Maximizing Therapeutic Effectiveness: Best Practices

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"Well, I do have this recurring dream that one day I might see some results."
Dream or Reality?

- We do get good results, with patients who are motivated, engaged and responsive – 20%
- What about the 80% who come to us with multiple problems and personality disorders?
- 47% still drop out prematurely
- Up to 8% get worse as the result of therapy
- RCTs distort data - Process research beginning to bear fruit
- Top 20% of therapists get better and more consistent results than the rest – study outliers
- Time to start studying who they are and what they do rather than relying on averages
The program

- Focus on WHAT we do and HOW we do it
- Outline the data on specific factors
- Define each and tie them to technique
- Integrate these factors into a coherent model of treatment – ISTDP has done that
- Look at the evidence supporting this model
- Illustrate the model with patients across the spectrum of psychopathology
- Outline the characteristics of top performers
Therapist View
Orlinsky & Ronnstad, 2005

• Followed development of 11,000 therapist
• 86% were highly involved and committed
• Most reported well developed capacity to establish rapport, BUT
• 76% lacked skill and confidence in their ability to 1) motivate patients; 2) understand moment to moment process and 3) employ specific techniques to address specific problems
Common factors aren’t so common (Weinberger, 1995)

- Factors include: nature of relationship; revival of hope; confronting what patient has been avoiding; increased sense of mastery and competence; and attributing success to their own efforts.
- Most therapies rely on only one or two of the factors most responsible for change.
- Suggested that common neglect may be responsible for lack of differences between models.
- Most important of these, by far, is helping patients face what they have been avoiding (41%), while relationship contributes 11%.
Specific Factors

• Create and maintain a high level of focus
• Establish trust by demonstrating skill and competence (not just about warmth)
• Build collaborative alliance
• Facilitating multiple levels of affective activation
• Activate moderate levels of anxiety
• Alternate with periods of calm consolidation
• Encourage intimacy and profound moments of meeting
• Integrate material - create coherent life narrative
Specific vs common factors
McCarthy, 2009

- Two process studies on both behavioral and psychodynamic psychotherapy
- Found that common factors did not predict outcome
- Specific factors (those interventions tied directly to theory) DID predict outcome
- Moderate levels of specific interventions were associated with positive outcome, while high and low levels did not
- Process-experiential interventions (rather than interpretation) were most highly associated with positive outcome in dynamic psychotherapy
Process Research: Focus

- Focus highly related to outcome (Shaw, 1989)
- Low relapse in focused group
- Three times relapse in non-focused group
- Lack of focus predicts poor outcome (Mohr, 1995)
- Up to the therapist at the start – ability to manage focus, pacing and timing critical
Process research: Alliance building

- Not just about warmth and support but skill and competence (Wampold, 2006)
- Involves therapist being an open, engaged and authentic presence, offering help
- Requires therapist to discover and strengthen the health and capacity in the patient to become a partner, not a passive recipient of treatment (Hubble, Duncan and Miller, 1999)
- Deal actively with threats to alliance
- Agree on the nature of the problem, the goals and the therapeutic task (Beutler 1997)
- Strong alliance often the RESULT of effective intervention, not the cause (Webb et al 2011)
Emotion focus

- Lack of emotional awareness and regulation is an underlying factor in all disorders (Barlow et al. 2010)
- More and more evidence of importance of emotional experience for effectiveness in therapy in short and long term (Abbass, 2006; Greenberg and Johnson, 1994; Hill, Kiesler, Weiss)
- Neurobiological studies suggest that new learning and neural growth are enhanced by experience of anxiety and emotions (Cozalino, 2009)
- Dose-response relationship between intensity of felt emotion and relief of symptoms (Abbass, 2006)
- High levels of emotional experiencing associated with “significant sessions” and superior outcome (Tang & DeRubeis, 1999; Wiser & Goldried, 1998)
- Patients report this is most important factor (Pirielo, 2004)
Process: Importance of Defense work

- Defenses are pervasive in human functioning (Cramer, 2000)
- Feelings that are defended against, still have an impact on functioning (Cramer, 2000)
- Those who rely on defenses suffer physically as well as emotionally (Cramer, 2000; Pennebaker, 1997)
- Defenses create resistance and undermine treatment efforts (Davanloo, 1990)
- Change in defensive structure predicts improvement (Hoegland & Perry, 1998; Vaillant, 1998).
Cognitive Clarity and Understanding

- Catharsis has no lasting value
- Conscious reflection on emotional experience is key distinguishing good from poor outcome (Warwar & Greenberg, 2000)
- Essence of working through (Wachtel, 1997)
- Deep understanding of self and other has greatest lasting value, but only patients who were emotionally involved in the process got that result (Pennebaker, 1997)
- Aids in development of coherent life narrative (Neborsky, 2001) and long term health and well being (Pennebaker, 2010)
Profound Moments of Meeting

- We wire one another’s brains (Scharch, 2010)
- Eye contact and emotional connection essential to this process (Stern, 2012)
- Defenses against closeness prevent absorption of the treatment being offered (Davanloo, 1990, 2000)
- Seeing and being seen in an intimate and unguarded manner has lasting effect on the brain and identity of patient (and therapist!) (Schnarch, 2010)
Neuroscientific Evidence

