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Integrating Psychotherapy into Clinical Care for Individuals with Parkinson's Disease

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Introduction

Psychotherapy has historically played a limited role in Parkinson's disease (PD) care, despite the high prevalence of neuropsychiatric and psychological conditions in this population. With sporadic evidence for the benefits of psychotherapy in PD, a clear pathway for psychotherapeutic intervention is still in development.

An interesting report (of 2025) by the British Association for Counselling and Psychotherapy [1] found that more than one third of adults in the UK have sought help from a counsellor or psychotherapist at some point in their lives. However, the survey did not specify how many responders were older than 65 - the age group most affected by PD - or living with chronic neurological disorders.

This is a commentary that does not present novel experimental or service improvement data; instead, it synthesizes existing evidence and insights from a recent project of ours. In this article, we follow up from previous work to discuss the need to offer a holistic psychological assessment to patients with PD. The aim of this commentary is to strengthen the view that psychotherapy should be integrated in standard of care practices in PD in a proactive way.

Underdiagnosing the Psychological Symptoms in PD

PD frequently includes a range of neuropsychiatric and psychological conditions that can significantly affect a patient's quality of life [2]. These symptoms often precede the cardinal motor symptoms of PD, and if they remain untreated, they usually get worse as the disease progresses. The most common psychological symptoms associated with PD are depression (affects approximately 40–50% of Parkinson's patients) [3] and anxiety (reported in 30–40% of patients) [4]. Psychological distress can be part of other non-motor symptoms and conditions including cognitive impairment (mild cognitive impairment as well as PD dementia) [5], impulse control disorders (affecting up to 17% of patients treated with dopamine receptor agonists) [6], sleep disorders (including REM sleep behavior disorder, insomnia, and excessive daytime sleepiness) [7], psychosis (visual hallucinations occur in approximately 20-40% of patients with PD [8], and (g) apathy (affecting approximately 20-40% of the general PD population) [9]. These figures underscore the high prevalence and diversity of neuropsychiatric symptoms in PD, their significant impact on quality of life, and the need for early intervention. While prevalence data highlight the high frequency of neuropsychiatric symptoms in PD, variability across studies and diagnostic challenges suggest these figures may underestimate the true burden. Understanding these limitations is crucial for interpreting the clinical significance and planning targeted interventions.

Currently, drug development in the fields of depression and anxiety are somewhat limited in PD. To deal with these two symptoms, the vast majority of patients rely, in practice, on effective licensed medication, and secondarily on their personal coping mechanisms [10,11]. We assume that individuals with PD who never had counselling or psychotherapy, nor any medicinal treatment for these symptoms, rely on the coping and survival mechanisms they have developed during their first years of life. However, some of these coping strategies can be often to the detriment of their close relationships, increasing psychological distress. Not all individuals have had a supportive enough early environment for systemic development and this needs to be factored in during history taking for those with unmet psychological needs.

In cases with mild-to-moderate anxiety and depression, the initiation of medicinal treatment for these symptoms may not be deemed appropriate, especially if the impact on the overall quality of life is not clinically significant. These symptoms may commonly remain underdiagnosed and undertreated for several months or years. Researchers with special interest in this field concur with this view highlighting the need to revisit this topic [12–14]. By reflecting on the above points, we support the view that there is a significant gap in therapeutics for patients with PD and mild-to-moderate psychological symptoms. We believe that this observation reflects a combination of diagnostic challenges, symptom overlap with motor and cognitive features, which are specific to PD, and the stereotyped view that PD is a purely movement disorder.

The traditional one target-one drug model of treatment has long supported pharmaceutical product development, as there have been excellent clinical outcomes for patients with various clinical phenotypes. Although medications provide symptomatic relief, their limitations in addressing emotional well-being underscore the need for integrating psychotherapy. Critically, the persistent underuse of psychological interventions reflects systemic and cultural barriers within the neurological community rather than lack of efficacy. Widely-used medicines for motor and non-motor symptoms in PD are cost-effective and easily accessible with highly favorable benefit:risk profiles. Nonetheless, psychotherapy is not a standardized, industrialized intervention and therefore cannot be directly compared to pharmacological treatments in terms of scalability, regulation, or commercial integration.

