

Evidence-Based Practice of Psychotherapy:
Boon or Bane?

Dianne L. Chambless, Ph.D.

University of Pennsylvania

PREMISE OF EVIDENCE-BASED PRACTICE

Outcomes for clients will be superior:

- If therapists take account of the empirical support for interventions
- If therapists renew their skills by learning new empirically supported approaches as they emerge

EBP INCLUDES

- Identification of the appropriate empirically supported interventions for the client's problems or situation
- Consideration of client's preferences and capacities and any restrictions (e.g., by financial resources, cultural factors)
- Consideration of the therapist's skills
- Consideration of treatment moderators - important factors that might interact with treatment choice (e.g., anger, reactance)

EMPIRICALLY SUPPORTED THERAPIES: THE CORE OF EBP

- psychotherapy procedures (e.g., interpersonal therapy, cognitive-behavioral therapy)
- for delineated target problems, most commonly a DSM Axis I disorder (e.g., major depression, social phobia)
- delivered reliably with clear instructions (e.g., a treatment manual)
- efficacious in randomized controlled trials

FOCUS ON ESTs DOES *NOT* MEAN

- EST ≠ CBT

- EST ≠ ignoring nonspecific therapy factors such as the therapeutic relationship

- ESTs are not required for all clients (e.g., adjustment disorders)

A Boon! Overview of Arguments

- Numerous psychological interventions found superior to waiting lists and control groups in randomized clinical trials (RCTs)
 - ESTs have been shown to be effective in applied settings, not just specialized research settings
-

A Boon!

- Evidence is accruing that ESTs are superior to treatment as usual
 - ESTs facilitate training
 - Extensively characterized in manuals
 - Videotapes often available
 - Adherence and sometimes competence rating forms available
 - Web sites providing EST information increasingly available
-

Wide Range of Efficacious ESTs Identified

(CHAMBLESS & OLLENDICK, 2001)

- 8 Largely Independent Review Groups
- Findings
 - 108 Category I and II treatments identified for adults
 - 37 for children
- Findings largely agree across review groups
- Caveat - Incomplete Data!
 - More treatments have been added to today's lists
 - Still not all treatments have been reviewed
 - Not all treatments have been studied

EXAMPLES OF PROBLEMS TREATED: ADULTS

- Anxiety
- Depression
- Health Problems
- Obesity
- Schizophrenia
- Eating Disorders
- Chemical Dependency
- Sleep Disorders
- Marital Discord

EXAMPLES OF PROBLEMS TREATED: CHILDREN

- ADHD
- Conduct/Oppositional Defiant Disorder
- Anxiety
- Depression
- Health Problems

ESTs Work in Clinically Representative Conditions: Effectiveness Research

Stewart & Chambless (2009) Meta-Analysis of CBT for Adult Anxiety Disorders

56 effectiveness studies

17 for panic disorder 11 for GAD

11 for social phobia 6 for PTSD

11 for OCD

Effectiveness of CBT for Anxiety Disorders

Stewart & Chambless (2009)

- Large pretest-posttest effect sizes for primary disorder change: $g = 0.83-2.59$, $N = 56$
 - Large effect size for primary disorder change relative to control group: $g = 1.29$, $N = 6$
 - Benchmarked against large well designed RCTs, these effect sizes fall in the range of ES obtained.
-

