Evidence-Based Therapies: overview

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Objectives

▪ acquire a basic understanding of some widely-used psychotherapies shown by research to be effective

▪ provide, or refer for, appropriate therapy to address specific disorders

▪ enhance interviewing skills and treatment planning
Evidence-based practice in psychology: APA definition

- “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences”

APA Presidential Taskforce on Evidence-Based Practice, adopted August 2005 and published in American Psychologist  May-June 2006
Common threads in all good therapy

- studies of many therapies have found that the quality of the therapist-patient relationship most strongly correlates with improvement

- important therapist qualities
  - being flexible, experienced, honest, respectful, trustworthy, confident, interested, alert, friendly, warm, open


Psychotherapy research

- In most studies, the ‘control’ condition is a waiting list or placebo-type intervention.
- This design can demonstrate that a therapy is effective, but cannot show if it is more or less effective than other therapies.
Evidence-based therapies we will consider

- Psychoeducation
- Cognitive Behavioral Therapy
- Eye Movement Desensitization and Reprocessing
- Dialectical Behavioral Therapy
- Motivational Interviewing
Psychoeducation

- many patients with a significant mental illness take a passive role in treatment with a provider ‘driving the car’
- the more a patient knows about him/herself, the illness, and the treatment, the more they can ‘take the wheel’, at least during times when the illness is not severe
- the provider, family, community can then serve as supportive copilots
Psychoeducation: How does it work?

- increased insight about illness and understanding of how the treatment works leads to better compliance
  - enhanced placebo effect?
- this promotes relapse prevention
- supports more independent functioning/coping

Psychoeducation building blocks

- educate about symptoms
  - especially “early warning” symptoms later in treatment
- discuss cause of illness
- explain role of stress, importance of self-care
- educate about medication
  - how medicine works
  - side effects
- crisis/suicide plan

Psychoeducation: GROUPS

- a provider teaches about meds, illness, life skills
- patients with similar problems exchange experiences
- supportive therapy and CBT techniques are used

Psychoeducational groups

- treat *general* aspects of the problem, not individual issues in depth
  - social isolation
  - identifying early signs of relapse
  - coping with medication side effects

Cognitive Behavioral Therapy (CBT)

- we interpret events and interactions on the spot with "automatic thoughts" which influence our actions, decisions, and feelings

- automatic thoughts are shaped by underlying "core beliefs" which reflect our understanding of ourselves, others, and expectations about the future

- CBT works to bring automatic thoughts to light, challenges "thinking errors", and manages anxiety arising when new thoughts are deployed

- a present-focused therapy

Thanks to Shona N. Vas of the University of Chicago for an excellent public-domain presentation on CBT from 2009
Core beliefs in CBT

- “I am...” (lovable, bad, competent, unworthy, etc.)
- “Others are...” (kind, untrustworthy, accepting, cruel etc.)
- “The world is...” (fair, brutal, beautiful, dangerous, etc.)
- “The future is...” (looking up, pointless, etc.)
Automatic thoughts in CBT

• are a key mediator between real-life situations and how we respond/cope
• occur spontaneously, not from reasoning
• may be images or fleeting impressions
• may be hard to put into words
• are difficult to ‘turn off’
Thinking errors (or cognitive distortions) in CBT

- emotional reasoning: conflating feelings with facts
- expecting the worst
- mental filter: ignoring the positive
- “all or nothing” thinking: if it’s not great, it’s horrible
- mind-reading
- personalization: it’s about me
How these elements interact

- **Situation**: my boss was crabby this morning
- **Automatic Thoughts**: it’s about me. she hates all of my work. I knew I’d get fired!
- **Response**: on the defensive, terrible headache, less engaged

- **Early Experience**: criticism, punishment for trying and failing
- **Core Beliefs**: nothing I do is good enough. it’s only a matter of time before things go bad
- **Strategy**: keep my head down, try not to be noticed

Modified from a 2009 presentation by Shona N. Vas of the University of Chicago
Cognitive part of CBT: correcting thinking errors

- patient describes a current-day situation
- ask, what was going through your mind right then (automatic thoughts)?
- then consider:
  - what is the evidence for and against the belief?
  - are alternative explanations possible?
  - what are the implications if an alternative is true?
Behavioral part of CBT: some techniques

