Counselling and Psychological Therapy: A Referenced Guide

The referenced companion to the counselling and psychological therapy patient leaflet

Introduction

This guide is the referenced companion to the patient leaflet on counselling and psychological therapy. It sets out the evidence and reasoning behind the claims made there, so interested readers can trace them to source and weigh them for themselves. It is meant to support understanding and shared decision-making, not to replace national guidance.[1]

"Counselling" is not one thing. In ordinary use the word groups together approaches that aim at quite different targets, are delivered by people with very different trainings, and rest on evidence of very different strength. A patient who says "counselling didn't work" may have had a brief, non-directive intervention that was never designed for their problem; another offered "counselling" may be referred to a therapy with a substantial trial base.

In addition, we have good evidence that psychological therapy helps, and much weaker evidence that any one type of therapy is reliably better than another for most common presentations. The most robust single finding in the field — that different types of therapy tend to produce broadly similar outcomes — sits uneasily beside the way services and trainings are organised around named models.[2,3] A named therapy is a description of a way of working, and what seems to help a given person is shaped at least as much by fit, timing and relationship as by the name or theory behind the therapy.

A way to organise the field: what is the approach trying to do?

Rather than sort therapies by their tradition, it can often be more useful to ask what each one mainly tries to do. Most named approaches lean toward one or more of a number of tasks:

- **Change patterns of thinking and behaviour** — CBT and its relatives.
- **Process and reduce the emotional charge of past experience** — trauma-focused and memory-focused therapies, much psychodynamic work.
- **Settle the body and nervous system** — breath, movement and arousal-regulation approaches.
- **Build solutions and a sense of forward movement** — solution-focused and strengths-based work.
- **Provide a relational space to be heard and understood** — person-centred and humanistic counselling.
- **Identify and meet unmet emotional needs** — needs-based and practical approaches.

Many experienced therapists integrate across several of them, and the same named therapy can be practised very differently by two practitioners. Also, as mentioned above, the named task or description of what a therapy aims to do is often not necessarily the most important factor — the common factors section below looks at this in more detail. Therapy choice, where available, can be viewed as a way of matching a patient's situation and preference to a plausible starting point.

The main approaches

For each approach below I have tried to say briefly what it does, who it tends to suit, where it sits in NHS provision, and how strong the evidence actually is. Listing an approach here does not mean it is available everywhere; what is recommended in guidance and what is actually offered locally often differ, as the service-context section sets out.

Person-centred and humanistic counselling

Person-centred counselling describes a broad humanistic family built around a warm, empathic, non-judgemental relationship: the therapist offers understanding and space rather than techniques or direction. It is the most commonly offered form of counselling in primary care, and many people find it helpful, particularly where distress is tied to current life difficulty, relationship strain or feeling unheard.

It helps to know what the NHS actually commissions here. The evidence-based modality within NHS Talking Therapies is named as **Counselling for Depression**, more formally **Person-Centred Experiential Counselling for Depression (PCE-CfD)**, which draws on both person-centred and emotion-focused (process-experiential) traditions and is manualised and time-limited.[1] However it is not available in all areas. NICE also lists emotion-focused therapy and non-directive/supportive/person-centred counselling among the options for less severe depression.[1] (A note on initials: "EFT" in this depression context means *emotion-focused therapy*, an experiential humanistic approach; it should not be confused with the *emotional freedom techniques* discussed under trauma below, which are an entirely different thing.)

When non-directive and supportive therapies are compared fairly with other approaches, much of their apparent disadvantage disappears once researcher allegiance is taken into account — that is, the gap narrows when the comparison is not run by people committed to the rival therapy.[4,5] The main practical caution is the one the patient leaflet makes: where emotional intensity is very high or trauma is active, talking in depth without additional ways to settle arousal can increase distress, which is why stabilisation and pacing are very important.