- Grawe, 2004; Cozolino, 2006; Scharch, 2010; Siegel, 2010)
- Create and maintain a high level of focus
- Establish trust and secure, autonomous attachment
- Facilitate multiple levels of experience (cognitive, emotional, physiological and interpersonal)
- Alternate moderate levels of anxiety with periods of calm
- Encourage intimacy and profound moments of meeting
- Creating meaning from experience (integrate right and left brain experience)
Patient’s View

• Piliero (2004) examined patients responses to two forms of therapy: ISTDP and supportive/expressive therapy
• 2/3rd of all patients were significantly improved after 30 sessions
• 90% attributed the gains to “in-session emotional experiencing”, with “intensely emotional”, “releasing buried feelings”, “affect focus was key”, “accessing bottled up feelings” most often sited.
• Technical expertise more important therapist factor than being “extremely warm” (11%)
• ISTDP therapists most likely to be viewed as competent than “supportive” cohorts
Davanloo

• Asserted that dynamic psychotherapy can be not merely effective but uniquely effective - suggesting that specific rather than non-specific variables are responsible for outcome. In particular, he found that helping the patient face and experience the feelings he had been avoiding was the key to deep and rapid change. In order to accomplish this, defenses need to be removed and anxiety must be tolerated/regulated.
Basic approach

• We understand the patient’s problems as the inevitable result of excessive reliance on defenses against anxiety provoking feelings
• Therapy works by helping patients to abandon defenses and experience previously avoided feelings, while regulating anxiety
• Experience of these feelings trigger unlocking of unconscious memories, making sense of patient’s problems and allowing for reworking
• Develop intimacy with self and other
THE TWO TRIANGLES

Triangle of Conflict

A = Anxiety
D = Defense
I/F = Impulse/Feeling

Triangle of the Person

T = Transference
C = Current Figures
P = Past Genetic Figures
Central Dynamic Sequence

- Inquiry with specificity and focus
- Focus on emotions activated in the precipitating situations giving rise to symptoms
- Block defenses that hurt patients and perpetuate their suffering
- Encourage openness and block distancing
- Offer a healthy alternative of contacting the genuine feelings involved
- Experience of feeling (on all levels) is key unlocking the unconscious and shedding light on origin of conflicts
- Understand and integrate memories that surface, creating meaning and coherence
Basic Human Feelings

- Love, fear, anger, sadness/grief, sexual desire, joy, curiosity

- Components of Affect
  1. cognitive label
  2. physiological activation
  3. impulse/action tendency
CHANNELS OF ANXIETY

- STRIATED MUSCLE
- SMOOTH MUSCLE
- COGNITIVE DISRUPTION
<table>
<thead>
<tr>
<th>REPRESSIVE</th>
<th>REGRESSIVE</th>
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<tr>
<td>Intellectualization</td>
<td>Projection</td>
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<td>Rationalization</td>
<td>Denial</td>
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<td>Minimization</td>
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<td>Displacement</td>
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<td>Reaction formation</td>
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TACTICAL DEFENSES

NON-VERBAL

- Avoiding eye contact
- Arms and legs crossed
- Smiling
- Laughing
- Weepiness
- Temper tantrums

VERBAL

- Vague and general
- Diversification
- Sarcasm
- Argumentative
- Contradictory
- Rate of speech
Meta-Processes/Goals

• Shift from focus on pathology to potential
• Seek to create a safe but challenging environment in which patients are WILLING to abandon Ds and OPEN up to the possibility of intimacy with self and other by experiencing and expressing genuine thoughts and feelings
• Replace symptoms and defenses with healthy alternatives
• Support development of true self
• Only possible if THERAPIST is an engaged, authentic presence in the room
Evidence

• Cochrane Review of over 60 RCT (Abbass, 2006); Harvard Review, 2012
• Clinically effective with 86% of all outpatients
• Low drop out (7% instead of 47%)
• Effective with wide range of disorders
• Effective inpatient, outpatient, and ER (Abbass, 2012)
• Effects sizes at 1.0 or above and standing up over 3 year follow up period
• Highly cost effective (save 3 X output on therapy)
ISTDP intake vs standard psychiatric interview

• Compared ISTDP initial interview with standard intake (Abbass, Jeffres & Ogrondniczuk, 2008)

• Random assignment of 30 consecutive cases

• 6 weeks no treatment with follow up

• Symptom reduction on BSI and IIP in ISTDP group >.0001

• 33% no longer required treatment

• 7 out of 10 off meds

• 2 back to work

• No significant therapeutic effects in standard intake group
ISTDP Inpatient unit
Solbaken, et al 2013

- 36 treatment resistant patients treated for 8 weeks (16-20 hours ISTDP)
- At termination 82% clinically significant change on OQ-45; 94% at one year follow up. No one got worse
- Effect sizes on OQ-45 1.42 at termination; 1.57 at follow up; SCL-90 .96 at termination; 1.24 at follow up
- 58% recovered (score below cut off for clinical population) at termination; 71% recovered at follow up
Day Two