Psychotherapy offers a highly personalized approach, addressing present challenges and unresolved psychological needs through one-on-one sessions. The psychotherapeutic approach is available to complement validated treatments in PD and offer patients the opportunity to develop effective emotional self-regulation skills, which are essential for integrated care.

Yet, the initiation of treatment plans is almost exclusively linked to medicines [15] for patients who are newly diagnosed with PD and a neurology-heavy clinical follow-up that may not include support by psychotherapists. Moreover, the most widely used dopaminergic drugs in PD act largely on the same neurochemical pathways as common antidepressant and anxiolytic medications, introducing variable modulatory effects on psychiatric symptom relief.

Barriers to Assessing Psychotherapy Services for Patients with PD

Patients seeking support for distressing psychological symptoms may not access psychotherapy services soon, unless regional clinical pathways integrate psychotherapy into standard care. In clinical practice, a common assumption among treating physicians with expertise in PD is that individuals with unmet psychological needs are capable of (i) identifying their own emotional states and needs, (ii) owning the emotions and acknowledge their limitations, (iii) having the willingness to cooperate, (iv) appropriately expressing difficult emotions, and (v) soothing themselves in periods of distress in a healthy way. These behaviors suggest that individuals with PD and mild-to-moderate anxiety and/or depression may miss psychotherapeutic interventions unless offered through primary care or a dedicated hospital team. The risk to miss this opportunity increases if the lead physician(s) assume(s) that the patient has a well-established system in place for effective psychological self-regulation. However, most patients with PD have impaired cognitive and behavioral pathways, because of PD, at both structural and functional levels, challenging their ability to secure effective emotional self-regulation without specialist help.

By not having niche psychotherapy services integrated into the care pathway for PD [15], there is no evidence that individual patients with anxiety and depression have access to all available resources. Not all barriers are equally consequential; for example, cognitive impairment may pose a greater obstacle than patient motivation alone. Evaluating which factors most impede access can guide the design of feasible, scalable care pathways. Individuals with limited capacity to seek psychological care, due to both disease-related factors and systemic fragmentation, will most likely experience a worsening in their symptoms, unless timely psychotherapeutic intervention is provided.

Most psychotherapists lack specialized PD training, creating a gap between patient needs and provider expertise. In the UK, NHS Talking Therapy services typically offer short-term interventions, often limited to 6-12 sessions, which are not routinely tailored to the complexities of PD. Access is further constrained by long waiting times, and limited therapist training in PD and other neurodegenerative conditions such as dementia. In many European countries and the USA,

psychotherapy remains largely within the private sector, introducing an additional element of inequality and gaps in continuity of high-quality care, highlighting that the problem is not UK-specific.

Systemic limitations underscore the need for integrated care models that embed psychological support within the broader framework of PD management. With no structured mechanism to bridge this divide, we recognize the need for a significant change in the PD care pathway.

The service improvement project that we recently completed [16] was delivered in North-West London as an example of how such integration can be operationalized within the NHS. This commentary explores further its implications and identifies areas for service improvement and clinical research. The findings from the 12-week psychotherapy initiative underscore a critical shift in how mental health care can be conceptualized in PD in the real world.

Historically, PD management has focused primarily on motor symptoms, with psychological distress often relegated to secondary concern. However, the high prevalence of anxiety, depression, and apathy in PD—each associated with poorer outcomes, poor compliance in medicinal treatment, and reduced quality of life metrics combined with increased caregiver burden—demands a more integrated clinical response.

The observed improvements in the patients who participated in the aforementioned project [16] in well-being, functioning, and symptom burden following short-term psychotherapy suggest that even brief, structured interventions can lead to meaningful benefits. Importantly, these gains were achieved without altering pharmacological regimens, reinforcing the notion that psychotherapy support is here to enhance the self-care element of treatment, to assist patients deal with distress with self-compassion.