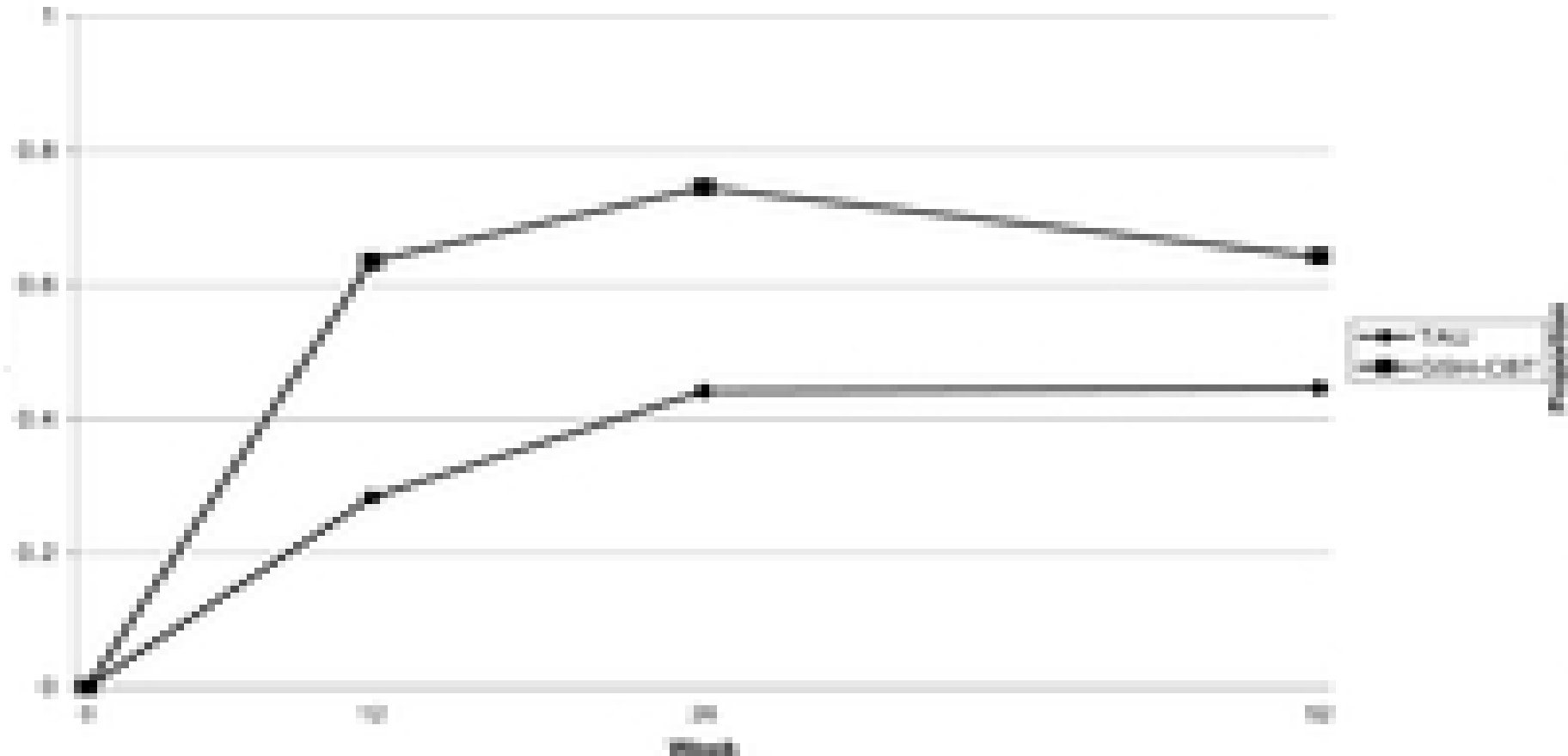
EXAMPLE OF EST VS. TREATMENT AS USUAL:

Striegel-Moore et al. (2010) CBT vs. Treatment as Usual for Binge Eating

- Manual-guided self-help program with 8 sessions with a MA level therapist
- Conducted in HMO where patients received psychological & medical care
- Tracked binge eating as well as all health care costs

Striegel-Moore et al. (2010) CBT vs. Treatment as Usual for Binge Eating

Proportion Abstinent from Binge Eating for the Last 4 Weeks



Resources for EST Training

- Published treatment manuals (e.g., Guilford Press & Oxford University Press)
 - Web sites for identification of ESTs
 - National Institute for Health & Clinical Excellence in the UK
<http://guidance.nice.org.uk/Topic/MentalHealthBehavioural>
-

Web sites, continued

- Division 12 of APA, a somewhat expanded version of the list compiled by the original Task Force:
www.psychologicaltreatments.org
 - Evidence-Based Mental Health for Children & Adolescents (joint effort of APA Division 53 and ABCT) <http://abct.org/SCCAP/>
-

Web sites, continued

- US Government site: National Registry of Evidence-Based Programs & Practices:
<http://www.nrepp.samhsa.gov/>
 - All to be posted on my web site, to be updated soon!
-

References for Articles & Web Sites Cited to be Posted

<http://www.psych.upenn.edu/~dchamb/ESTs/EST.html>

ARE PRACTICING CLINICIANS USING ESTs?

