Psychology

Self-study CPD activity

Activity Reference Number
C3(26) 2029

Topic

Adults with psychiatric disorders

Article(s)

Psychotherapies at a Glance: Consensus Guideline–Recommended Psychotherapies for Adults with Psychiatric Disorders

Profession(s)

Psychiatrist
Psychologist
Registered Counsellor

You can complete any one, or all the parts of this activity

Part 1 is approved for **THREE (3)** ***Clinical*** Continuing Education Units (CEU's)
Part 2 is approved for **TWO (2)** ***Clinical*** Continuing Education Units (CEU's)

Psychotherapies at a Glance: Consensus Guideline–Recommended Psychotherapies for Adults With Psychiatric Disorders

Paula Ravitz, M.D., F.R.C.P.C., Luis E. Flores, Jr., Ph.D., C.Psych., Danielle Novick, Ph.D., Priya Watson, M.D., F.R.C.P.C., Holly A. Swartz, M.D.

Clinical decision making by psychiatrists and informed consent by patients require knowledge of evidence-based psychotherapies (EBPs) and their indications. However, many mental health professionals are not versed in the empirical literature on EBPs or the consensus guideline recommendations derived from this literature. The authors compared rigorous national consensus guidelines for EBP treatment of *DSM*-defined adult psychiatric disorders—derived from well-conducted randomized controlled trials and meta-analyses and from expert opinions from the United States, United Kingdom, and Canada—to create the Psychotherapies-at-a-Glance tool. Recommended EBPs are cognitive-behavioral therapy, family therapy, contingency management, dialectical behavior therapy, eye movement desensitization reprocessing, interpersonal psychotherapy, mentalization-based treatment, motivational interviewing, peer support, problem-solving therapy, psychoeducation, short-term psychodynamic psychotherapy, and 12-step facilitation. The Psychotherapies-at-a-Glance tool summarizes the indications, rationales, and therapeutic tasks that characterize these differing psychotherapies and psychosocial treatments. The tool is intended for use in clinical teaching, treatment planning, and patient communications.

Am J Psychother 2024; 77:79–87;
doi: 10.1176/appi.psychotherapy.20230004

Treatment of psychiatric disorders with psychotherapy has been shown in randomized controlled trials (RCTs) and meta-analyses to improve patients' symptoms, functioning, and quality of life. Additional benefits of psychotherapy include decreased relapse rates, mitigation of the stigma associated with mental illness, and improved satisfaction with mental health care. Many clinical populations, such as individuals with unresolved trauma, personality disorders, or substance use disorders, benefit from psychiatric care that includes psychotherapy as a primary treatment modality. Thus, guideline-concordant practices in the comprehensive psychiatric care of individuals with mental disorders optimally include psychotherapy treatments (1).

Clinical decision making by psychiatrists and informed consent by patients require knowledge of evidence-based treatments and their indications in order to ensure informed treatment planning (2). Evidence-based psychotherapies (EBPs) are defined by the American Psychological Association as interventions that have demonstrated efficacy on the basis of empirical research and expert consensus, with consideration of patient characteristics, culture, and preferences (3). Without working knowledge about the empirical literature on EBPs or about consensus guidelines derived from this literature, psychiatrists may have difficulty providing patients with a clear rationale for why they are recommending a psychotherapy treatment. Many otherwise well-trained psychiatrists lack comprehensive knowledge about extant EBPs that are indicated for specific psychiatric disorders. For example, U.S. and Canadian postgraduate regulatory bodies require modest levels of training in psychodynamic psychotherapy, cognitive-behavioral therapy (CBT), and supportive psychotherapy; in the United Kingdom, the Royal College of Psychiatrists stipulates that trainees conduct a range of individualized, group, and family psychotherapies for integration of psychiatric care and biosociocultural interventions. Despite these requirements, few psychiatrists are fully versed in all EBPs, their content, and their indications.

In the absence of firsthand knowledge of the full range of EBPs and the associated literature, psychiatrists and psychiatric trainees use expert consensus guidelines to assist with clinical decision making. Although consensus guidelines can be confusing, are not updated annually, and are not written in language that can be easily used to communicate with patients, they nonetheless provide clinical, evidence-based guidance on indications for specific psychotherapies

BOX 1. Considerations for use and attributes of the Psychotherapies-at-a-Glance tool to enhance clinical decision making and provider-patient communication

- Rigorously developed consensus guidelines from the United States, United Kingdom, and Canada, based on well-conducted randomized controlled trials and meta-analyses, provide evidence-based psychotherapy treatment recommendations for adults with psychiatric disorders.
- Clinical decision making that draws from evidence-based psychotherapy treatment recommendations can be guided by consensus guidelines as well as by patient preferences and the availability of resources.
- The Psychotherapies-at-a-Glance tool, which includes the indications, rationales, and tasks associated with consensus guideline–recommended psychotherapy treatments for psychiatric disorders, can be used as a decision support tool and for informed-consent discussions in patient-centered mental health care.
- Cognitive-behavioral therapy, contingency management, dialectical behavior therapy, eye movement desensitization and reprocessing, family therapy, interpersonal psychotherapy, mentalization-based treatment, motivational interviewing, problem-solving therapy, and short-term psychodynamic psychotherapy may be used for differing psychiatric disorders, as detailed in the Psychotherapies-at-a-Glance tool.
- Clinicians must also take into account patients' comorbid conditions, preferences, and access considerations when making recommendations about evidence-based psychotherapies.

to treat specific mental disorders. Consensus guidelines are helpful because they combine a careful review of the evidence with clinical expertise, thereby offering a clinically relevant and evidence-informed set of recommendations. Therefore, we reviewed and compared commonly used and cited English-language psychiatric consensus guidelines for psychotherapy treatments of psychiatric disorders in order to summarize the evidence-informed guidelines in our Psychotherapies-at-a-Glance tool to enhance clinical decision making and communication with patients.

