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# Evidence - based Psychological Therapy

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# Overview

- Some definitions and terminology
- What is psychological therapy?
- What is meant by ‘evidence-based’ ?
- Why does this matter?
- Practical example
- Cognitive behavioural therapy for Agoraphobia

# Definitions & Terminology

**There are hundreds of different ‘Psychological’ approaches to mental distress**

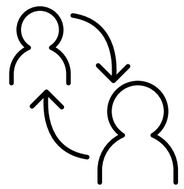
*https://en.wikipedia.org/wiki/List_of_psychotherapies*

H [ edit ]

- Habit reversal training
- Hagiotherapy
- Hakomi
- Heimler method of human social functioning
- Hip hop therapy
- Holotropic breathwork
- Holding therapy
- Humanistic psychology
- Human givens
- Hypnotherapy

Most have no evidence base in research

# Definitions & Terminology

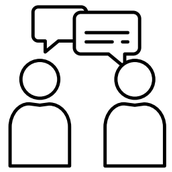


## Counselling

Aims to provide practical and emotional support in overcoming life transitions and challenges

## Psychotherapy

Refers to longer term approaches to overcoming emotional and relationship difficulties, often understanding current difficulties in terms of early experiences



## Psychological therapy

Refers to evidence-based ‘talking treatments’ designed to address specific mental health difficulties

# Qualifications & Regulation

“Therapist”, “Psychotherapist” and “Psychologist” are not protected titles in the UK
Anyone can advertise themselves as such

Counselling and psychotherapy are not legally regulated in the UK

Clinical psychologist and Counselling psychologist are protected titles and legally regulated in the UK by the Health and Care Professions Council (HCPC)

Evidence based psychological therapies are usually delivered by (or provided under the supervision of) a Clinical or Counselling Psychologist in the UK