Cognitive behavioural therapy (CBT)

CBT focuses on the links between thoughts, feelings and behaviour, typically noticing unhelpful patterns and testing different ways of thinking or acting. Many people find it practical and structured; others engage less well when their threat system is highly activated and clear and as a result flexible thinking is more difficult to engage.

CBT has the largest evidence base of the talking therapies and the widest NHS availability. It is worth being honest about why. Its prominence reflects decades of investment in training, manualisation and trials, and the structure of services built around it, at least as much as any reliable superiority over other approaches.[2,3] Where head-to-head comparisons appear to favour CBT, the advantage is often small, confined to targeted symptoms, or attributable to the allegiance of the researchers running the trial rather than to the therapy itself.[5] This is not an argument against CBT, which is genuinely effective and a reasonable default for many problems; it is an argument against assuming it is the right fit for everyone, and against assuming "didn't respond to CBT" means "didn't respond to therapy."

Low-intensity interventions and stepped (matched) care

For most people presenting in primary care, the first evidence-based step is a low-intensity one: guided self-help, behavioural activation, or computerised/digital CBT, supported by a psychological wellbeing practitioner.[1] NHS Talking Therapies operates a stepped model — increasingly described as *matched* care in NICE's depression guidance, with treatment matched to severity and need rather than everyone starting at the bottom rung — so that the least intrusive effective option is offered first, with step-up to high-intensity therapy where needed, or going straight to it where the presentation (for example PTSD or social anxiety) warrants.[1] In areas where this is offered, being clear about this helps in the consultation, because patients often expect "a counsellor" and can be surprised by guided self-help.

Interpersonal therapy (IPT)

IPT is a structured, time-limited therapy that works on the link between mood and current relationships, focusing on one of a few problem areas: grief, role transitions, interpersonal disputes, and interpersonal sensitivity or isolation. It does not work primarily on thoughts or on the distant past, which makes it a good fit where low mood is bound up with bereavement, a major life change, or relationship difficulty.

It is NICE-recommended for depression and is one of the high-intensity therapies within NHS Talking Therapies, though local availability varies. The evidence is strong: meta-analysis shows moderate-to-large effects, comparable to other established psychotherapies and to antidepressants, with combined treatment often better than either alone.[6]

Behavioural activation

Behavioural activation works by restoring rewarding and meaningful activity whose loss helps drive the depressive cycle, and performs about as well as more elaborate therapies with far less complexity. It is available as both a low- and high-intensity intervention.

Psychodynamic counselling and therapy

Psychodynamic approaches focus on how past experience, especially early relationships, affects current patterns of feeling, thinking and relating. Some people find this deeply valuable, particularly where they have the capacity to reflect and tolerate emotional intensity; for others, especially where trauma is active or emotional regulation is limited, revisiting the past without ways to settle arousal can increase distress.

The open-ended psychodynamic therapy that people commonly imagine is largely *not* what the NHS provides; where psychodynamic work is commissioned, the versions are brief and manualised. **Short-term psychodynamic psychotherapy (STPP)** is NICE's term and has a reasonable evidence base for depression.[7] **Dynamic Interpersonal Therapy (DIT)** is the specific time-limited manualised model associated with NHS Talking Therapies, with a pilot randomised trial in moderate-to-severe depression.[8] The boundary with IPT is genuinely blurry — both are brief, relational and time-limited — which is itself a small illustration of the importance of the shared relational work.

Dialectical behaviour therapy (DBT)

DBT was developed for people who experience very intense emotions or recurrent self-harm. It combines CBT elements with skills for emotion regulation, distress tolerance and mindfulness, and is usually offered through specialist or secondary care services rather than primary care. Of the structured therapies for people diagnosed with a personality disorder, DBT is the most extensively studied, and the Cochrane

review finds it reduces self-harm and symptom severity and improves psychosocial functioning compared with usual treatment — though, as with all treatments in this group, the effect sizes are modest and the certainty of the evidence limited.[9] It is the standard secondary care option when emotional reactions are overwhelming and safety is a recurring concern.