This tool's summary of recommendations relies on the accuracy and validity of consensus treatment guidelines; thus, it is important to consider the processes used to generate this information. Guideline development requires experts to thoroughly review the evidence, weigh the potential benefits against the detriments of a recommendation, and identify levels of confidence for each recommendation. This process is known as the GRADE (Grading of Recommendations Assessment, Development and Evaluation) approach (4). The level of confidence in treatments is determined by available evidence from well-conducted clinical trials, meta-analyses, expert opinion, and consensus of the groups writing the guidelines. In most cases, when recommendations are made in guideline statements, the strength of the evidence and defined criteria for evidence thresholds are reported. For example, level 1 and level 2 recommendations from the Canadian Network for Mood and Anxiety Treatments (CANMAT) guidelines require that a treatment has been shown to be effective in at least one meta-analysis or an RCT with an adequate sample size (5). Although not all guideline development processes strictly adhere to GRADE for RCTs or meta-analyses, and guideline recommendations are not updated annually, guidelines for evidence-based mental health care remain important for best clinical practices.

The objective of this article was to describe and provide the Psychotherapies-at-a-Glance tool, which summarizes EBPs for psychiatric disorders as recommended by leading treatment guidelines from the United States, Canada, and the United Kingdom and that generally appear in more than one guideline or for more than one psychiatric disorder.

METHODS

The Psychotherapies-at-a-Glance tool was modeled by two authors (P.R., P.W.) on a "fast facts" summary of guideline-concordant psychotherapy treatments, which was initially created for a course designed to prepare students for a psychiatry credentialing examination. We subsequently redesigned and updated the tool for trainees and practicing clinicians to aid in evidence-informed clinical decision making about EBPs and to enhance provider-patient communication (Box 1).

To create the tool, we searched the research literature for English-language, expert consensus guidelines on psychiatry treatment in order to select, compare, and summarize psychotherapy recommendations for specific psychiatric disorders. To achieve consensus recommendations of EBPs for *DSM*-defined psychiatric disorders, we selected guidelines that used rigorous methods, including systematic evaluations of evidence from well-conducted RCTs and meta-analyses supporting the use of specific treatments for specific disorders. The chosen guidelines are gold standards for the field: the U.S.-based American Psychiatric Association (APA) guidelines (6–13); the U.K.-based National Institute for Health and Care Excellence (NICE) guidelines (14–23); and Canadian guidelines, including those from CANMAT (24–27). APA provides comprehensive practice guidelines for numerous disorders on its website. The NICE guidelines provide the most thorough updates on psychotherapy treatment recommendations for people with psychiatric disorders. Rather than residing on a website, the Canadian guidelines are published in a national psychiatric association journal and other peer-reviewed publications, with separate consensus panels for different disorders, including for mood and anxiety (CANMAT guidelines) and schizophrenia spectrum disorders.

To select disorder-specific treatments, we extracted data from the guidelines, including the year that each guideline

TABLE 1. Psychotherapies-at-a-Glance tool[a]

Psychotherapy modality	Format and dose	Targeted disorders	Treatment rationale and tasks
Cognitive-behavioral therapy (CBT)	16–20 individual or group sessions	Transdiagnostic disorders; CBT adaptations (e.g., behavioral activation, exposure and response prevention, mindfulness-based cognitive therapy, and acceptance and commitment therapy)	Thoughts, feelings, and behaviors are interconnected. Perceptions and beliefs about oneself, others, circumstances, and the future may be distorted and exacerbate symptoms when ill or stressed. Structured exploration is directed at modifying distorted, biased thinking or problematic behaviors associated with symptoms in order to change one's thinking and behaviors and to improve symptoms.
Contingency management	Unspecified format for ≥12 weeks	Substance use disorders	Behavior is shaped by consequences. When the rewards of abstinence or reduced substance use are greater than the rewarding effects of substance misuse, patients are better able to reduce substance use and feel better. Opportunities to earn rewards, including vouchers for prizes or services, can promote positive behaviors, including reduced substance use and abstinence.
Dialectical behavior therapy (DBT)	Individualized and group formats for 12 months	Borderline personality disorder	Having emotions that are frequently out of control worsens symptoms, distress, and relationships and exacerbates problematic behaviors such as self-harm. DBT encourages patients to make changes while validating and accepting their painful experiences in order to find ways to better cope with stress and emotions. A multimodal format with skills training groups, individual therapy, and between-session telephone coaching provides structured exploration and skills teaching that aim to reduce behaviors that are life threatening or that interfere with treatment, decrease emotional dysregulation, and improve coping skills.
Eye movement desensitization and reprocessing (EMDR)	6–12 individual sessions	Trauma- and stressor-related disorders	When individuals experience traumatic life events, information processing can become blocked or imbalanced and exacerbate symptoms and distress. EMDR aims to restore the ability to process information for recovery from trauma- and stressor-related disorders. Repeated structured exploration and discussion of a traumatic memory, where patients simultaneously focus on a memory and move their eyes back and forth, tracking a light or a therapist's finger, can lead to a decrease in PTSD symptoms and to enhanced processing of trauma.
Family and couples therapy	≥10 sessions, 3 months	Schizophrenia spectrum disorders, bipolar depression and bipolar maintenance treatment, substance use disorders	Conflicts in relationships with a partner or family can contribute to or be a sequela of symptoms. Recovery is aided by understanding and helping individuals within family and social systems. Structured exploration as a familial unit aims to improve the boundaries, communication, and interactions between family members.

continued

TABLE 1, *continued*

Psychotherapy modality	Format and dose	Targeted disorders	Treatment rationale and tasks
Interpersonal psychotherapy (IPT) and interpersonal and social rhythm therapy (IPSRT)	8–16 individual or up to 20 group sessions	Bipolar depression and bipolar maintenance treatment, depressive disorders, and eating disorders	IPT helps patients work through interpersonal problems and stressful life events of grief, role transitions, role disputes, or interpersonal sensitivity that are associated with worsening symptoms and exacerbated by illness states. IPSRT enhances IPT with an added focus on tracking and stabilizing circadian and social rhythms to decrease the risk for bipolar disorder relapse. Both IPT and IPSRT involve focused exploration of emotions and relational experiences to aid recovery.
Motivational interviewing (MI)	1–6 individual sessions	Substance use disorders	MI helps patients engage in healthier behaviors (e.g., reduced substance misuse) by understanding ambivalence and barriers to change and by supporting self-efficacy and motivation for recovery. Focused elicitation and discussion of change readiness help to identify and support health- and values-based changes.
Problem-solving therapy (PST)	4–12 individual or group sessions	Bipolar depression and depressive disorders	Life changes, problems, and difficulties with adapting or problem solving can contribute to psychological distress. PST provides strategies to recognize, address, and cope with stressors to aid recovery. Structured learning and practice of problem-solving strategies aim to improve self-efficacy.
Short-term psychodynamic psychotherapy	12–20 individual sessions	Bipolar depression, depressive disorders, eating disorders, and borderline personality disorder	Reflecting within a psychologically safe process and therapeutic alliance aids patients in addressing past and current problems, processing emotions and experiences, and developing insight into and awareness of connections between past and present inner subjective experiences or problems. Exploration and discussion of conscious and subconscious mental and emotional processes, related to a manifesting problem, aid the process of working through distressing experiences toward recovery.