- relaxation, breathing
- problem-solving skills
- exposure
- social skills training
- graded task assignment
Changing ‘automatic’ thoughts

situation: my boss was crabby this morning

automatic thoughts: “what’s up with her?”, she must be having a bad day

new action: “Is there anything I can help with?” “Is my work on this OK?”

core beliefs: I can trust my feelings, I’m good at what I do

strategy: be supportive when others are in distress, ask ? if you are unsure

Modified from a 2009 presentation by Shona N. Vas of the University of Chicago
CBT process, summarized

- assessment
- explain rationale of therapy
- explore, challenge automatic thoughts
- behavioral strategies → *homework*
  - self-monitor automatic thoughts
  - apply new coping strategies
- core beliefs change as a result of new experiential data from changed cognition and behavior
Dialectical Behavioral Therapy (DBT)

- developed as a method to treat people with severe personality disorders
  - unstable relationships
  - severe mood swings interfering with function
  - self-injury and suicide attempts

- *it is a specialized technique, requiring proprietary training and certification*
Dialectical Behavioral Therapy (DBT)

- shares much with CBT
- importance of the *dialectic*
  - I can’t bear this, I am bearing this
  - I’m working as hard as I can, I have to try harder
DBT: four elements of the therapy

- individual therapy
- skills training group
- phone coaching
- therapist consultation team
**DBT: individual therapy**

- usually weekly for 1 hour, concurrent with skills group participation
- review of *diary card*, a tool for recalling events, coping skills tried, results
- *chain analysis*: detailed exploration of critical episodes such as self injury
DBT: skills training group

- focused on enhancing capabilities by teaching coping skills (as in CBT, EMDR, others)

- weekly for approximately 2.5 hours, 24-week curriculum, which is often repeated to create a 1-year program

- group leader teaches skills and assigns homework for practice using the skills in everyday life
**DBT: 4 Modules of Skills**

- **Mindfulness**: being present in this one moment; *focusing*
- **Distress Tolerance**: tolerating, not changing; *crisis survival*
- **Emotion Regulation**: changing emotions that you want to change; *de-escalation*
- **Interpersonal Effectiveness**: asking for what you want and saying no while maintaining self-respect and relationship with others; *people skills*
Mindfulness: at the core of DBT

WHAT skills

▪ observe
  ▪ not mind reading, judging
▪ describe
▪ participate

HOW skills

▪ one- mindfully
▪ non- judgmentally
  ▪ “radical acceptance”
▪ effectively
DBT: phone coaching

- clients can call their individual therapist 24/7 between sessions to receive coaching at the times when they need help the most
- they receive on-the-spot coaching on use of skills to cope with difficult situations
  - “what skills have you already tried?”
  - coaching is not available if client injures self
DBT: therapist consultation team

▪ therapy for therapists who work with people with severe, complex, difficult-to-treat disorders

▪ designed to help therapists stay motivated and competent so they can provide the best treatment possible

▪ weekly meetings of individual therapists and group leaders who share responsibility for each client's care
  ▪ DBT skills are used
Video on DBT for adolescents

- https://www.youtube.com/watch?v=Stz-d17ID4
Terms you will hear in DBT

- chain analysis
- diary cards
- DEAR MAN (Describe, Express, Assert, Reinforce, stay Mindful, Appear confident, Negotiate)
- 24 hour rule
Eye Movement Desensitization and Reprocessing (EMDR)

- alleviates distress associated with the recall of traumatic experiences
- based on use of CBT-derived coping techniques along with therapist-directed lateral eye movements or other therapist-directed sensory input (hand-tapping, etc.)
- *it is a specialized technique, requiring proprietary training and certification*

www.emdr.com
8 phases of EMDR

1. client history and treatment planning
2. preparation: what to expect, coping skills
3. assessment: images/cognition that accompany target memory, rating of intensity
4. desensitization: focuses on negative affect
5. installation: replaces with positive cognition
6. body scan: reintroduce target
7. closure: returning to equilibrium
8. re-evaluation: at beginning of each new session
EMDR video

- https://www.youtube.com/watch?v=hDivEv1U3Pg
Eye Movement Desensitization and Reprocessing (EMDR)

- a meta-analysis of 26 studies (1991-2013) of EMDR for treatment of PTSD
- EMDR found to reduce PTSD symptoms, depression, anxiety, and subjective distress in patients with PTSD