Acceptance- and compassion-based approaches

Some therapies work less on changing the content of thoughts and more on changing the person's relationship to their inner experience. **Acceptance and Commitment Therapy (ACT)** emphasises responding differently to difficult thoughts and feelings while acting in line with personal values. **Compassion-Focused Therapy (CFT)** aims to reduce shame and self-criticism and build a sense of internal safety, and is often particularly relevant where self-criticism is prominent. Both have a growing evidence base and are reasonable options; neither has been shown to be reliably superior to the established therapies for common presentations, which is the expected pattern.

Mindfulness-based approaches (MBCT)

Mindfulness-based cognitive therapy deserves a specific mention because it carries one well-evidenced, defined claim rather than a general one: in people who have had recurrent episodes of depression, MBCT reduces the risk of relapse, with benefit on a par with maintenance antidepressants.[10] The broader claims sometimes made for mindfulness are more modest once compared against active alternatives; MBCT's relapse-prevention role is the part that holds up most firmly.

Solution-focused brief therapy (SFBT)

In SBFT, the client is taken to be the expert in the details of their own life, while the therapist brings expertise in asking useful questions, and the person is viewed through a lens of resource rather than deficit — as someone already getting through, with capacities that can be turned toward what they most want. The work is organised around a desired outcome: the therapist helps establish the person's "best hopes" or preferred future, then asks questions that move across time in its light — evidence that pieces of the desired outcome have already occurred, even in small ways (the past); resources and small instances of it now (the present); and a detailed description of the preferred future. So SFBT does engage the past; it simply asks about it differently, looking for instances and exceptions rather than dwelling on problem-saturated detail. A distinctive feature is the careful, micro-level description of concrete things in the presence of the desired outcome; in the solution-focused account, the description itself is the active intervention rather than preparation for one.

It is practised across the full range of difficulty, including serious mental health problems and trauma, so the perception that it suits only simpler presentations is mistaken. That said, the controlled evidence is strongest for depression and common psychosocial problems — where several studies find it comparable to established treatments such as CBT[11] — and is thinner specifically in severe and trauma populations. Pooled effects in meta-analysis are large, but the literature is more heterogeneous and methodologically variable than CBT's, with signs of publication bias, and a recent umbrella review, while positive, calls for more rigorous studies.[12] As with every approach here, the common-factors evidence applies here also.

Needs-based and practical approaches (including Human Givens)

Some approaches centre on identifying unmet emotional needs — security, connection, autonomy, competence, meaning — and finding practical ways to meet them, alongside techniques to settle the nervous system. This is a pragmatic, present-focused way of working that many patients find intuitive.

The best-known version is the **Human Givens** approach, and many clinicians will meet patients who have seen Human Givens practitioners, so it deserves a clear appraisal. The needs-based *content* is sound, and actually maps well onto better-evidenced psychological research. The list of needs maps closely onto **Self-Determination Theory**, in which autonomy, competence and relatedness are well-supported psychological requirements for wellbeing;[13] framed that way, the insight stands on firm ground without relying on the claim that these are fixed "innate" needs in a strong evolutionary sense. Some of the approaches distinctive theoretical add-ons (the "orientation response," the associated theory of dreaming) are the originators' own hypotheses, not established science, and Human Givens as a whole modality has essentially no independent randomised evidence base. So I would not present it as evidentially equal to NICE-recommended therapies. The one technique from this approach with a developing trial base — the rewind technique — is discussed under traumatic memories below.

Couples, family and systemic approaches

Where low mood or distress is bound up with a relationship, **behavioural couples therapy** is NICE-recommended for depression and can be more effective than individual work for the right couple.[1] Systemic and family approaches matter particularly for children and young people, and for adult difficulties embedded in family patterns. These are easy to forget in a list organised around individual therapy, but the relational frame is sometimes the one that fits the problem.