[a] See the online supplement for full guideline-recommended psychotherapy and psychosocial treatments, including CBT adaptations, mentalization-based treatment, peer support, psychoeducation, and 12-step facilitation.

was published and the disorders for which psychotherapy treatments are recommended by more than one guideline. Each guideline panel used its own system for rating EBPs; therefore, we selected the EBPs with the highest recommendations in each guideline. These included level 1 recommendations in most APA guidelines, recommendations designated by the NICE guidelines as suggestions to "offer, advise or refer to" rather than to "consider," and recommendations with level 1 or level 2 evidence in the CANMAT guidelines, given that both levels require a meta-analysis or an RCT with an adequate sample size.

RESULTS

Recommended Psychotherapy Treatments

The indications, rationales, and tasks that characterize the selected recommended psychological treatments are outlined in the Psychotherapies-at-a-Glance tool (Table 1), which was designed to be an easy reference and pragmatic synopsis for clinical decision making and communication with patients. The online supplement to this article details numerous disorder-specific adaptations of CBT and includes information about additional guideline-recommended psychosocial interventions, including mentalization-based treatment (MBT), peer support, psychoeducation, and 12-step facilitation. Psychotherapy treatments recommended with only moderate confidence or suggested only as a "consideration" (e.g., not a first-line recommendation) were generally not included in the tool or the online supplement because more evidence is needed for these interventions to be recommended with confidence.

Table 2 lists disorder-specific psychotherapy treatments that are recommended in more than one of the surveyed guidelines or for more than one disorder, highlighting the year that each guideline was last updated. The publication dates of the guidelines range from 2001 to 2023, mostly before the publication of the *DSM-5-TR* in 2022. Thus, the guidelines are primarily based on *DSM-IV-TR* (2000) or

TABLE 2. Guideline-recommended psychotherapy treatments for adult psychiatric disorders

Psychiatric disorder and treatment	Guideline source[a]		
	Canada	United States	United Kingdom
Schizophrenia spectrum[b]			
CBT	X	X	X
Family therapy	X		X
Psychoeducation	X	X	
Bipolar disorder, acute depression treatment[c,d]			
CBT	X		X
Family therapy	X		
IPT	X		X
PST			X
Short-term psychodynamic psychotherapy			X
Bipolar disorder, maintenance treatment[c]			
CBT	X		X
Family therapy	X		X
IPT	X		X
Peer support	X		
Psychoeducation	X	X	
Depressive disorder[e]			
CBT	X	X	X
IPT	X	X	X
PST	X		X
Short-term psychodynamic psychotherapy	X		X
Anxiety[f]			
CBT	X	X	X
Obsessive-compulsive disorder[g]			
CBT	X	X	X
Trauma- and stressor-related disorders[h]			
CBT	X	X	X
EMDR	X		X
Eating disorders[i]			
CBT		X	X
IPT		X	
Short-term psychodynamic psychotherapy		X	
Substance use[j]			
CBT		X	
Contingency management		X	X
Family and couples therapy		X	
Motivational interviewing		X	X
12-step facilitation		X	
Borderline personality disorder[k]			
DBT		X	
MBT		X	
Short-term psychodynamic psychotherapy		X	

[a] Sources: Canadian guidelines are primarily from the Canadian Network for Mood and Anxiety Treatments, U.S. guidelines are from the American Psychiatric Association, and U.K. guidelines are from the National Institute for Health and Care Excellence. CBT, cognitive-behavioral therapy; DBT, dialectical behavior therapy; EMDR, eye movement desensitization and reprocessing; IPT, interpersonal psychotherapy; MBT, mentalization-based treatment; PST, problem-solving therapy.
[b] Canada, 2017; United States, 2021; United Kingdom, 2014 (6, 14, 24).
[c] Canada, 2018; United States, 2002; United Kingdom, 2014 (7, 15, 25).
[d] No specific psychotherapy treatment is highly recommended by U.S. guidelines (i.e., at level 1) (7, 23).
[e] Canada, 2016; United States, 2010; United Kingdom, 2022 (8, 16, 26).
[f] Canada, 2014; United States, 2009; United Kingdom, 2011 and 2013 (9, 17, 18, 27).
[g] Canada, 2014; United States, 2007; United Kingdom, 2005 (10, 19, 27).
[h] Canada, 2014; United States, 2004; United Kingdom, 2018 (11, 20, 27).
[i] Canada, no guideline; United States, 2023; United Kingdom, 2017 (12, 21).
[j] Canada, no guideline; United States, 2006; United Kingdom, 2007 (13, 22).
[k] Canada, no guideline; United States, upcoming guideline available online but not finalized (see https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines for updates); United Kingdom, 2009 (DBT and MBT suggested as considerations only) (23).

DSM-5 (2013) diagnostic criteria; however, some guidelines cite studies conducted with diagnostic criteria from earlier versions of the *DSM* (*DSM-III* or *DSM-IV*). Formats of psychotherapy delivery include individualized or group, in person, videoconferencing, or telephone. First-line, guideline-recommended psychotherapy modalities that appear in these psychiatric treatment guidelines, as summarized in Table 2, are CBT (28), contingency management (29), dialectical behavior therapy (DBT) (30), eye movement desensitization and reprocessing (EMDR) (31), family therapy (24, 32), interpersonal psychotherapy (IPT) (33), MBT (34), motivational interviewing (MI) (35), peer support (36), problem-solving therapy (PST) (37), short-term psychodynamic psychotherapy (38), psychoeducation (39), and 12-step facilitation (40). An additional noteworthy psychotherapy that is not included in Tables 1 or 2 or the online supplement is the integrative Maudsley model of anorexia nervosa treatment for adults (MANTRA). MANTRA focuses on identifying and coping with cognitive, emotional, relational, and biological factors that worsen or contribute to continued disordered eating behaviors (41). This psychotherapy is accruing evidence for efficacy, is recommended for anorexia in APA guidelines (12), and may need to be incorporated into future updates of the Psychotherapies-at-a-Glance tool.