- Not a promising picture.
- Research on use of ESTs for specific disorders
 - Eating disorders (e.g., von Ranson & Robinson)
 - Anxiety (e.g., Becker, Zeyfert, & Anderson, 2004)
- Research on the science-practice gap
 - Cohen, Sargent, & Sechrest (1986)
 - Morrow-Bradley and Elliott (1986)
 - Stewart and Chambless (2007, 2010, in press)

WHY NOT?

- Training programs are not doing all they could
 - Crits-Christoph, Frank, Chambless et al. (1995)
22% of clinical psychology programs in USA failed to provide even minimal didactic coverage of ESTs in their coursework.
 - Woody, Weisz, & McLean (2005) a decade later, the picture had not improved.

WHY DO SOME SEE EBP AS A BANE?

CHIEF OBJECTIONS TO ESTs: A SURVEY OF PSYCHOLOGISTS IN PRIVATE PRACTICE

- The relationship is more important than the approach – all important?
- Clinical experience is a better guide than data
- Patients in practice are more troubled, have more comorbidity than those in research trials

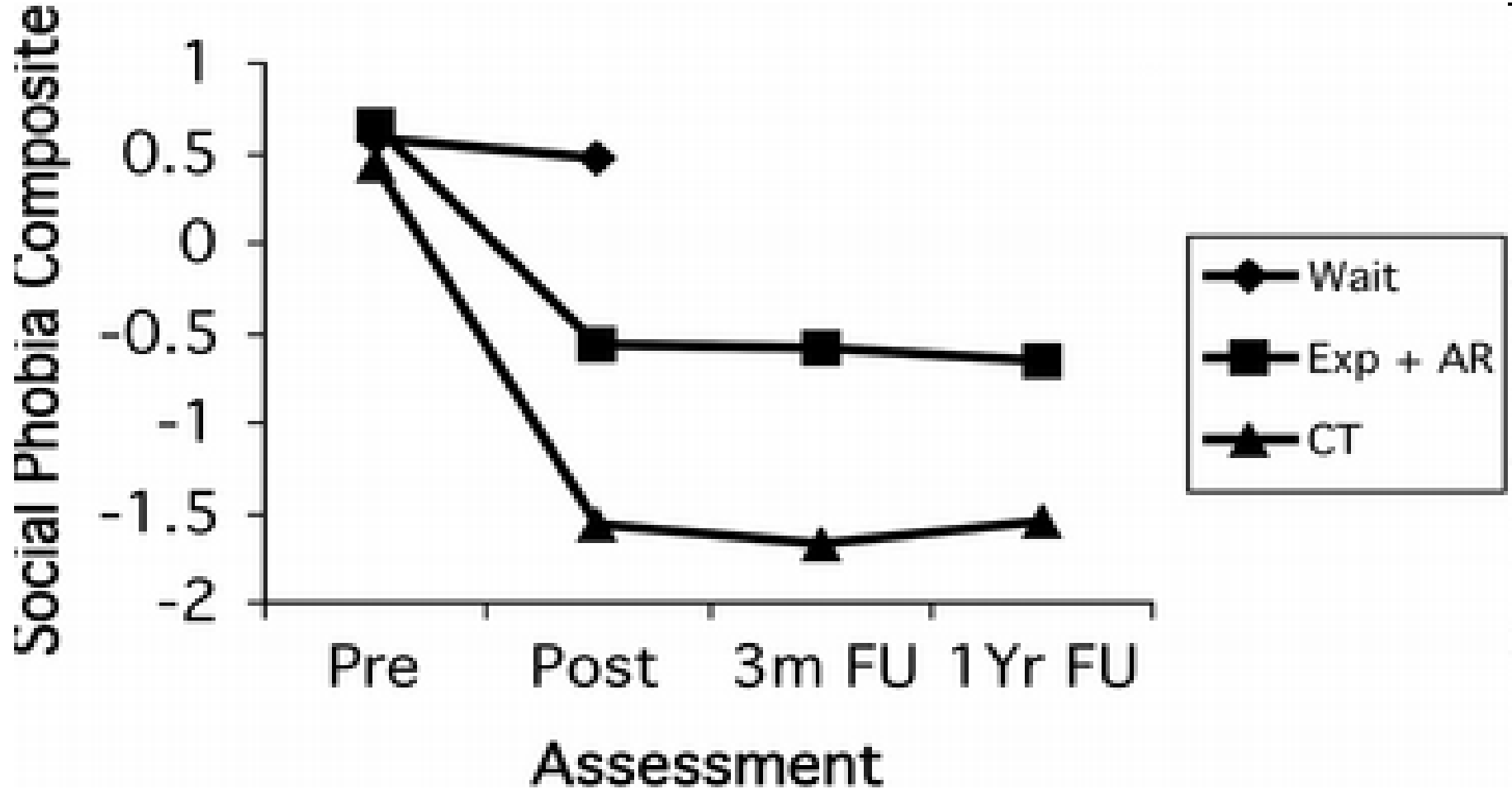
Stewart, Chambless, & Baron (in press)

