Canadian Psychiatric Association
Dedicated to quality care
Association des psychiatres du Canada
Dévouée aux soins de qualité

POSITION STATEMENT

Psychotherapy in Psychiatry

Gary Chaimowitz, MB, ChB, FRCPC[1]; Priyanthy Weerasekera, MD, MEd, FRCPC[2]; Paula Ravitz, MD, FRCPC[3]

This position statement has been substantially revised by the Canadian Psychiatric Association's (CPA) Professional Standards and Practice Committee and approved for republication by the CPA's Board of Directors on August 13, 2020. The original position statement[1] was developed by the Professional Standards and Practice Committee and approved by the Board of Directors on January 25, 2003.

Introduction

The delivery of biological, psychosocial and psychotherapeutic interventions remains central to the treatment of patients with psychiatric disorders.[1–3] It is therefore essential to manage the provision of these treatment modalities. Psychotherapy is therefore considered a core skill set for psychiatrists, and the Canadian Psychiatric Association (CPA) affirms the position of psychotherapy in psychiatry.

Canadian psychiatry has emphasized an integrated biopsychosocial approach to the assessment and management of mental health problems.[1–7] Psychiatrists must possess competence in evidence-supported treatments including psychotherapies.[7–9] Treatment strategies should consider the place of pharmacology, psychotherapy, and systemic interventions.[8,9] The inherent private nature of the practice of psychotherapy, and the often-competing theoretical schools contribute to ambiguity and differing definitions or descriptions of different therapies. Today, most psychotherapies and common factors have been operationally defined with greater clarity (e.g.[10–13]), although some constructs remain more abstract.[14] Treatments should demonstrate both their efficacy and clinical- and cost-effectiveness, or benefit in real-world settings irrespective of their orientation.[15–18]

The last few decades have witnessed a significant growth of research in psychotherapy. Randomized controlled trials and meta-analyses demonstrate that numerous psychotherapies can be effective for mood, anxiety, psychotic, substance misuse, eating, and personality disorders (e.g.[19–25]). Research has contributed to treatment guidelines that recommend specific psychotherapies across the life span.[26–28] Research also demonstrates that common factors across therapies, including therapist interpersonal effectiveness, predict psychotherapy outcomes.[29]

[1] Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University, Hamilton, Ontario
[2] Professor Emeritus, Department of Psychiatry and Behavioural Neurosciences, McMaster University, Hamilton, Ontario
[3] Associate Professor, Department of Psychiatry, University of Toronto, Toronto, Ontario

The Goal of the Position Statement

The CPA affirms the role of psychotherapy as an integral and essential component of psychiatric care. The statement highlights the unique contributions psychiatrists can make when they are able to integrate psychological, psychosocial and biological approaches in a treatment plan. This position is also supported by the empirical literature and encourages evidence-based practice. The CPA identifies the importance of research into the effectiveness of all psychotherapeutic approaches, in turn shaping clinical practice. It reinforces the place of training in the psychotherapies for psychiatric residents. The CPA also defines psychotherapy as a medical act in psychiatry. The need to maintain professional standards of practice is recognized within psychotherapy and all aspects of psychiatric treatment. The statement acknowledges the history, current use and future potential of psychotherapy. Definitions and recommendations are structured to encompass the professional practice of the broad psychiatric community. This paper delineates general principles to guide the future development and utilization of the psychotherapies as an integral part of psychiatric practice.

Definition and Background

Psychotherapy is the informed and intentional application of clinical methods and interpersonal stances derived from psychological principles and treatment approaches that focus on behaviours, cognitions, emotions, relationships and/or other personal characteristics. It is grounded in conceptual frameworks and theoretical orientations.[1] The psychotherapies are distinct psychological treatments, many of which have been demonstrated to assist patients with specific psychiatric disorders and other psychological problems.[1,4,10,11,13,14,27,30] In addition to specific clinical adherence guidelines that distinguish differing models of psychotherapy, there are common factors that cross differing modalities and which are important for optimizing outcomes. These include the therapeutic alliance, use of empathy, managing countertransference and patient expectations along with consensus on treatment goals.[13,27,31–34] The psychotherapies, integrated into psychiatric practice as a component of a comprehensive treatment plan, can improve patient outcomes and experience of care.