Psychiatric disorders for which the psychotherapies listed in Table 1 are recommended include schizophrenia

spectrum disorder, mood and anxiety disorders, obsessive-compulsive disorder (OCD), trauma- and stressor-related disorders, eating disorders, substance use disorders, and personality disorders. Psychotherapy may be used alone or sequenced or coadministered with medication. For bipolar disorder and psychotic disorders such as schizophrenia, psychotherapies are recommended only as an adjunct to pharmacotherapy. Some of the modalities included in Tables 1 and 2 specify modifications or adaptations for specific populations and are subsumed under the psychotherapy modalities from which the adaptations evolved (see online supplement). Guideline-recommended, evidence-based derivatives of CBT for specific disorders include behavioral activation (BA) for depression (42), acceptance and commitment therapy (ACT) for depression (43), mindfulness-based cognitive therapy (MBCT) for depression relapse prevention (44), and exposure and response prevention for OCD (45). For example, BA promotes participation in values-based activities that provide a sense of pleasure, connection, or achievement. MBCT enhances CBT with mindfulness and meditation to help individuals focus on present moments with nonjudgmental, self-compassionate awareness. ACT, which is scaffolded on mindfulness and aligned with BA, helps individuals move toward engaging in values-based behaviors. Interpersonal and social rhythm therapy (IPSRT) is an evidence-based derivative of IPT that is recommended for treatment of bipolar disorder (46, 47). IPSRT enhances IPT with an added focus on stabilizing circadian and social rhythms. Although DBT is not recommended as a first-line treatment by more than one set of guidelines, it is a first-line recommendation in the 2001 APA guideline on borderline personality disorder (48) and is mentioned as a consideration in the NICE guideline on borderline personality disorder (23).

Psychotherapy Recommendations for Specific Psychiatric Disorders

CBT is recommended by all three sets of guidelines for the treatment of schizophrenia (6, 14, 24). Family therapy is also recommended by the Canadian and U.K. guidelines (14, 24), and psychoeducation is recommended by the Canadian and U.S. guidelines (6, 24). CBT and IPT are recommended for acute depressive disorders by all three sets of guidelines (8, 16, 26), and PST and short-term psychodynamic psychotherapy are recommended by the Canadian and U.K. guidelines (16, 26).

The Canadian guidelines recommend CBT, family therapy, and the adaptation of IPT for bipolar disorder and IPSRT for the treatment of acute bipolar depression (25). The U.K. guidelines recommend using the same therapies as indicated for acute severe depression treatment (i.e., CBT, IPT, PST, and short-term psychodynamic psychotherapy) (15). The 2018 Canadian guidelines on treatment of bipolar disorder relapse prevention added peer support and psychoeducation to CBT, family therapy, and IPSRT (25). The 2014 U.K. guidelines recommend family interventions and a structured, evidence-based, manualized psychological intervention designed for bipolar disorder (e.g., IPSRT, family therapy, or CBT) (15). The 2002 U.S. guidelines could not consider newer studies conducted in the past two decades; therefore, they recommend only support groups and psychoeducation (7). Evidence for CBT, family therapy, and IPSRT has accrued since these U.S. guidelines were published, and these therapies are included in the more recently published guidelines from the United Kingdom and Canada (15, 25). No specific therapies are recommended by any guideline for acute manic episodes, which are treated primarily with pharmacotherapy (7, 15, 25).

All sets of guidelines recommend CBT for OCD (10, 19, 27). The U.K. guidelines from 2011 provide recommendations for generalized anxiety and panic disorders (17), with social anxiety disorder added in 2013 (18). The U.S. guidelines from 2009 cover panic disorder (9). The Canadian guidelines from 2014 review treatments for panic disorder, agoraphobia, specific phobia, social anxiety disorder, generalized anxiety disorder, OCD, and posttraumatic stress disorder (27). All sets of guidelines recommend CBT for these disorders, with an emphasis on exposure as a first-line treatment (9, 17, 18, 27). In addition, all sets of guidelines recommend exposure-based CBT for trauma- and stressor-related disorders (11, 20, 27), and the Canadian and U.K. guidelines recommend EMDR (20, 27).

The U.S. guidelines recommend CBT, IPT, short-term psychodynamic psychotherapy, and the integrative MANTRA for anorexia nervosa. For bulimia nervosa, U.S. guidelines recommend CBT. For binge eating disorder, U.S. guidelines recommend CBT and IPT (12). The U.K. guidelines recommend self-help and group CBT for binge eating disorder. Furthermore, the U.K. guidelines suggest considering individual CBT for binge eating disorder, CBT or MANTRA for anorexia nervosa, and CBT for bulimia nervosa (21). No Canadian guidelines on adult eating disorders had been published at the time this article was written.

U.S. guidelines recommend CBT and behavioral therapies (e.g., contingency management) for treating alcohol, cocaine, and nicotine misuse (13). Twelve-step facilitation is recommended for alcohol and cocaine misuse, and family or couples interventions and MI are also recommended for alcohol misuse. No psychotherapy treatments are specified as recommendations for cannabis, opioid, or other substance misuse. U.K. guidelines recommend contingency management and MI for substance use disorders (22). Because Canadian guidelines for substance use disorders do not use the GRADE approach, they are not included.

Finally, the U.K. guidelines do not recommend any particular psychotherapy for borderline personality disorder but suggest considering DBT or MBT for women with borderline personality disorder and recurrent self-harming behavior (23). Upcoming U.S. guidelines (see https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines for updates) recommend a structured, empirically

supported psychotherapy that targets core symptoms of the disorder. Several examples of psychotherapy treatments are listed, including DBT, MBT, and psychodynamic-oriented therapies. No Canadian guidelines are available for this disorder.