Is It All in the Therapeutic Relationship?

- Meta-analyses show that the alliance accounts for about 4% of outcome (e.g., Martin et al., 2000), but
- Properly conducted studies shrink that to about 2% of outcome
- Research designed to experimentally improve alliance has not shown significant effects although some promise (Crits-Christoph et al. (2006), but
- No experimental evidence that improving therapists' alliance abilities leads to better treatment outcome.

Is It All in the Relationship?

Clark et al. (2006)



Is It All in the Therapeutic Relationship?

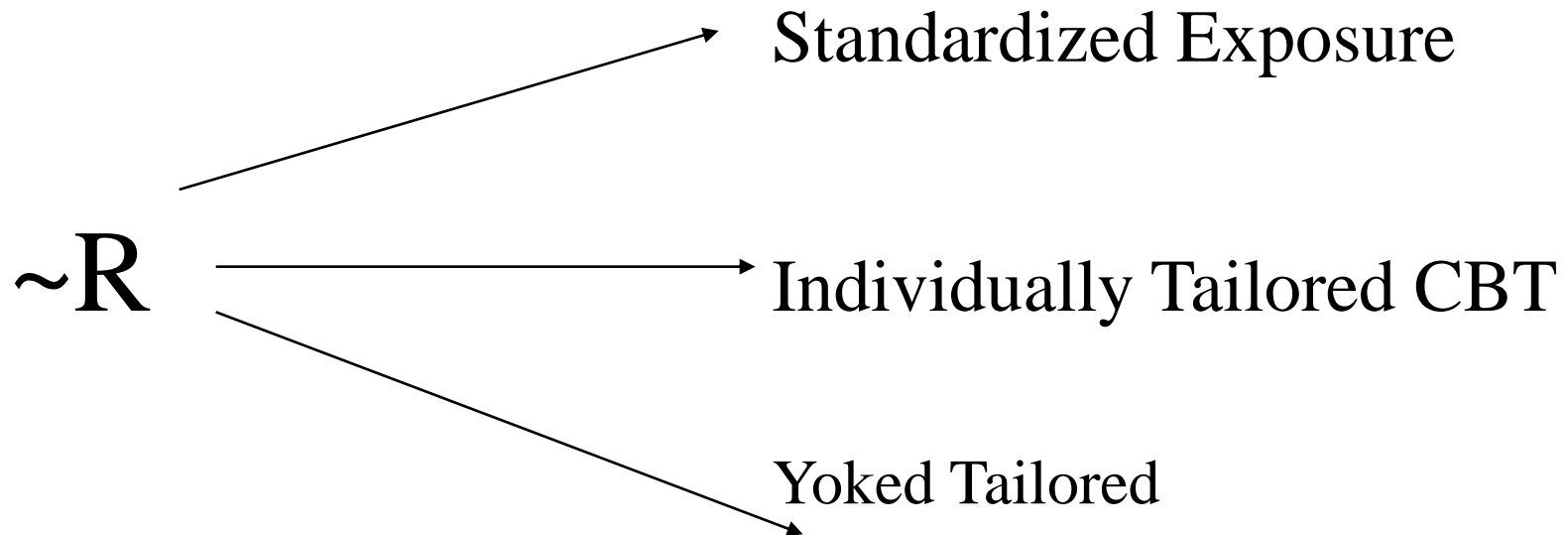
Rapee et al. (2009)