- Therapist Variable
- Most important but neglected variable in outcome research until recently
Therapist Variable

- Accounts for more of the variance than the model or technique used (Okilski, et al 2003)
- Sophisticated set of interpersonal skills – masters of connection (Wampold, 2005;2010)
- Ability to forge an alliance and get agreement (persuasive and passionate)(Beutler, 1997)
- Understand the patients struggles and present a coherent plan of treatment (Wampold, 2010)
- Confident yet humble – demonstrates skill and inspires trust and co-operation (Hubble, Duncan & Miller, 1999)
Jerome Frank (1971, 1991) was right

- Emotionally charged relationship
- Patient has faith in the therapist’s competence and desire to help – sees him as a resource
- Therapist understands the patient’s problems and suggests a clear method for eliciting change
- Provides the patient with experiences of success and mastery
Super Shrinks

• Top 20% get better and more consistent results than the other 80% combined (Duncan & Miller, 2007; Gawande, 2011)
• They are enthusiastic, engaged, authentic, approachable, courageous and confident, yet humble
• They are passionate about their approach but flexible in implementing it, depending on the needs and capacities of their patient
• They are ambitious, pushing for exceptional results
• They are life long learners who are open to feedback and often solicit it from patients
• They are masters at managing relationships, particularly when it comes to dealing with negative and hostile interactions (Wampold, 2006)
Superior at creating alliance

• Persuasive and enthusiastic
• Get agreement about the problem, the goal and the task (Wampold, et al 2005, 2006)
• They have a game plan and it makes sense to the patient
• Encourages patient to get involved, take action in accordance with plan and in his best interest
• Not enough to reduce symptoms and pathology but to DO something healthy
• Best psychiatrists get better results with placebo than less able with meds (McKay, 2006)
Personal characteristics

• Confident but humble
• Approachable and engaged
• Life long learner – open and flexible
• Persistent and tenacious – work harder
• Practice specific skills just beyond current level of competence
• Self reflective
• Aware of his impact and can acknowledge same
• Optimistic and encouraging
What helps with therapist development?

• Not clear that personal therapy makes a difference (Geller, et al, 2005)
• Traditional training and supervision don’t matter much (Beutler, et al, 2004)
• Dedication and life long learning
• Work harder; practice specific skills,
  just beyond current level of competence
• Open and receptive to feedback from others
• Videotape and watch your work
Bell Shaped Curve

- Practitioners fall along the curve (Gawande, 2004)
- If you have an average problem, an average practitioner is OK
- If you have a serious problem (somatoform disorder, conversion, personality disorder, borderline, etc) who you see REALLY matters
- Bottom 20% should be avoided at all cost
Negative Factors (Mohr, 2006)

- Lack of therapeutic focus
- No agreement about task
- Therapists who lack empathy
- Distant and unavailable for connection
- Demeaning and critical
- Authoritarian and dominant
- High level of transference interpretations
- Poor technique
- Counter transferece
Training and Supervision

- Most of our training efforts fail (70-95%).
- 93% considered “inadequate” (Ellis, et al, 2014)
- 35% considered “harmful’ (Ellis, et al, 2014)
- Coaching and video tapes help (Gawande, 2011; Abbass, 2011).
- Specific skills, including meta cognitive ability to conceptualize (Fauth, et al, 2007)
- Getting feedback from patient (Milham & Miller, 2011)
Take home message

• It is WHO you are and WHAT you do that makes the difference
• Keep learning to enhance specific skills (Coaching with video particularly useful)
• Evidence that creating and maintaining focus, facilitating emotional experience and removing defenses will enhance outcome
• Get feedback from patients and do follow up
• Watch your tapes and get supervision
• Practice what you preach!
Atul Gawande’s Advice “Better”, 2007

- Always be open and curious – learn from your patients
- Don’t complain – do something and be grateful for the opportunity to engage with patients
- Count something – record your outcomes
- Write something – put your thoughts, ideas and experiences in writing
- Change – try something new and push yourself out of your comfort zone
- Get a coach – show your work – accept feedback
Woman in a 20 year fog

• Do as much with as little as possible
• Work at highest level of capacity and challenge patient to do the same
• While patient is functioning at neurotic level her suffering has been massive and previous treatments – from therapy to Rolfing have been ineffective
• What are the specific factors required to help her?
Man Addicted to Porn

- 65 year old man
- Life long symptoms and suffering
- Character defenses prevalent
- Enacting same pattern in T
- Previous therapies not helpful
- What is required to create a collaborative alliance?
- Turn patient on Ds and challenge him to get authentically involved
The Woman who thought it was too late

- 69 year old single woman referred by her Physician; failed at many therapies
- Specific factors:
  - Block defenses that will prevent the creation of a collaborative alliance while appealing the healthy part of her
  - Assessing anxiety and intervening in order to get it into a manageable range
  - Inviting her to experience and express the ready made transference feelings underneath the anxiety and defense
Woman with Dissociation

- 42 year old married woman in crisis
- Current trauma activated old trauma
- Dissociation and migraine since age 8
- No previous therapy
- What are the factors contributing to outcome?
- What is the nature of the therapeutic alliance?