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Italian guidelines on psychological therapies for anxiety and depression: innovation or missed opportunity?[1]

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ABSTRACT. – The aim of this work is to contribute to the ongoing debate on the Consensus Conference on Psychological Therapies for Anxiety and Depression. Taking a scientific approach to implement the guidelines of the *Istituto Superiore di Sanità*, I will frame my reflections in a peer-review format identifying five areas that might benefit from the review. Obviously, the opinions I express here may be faulty opinions that I will attempt to justify from the standpoint of existing scientific literature.

Key words: psychotherapy, consensus conference, evidence-based practice, common factors, specific factors.

Existing guidelines and reference literature

The first element that deserves evaluation is the almost exclusive focus on the guidelines of the National Institute for Health and Clinical Excellence (NICE). The general structure of the document seems oriented toward implementing these guidelines in the Italian context. In my opinion, there are some problematic elements to consider in this approach. The first is that NICE was formulated nearly 20 years ago, and although there have been numerous updates up to the last one cited by the Consensus Conference, the initial perspective remains unchanged. It is surprising that Italy has failed to produce a critical review that could have benefitted from the advantages and disadvantages of what has been done by NICE and its implementation program in psychotherapy called 'Improving Access to Psychological Therapies' (IAPT). First of all, the Italian document presumes a categorical perspective to diagnoses which renders the psychopathological and psychotherapeutic debate of

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the last 20 years almost totally irrelevant. Indeed, this debate has increasingly focused attention on the clinical utility of interventions focused on processes, mechanisms, and dimensions.

Data (Clark, 2018) suggest that the English healthcare system is highly effective in its adherence to IAPT practices (89% started treatment within 6 weeks of the initial assessment; 99% of patients with anxiety or depression received an initial and final intervention assessment), whereas the responses in terms of clinical efficacy are less clear. Diagnosis remission rates are 51% and drop-out rates are nearly 60% (only 40.3% completed more than one session). These metrics are hardly in line with the meta-analyses on Cognitive-Behavioral Therapy (CBT) for anxiety (Springer *et al.*, 2018) and depression (Cuijpers *et al.*, 2013) which in NICE is indicated as the first choice in second-level interventions. However, numerous are non-responders in cognitive therapies, and IAPT does not match the efficacy of CBT.

While on the one hand, our national health system would greatly benefit from clear guidelines, on the other I should point out that the same meta-analytical data that lead to the implementation of therapeutic protocols and have, for example, brought CBT to the so-called Third Wave, are not taken into consideration in the Italian document. It is as if all the studies (strictly CBT based) on Mindfulness-Based Cognitive Therapy (MBCT), Acceptance and Commitment Therapy, or Metacognitive Therapy count for nothing. The IAPT was and is a commendable initiative, but it is unsatisfactory that only 1 out of 5 patients go into remission (40.3% complete the course and of these, only 51% no longer meet the diagnostic criteria at the end).

Comorbidity and specificity of the constructs of depression and anxiety

Let us imagine a person who accesses the first level of assessment and reports feelings of emotional flattening, reduced activity, and feelings of self-devaluation. The Italian guidelines require an 'operator' to make an initial assessment in a primary care setting using standard testing tools and then start guided self-help. If the operators are psychotherapists with experience in differential diagnoses, they would consider the reported depressive symptoms as non-specific and would conduct a broad-spectrum examination which would hopefully include the patient's symptomatology as a whole and personality functioning. In the case of operators with limited experience in differential diagnoses (NICE also includes nurses – in the Consensus Conference, as we will see, terminological confusion leaves room for multiple interpretations) there is the risk of limiting the assessment to depressive symptomatology.

The distinction I make is not an academic one, but a studied case based on

data that have emerged in the last 20 years. First, since 1990, Harvard Medical School has been conducting comorbidity studies that show the limited specificity of categorical diagnoses. In fact, in psychodiagnostics, it is an exception to receive only one diagnosis. Specifically, the comorbidity of anxiety with depressive symptoms was estimated at between 80% and 95% (Gorman, 1996), and, the comorbidity of the latter with personality disorders was at least equal to 62% (Hirschfeld, 1999). Therefore, the depressive symptoms reported above could refer to very different functioning mechanisms, and an accurate differential diagnosis would allow the setting up of treatment able to target these mechanisms. The patient could present a flat affect that is the result of a perfectionistic dynamic typical of obsessive-compulsive personality disorder, an experience of emptiness that may be associated with a form of pathological narcissism, or an onset of major depression following the end of a relationship.