Prior to the emergence of biological therapies, psychosocial and talk therapies were the primary tools of the psychiatrist. Theoretical schools helped to further our understanding of the psychopathology of individuals, families and groups, facilitating the development of theories and defining the practice of psychotherapeutic treatments.[35] Over the past decades, psychotherapy has witnessed an expansion of cognitive-behavioural, affect- and, interpersonally-focused or relationally-oriented approaches, psychodynamic psychotherapy treatments and additional structured, goal-focused treatments.[19–24,36,37] There is an acknowledgement of something unique that occurs between psychiatrist and patient, a process that allows for the relationship to become therapeutic. This is affected by its parameters and the interpersonal facilitative skills of the psychiatrist. The therapeutic alliance has consistently been shown to moderate outcomes, this then being an important element of the delivery of psychotherapy and psychiatric care.[12,13,38–40]

Psychiatrists are medical specialists with training in medical, social and psychological aspects of psychopathology. They have additional unique skills to identify and treat the medical disorders that interfere with and affect thought processes, mood, relationships or behaviours. Given the numerous known medical and biological conditions that may have a psychological impact on patients, psychotherapy skills add considerably to the treatment process to enhance outcomes. A psychiatrist's knowledge and ability to prescribe biological treatments for psychiatric disorders has the potential to add further value to therapy. Psychotherapy is deliberate and distinguished from providing advice.

Discussion

Through the therapeutic relationship between psychiatrist and patient, change can be effected in the patient.[13,41] How that relationship is conducted is subject to rules governing physician–patient contact and follows established psychotherapeutic practice. The theoretical basis of the therapy and how it is practised may vary across circumstances. There is an expectation that psychotherapy is one of a psychiatrist's treatment skill sets and can be applicable to all socioeconomic and clinical population groups. Its use is determined by clinical need, justified by treatment outcome and an intervention determined by choice on the part of the parties involved.[42,43] However, the intervention selected should be supported by acceptable evidence. In addition to upholding fidelity standards, psychiatrists should have an ability to establish a therapeutic alliance, with an agreement on goals.[33] Psychotherapies can be integrated with biological treatments and in many cases such as depression, anxiety, eating disorders, personality disorders, posttraumatic stress disorder (PTSD) and unresolved developmental trauma, this integrated treatment is the treatment of choice.[20,27,30,37,44–48]

Psychotherapy has historically been delivered by a person, the *therapist,* to another person, the *patient;* however, online, telephone, tele-video and web-based formats are increasingly being used.[48]

The therapeutic alliance has also been understood historically as the transference and countertransference in psychodynamic therapy.[33,34] Although not all therapies adhere to understanding the therapeutic relationship in these terms, it is important to note that these concepts may offer a rich perspective in understanding the patient, the therapist and the therapeutic relationship, and are especially important in ensuring that boundary violations are not crossed and are discussed prior to beginning therapy. At its base, the strength of the therapeutic alliance can be linked to outcomes.

Much like other treatments, psychotherapy requires an appropriate initial assessment, indications for use, training and skill on the part of the psychiatrist. It should take into account the characteristics of the patient, some of which have been found to predict differential responses to specific forms of therapy.[20,22,29,49–52] Some psychotherapies are more prescriptive and structured while others provide a less directive environment. In most therapies tools are available to assess the therapeutic alliance, adherence and treatment outcomes for quality, measurement-based care.[53] The use of psychotherapy as a form of, or part of, treatment is deliberate and involves choice. The decision as to the type of psychotherapy and the frequency of the psychotherapeutic interactions should depend on the psychiatric disorder, the evidence base which supports the use of a specific therapy, the patient's ability to use the therapy and the therapist's interpersonal effectiveness and skill in delivering the intervention. As with any treatment that has efficacy, inappropriate use may have deleterious effects.[54,55]

Randomized controlled trials have established psychotherapy modalities as effective treatments for specific psychiatric disorders, with effect sizes equivalent to and sometimes greater than pharmacotherapy treatments alone. In children and adolescents, psychotherapy is considered first line treatment. Choosing Wisely has been invaluable in providing guidance in this regard.[54] Psychotherapy is superior to pharmacology in long term follow up of some conditions, especially in anxiety disorders.[22,49,50,56–59] Empirically-supported psychotherapies include cognitive behavioural therapy (CBT),[37,60,61] interpersonal psychotherapy (IPT),[23,62] group psychotherapy,[63] dialectical behaviour therapy (DBT),[24,25,64] mindfulness interventions,[65] motivational interviewing (MI)[66] and psychodynamic psychotherapy.[21,41,67] Psychotherapeutic principles can guide assessment and treatment decisions for improved outcomes of complex dynamics that can arise.[13] Benefits of using psychotherapy include decreased relapse rates, enhancing of patients' resilience, self-esteem, relationships and quality of life, decreasing or remitting of symptoms and improved functioning.