Body- and breath-based approaches

These use breathing, movement, posture or awareness practices to settle the body and reduce physical tension and rumination, and are particularly useful where distress is strongly physical or where talking alone feels difficult. They are usually integrated into other therapies rather than offered alone. There are many different physiological mechanisms and approaches, but when the evidence is reviewed the most important active ingredients appear to be largely slow, exhale-weighted breathing and a restored sense of control, which seem of comparable efficacy in their own right to some therapeutic approaches.

A note on EFT

Patients may also encounter approaches whose mechanistic rationale has less in the way of a clearly accepted scientific basis — for example emotional freedom techniques (EFT, "tapping"), which pair exposure with tapping on acupressure "meridian" points. There are randomised trials and meta-analyses, including for PTSD, reporting substantial effects[14] and proponents point to compelling case material and physiological correlates. The difficulty is that this evidence is concentrated among investigators committed to the method and published largely in its own outlets, with all the allegiance and control problems that implies. Tested against credible comparators, the active ingredients look like the familiar ones — exposure, arousal reduction and the ordinary therapeutic factors — rather than the meridian rationale, for which there is no scientifically plausible mechanism I am aware of. The honest reading as I see it is of a practice that can genuinely help some people through well-understood routes, but often explained by a mechanism for which scientific evidence is lacking. It is not recommended in guidelines

and it is not recommended ahead of the evidence-based therapies — but, as the common-factors section explains, that it appears to help some people is exactly what the common factors evidence shows should be expected.

What the evidence shows: common factors

This is an important section, because it informs how to read everything above.

There are common factors figures that are sometimes cited — roughly 40% of outcome attributable to client and life factors, 30% to the relationship, 15% to expectancy, 15% to technique. They trace to a single heuristic estimate by Lambert (1992), popularised by Asay and Lambert (1999), and were never the product of a formal meta-analysis; they are an "observation" or "estimate" rather than a measured partition of variance.[15] The conclusion they are used to support is sound; the numbers themselves are less so, and the robust evidence makes the same point more securely:

Different therapies produce broadly similar outcomes. Across decades of head-to-head trials, bona fide therapies built on quite different theories tend to come out about even — the so-called dodo-bird verdict.[2,3] Direct comparisons of the major approaches for depression and anxiety bear this out, with broadly similar average effects and combined treatment often, though not always, better than either component alone.[16]

The therapeutic relationship reliably tracks outcome. The alliance — the sense of a collaborative, trusting bond and agreement on goals — is one of the most consistent predictors of outcome in the field. The largest synthesis, covering 295 studies and more than 30,000 patients, found an alliance–outcome correlation of about r = 0.28 (equivalent to d ≈ 0.58), stable across treatment approaches, measures, countries and patient groups.[17] The honest caveat is about causality: a correlation cannot by itself prove the alliance *drives* improvement, since early symptom improvement can also strengthen the alliance, and the two probably reinforce each other. But the association is robust, and it is one of the better reasons to attend to relationship and fit rather than technique alone.

Apparent differences between therapies partly reflect who ran the trial. When a study is conducted by researchers committed to one of the therapies, that therapy tends to do better. Across 30 meta-analyses, this researcher-allegiance effect is about r = 0.26 — a moderate association, robust across treatments and populations.[5] This is not an accusation of bad faith; it is better read as the ordinary human tendency to deliver the therapy one believes in more skilfully and to design trials that favour it. It is, though, a strong reason to discount claims that any one therapy is the uniquely effective option, and it partly explains the apparent dominance of the most heavily researched approaches.

Common factors are the mechanism, not the absence of one

The temptation is to read all this cynically: if the type of therapy matters much less than we have previously thought, perhaps none of it works. That is the wrong conclusion - what the convergence shows is not that therapy is ineffective, but that what works is largely *shared* across therapies: a collaborative relationship and a credible rationale; the expectation that help is possible; a structured, repeated engagement with what is being avoided; and the restoration of a sense of agency and hope. These are not the residue left when the "real" treatment is subtracted — they are a large part of the treatment. This is

the old observation, well made by Frank, that much of what heals across approaches is the remoralisation of someone who had become demoralised.[18] A response shaped by relationship and expectation is a real response, with real and measurable effects; it is not a placebo in the dismissive sense.