# What is meant by ‘evidence-based’?

There are many different types of evidence

Not all types of evidence are equal

Uncontrolled / observational studies can’t prove causation

Confounding variables

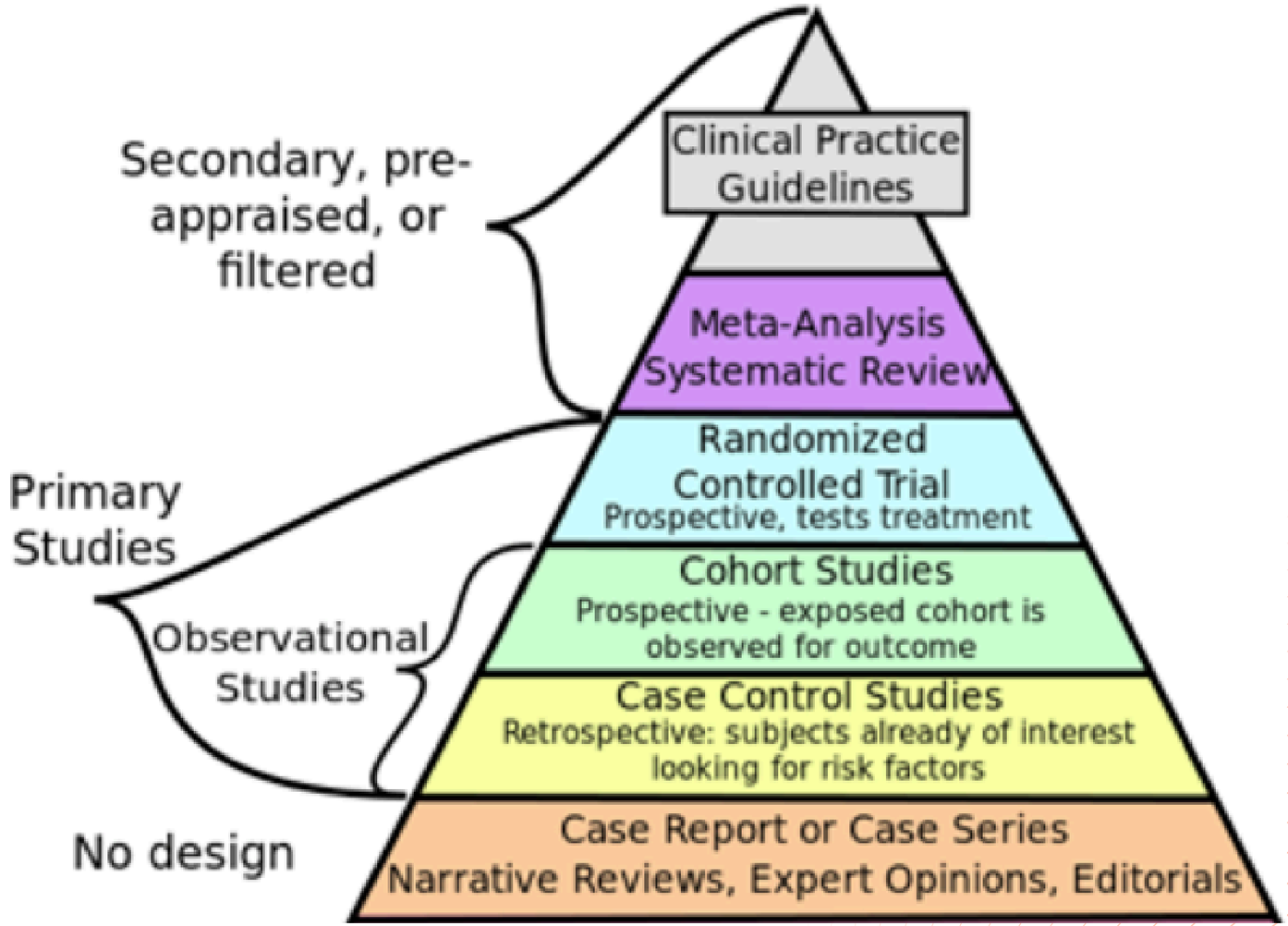
Placebo effect

Randomised controlled trials

* Treatment fidelity in trials *
- Treatment protocols
- Detailed clinical supervision

# What counts in evidence-based practice?

https://pressbooks.library.upei.ca/montelpare/chapter/the-hierarchy-of-evidence/



# What counts in evidence-based practice?

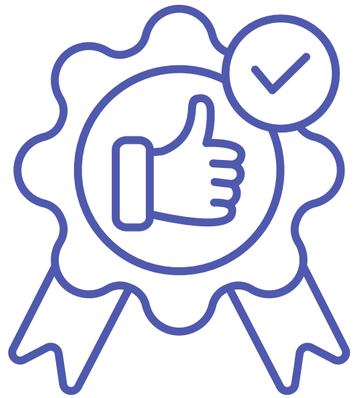
Image from UC Davis Library Evidence-Based Practice Resource Guide

# Evidence-based Clinical Guidelines

High volumes of RCTs published annually

Need to critically evaluate and amalgamate research findings

National Institute of Health and Care Excellence (NICE) produces best practice clinical guidelines



-> Systemic reviews of published RCTs

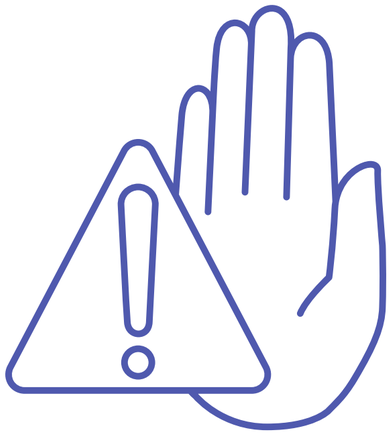
-> Input from expert clinicians

-> Input from service users & carers

-> Guidelines for assessment, treatment, service delivery

-> Recommendations for psychological therapy very brief

# Limitations of Evidence Base



No treatment works for everyone

Improvement / remission can happen with no treatment

RCTs typically compare averages across groups

May not reflect outcomes of individuals

Inclusion and exclusion criteria for RCTs

RCTs can’t test every component of a model

Best practice guidelines are only updated every few years

# Why is Evidence-based Practice Important?

- Evidence-based practice (EBP) gives the best chance of a good outcome
- For mild / transitory mental health issues,  “watch and wait” or counselling may be okay
- For moderate to severe diagnosed mental health conditions, no good quality evidence for non-EBP approaches
- Informed consent & patient values
- Information on treatment options, pros & cons and possible outcomes