Furthermore, the idea that a psychometric test (however validated) recognizes the same depressive symptomatology investigated by another test is illusory (Chavence *et al.*, 2020). The terms depression or anxiety encompass diversified psychopathological experiences and clusters which can lead to specific psychosocial problems. From a clinical viewpoint, it is easy to see how 4 out of 5 patients fail to achieve remission from their diagnosis. This is not to say that therapists in the English health system are incompetent, but it may be that they treat very different problems in the same way. In addition to the obvious critical clinical challenge, a critical organizational challenge emerges. An efficient stepped-care system is one that allows a person access to a specific intervention. Alternatively, a 'Fordist' healthcare organizational model is used where healthcare is strengthened and supplied but is not aligned to demand as implied by the so-called 'lean' models (D'Andreamatteo *et al.*, 2015). This fundamental distinction is necessary to evaluate the economic sustainability of the guidelines.

Processes, mechanisms, and dimensions in psychopathology

The response of psychopathology and psychotherapy to the problems described so far corresponds to three lines of research that have dominated the international debate for over 15 years: i) the role of transdiagnostic processes and mechanisms in the onset and maintenance of disorders; ii) a review of the diathesis-stress model in the light of dimensional perspectives on psychopathology; iii) the development of psychotherapeutic protocols informed by processes, mechanisms, and dimensions in an increasingly integrated perspective. It is regrettable that there is no trace of all this in the document proposed by the Consensus Conference. While a policy of maintaining a conservative position to avoid academic disputes may be under-

standable, we are baffled that there is no reference to the thousands of scientific articles that address these three issues. For example, the comorbidity of strong anxiety and depressive disorders is associated with a series of transdiagnostic processes primarily referable to forms of persevering thought which are the basis of some of the protocols with the most scientific evidence, such as MBCT for chronic depression (McEvoy *et al.*, 2013). In parallel, this spectrum of internalizing manifestations has been associated with a personality trait called neuroticism whose clinical manifestations are best understood in the light of specific maintenance mechanisms such as experiential avoidance (Naragon-Gainey & Watson, 2018). Finally, the so-called common factors are indeed transdiagnostic but are specific to each patient's functioning. We know that patients with a high level of neuroticism expose the setting to some risk: therapists (especially if inexperienced) tend to give a low assessment of the therapeutic alliance level while patients give high ones, generating some discrepancy in the shared experience of therapy (Chapman *et al.*, 2009). The Consensus Conference document refers to the therapeutic alliance construct only once in one of the annexes and never mentions either the constructs of transdiagnostic processes and mechanisms or those of personality dimensions or traits.

Distinction between psychotherapy and psychological therapy

Consistent with the British model where first-level interventions can be provided by nurses and social workers, IAPT generically refers to psychological therapies. In the Italian context, where very different legislation exists, the authors of the Consensus Conference document should perhaps have paid more attention to the use of terms, or – as I mentioned in the first paragraph – they should have integrated IAPT with other perspectives. The reader will notice how the term 'psychotherapy' is used in three contexts: the initial declarations on the importance of evidence-based approaches, the sentences in which this evidence is reviewed, and the references to graduate schools recognized by the *Ministero dell'Istruzione e del Merito*. The expression 'psychological therapies' is used in the titles or phrases that refer to an overview of the document's implications. The glossary specifies that psychological therapies include psychotherapy as a primary focus and that other interventions would be mentioned but not covered in the document. The reader is further confused in the next line which states that for low-intensity interventions there are self-help manuals (discussed in the document) and physical activity. The last two forms of intervention 'do not qualify as psychological and/or as therapies' (ISS, 2022). In short, my comment on the lack of terminological clarity is not unfounded and results in significant regulatory and applicative chaos.

In Italy, psychotherapy practice is carefully regulated and requires specific training and qualifying courses. On an initial reading, given that the glossary clearly states that the text is not concerned with 'non-psychotherapeutic' psychological therapies we are led to believe that the guidelines refer to the work of psychotherapists. Unfortunately, excessive use of IAPT (where, as you will recall, the rules are different and certain activities are assigned to nurses and social workers) generates a bug that may or may not be intentional. The existence of non-psychological or therapeutic interventions (such as manuals and physical activities) means involving other figures. It remains to be seen whether these figures, without the skills to understand the functioning of patients (beyond the symptom) and to treat them effectively, can adequately manage the first level of assessment and treatment. As mentioned above, this and other doubts are related less to irrelevant intellectual or academic distinctions and more to aspects that inform hopefully effective, sustainable intervention.

Conclusions on economic sustainability

Efficient and effective therapeutic protocols must be supported by organizational models consistent with this aim. It implies developing sustainable interventions for the delivery system and for users. The approach proposed by the Consensus Conference seems to be aimed at maximizing the number of services provided in a generalist way (focus on diagnostic macro-categories with limited attention to the subjective functioning of the patient and the professional's skills) at the risk of increasing costs instead of effectiveness (IAPT brings only 1 in 5 patients to remission). The document drafted may well be a missed opportunity to consider specific interventions which are able to tailor the healthcare offered to demand, maximizing existing skills and resulting in better use of resources.

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