This also reframes how to read trial results for patients. A trial is designed to isolate what a *specific* technique adds *over and above* a strong comparison — and that comparison is usually delivering the common factors on purpose. So "no specific advantage over an active control" means only that the increment attributable to the brand is small; it does not mean nothing distinctive happened. No one taking up therapy receives only the increment; they receive the whole — the shared ingredients plus whatever the particular method adds — and many people benefit substantially from that sum, even where the measured extra is modest. Averages, too, hide individuals: behind a moderate mean sit people who gained a great deal and people who gained little, and the average is a summary of a population average, not an individual prediction for the person in front of you.

Practical caveats on fit

Beyond the model itself, fit is shaped by mundane but real factors: session frequency and total number; the emotional impact between sessions; how therapy fits around work, family and health; and the particular therapist. If therapy does not help, it may simply be the wrong approach, the wrong timing, or the wrong fit with that therapist, rather than evidence that the person is beyond help or that "therapy doesn't work for me."

When therapy can do harm

Therapy is an active treatment, and like any active treatment it can do harm as well as good. This is under-recognised, easily left out of the consultation, and something I have seen borne out many times in practice.

In the largest UK survey — almost 15,000 people receiving NHS therapy for depression or anxiety across England and Wales — about one in twenty (5.2%) reported lasting bad effects from the treatment, and the broader literature estimates that somewhere between 5 and 10% of people deteriorate over a course of therapy.[19] Some of that deterioration reflects the natural course of the illness rather than the therapy, but not all of it does, and the survey's authors reasonably concluded that clinicians should discuss the possibility of negative as well as positive effects before therapy begins. Lasting bad effects were reported more often by people from sexual and ethnic minority backgrounds, which is itself worth attending to.[19]

The ways harm happens are recognisable from practice:

- **Opening painful material without the means to settle it.** This is the commonest mechanism I see: trauma or other distressing experience is brought up in depth without dealing with it immediately in the room or helping the person to manage the arousal it provokes, and they leave sessions more dysregulated, sleeping worse, or destabilised — sometimes dropping out, sometimes worse than when they started. This can happen when counselling is considered to be a place to ‘offload’ or talk about difficult experience in detail. Stabilisation, pacing and a trauma-informed stance are so important, and going straight for the painful content, or talking about

past difficult experiences without the means to reduce the emotional intensity of the associated memories (see the traumatic memories section below), are not necessarily the right approach.

- **The wrong approach, or the wrong timing.** A method that suits one person can be unhelpful or distressing for another, and the same method can be wrong for the right person at the wrong moment.
- **A poor or ruptured relationship.** Feeling judged, pushed, or misunderstood can leave a lasting mark; in the survey, a notable proportion of people reported feeling hurt by things their therapist said. A weak alliance is not merely an absent benefit but a potential source of harm in its own right.
- **Fostering dependence or eroding agency.** Therapy that becomes a substitute for a person's own life and relationships, rather than a support to them, can wear away the very sense of agency it should be rebuilding.
- **Specific practices with evidence of harm.** Some interventions can make things worse: single-session psychological debriefing after a trauma does not prevent PTSD and may increase the risk of it, which is why NICE advises against it,[20] and the wider literature catalogues other well-meant treatments that have harmed.[21]

It is worth being clear about the common belief that therapy must get "worse before it gets better," because it is sometimes used to excuse work that leaves people repeatedly distressed. The evidence does not support it as a rule. In trauma-focused therapy, distress can rise transiently when a memory is first worked on, but studies of prolonged exposure and cognitive processing therapy find this occurs in only a minority of patients, is usually small and short-lived, and does not predict whether treatment ultimately succeeds or whether people drop out.[22,23] The fear that exposure routinely worsens people derives largely from a handful of old case reports, not from controlled trials. Skilled trauma therapy uses specific methods to bring the emotional intensity of a memory down, not up — so a person leaving sessions consistently more distressed is not evidence of necessary "processing." It is a signal that the work may be poorly paced or poorly matched, or lacking the techniques to keep arousal manageable, and a reason to review rather than to persevere unchanged.