# Cognitive Behavioural Therapy (CBT)

- CBT is one of the most rigorously researched psychological therapies
- Efficacy of CBT for a range of mental health conditions from numerous RCTs and meta-analyses
- However, this doesn't mean all CBT is evidence-based
- CBT has become an 'umbrella' term used to refer to a number of approaches which focus on thoughts, emotions and behaviours
- May not reflect evidence-base or best-practice clinical guidelines

# UCL Competence Frameworks

UCL Centre for Outcomes Research and Effectiveness

Summarise core knowledge, skills, and therapist attitudes needed to deliver specific evidence-based  psychological therapies

ttps://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/competence-frameworks-0

**Competence Frameworks**

- Cognitive and Behavioural Therapy
- Counselling for Depression
- Couple Therapy For Depression
- Humanistic Therapy
- Interpersonal Psychotherapy
- Systemic Therapy
- Supervision of Psychological Therapies
- Psychoanalytic/Psychodynamic Therapy

# Generic Therapeutic Competences

UCL Competence Framework :https://www.ucl.ac.uk/pals/sites/pals/files/migrated-files/Generic_Competences.pdf

- ✓ Knowledge and understanding of mental health problems
- ✓ Knowledge of, and ability to operate within, professional and ethical guidelines
- ✓ Knowledge & understanding of therapy model
- ✓ Ability to implement the model in practice
- ✓ Ability to create & maintain a good therapeutic alliance and recognize & repair ruptures
- ✓ Ability to grasp the client's perspective and 'world view'

# Basic CBT Competences

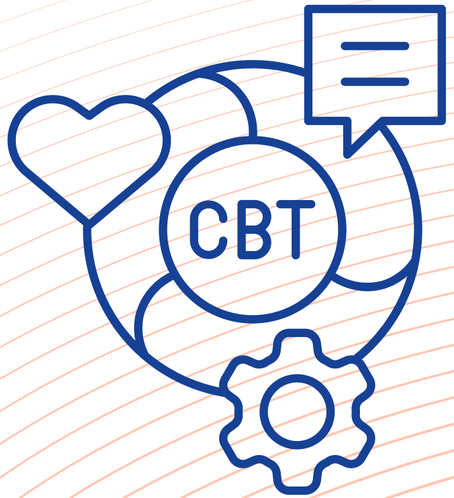
UCL Competence Framework : https://www.ucl.ac.uk/pals/sites/pals/files/migrated-files/Basic_CBT_Competences.pdf

- Thoughts / beliefs / images, emotions and behaviours are interconnected
- The ways we respond to distress can maintain or worsen problems e.g. safety behaviours
- Client and therapist work together
- Agree measurable goals & monitor outcomes
- Aim of therapy is for client to become expert
- Ability to structure sessions & use agenda
- Detailed CBT maintenance cycle
- Between-session therapy tasks – “therapy homework”
- Knowledge of cognitive biases & Problem solving
- Preparation for ending and relapse management

# Core CBT Techniques

UCL Competence Framework : https://www.ucl.ac.uk/pals/sites/pals/files/migrated-files/Specific_Behavioural_Competences.pdf

- Exposure techniques
- Activity monitoring and scheduling
- Guided Discovery and Socratic Questioning
- Ability to teach clients to articulate automatic thoughts
- Use of thought records
- Working with safety behaviours
- Ability to help client reality test automatic thoughts & beliefs
- Planning and conducting behavioural experiments
- Ability to identify and re-evaluate assumptions / rules and core beliefs