- CBT superior to stress management for treatment of social phobia despite
 - Equivalence on treatment credibility
 - Equivalence on the Working Alliance Inventory
-

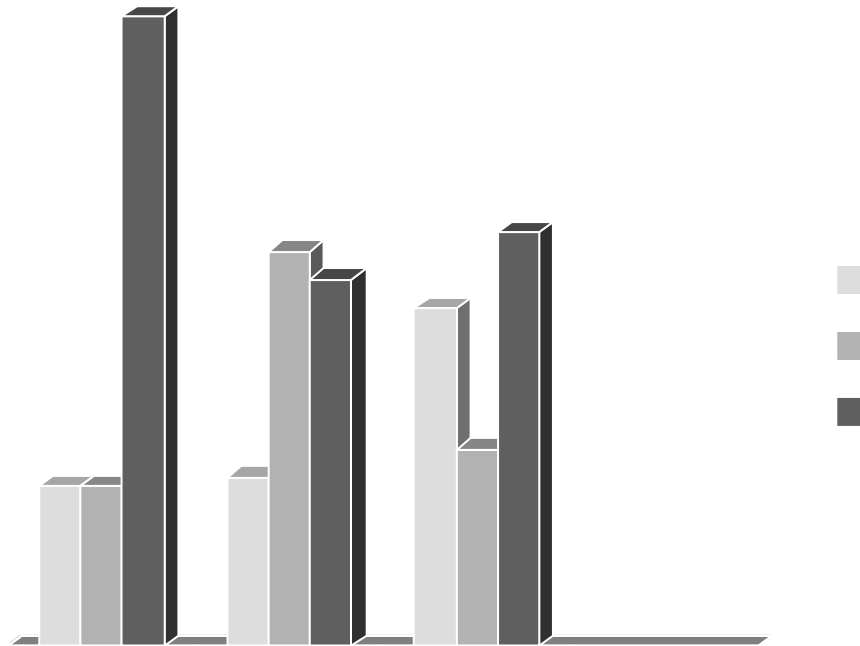
IS CLINICAL EXPERIENCE A BETTER GUIDE THAN DATA?

- A selection of 3 studies
-

SCHULTE ET AL. (1992)
TREATMENT OF 120 PHOBIC PATIENTS



SCHULTE ET AL. (1992)



TREATMENT MATCHING FOR ALCOHOLIC PATIENTS

KADDEN ET AL. (1989)

Inpatient therapists predict which outpatient treatment will be best for their patients

Yalom-type group therapy

Or

Structured CBT group therapy

TREATMENT MATCHING FOR ALCOHOLIC PATIENTS

KADDEN ET AL. (1989)

- Patients randomly assigned to treatment, creating 4 groups

CBT - mismatched	CBT - matched
Yalom - mismatched	Yalom - matched

- Results: Therapists' predictions were no better than chance. Empirical data did predict.

HANNAN, LAMBERT ET AL. (2005)

RISK FOR TREATMENT FAILURE & DETERIORATION

- 332 cases at college counseling centers for multiple sessions
- 49 therapists of various theoretical orientations
- Cases followed over time with the Outcome Questionnaire – 45
- Therapists asked to identify which of their clients were at risk for deterioration
- Therapists told 8% of clients in their centers typically deteriorated
- OQ-45 feedback not provided for duration of study

HANNAN ET AL. RESULTS

- 7.8% of clients deteriorated
- Therapists overpredicted improvement, failed to recognize clients who would deteriorate – predicted correctly only 1 case
- OQ-45 data by Session 3 predicted correctly 85% of cases who ultimately deteriorated
- OQ-45 overpredicted deterioration but 74% of clients falsely predicted to deteriorate did fail to improve in treatment

ARE CLIENTS SEEN IN PRACTICE UNLIKE THOSE IN RCTs?