Harm is poorly captured by trials, which measure symptom scores over a few weeks and are far weaker at detecting subtler damage — lost confidence, a worse relationship to one's own experience, reinforced hopelessness — so its true rate is probably underestimated. Also, the protections are mundane and effective: set the expectation that, although hard things may be faced, a person should generally leave a session no worse — and ideally a little steadier — than they arrived; monitor how they are doing between and across sessions; take a stalled or worsening course seriously rather than waiting it out for an upturn the evidence does not promise; and treat "this isn't helping" or "this is making me worse" as information rather than resistance. All this said, most people are helped, and knowing that therapy can occasionally make things worse is part of choosing and steering it well.

Traumatic memories: how memory-focused approaches work

Memory needs to be fully discussed in its own section. The companion PTSD guide develops this in full; here is the core, with the reasoning made clear.

The shared logic

The memory-focused therapies look different on the surface — talking through a narrative, moving the eyes, "rewinding" an image — but they share a logic. A distressing memory is brought to mind under conditions the brain registers as safe, with arousal kept manageable, and is then re-experienced or updated in a way that lets it be re-coded as belonging to the past rather than feeling present. The aim is integration of the memory. Distress may rise while a memory is actively being worked on, but skilled trauma therapy keeps that arousal within manageable limits and brings it back down within the session, so the person leaves settled rather than dysregulated. A sustained worsening between sessions is not an expected part of recovery (see "When therapy can do harm"), and the goal throughout is to reduce the emotional charge of the memory.

Four overlapping accounts

There is no consensus on a single mechanism, but four accounts are useful and overlap:[24]

- **Ehlers and Clark's cognitive model.** PTSD persists when the trauma is processed in a way that produces a sense of *current* threat, through very negative appraisals and a poorly elaborated, disjointed memory that is easily triggered. Therapy targets both the appraisals and the memory.[25]
- **Brewin's dual representation theory.** Trauma memories are held in two systems — a verbal, contextualised one and a sensory, image-based one. Flashbacks reflect sensory memory not yet bound to its context in time and place; treatment helps integrate the two. This is the formal version of the everyday intuition that the memory needs "filing" as past.[26]
- **Inhibitory learning (the basis of exposure).** The old fear memory is not erased; new, safety-based learning is built that competes with and inhibits it. Modern exposure is best understood as maximising that new learning rather than simply wearing arousal down.[27]
- **Memory reconsolidation.** When a memory is retrieved it can briefly become open to updating before being stored again; information introduced in that window may change the memory itself.[28,29] This is a promising modern theory and the one several brief techniques invoke. It is genuinely promising but not yet in routine clinical use — the conditions for triggering it in humans are quite specific — and is best held as a strong candidate rather than an established fact.[24]

The practical implication is shared across all four: controlled re-engagement with the memory, under safety and with arousal kept manageable, is what helps.

Dual attention, EMDR and the brief techniques

A related strand concerns *how* arousal is kept down during re-engagement. Holding a vivid memory in mind while doing a demanding second task — eye movements, but also tapping or counting — leaves fewer mental resources for the memory, which becomes less vivid and less emotional and is re-stored that way. This working-memory account is well supported in laboratory studies and offers a tidy, non-mystical explanation for the eye movements in EMDR.[30] In clinical terms the debate about whether the

eye movements specifically add anything matters less than it sounds: EMDR works; the question is only about the active ingredient.