Consensus treatment guidelines recommend psychotherapies for diagnoses such as mood and anxiety disorders, PTSD, substance use disorders, personality disorders, eating disorders and psychological trauma, either as monotherapy, or sequenced or combined with medication. CBT, IPT, DBT, MI, mindfulness-based interventions and psychodynamic psychotherapy are *recommended in national and international consensus treatment guidelines* for patients of differing psychiatric conditions (e.g. World Health Organization,[26] the U.S.[68,69] Canada[27,28,57] and the United Kingdom (NICE)[70]).

Psychiatric treatment including evidence-supported psychotherapies should be geared to patients' diagnoses, personal attributes and the social context.[49] As with all treatments, ongoing research into effectiveness and efficacy is critical. Quality management strives to seek out the best therapy for the specific disorder or condition. In the past, the abstract theoretical basis and long-term open-ended psychotherapies made outcomes and processes more difficult to measure, giving rise to questions about their validity.[54] Psychotherapy treatments informed by outcome and process research have evolved substantially, both methodologically and conceptually.[71] Research to date has demonstrated the efficacy of many psychotherapies alone, sequenced or combined with medication for numerous psychiatric disorders.[31] Despite challenges in conducting research in an area as complex as psychopathology, significant advances over the past several decades have produced robust instruments to assess complex constructs salient to psychiatric care such as the transference, the therapeutic alliance, depth of experiencing in sessions, attachment patterns of relating and others (e.g.[72,73]).

As with any treatment or intervention, measurement and evaluation of outcomes needs to be considered by funders of healthcare, providers and educators. It is this type of research that will continue to solidify the place of psychotherapy as part of evidence-based medicine. In the training of future psychiatrists, we will require this evidence to continue to include psychotherapy training in curricula. Efficacy, measurement and evaluation of different types of psychotherapies will affect the type and nature of the training provided.

Longitudinal case-based clinical supervision of trainees and measurable skill acquisition is encouraged and effective methods of instruction should be utilized in

the training process.[74] Effective training approaches include modelling, coaching and feedback; the use of audio or video tapes in training; moving from past, process note driven supervision to performance-based observational, formative feedback to foster adaptive expertise and competence.[75]

Conclusion

The psychotherapies are treatments that can be delivered alone or in combination with other treatments. Competent delivery of psychotherapy requires an understanding of theoretical concepts and common factors, and skill acquisition using evidence-based teaching methods. Psychotherapy use in psychiatry needs to be guided through evidence-based practice, similar to that used to rank other medical treatments. As trained mental health professionals with both medical and psychotherapeutic skills, psychiatrists are uniquely situated to offer integrated medical and psychotherapeutic treatments that can benefit patients with more complex comorbid conditions. In some cases, a specific psychotherapy may be the focus of treatment, and in other cases medication may be all that is required and needed. Training in both biological treatments and the psychotherapies will permit psychiatrists to make evidence-informed decisions that will benefit patients.

Psychotherapy may focus on individuals, couples, families or groups across the life span. These treatments may differ in many ways, including orientation, strategy, frequency, locus of assumed change and therapeutic goals. The ability to competently deliver evidence-based, consensus guideline-recommended psychotherapy in the context of a positive therapeutic alliance remains a core skill set of Canadian psychiatrists.

It is the position of the CPA that the psychotherapies continue to be an integral part of the *training and practice* of psychiatry.