DISCUSSION

Psychiatrists may struggle to know which psychotherapy treatment to recommend to patients and when. Our Psychotherapies-at-a-Glance tool (Table 1) can be used as an easy reference for understanding which psychotherapy treatments are recommended for specific psychiatric disorders on the basis of graded evidence from consensus guidelines from different countries in order to aid clinical decision making and communication with patients. We envision that the tool may be especially useful for trainees and early-career professionals who are striving to master multiple domains of psychiatric knowledge, including the extensive literature on EBPs. Having a quick, reliable reference on which to base, at least in part, psychotherapeutic recommendations for psychiatric disorders may also facilitate shared decision making with patients, enabling professionals to explain the rationales and tasks of these EBPs.

Psychotherapy is a critically important component of comprehensive mental health care to resolve symptoms, support patient recovery, and improve quality of life. Many psychotherapy models exist; however, few have reached the level of evidence required for inclusion in evidence-based treatment guidelines. In reviewing U.S., U.K., and Canadian guidelines, the most frequently recommended modalities are CBT, IPT, family therapy, and short-term psychodynamic psychotherapy. Contingency management, DBT, EMDR, MBT, MI, peer support, PST, psychoeducation, and 12-step facilitation are also recommended.

The Psychotherapies-at-a-Glance tool was based on recommendations from three sets of national psychiatric guidelines. However, relying solely on consensus recommendations to guide clinical decision making has limitations. Individuals with severe, persistent, and complex or comorbid psychiatric disorders are rarely included in the clinical trials used to generate the evidence base for these guidelines; therefore, recommendations may not fully generalize to this population. However, these individuals will likely benefit from comprehensive biopsychosocial care that integrates EBPs. Controversies and questions exist about the EBP paradigm (49, 50), and guidelines have been critiqued for their narrow focus on treatment models and specific disorders and for their general lack of focus on comorbid conditions; their underemphasis on individual patient differences in culture, intersectional identities, and patterns of relating; and their lack of consideration of how social determinants of health influence treatment responses. Importantly, although EBPs differ in their rationales, foci, and therapeutic techniques, they converge in the use of evidence-based common factors that contribute to their effectiveness, such as the centrality of therapeutic alliances and the use of empathy (51, 52). The 2018 Canadian guidelines emphasized the importance of these common factors to optimizing outcomes (5, 26). Additional limitations inherent to guidelines include their intermittent updates and biases that affect all research, such as from funding sources and therapeutic allegiances, and that influence the production of the research evidence on which guideline panel treatment recommendations are made. Clinical decision making needs to also take into consideration patients' preferences or readiness to participate in different forms of treatment, such as exposure-based treatments. In addition, the decisions must account for pragmatic barriers to access, such as the availability or costs of psychotherapy treatments with trained providers across geographic locations and differing clinical settings. Finally, as with all decision support instruments, this tool should be tested systematically to evaluate its utility (52).

CONCLUSIONS

International consensus on psychiatric treatment, as evidenced in guidelines from multiple nations, reifies psychotherapy as an effective treatment for patients with psychiatric disorders. EBPs such as CBT, family therapy, IPT, and short-term psychodynamic psychotherapy are routinely included in expert consensus guidelines for adult patients with psychiatric disorders. Few psychiatrists are intimately familiar with the extant literature on EBPs; therefore, most clinicians can benefit from this summary of guideline-recommended psychotherapies in their treatment planning with patients. The Psychotherapies-at-a-Glance tool, a pragmatic synopsis of the EBPs in consensus guidelines and their indications, rationales, and tasks, can be used as a decision support tool by mental health trainees and professionals seeking to deliver evidence-based treatment recommendations for psychiatric disorders.

AUTHOR AND ARTICLE INFORMATION

Department of Psychiatry, Temerty Faculty of Medicine, University of Toronto, Toronto (Ravitz); Department of Psychology, Queen's University, Kingston, Ontario, Canada (Flores); U.S. Department of Veterans Affairs Pittsburgh Healthcare System, Pittsburgh (Novick); Department of Psychiatry, University of British Columbia, Vancouver (Watson); Department of Psychiatry, University of Pittsburgh School of Medicine, Pittsburgh (Swartz).

Send correspondence to Dr. Ravitz (paula.ravitz@sinaihealth.ca).

The authors thank Priyanthi Weerasekera, M.D., F.R.C.P.C., professor emeritus at McMaster University, and Natalie Heeney, research coordinator at Sinai Health System (SHS), Department of Psychiatry, for their insights and contributions to the manuscript and gratefully acknowledge past support from the University of Toronto, Temerty Faculty of Medicine, Department of Psychiatry, and from the Morgan Firestone Psychotherapy Chair, SHS Department of Psychiatry.

Drs. Ravitz and Watson receive royalties from W.W. Norton. Dr. Swartz reports receiving royalties from UpToDate (Wolters Kluwer) and the American Psychiatric Association and has served as a consultant to the Clinical Education Alliance, Intra-Cellular Therapies, Mediflix, Medscape

(Internet Brands/WebMD), and Physicians Postgraduate Press. The other authors report no financial relationships with commercial interests. Dr. Swartz is editor of the journal. Lois W. Choi-Kain, M.D., M.Ed., served as decision editor on the manuscript.

Received February 7, 2023; final revision received December 14, 2023; accepted December 20, 2023; published online March 15, 2024.