- Unsystematic survey of some RCTs in which rates of Axis I & II comorbidity were reported
- Range of patients in trials for anxiety disorders and depression with comorbid disorders =
35-74%

VIRTUAL CLINIC APPROACH

Stirman et al. (2003)

- 347 outpatients in employee assistance program matched to RCTs to determine eligibility
- Many had adjustment disorders for which there is no EST
- 80% of patients who had diagnoses represented in the RCT literature (e.g, major depressive disorder) matched with at least 1 RCT

REASONS FOR INELIGIBILITY: THE OTHER 20%

• Insufficient severity or duration	14
• Wrong demographic	12
• Substance use disorder	8
• Comorbidity	4
• Acute Suicidality	3
• Medical condition	2
• Too severe	1
• Prior treatment	1
• Psychotic features	1

STIRMAN ET AL. (2005): VIRTUAL CLINIC STUDY 2

- What proportion of patients screened out of some RCTs at Penn would be eligible for participation in another RCT?
- For example, screened out of depression trial but eligible for PTSD treatment trial

VIRTUAL CLINIC FOR SCREENED-OUT PATIENTS

- Among screened-out patients, 73% had primary diagnoses that were studied in the RCT literature

Of these:

- 95% would have been eligible for 1 or more published RCT

STIRMAN ET AL. INELIGIBILITY REASONS

- Substance dependence (if in study not about substance use)
- Psychosis (if in study not focused on psychotic disorders)
- **In partial remission**
- **Not severe enough**

CLINICIANS' OBJECTIONS TO ESTs: REVIEW

- The relationship is more important than the approach – all important? NO SUPPORT
- Clinical experience is a better guide than data. NO SUPPORT
- Patients in practice are more troubled, have more comorbidity than those in research trials. NO SUPPORT (though no direct comparison)

CORRELATES OF PRACTITIONERS' REJECTION OF ESTs

- 3 surveys by Stewart & Chambless (2007, 2010, in press) of randomly selected samples of psychologists in private practice belonging to the American Psychological Association
- 1 qualitative study by Stewart & Chambless (under review) of a randomly selected sample of clinical & counseling psychologists in Philadelphia region
- Mostly Ph.D. psychologists in practice over 20 years

CORRELATES OF PRACTITIONERS' REJECTION OF ESTS

- Beliefs we have just reviewed (+ additional beliefs)
- Theoretical orientation – CBT most positive, psychodynamic most negative
- Lack of graduate school emphasis on psychotherapy outcome research
- Time & resources required for further training

WILLINGNESS TO OBTAIN EST TRAINING

STEWART, CHAMBLESS & BARON, IN PRESS

Conducted multiple regression with the willingness to obtain training as criterion

Overall model significant, $F(10, 1209) = 51.08$
 $p < .0001$, 24% of variance

Who is more likely to attend the workshop?

- Those with less demanding workshop
- Those who agree less with the barriers
- More graduate training in psychotherapy outcome
- Less years in practice
- Psychodynamic were less willing, and eclectic practitioners were more willing to go than CBT practitioners

Effect sizes are considered small at .01, medium at .06, and large at .13

Predictor	Likelihood
Gender	-.04
Research training in psychotherapy outcome	.05*
Years in clinical practice	-.06*
Workshop demand	-.40***
Disagreement with theoretical barriers	.28***
Psychodynamic	-.10**
Eclectic	.05*
Humanistic	.02
Family Systems	.02
Other	-.05

HOW DO WE ENCOURAGE EST USE?

- More RCTs on the efficacy of psychodynamic therapy
- Graduate training emphasis on following the psychotherapy research literature by accessing available reviews
- Graduate training to undermine reliance on clinical reasoning – training students in errors of judgment and decision making

ENCOURAGING EST USE

- In graduate training and clinics, use outcome measures routinely with all clients
 - to undermine false belief that the great majority of clients are doing well and
 - to encourage therapists to change course when treatment is not progressing (e.g., Lambert, Grawe)
- Include case studies in publications and presentations of EST outcome research to make findings more compelling to clinicians (Stewart & Chambless, 2010)

-
- Provide EST outcomes in format appealing to practitioners – e.g., books describing treatment without statistical details
 - Determine what are the central components of the efficacy of common ESTs – Could these be used eclectically?
 - Stop berating therapists in practice and start helping them to obtain training

References for Articles & Web Sites Cited to be Posted

<http://www.psych.upenn.edu/~dchamb/ESTs/EST.html>