References

1. Chaimowitz G. Psychotherapy in psychiatry. Canadian Psychiatric Association Position Paper. Can J Psychiatry. 2004;49(2):1–4.
2. Grant S, Holmes J, Watson J. Guidelines for psychotherapy training as part of general professional psychiatric training. Psychiatric Bulletin. 1993;17(11):695–698.
3. Cameron PM, Leszcz M, Bebchuk W, et al. The practice and roles of the psychotherapies: a discussion paper. Working group 1 of the Canadian Psychiatric Association Psychotherapies Steering Committee. Can J Psychiatry. 1999;44(Suppl 1):17S–30S.
4. Katz P. The role of the psychotherapies in the practice of psychiatry: the position of the Canadian Psychiatric Association. Can J Psychiatry. 1986;31(5):458–465.
5. Joint Task Force on Standards for Medical (Psychiatric) Psychotherapy. A report to Council of the Ontario Psychiatric Association and to the executive of the section on psychiatry, on the definition, guidelines and standards for medical (psychiatric) psychotherapy. Toronto, ON: OMA; 1995.
6. Ontario Medical Association (OMA), Section of Psychiatry. The definition, guidelines and standards for medical (psychiatric) psychotherapy. Toronto, ON: OMA; 1995.
7. The Coalition of Ontario Psychiatrists. Talk and transformation: recommendations for moving forward with a structured psychotherapy program in Ontario. Toronto, ON: The Coalition of Ontario Psychiatrists; 2017.
8. Royal College of Physicians and Surgeon of Canada (RCPSC). Objectives of training in the specialty of psychiatry. Ottawa, ON: RCPSC; 1995.
9. Shapiro Y, John N, Scott R, et al. Psychotherapy and its role in psychiatric practice: a position paper. II. Objective, subjective, and intersubjective science. J Psychiatr Pract. 2016;22(4):321–332.
10. Beck A, Rush AJ, Shaw BF, et al. Cognitive therapy of depression. New York, NY: Guilford Press; 1979.
11. Weissman M, Markowitz J, Klerman GL. The guide to interpersonal psychotherapy. New York, NY: Oxford University Press; 2018.
12. Wampold BE. How important are the common factors in psychotherapy? An update. World Psychiatry. 2015;14(3):270–277.
13. Norcross JC, Wampold BE. Evidence-based therapy relationships: research conclusions and clinical practices. Psychotherapy. 2011;48(1):98–102.
14. Gabbard GO. Long-term psychodynamic psychotherapy: a basic text. 2nd ed. Washington, D.C.: American Psychiatric Association; 2010.
15. Lazar SG. The cost-effectiveness of psychotherapy for the major psychiatric diagnoses. Psychodyn Psychiatry. 2014;42(3):423–457.
16. Kurdyak P, Newman A, Segal Z. Impact of mindfulness-based cognitive therapy on health care utilization: a population-based controlled comparison. J Psychosom Res. 2014;77(2):85–89.
17. Gabbard GO, Lazar SG, Hornberger J, et al. The economic impact of psychotherapy: a review. Am J Psychiatry. 1997;154(2):147–155.
18. Altmann U, Zimmermann A, Kirchmann HA, et al. Outpatient psychotherapy reduces health-care costs: a study of 22,294 insurants over 5 years. Front Psychiatry. 2016;7:98.
19. Karyotaki E, Smit Y, de Beurs DP, et al. The long-term efficacy of acute-phase psychotherapy for depression: a meta-analysis of randomized trials. Depress Anxiety 2016;33(5):370–383.
20. Zhou XY, Hetrick SE, Cuijpers P, et al. Comparative efficacy and acceptability of psychotherapies for depression in children and adolescents: a systematic review and network meta-analysis. World Psychiatry 2015;14(2):207–222.
21. Driessen E, Hegelmaier LM, Abbass AA, et al. The efficacy of short-term psychodynamic psychotherapy for depression: a meta-analysis update. Clin Psychol Rev. 2015;42:1–15.
22. Cuijpers P, Karyotaki E, Weitz E, et al. The effects of psychotherapies for major depression in adults on remission, recovery and improvement: a meta-analysis. J Affect Disord. 2014;159:118–126.
23. Cuijpers P, Donker T, Weissman MM, et al. Interpersonal psychotherapy for mental health problems: a comprehensive meta-analysis. Am J Psychiatry. 2016;173(7):680–687.
24. Linehan MM, Comtois AA, Murray AM, et al. Two-year randomized controlled trial and follow-up of dialectical behavior

therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. Arch Gen Psychiatry. 2006;63(7):757–766.