Controversies around EMDR

- the controversial aspect of EMDR is whether the eye movements have a unique therapeutic value
- studies disagree as to the value of the eye movements themselves, though a recent meta-analysis finds eye movements (or other bilateral stimulation) to add value

Lee C and Cuijpers P. A meta-analysis of the contribution of eye movements in processing emotional memories. *J Beh Therapy and Exper Psychiatry*. V44 No 2; June 2013: pp231-239
Motivational Interviewing

▪ “a collaborative, person-centered form of guiding to elicit and strengthen motivation for change”

▪ a technique that can be used in any helping setting
  ▪ not just psychotherapy

Miller W and Rollnick S: Motivational Interviewing: Preparing People for Change
Miller W and Rollnick S: Ten things that Motivational Interviewing is not.
Behavioural and Cognitive Psychotherapy; Vol 37: 129-140
Spirit of Motivational Interviewing

- **COLLABORATION**: partnership between therapist and client, rather than therapist in “expert” role
- **EVOCATION**: drawing out, rather than imposing ideas
- **AUTONOMY**: power for change rests with client
Principles of Motivational Interviewing

- express empathy
- support self-efficacy
- roll with resistance
- develop discrepancy
Motivational Interviewing and ‘Stages of Change’

- pre-contemplation (unaware, in denial)
- contemplation (beginning to envision the future as fluid)
- preparation (more concrete pictures and plans for a different future)
- action (making the envisioned changes real)
- maintenance/relapse prevention

Pre-contemplation

goal: patient will begin thinking about change

▪ “what would have to happen for you to know that this is a problem?”

▪ what warning signs would let you know that this is a problem?

▪ have you tried to change this in the past?”

Contemplation

goal: patient will examine benefits and barriers to change

▪ *why do you want to change at this time?* (elicit client values)
▪ what would be better from the change? (pros)
▪ what were the reasons for not changing? (cons)
▪ what would keep you from changing?
▪ what might help you with (each barrier)?
  ▪ what has helped in the past?
  ▪ what would help now?
Preparation

goal: patient will rehearse and experiment with change

- what concrete actions need to be taken?
- what “toe in the water” actions might help?
- what do you expect to be easy? what hard? picture the change, anticipate and plan for snags
Action

goal: patient initiates behavior/lifestyle change

- quits smoking
- begins diet
- sets a limit in a relationship
- stops depending on parents’ financial support
- POSITIVE REINFORCEMENT for any success
Maintenance and relapse prevention

goal: change becomes the “new normal”, see slips as learning opportunities, fine-tune actions

▪ what makes it easy to keep up the change?
▪ what makes it hard? (review slips if any)
▪ what will I do next time a trigger happens?
▪ it is helpful to cycle back here and review, “why do I want this change?”
▪ POSITIVE REINFORCEMENT for any success
Summary

- many specific, manualized treatments have been shown effective for various mental health problems
- there is very little data comparing specific therapies “head to head”
- the therapeutic alliance and positive therapist qualities remain very important in outcome of any treatment
Summary

- Aspects of some therapies are easily incorporated into “eclectic” treatment (psychoeducation, CBT, motivational interviewing).

- DBT and EMDR should be delivered faithfully; they require training approved by their founders’ organizations.

- There is no evidence that ‘pieces’ taken from EMDR or DBT are helpful, except for aspects of DBT skills group.
Trends in psychotherapy

- short-term, or specified length
- groups/classes
- much more focused on present *functioning* than revisiting the past
- transference is not explicitly employed as a treatment tool
How to get training in DBT and EMDR

- **DBT**: for ‘level 3’ training, two 5-day weeks of on-site training with six to nine months of home study between the two training sessions
  - cost: 3 members = $10000, 6 members = $12500, 8 members = $20000
  - [http://behavioraltech.org/training/options.cfm](http://behavioraltech.org/training/options.cfm)

- **EMDR**: must complete an approved EMDR training, have an independent license as a mental health practitioner, have 2 years’ experience in your field of licensure, have received 20 hours’ consultation by an Approved Consultant in EMDR and have conducted at least 50 EMDR sessions with at least 25 clients
  - cost: about $1500 for the class, consultation cost
  - [http://www.emdria.org/page/emdrtrainingfaq](http://www.emdria.org/page/emdrtrainingfaq)