REFERENCES

1. Chaimowitz G, Weerasekera P, Ravitz P: Psychotherapy in psychiatry. Can J Psychiatry 2021; 66:999–1004
2. Hall DE, Prochazka AV, Fink AS: Informed consent for clinical treatment. CMAJ 2012; 184:533–540
3. Hamdi NR, Cuttler MJ, Hollon SD, et al: Professional Practice Guidelines for Evidence-Based Psychological Practice in Health Care. Washington, DC, American Psychological Association, 2021
4. Balshem H, Helfand M, Schünemann HJ, et al: GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol 2011; 64:401–406
5. Resources. Canada, Canadian Network for Mood and Anxiety Treatments. https://www.canmat.org/resources. Accessed Feb 20, 2024
6. Practice Guideline for the Treatment of Patients With Schizophrenia, 3rd ed. Washington, DC, American Psychiatric Association, 2021
7. Practice Guideline for the Treatment of Patients With Bipolar Disorder, 2nd ed. Washington, DC, American Psychiatric Association, 2002
8. Practice Guideline for the Treatment of Patients With Major Depressive Disorder, 3rd ed. Washington, DC, American Psychiatric Association, 2010
9. Practice Guideline for the Treatment of Patients With Panic Disorder, 2nd ed. Washington, DC, American Psychiatric Association, 2009
10. Practice Guideline for the Treatment of Patients With Obsessive-Compulsive Disorder. Arlington, VA, American Psychiatric Association, 2007
11. Practice Guideline for the Treatment of Patients With Acute Stress Disorder and Posttraumatic Stress Disorder. Washington, DC, American Psychiatric Association, 2004
12. Practice Guideline for the Treatment of Patients With Eating Disorders, 4th ed. Washington, DC, American Psychiatric Association, 2023
13. Practice Guideline for the Treatment of Patients With Substance Use Disorders, 2nd ed. Washington, DC, American Psychiatric Association, 2006
14. Psychosis and Schizophrenia in Adults: Prevention and Management. London, National Institute for Health and Care Excellence, 2014. https://www.nice.org.uk/guidance/cg178. Accessed Dec 16, 2022
15. Bipolar Disorder: Assessment and Management. London, National Institute for Health and Care Excellence, 2014. https://www.nice.org.uk/guidance/cg185. Accessed Dec 16, 2022
16. Depression in Adults: Treatment and Management. London, National Institute for Health and Care Excellence, 2022. https://www.nice.org.uk/guidance/ng222. Accessed Dec 16, 2022
17. Generalised Anxiety Disorder and Panic Disorder in Adults: Management. London, National Institute for Health and Care Excellence, 2011. https://www.nice.org.uk/guidance/cg113. Accessed Dec 16, 2022
18. Social Anxiety Disorder: Recognition, Assessment and Treatment. London, National Institute for Health and Care Excellence, 2013. https://www.nice.org.uk/guidance/cg159. Accessed Dec 16, 2022
19. Obsessive-Compulsive Disorder and Body Dysmorphic Disorder: Treatment. London, National Institute for Health and Care Excellence, 2005. https://www.nice.org.uk/guidance/cg31. Accessed Dec 16, 2022
20. Post-Traumatic Stress Disorder. London, National Institute for Health and Care Excellence, 2018. https://www.nice.org.uk/guidance/ng116. Accessed Dec 16, 2022
21. Eating Disorders: Recognition and Treatment. London, National Institute for Health and Care Excellence, 2017. https://www.nice.org.uk/guidance/ng69. Accessed Dec 16, 2022
22. Drug Misuse in Over 16s: Psychosocial Interventions. London, National Institute for Health and Care Excellence, 2007. https://www.nice.org.uk/guidance/cg51. Accessed Dec 16, 2022
23. Borderline Personality Disorder: Recognition and Management. London, National Institute for Health and Care Excellence, 2009. https://www.nice.org.uk/guidance/cg78. Accessed Dec 16, 2022
24. Norman R, Lecomte T, Addington D, et al: Canadian treatment guidelines on psychosocial treatment of schizophrenia in adults. Can J Psychiatry 2017; 62:617–623
25. Yatham LN, Kennedy SH, Parikh SV, et al: Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder. Bipolar Disord 2018; 20: 97–170
26. 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; 61:524–539
27. 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
28. 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: 376–385
29. Prendergast M, Podus D, Finney J, et al: Contingency management for treatment of substance use disorders: a meta-analysis. Addiction 2006; 101:1546–1560
30. Linehan MM, Comtois KA, 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; 63:757–766
31. Davidson PR, Parker KC: Eye movement desensitization and reprocessing (EMDR): a meta-analysis. J Consult Clin Psychol 2001; 69:305–316
32. Miklowitz DJ, Otto MW, Frank E, et al: Psychosocial treatments for bipolar depression: a 1-year randomized trial from the Systematic Treatment Enhancement Program. Arch Gen Psychiatry 2007; 64: 419–426
33. Cuijpers P, Donker T, Weissman MM, et al: Interpersonal psychotherapy for mental health problems: a comprehensive meta-analysis. Am J Psychiatry 2016; 173:680–687
34. Bateman A, Fonagy P: 8-year follow-up of patients treated for borderline personality disorder: mentalization-based treatment versus treatment as usual. Am J Psychiatry 2008; 165:631–638
35. Hettema J, Steele J, Miller WR: Motivational interviewing. Annu Rev Clin Psychol 2005; 1:91–111
36. Jorm AF: Mental health literacy: empowering the community to take action for better mental health. Am Psychol 2012; 67: 231–243
37. Bell AC, D'Zurilla TJ: Problem-solving therapy for depression: a meta-analysis. Clin Psychol Rev 2009; 29:348–353
38. 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
39. Colom F, Vieta E, Martinez-Aran A, et al: A randomized trial on the efficacy of group psychoeducation in the prophylaxis of recurrences in bipolar patients whose disease is in remission. Arch Gen Psychiatry 2003; 60:402–407
40. Ferri M, Amato L, Davoli M: Alcoholics Anonymous and other 12-step programmes for alcohol dependence. Cochrane Database Syst Rev 2006; 3:CD005032