25. McMain SF, Links PS, Gnam WH, et al. A randomized trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. Am J Psychiatry. 2009;166(12):1365–1374.
26. World Health Organization. mhGAP intervention guide for mental, neurological and substance Use disorders in Non-specialized health settings: mental health Gap action programme (mhGAP). Geneva: World Health Organization; 2010.
27. Parikh SV, Quilty LC, Ravitz P, et al. Canadian Network for mood and anxiety treatments (CANMAT) 2016 clinical guidelines for the management of adults with major depressive disorder: section 2. Psychological treatments. Can J Psychiatry. 2016;61(9):524–539.
28. Health Quality Ontario. Major depression care for adults and adolescents. 2017; Available from: http://www.hqontario.ca/portals/0/documents/evidence/quality-standards/qs-depression-clinical-guide-1609-en.pdf
29. Norcross J, Lambert M. Psychotherapy relationships that work II. Psychotherapy (Chic). 2011;48(1):4–8.
30. Parikh S, Segal ZV, Grigoriadis S, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) clinical guidelines for the management of major depressive disorders in adults. II. Psychotherapy alone or in combination with antidepressant medication. J Affect Disord. 2009;117(Suppl1):S15–S25.
31. Constantino MJ, Arnkoff DB, Glass CR, et al. Expectations. J Clin Psychol. 2011;67(2):184–192.
32. Hayes JA, Gelso CJ, Hummel AM. Managing countertransference. Psychotherapy. 2011;48(1):88–97.
33. Safran JD, Muran JC, Eubanks-Carter C. Repairing alliance ruptures. Psychotherapy. 2011;48(1):80–87.
34. Hayes JA, Gelso CJ, Goldberg S, et al. Countertransference management and effective psychotherapy: meta-analytic findings. Psychotherapy. 2018;55(4):496–507.
35. Norcross JC, VandenBos GR, Freedheim DK. History of psychotherapy: continuity and change. 2nd ed. Washington DC: American Psychological Association; 2011.
36. Weissman M, Cuijpers P. Psychotherapy over the last four decades. Harv Rev Psychiatry. 2017;25(4):155–158.
37. Cuijpers P, Berking M, Andersson G, et al. A meta-analysis of cognitive-behavioural therapy for adult depression, alone and in comparison with other treatments. Can J Psychiatry. 2013;58(7):376–385.
38. Martin DJ, Garske JP, Davis MK. Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. J Consult Clin Psychol. 2000;68(3):438–450.
39. Horvath A, Del Re AC, Fluckiger C, et al. Alliance in individual psychotherapy. Psychotherapy (Chic). 2011;48(1):9–16.
40. Fluckiger C, Del Re AC, Wampold BE, et al. The alliance in adult psychotherapy: a meta-analytic synthesis. Psychotherapy. 2018;55(4):316–340.
41. Abbass AA, Hancock JT, Henderson J, et al. Short-term psychodynamic psychotherapies for common mental disorders. Cochrane Database Syst Rev. 2014;7:CD004687.
42. McHugh RK, Whitton SW, Peckham AD, et al. Patient preference for psychological vs pharmacologic treatment of psychiatric disorders: a meta-analytic review. J Clin Psychiatry. 2013;74(6):595–602.
43. Magnani M, Sasdelli A, Bellino S, et al. Treating depression: what patients want; findings from a randomized controlled trial in primary care. Psychosomatics. 2016;57(6):616–623.
44. Steenkamp MM, Litz BT, Hoge CW, et al. Psychotherapy for military-related PTSD a review of randomized clinical trials. JAMA. 2015;314(5):489–500.
45. Bisson JI, Roberts NP, Andrew M, et al. Psychological therapies for chronic post- traumatic stress disorder (PTSD) in adults. Cochrane Database Syst Rev. 2013;(12):CD003388.
46. Leichsenring F, Rabung A. Effectiveness of long-term psychodynamic psychotherapy: a meta-analysis. JAMA. 2008;300(13):1551–1565.
47. Fonagy P, Rost F, Carlyle J, et al. Pragmatic randomized controlled trial of long-term psychoanalytic psychotherapy for treatment-resistant depression: the Tavistock Adult Depression Study (TADS). World Psychiatry. 2015;14(3):312–321.
48. Matsuzaka CT, Wainberg M, Norcini Pala A, et al. Task shifting interpersonal counseling for depression: a pragmatic randomized controlled trial in primary care. BMC Psychiatry. 2017;17(1):225.
49. Roth A, Fonagy P. What works for whom? A critical review of psychotherapy research. 2nd ed. New York, NY: Guilford Press; 2005.
50. Cuijpers P, Sijbrandij M, Koole SL, et al. The efficacy of psychotherapy and pharmacotherapy in treating depressive and anxiety disorders: a meta-analysis of direct comparisons. World Psychiatry. 2013;12(2):137–148.
51. Barth J, Munder T, Gerger H, et al. Comparative efficacy of seven psychotherapeutic interventions for patients with depression: a network meta-analysis. PLoS Med. 2013;10(5):e1001454.
52. Hannan C, Lambert MJ, Harmon C, et al. A lab test and algorithms for identifying clients at risk for treatment failure. J Clin Psychol. 2005;61(2):155–163.
53. Weerasekera P. The state of psychotherapy supervision: recommendations for future training. Int Rev Psychiatry. 2013;25(3):255–264.
54. Urness D, Parker NJ, Rapoport MJ, et al. Choosing Wisely: wise choices in psychiatry. Can J Psychiatry. 2016;61(11):700–704.
55. Kraus DR, Castonguay L, Boswell JF, et al. Therapist effectiveness: implications for accountability and patient care. Psychother Res. 2011;21(3):
267–276.
56. Cuijpers P, Anderssen G, Donker T, et al. Psychological treatment of depression:
results of a series of meta-analyses. Nord J Psychiatry. 2011;65(6):354–364.
57. Katzman MA, Bleau P, Blier P, et al. Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorders. BMC Psychiatry. 2014;14(Suppl 1):S1.
58. Fonagy P. The effectiveness of psychodynamic psychotherapies: an update. World Psychiatry. 2015;14(2):137–150.
59. Abramowitz JS, Whiteside SR, Deacon BJ. The effectiveness of treatment for pediatric obsessive-compulsive disorder: a meta-analysis. Behav Ther. 2005;36(1):55–63.
60. In-Albon T, Schneider S. Psychotherapy of childhood anxiety disorders: a meta-analysis. Psychother Psychosom. 2007;76(1):15–24.
61. Reynolds S, Wilson C, Austin J, et al. Effects of psychotherapy for anxiety in children and adolescents: a meta-analytic review. Clin Psychol Rev. 2012;32(4):251–262.

