference expert group's extensive and laborious work of analyzing evidence in the literature has however only partially touched on the field of developmental psychology' (Gruppo di lavoro Consensus, 2022, p. 90), and that it is, therefore, necessary to 'further analyze the specific aspects related to childhood and adolescence' (Gruppo di lavoro Consensus, 2022, p. 91).

However, the subject of training is also particularly critical in the second part of the document where:

a. no clear distinction is made between post-graduate schools in psychotherapy and post-graduate schools in psychiatry, child and adolescent neuropsychiatry, and clinical psychology when 'an increase in the number of public post-graduate schools is recommended, which should be present in all universities' (Gruppo di lavoro Consensus, 2022, p. 95);
b. 'it is advisable to increase the hours of traineeship in private schools of specialization (so too, one imagines, in psychotherapy, ed.), so as to equate them to public ones' (Gruppo di lavoro Consensus, 2022, p. 95);
c. a part of the text which, together with the next point that calls for 'a greater availability of public and affiliated facilities in psychiatry, child neuropsychiatry and clinical psychology to host traineeships for trainees' (Gruppo di lavoro Consensus, 2022, p. 95) foreshadows a scenario that seems to take no account of the quality of training (would taking the psychotherapy traineeships to thirty-eight hours per week compared to the current 4-5 be functional to the training of the trainees and the quality of the response to patients or would it create a second-class workforce?) nor of the costs (psychotherapy training today is not paid: is it imaginable to think that it could be paid if we increase training to that number of hours?) nor of a reality of a few hundred private psychotherapy schools (and no public ones) whose fate does not seem to worry us particularly.

But it is even more worrying that the notorious unpreparedness for psychotherapy provided by the medical schools is overlooked, which also qualifies trainees for psychotherapy due to a political-professional compromise which, if it was necessary at the time of Law 56/89, would be more appropriate today in being unmasked and amended, treating them as if they were comparable to private schools in terms of the quality of the training they provide. Moreover, the recommendation to increase public schools seems antiquated (of psychiatry? of child and adolescent neuropsychiatry? of psychotherapy?) when it becomes clear that it is not a question of making what is private public, but of working at other levels

on the quality of psychotherapy training (while the path chosen, we know, is that of bureaucracy).

On the other hand, when talking about training doctors, the indications of 'understanding and knowing how to apply empathy as a relational construct, which is fundamental for adherence to treatment, communication of a diagnosis and the outcome of treatment (Gruppo di lavoro Consensus, 2022, p. 97)' and, speaking of training for psychologists 'having relevant skills regarding the therapeutic alliance' (Gruppo di lavoro Consensus, 2022, p. 98).

One point which is affected by a prejudicial and questionable approach relates to the public-private relationship. In the first part of the document, it is explicitly stated that 'even in the absence of reliable data, experts believe that at least two-thirds of the demand for psychotherapeutic treatments is fulfilled in professional private practice' (Gruppo di lavoro Consensus, 2022, p. 30), and then it recommends 'strengthening the offer of psychological therapies in public services and possibly introducing forms of affiliation and accreditation of private professionals' (Gruppo di lavoro Consensus, 2022, p. 32).

Beyond the forcing of a dichotomy thus formulated that does not take into account the whole world of psychological care operating in the third sector, and therefore in organizations with 'third sector' characteristics between public and private, the implicit idea that seems to slither through the document is that only public service is 'governable' and 'universally accessible'. It seems unfounded when it becomes apparent that private professionals, including for-profit ones, do not operate in a regulatory and cultural vacuum and could well be included in clinical and training networks if they so wished and that accessibility for the less well-off can be ensured, in addition to the work of third sector organizations, through forms of affiliation, accreditation, corporate welfare, bonuses, *etc*., and that not including these social actors in care systems means pursuing unachievable pan-public utopias.

Conclusions

If we were to sum up our thoughts, it seems to us that the initial good intentions of the document seem to have been translated into a form that is very much objectionable and that the final recommendations can be accepted only partially. A storm in a teacup. Certainly, the orientation to promote better accessibility and appropriateness (the right treatment for the specific problem and subject) for the entire population is an objective to be pursued, and what often, for not very noble reasons, prevails in the 'care market' should be stigmatized and contained. But of course, the process of develop-

ing a treatment with human subjects that focuses on quality is still long and perhaps the contribution of this document provides more mediocre help than would have been desirable.

It does not seem easy to trace the training and organizational paths of services to a set of rules, however valid and empirically well-founded they may be, particularly when one considers the difficulties and complexities of the journey leading to becoming an 'effective' therapist. Fava writes in the introduction to The competence to cure: 'On the other hand only a fool could think of winning a tennis match by having memorized a manual on the subject. In the same way, no one could face the same match without knowing the rules of the game or using incomplete or poor materials' (Fava & Gruppo Zoe, 2016, pg. 6).

Because the human being is wonderfully complex, so is our job, and we are therefore convinced that the more we manage to take on as people and as a community by moving away from adherence/contrast logic, the more we will be able to provide effective political and health responses as well.

However, a close critical debate is absolutely necessary if the ideas proposed are not entirely convincing.

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