41. Schmidt U, Wade TD, Treasure J: The Maudsley model of anorexia nervosa treatment for adults (MANTRA): development, key features, and preliminary evidence. J Cogn Psychother 2014; 28:48–71
42. Dimidjian S, Hollon SD, Dobson KS, et al: Randomized trial of behavioral activation, cognitive therapy, and antidepressant medication in the acute treatment of adults with major depression. J Consult Clin Psychol 2006; 74:658–670
43. Hayes SC, Luoma JB, Bond FW, et al: Acceptance and commitment therapy: model, processes and outcomes. Behav Res Ther 2006; 44: 1–25
44. 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; 68:615–623
45. Rosa-Alcazar AI, Sanchez-Meca J, Gomez-Conesa A, et al: Psychological treatment of obsessive-compulsive disorder: a meta-analysis. Clin Psychol Rev 2008; 28:1310–1325
46. Frank E, Kupfer DJ, Thase ME, et al: Two-year outcomes for interpersonal and social rhythm therapy in individuals with bipolar I disorder. Arch Gen Psychiatry 2005; 62:996–1004
47. Swartz HA, Levenson JC, Frank E: Psychotherapy for bipolar II disorder: the role of interpersonal and social rhythm therapy. Prof Psychol Res Pr 2012; 43:145–153
48. Practice Guideline for the Treatment of Patients With Borderline Personality Disorder. Washington, DC, American Psychiatric Association, 2001
49. Westen D, Novotny CM, Thompson-Brenner H: The empirical status of empirically supported psychotherapies: assumptions, findings, and reporting in controlled clinical trials. Psychol Bull 2004; 130:631–663
50. Crits-Christoph P, Wilson GT, Hollon SD: Empirically supported psychotherapies: comment on Westen, Novotny, and Thompson-Brenner (2004). Psychol Bull 2005; 131:412–417; discussion 427–433
51. Flückiger C, Del Re AC, Wampold BE, et al: The alliance in adult psychotherapy: a meta-analytic synthesis. Psychotherapy 2018; 55: 316–340
52. Norcross JC, Wampold BE: Evidence-based therapy relationships: research conclusions and clinical practices. Psychotherapy 2011; 48: 98–102

QUESTIONNAIRE
C3(26) Part 1 of 2
Psychotherapies at a Glance: Consensus Guideline–Recommended Psychotherapies for Adults with Psychiatric Disorders

INSTRUCTIONS

- Read through the article and answer the multiple-choice questions provided below.
- There is only ONE correct answer per question.

Introduction and Background

Question 1: Besides improving symptoms, functioning and quality of life, which of the following is an additional benefit of psychotherapy demonstrated in randomized controlled trials and meta-analyses?

- **A:** Increased effectiveness of medication
- **B:** Enhanced neuroplasticity
- **C:** Accelerated diagnostic clarity
- **D:** Decreased relapse rates

Question 2: According to the American Psychological Association (APA), which component must be considered in the definition of Evidence-Based Psychotherapies (EBPs) along with empirical research and expert consensus?

- **A:** Use of algorithms
- **B:** Provider scope of practice
- **C:** Patient characteristics, culture and preferences
- **D:** Specific disorder severity

Question 3: Despite postgraduate training requirements in psychotherapies for psychiatrists in the U.S., Canada and the U.K., what limitation regarding their knowledge is noted in the article?

- **A:** They are only versed in psychodynamic psychotherapy
- **B:** Few psychiatrists are fully versed in all EBPs, their content, and their indications
- **C:** They lack knowledge about the empirical literature on EBPs
- **D:** They only receive training in supportive psychotherapy

Question 4: TRUE/FALSE: Consensus guidelines are not updated annually, but they are nonetheless valuable because they provide clinical, evidence-based guidance on indications for specific psychotherapies.

- **A:** TRUE
- **B:** FALSE

Question 5: Clinical decision making based on EBP treatment recommendations should be guided by consensus guidelines, as well as which two other factors?

- **A:** Guideline publication date and evidence level
- **B:** Therapist allegiance and research funding
- **C:** Diagnostic complexity and symptom frequency
- **D:** Patient preferences and the availability of resources

Question 6: The process used for guideline development, which requires experts to review evidence, weigh benefits against detriments and identify confidence levels for each recommendation, is known by what acronym?

- **A:** APA
- **B:** NICE
- **C:** CANMAT
- **D:** GRADE

Methods and Psychotherapy Tasks

Question 7: Which one of the following is listed as a gold standard guideline source used to create the Psychotherapies-at-a-Glance tool?

- **A:** World Health Organization (WHO) guidelines
- **B:** U.S.-based American Psychiatric Association (APA) guidelines
- **C:** Australian Psychological Society (APS) guidelines
- **D:** European Psychiatric Association (EPA) guidelines

Question 8: For which psychotherapy modality is the primary treatment rationale based on the idea that thoughts, feelings and behaviors are interconnected and that modifying distorted thinking can improve symptoms?

- **A:** Dialectical behaviour therapy (DBT)
- **B:** Interpersonal psychotherapy (IPT)
- **C:** Cognitive-behavioural therapy (CBT)
- **D:** Short-term psychodynamic psychotherapy

Question 9: The Dialectical Behavior Therapy (DBT) modality is primarily targeted toward which specific disorder?

- **A:** Schizophrenia spectrum disorders
- **B:** Trauma- and stressor-related disorders
- **C:** Substance use disorders
- **D:** Borderline personality disorder

Question 10: What is the core mechanism of change in Eye Movement Desensitization and Reprocessing (EMDR)?

- **A:** Structured practice of problem-solving strategies
- **B:** Restoring the ability to process information for recovery from trauma- and stressor-related disorders
- **C:** Focused elicitation and discussion of change readiness
- **D:** Tracking and stabilizing circadian and social rhythms

Question 11: Interpersonal Psychotherapy (IPT) and Interpersonal and Social Rhythm Therapy (IPSRT) help patients work through interpersonal problems associated with worsening symptoms, such as all the following, **except** ……?

- **A:** Substance use disorders
- **B:** Grief
- **C:** Role transitions
- **D:** Role disputes

Question 12: The rationale for Motivational Interviewing (MI) is centered on helping patients engage in healthier behaviors by ……?

- **A:** Insight and awareness
- **B:** Understanding ambivalence and barriers to change
- **C:** Reward and consequence
- **D:** Supporting self-efficacy and motivation for recovery

Results and Disorder-Specific Recommendations

Question 13: The integrative Maudsley model of anorexia nervosa treatment for adults (MANTRA) is noteworthy because it focuses on identifying and coping with which factors?

- **A:** Social and cultural factors that influence body image
- **B:** Historical and developmental factors leading to trauma
- **C:** Circadian and social rhythms that affect appetite
- **D:** Cognitive, emotional, relational, and biological factors that worsen or contribute to continued disordered eating behaviours

Question 14: Which two of the following psychotherapies are specifically listed as guideline-recommended, evidence-based derivatives of CBT for specific disorders?