62. Cuijpers P, Geraedts AS, van Oppen P, et al. Interpersonal psychotherapy for depression: a meta-analysis. Am J Psychiatry. 2011;168(6):581–592.

63. Yalom I, Leszcz M. The theory and practice of group psychotherapy. 6th ed. New York, NY: Basic Books; 2020.

64. Binks CA, Fenton M, McCarthy L, et al. Psychological therapies for people with borderline personality disorder. Cochrane Database Syst Rev. 2006;1:CD005652.

65. Teasdale JD, Segal ZV, Williams JM, et al. Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. J Consult Clin Psychol. 2000;68(4):615–623.

66. Hettema J, Steele J, Miller WR. Motivational interviewing. An Rev Clin Psychol. 2005;1:91–111.

67. Leichsenring F, Rabung S, Leibing E. The efficacy of short-term psychodynamic psychotherapy in specific psychiatric disorders: a meta-analysis. Arch Gen Psychiatry. 2004;61(12):1208–1216.

68. Working Group on Major Depressive Disorder. Practice guidelines for the treatment of patients with major depressive disorder. 3rd ed. Washington, D.C.: American Psychiatric Association Publishing; 2010. Available from: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf

69. The Management of Major Depressive Disorder Working Group. VA/DoD clinical practice guideline for the management of major depressive disorder; 2016. Available from: https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf

70. Pilling S, Anderson I, Goldberg D, et al. Guidelines depression in adults, including those with a chronic physical health problem: summary of NICE guidance. Br Med J. 2009;339:b4108.

71. Lambert MJ, ed. Bergin and Garfield's handbook of psychotherapy and behavior change. 6th ed. Hoboken, NJ: John Wiley and Sons; 2013.

72. Hatcher RL, Gillaspy JA. Development and validation of a revised short version of the working alliance inventory. Psychother Res. 2006;16(1):12–25.

73. Ravitz P, Maunder R, Hunter J, et al. Adult attachment measures: a 25-year review. J Psychosom Res. 2010;69(4):419–432.

74. Sholomskas D, Syracuse-Siewert G, Rounsaville BJ, et al. We don't train in vain: a dissemination trial of three strategies of training clinicians in cognitive-behavioral therapy. J Consult Clin Psychol. 2005;73(1):106–115.

75. Ravitz P, Lawson A, Fefergrad M, et al. Psychotherapy competency milesones: an exploratory pilot of CBT and psychodynamic psychotherapy skills acquisition in junior psychiatry residents. Acad Psychiatry. 2019;43(1):61–66.