It is a shared view among scholars, that clinicians and policy-makers with expertise in chronic disorders such as PD are encouraged to view psychological interventions in neurology not as ancillary, but as essential components of integrated care. These interventions do not diminish the contributions of other clinical staff; rather, they enhance the patients' overall quality of life. Implementing this approach necessitates a cultural transformation within neurology and PD communities, so that mental health screening is no longer compartmentalized. The self-referral model in our recent project empowered our patients to actively seek support and enabled them to respond proactively and reactively to excessive stress, mood swings, and anxiety-inducing stimuli.

The success of this initiative highlights that embedding psychotherapy within NHS neurology services is feasible and appropriate for the scale of small, albeit diverse urban population. The project demonstrated that psychological care can be delivered efficiently and safely at scale. Although the 12-week project demonstrates promising benefits, its small scale and short duration limit generalizability. Careful interpretation is required before applying these findings to larger PD populations or healthcare settings.

First, therapist training is paramount. The psychotherapists involved in this project received targeted education on PD and its neuropsychiatric features, enabling them to tailor interventions appropriately. Second, flexibility in delivery is essential. Many participants faced barriers related to mobility, speech, or travel logistics—which are commonly seen in PD clinical settings. Offering remote or hybrid therapy sessions, assisted by digital mental health tools, could mitigate these challenges and enhance accessibility. Additionally, integrating therapy into multidisciplinary clinics would facilitate seamless coordination between neurologists, specialist nurses, and mental health professionals. Third, funding mechanisms will have to evolve to support fully (or at least partly) private psychotherapeutic interventions. Finally, whilst fellow academics in London have developed assessment tools [17] to identify sexual and intimate lifestyle changes in individuals with PD, it is essential to facilitate referrals to specialists trained in both sex and relationship therapy to address these concerns within PD comprehensively.

This service improvement project [16] was supported by the largest charity in Europe (region) in PD; however, long-term sustainability for further work in this field requires commissioning models that recognize the value of psychological care in chronic disease management. This includes outcome-based funding, cross-sector collaboration, and alignment with national NHS long-term goals for a radical shift from the hospital environment to community services [18].

We recommend new service improvement projects as well as academically-led research with rigorous designs, including scalability and sustainability studies to establish a plan for adoption of psychotherapy practices in the clinical pathway for PD. This includes identifying barriers to adoption, evaluating cost-effectiveness, and capturing patient, carer, and clinician perspectives, and the integration of digital mental health tools and platforms. Importantly, stigma—both societal and institutional—remains a significant obstacle. Addressing this requires not only education but also structural change in how mental health is prioritized within neurological care.

The 12-week psychotherapy initiative for people with PD [16] offers an exceptional case for how to integrate psychotherapy into routine neurological services for patients with unmet psychological needs. The project demonstrates that short-

term talking therapy can be most effective and highly feasible in the existing NHS framework and in line with global digital health transformation trends.

Conclusion

The integration of psychotherapy into the standard clinical care pathway for individuals with PD is essential to address the unmet psychological needs of this patient population. Despite the high prevalence of neuropsychiatric symptoms such as depression and anxiety, these are often underdiagnosed and undertreated due to systemic barriers and a lack of tailored services. Implementing integrated care models that include psychological support can enhance the overall quality of life for individuals with PD and improve treatment outcomes.

Author Contributions

Manuscript: A. Writing of the first draft, B. Review and Critique. A.A.R.: A, B; R.H.: B; C.M.: B; P.P.: B.

Competing Interests

A.A.R. and P.P. were full-time employees of Imperial College London at the time the project was conducted. A.A.R. and P.P. report no competing interests. R.H. and C.M. report consultancies to Imperial College London and the receiving of honoraria from Imperial College London. At the time this manuscript was written, C.M. held an honorary teaching fellowship with Birkbeck and a professional affiliation at the Tavistock Relationships as a Senior Clinician.

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