- **A:** Interpersonal and Social Rhythm Therapy (IPSRT) and Mentalization-Based Treatment (MBT)
- **B:** Behavioural Activation (BA) and Acceptance and Commitment Therapy (ACT)
- **C:** 12-step facilitation and Peer Support
- **D:** Dialectical Behaviour Therapy (DBT) and EMDR

Question 15: TRUE/FALSE: Interpersonal and Social Rhythm Therapy (IPSRT) is an evidence-based derivative of Interpersonal Psychotherapy (IPT) that is recommended for the treatment of bipolar disorder.

- **A:** TRUE
- **B:** FALSE

THE END

QUESTIONNAIRE
C3(26) Part 2 of 2
Psychotherapies at a Glance: Consensus Guideline–Recommended Psychotherapies for Adults with Psychiatric Disorders

INSTRUCTIONS

- Read through the article and answer the multiple-choice questions provided below.
- There is only ONE correct answer per question.

Question 1: In the guidelines surveyed, which one of the following psychotherapy modalities is **most** frequently recommended for the treatment of schizophrenia spectrum disorder?

- **A:** Interpersonal psychotherapy (IPT)
- **B:** Dialectical behaviour therapy (DBT)
- **C:** Cognitive-behavioural therapy (CBT)
- **D:** Short-term psychodynamic psychotherapy

Question 2: Which two psychotherapies are recommended by all three sets of guidelines (U.S., U.K. and Canadian) for the treatment of acute depressive disorders?

- **A:** Problem-solving therapy and psychoeducation
- **B:** Family therapy and MI
- **C:** CBT and IPT
- **D:** Short-term psychodynamic psychotherapy and PST

Question 3: For the acute treatment of manic episodes in bipolar disorder, what is the primary recommendation across all guidelines?

- **A:** Acute manic episodes are treated primarily with pharmacotherapy
- **B:** CBT and IPT
- **C:** Family therapy and psychoeducation
- **D:** Short-term psychodynamic psychotherapy

Question 4: For anxiety, posttraumatic stress, and obsessive-compulsive disorders (OCD), all sets of guidelines recommend CBT, with a specific emphasis on what as a first-line treatment?

- **A:** Self-monitoring
- **B:** Exposure
- **C:** Cognitive restructuring
- **D:** Mindfulness

Question 5: Which psychotherapy is recommended by the U.S. guidelines for anorexia nervosa, bulimia nervosa and binge eating disorder?

- **A:** Short-term psychodynamic psychotherapy
- **B:** Interpersonal psychotherapy (IPT)
- **C:** MANTRA
- **D:** Cognitive-behavioural therapy (CBT)

Question 6: For women with borderline personality disorder and recurrent self-harming behaviour, the U.K. guidelines suggest considering which two psychotherapies?

- **A:** CBT and IPT
- **B:** Psychoeducation and Peer support
- **C:** Contingency Management and MI
- **D:** DBT or MBT

Discussion and Conclusion

Question 7: For whom is the Psychotherapies-at-a-Glance tool primarily intended to be especially useful?

- **A:** Seasoned clinicians looking for annual guideline updates
- **B:** Researchers studying therapeutic allegiance biases
- **C:** Trainees and early-career professionals striving to master multiple domains of psychiatric knowledge
- **D:** Patients seeking a comprehensive list of all psychosocial treatments available

Question 8: According to a review of U.S., U.K., and Canadian guidelines, which four psychotherapy modalities are the **most frequently** recommended?

- **A:** MI, PST, Psychoeducation and Peer Support
- **B:** DBT, MBT, Contingency Management and EMDR
- **C:** CBT, IPT, family therapy and short-term psychodynamic psychotherapy
- **D:** ACT, BA, MBCT and Exposure/Response Prevention

Question 9: Relying solely on consensus recommendations to guide clinical decision making has a limitation because the recommendations may not fully generalize to which population?

- **A:** Patients treated in outpatient settings
- **B:** Patients newly diagnosed with a disorder
- **C:** Individuals with severe, persistent and complex or comorbid psychiatric disorders
- **D:** Individuals who prefer medication over psychotherapy

Question 10: Although Evidence-Based Psychotherapies (EBPs) differ in their rationales and foci, they are noted to converge in the use of what factors that contribute to their effectiveness?

- **A:** Specific structured manualized interventions
- **B:** Diagnostic-specific treatment protocols
- **C:** The use of pharmacotherapy adjuncts
- **D:** Evidence-based common factors like therapeutic alliances and empathy

THE END

FOCUS ON HEALTH
www.foh-cpd.co.za
Cell: 074 230 3874
Tel: 012 653 0133 / 2373 / 2394
Mon-Fri: 08:00-16:00

400 Theuns van Niekerk Street
Wierda Park
0157

PO Box 71
Wierda Park
0149

MEMBER INFO

(Complete sections marked with an asterisk *)

*FOH number	*HPCSA number

ID number

Personal detail changes

I hereby declare that the completion of this document is my own effort without any assistance.

SIGNED: DATE:

This activity is accredited for **FIVE (5) CLINICAL** CEU'S. You have to achieve **70%** to pass this activity.

ANSWER SHEET

C3(26)

Psychotherapies at a Glance: Consensus Guideline–Recommended Psychotherapies for Adults with Psychiatric Disorders

***Time spent on activity hour min**

You can complete any one, or all the parts of this activity.

PART 1

	A	B	C	D	E		A	B	C	D	E
1						11					
2						12					
3						13					
4						14					
5						15					
6											
7											
8											
9											
10											

PART 2

	A	B	C	D	E		A	B	C	D	E
1						6					
2						7					
3						8					
4						9					
5						10					

How relevant was the content of this activity to your scope of practice?			
Not at all	Somewhat	Mostly	Extremely

RETURN ANSWER SHEET TO

Online members, complete your answer sheet online

CPD PORTAL: http://foh-cpd.co.za/cpd-online/cpd-user (Username: FOH number & Password: ID)

(Results are available immediately)

Email or **hard copy members**, complete your answer sheet online or return it to:

WHATSAPP: 074 230 3874 **EMAIL:** info@foh-cpd.co.za

(Results will be sent via email)

You will receive a confirmation of receipt SMS within 12-24hours, if not received please send again.

Have a suggestion or comment?

Send it to us on **EMAIL or WHATSAPP**