What is first-line, and where rewind sits

For PTSD, the evidence-based first-line treatments are **trauma-focused CBT** (for example cognitive therapy for PTSD, cognitive processing therapy, or prolonged exposure) and **EMDR**, both recommended by NICE, with medium-to-large effect sizes across meta-analyses.[20,31] The **rewind technique** — a brief, non-intrusive visual–kinaesthetic dissociation protocol refined within the Human Givens approach — has a developing evidence base, including an exploratory randomised trial reporting a large effect size, but that trial is small, compared against a waitlist, and conducted by investigators close to the method; rewind is not recommended in NICE.[32] The fair summary is that it has moved from anecdote to a preliminary efficacy signal, plausibly working through the same arousal-reduction and reconsolidation routes as the established therapies. It is not established to the standard of trauma-focused CBT or EMDR, and should not be offered in their place; its appeal is mainly practical, in being brief and not requiring detailed verbal disclosure.

Trauma-informed care as a cross-cutting stance

"Trauma-informed" is not a therapy but a way of working that can apply across all of the above: prioritising safety, stabilisation and choice, and helping someone feel more settled before exploring painful material in depth. It matters in particular where trauma is prolonged or complex (ICD-11's complex PTSD), which generally calls for a phased approach — stabilisation and affect regulation before and alongside memory-focused work — rather than brief intervention.[20] Framing it as a stance helps colleagues see that the choice is rarely "trauma therapy or not" but "how much stabilisation does this person need before, and during, the deeper work."

The service context: what a referral actually means, and what is actually available

Access is the practical bottleneck, and it helps patients to be honest about it. NHS Talking Therapies handles milder to moderate presentations through stepped/matched care, usually time-limited and structured, with low-intensity options first and high-intensity therapy as a next step or directly for specific conditions.[1] Limits on session length, total sessions and flexibility reflect capacity and fairness, not the seriousness or validity of a person's difficulties. People can often be re-referred later, and specialist or secondary care services exist for complex PTSD, personality difficulties (where DBT is sometimes offered), severe presentations and high risk.

A word on what is actually available, because it differs from what guidance recommends. In practice, NHS provision in most areas is largely person-centred counselling and CBT. Some therapists also offer EMDR, and individual practitioners may bring solution-focused, interpersonal or other approaches depending on their training and who happens to be in post locally — provision can shift noticeably when a particular therapist arrives or leaves. Several of the named modalities in this guide — solution-focused brief therapy, Human Givens and others — are not usually commissioned within the NHS and are more often found in private practice or the third sector. So local availability varies, and in most places a referral for "counselling" will mean person-centred work or CBT, with other models only possibly available.

This variability reinforces a theme that runs through the whole guide: the type of therapy captures only part of what happens in the room. Individual therapists routinely draw on aspects of several models, integrating them around the person in front of them — which is consistent with the common-factors evidence, and a reason not to over-read either the label a patient was given or the one they say "didn't work." Trauma-focused therapy in particular is effective but therapist-time intensive, and waits for adequately "dosed" treatment can be long; it is reasonable to begin support, stabilisation, sleep and arousal-regulation work while people wait in accordance with local resources available.

How this maps to the patient leaflet

The patient leaflet puts all of this into plain, validating language and leaves the references out. Its main ideas — that "therapy" is a broad set of different approaches delivered by individual human beings; that the right question is what an approach is trying to do and whether it fits; that fit, relationship and timing matter more than the therapy type; that what is available locally varies; that therapy usually helps but can occasionally do harm, so it is worth steering and reviewing; that good therapy should not leave a person repeatedly worse, trauma work included; that memory-focused approaches work by re-engaging a memory safely so it can settle as past; and that not finding one approach helpful does not mean therapy cannot help — line up with the sections above and trace back to the sources listed here.

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Companion documents: the counselling and psychological therapy patient leaflet; the PTSD clinician guide; the depression and antidepressant guides; and the two physiology and self-regulation papers, which develop the common-factors argument and the breath/arousal mechanisms in full.