# Flexibility within fidelity – Metacomptences

UCL Competence Framework : https://www.ucl.ac.uk/pals/sites/pals/files/migrated-files/Specific_Behavioural_Competences.pdf

Capacity to implement treatment models in a flexible but coherent manner

Ability to adapt interventions in response to client feedback, staying within core CBT principles

Adapt, formulate and to apply general CBT models to the individual client

Ability to select and apply most appropriate CBT intervention approach

Ability to manage obstacles to carrying out CBT

# Case Example - Agoraphobia

*All identifying details have been fully anonymised

Amy*, a 28-year-old woman with diagnoses of Agoraphobia and Borderline personality disorder (BPD)

<u>Brief background</u>

History of childhood trauma and CSA

Inpatient admission aged 18 years old

Since then, deliberate self-harm ongoing

Moved back to live in the family home in mid-twenties, symptoms of agoraphobia (ie. fear and avoidance of leaving the home) gradually increased over time

<u>Rationale for focus on Agoraphobia</u>

Barrier to accessing treatment for ongoing symptoms of Borderline personality disorder

# Case Example

## Diagnostic & Statistical Manual, Fifth Edition (DSM-5) Criteria for Agoraphobia

A. Marked and disproportionate fear associated with at least two different situations, such as open spaces, public transport or crowded areas

B. Phobic situation almost always provokes immediate anxiety

C. Fear or anxiety is out of proportion to the actual danger posed by the situation

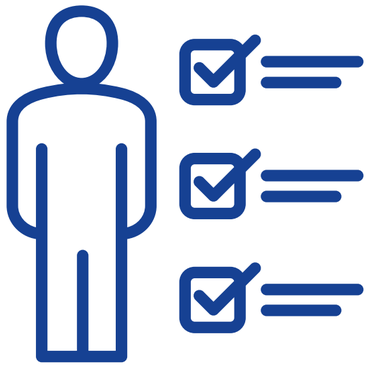
D. Fear or anxiety is out of proportion to the actual danger posed by the situation

E. Fear, anxiety or avoidance has persisted at least 6 months

F. Avoidance behaviors, distress or anticipatory anxiety that significantly disrupts normal routine, relationships, occupational or social activities

G. Symptoms are not better explained by another psychological condition

# Case Example
## Assessment



- Intense fear of leaving the home, had not been outside the home alone for several months
- Spending all day indoors, irregular sleep pattern
- Anxiety increased with approach to the front door
- Symptoms of intense anxiety (e.g. increased HR, muscle tension, nausea) on opening the front door
- Cognitions – “Someone will recognise me (from photographs of CSA) and they’ll confront me in public”
- Safety behaviours (if going out accompanied) – wear hoodie pulled over face, head down, avoid eye contact with passers by, walked fast and returned home asap
- Other co-existing symptoms – Circadian Rhythm disorder and Depressive disorder
- Outcome measures - Mobility Inventory, PHQ-9, sleep diary

# Case Example

## Therapy Goals & Agreement

Amy wanted to be able to access treatment for BPD, and also to work part time alongside her mum in a local shop

Agreed 18 sessions, initially home visits, progressing to Amy attending appointments at the mental health centre

## Psychological Formulation and Rationale for Intervention

Phobias initially start by a learned association (e.g. noticing that you're feeling more anxious when you're leaving the home) – "classical conditioning"

This association is strengthened if you notice that anxiety reduces when you've avoided leaving the home - "negative reinforcement, operant conditioning"

Specific beliefs can make the anxiety worse e.g. "Someone will recognise me and they'll confront me in public"

# Case Example - Agoraphobia

## Preparation Phase

Initial sessions focused on regularising sleep pattern

Behavioural activation (activity scheduling) to stabilise mood

## Cognitive Restructuring

Planned how to test the belief that “Someone will recognise me and confront me in public”

Alternative assumption – “No-one would recognise me from a childhood photograph. People I pass on the street will be busy with their own lives”

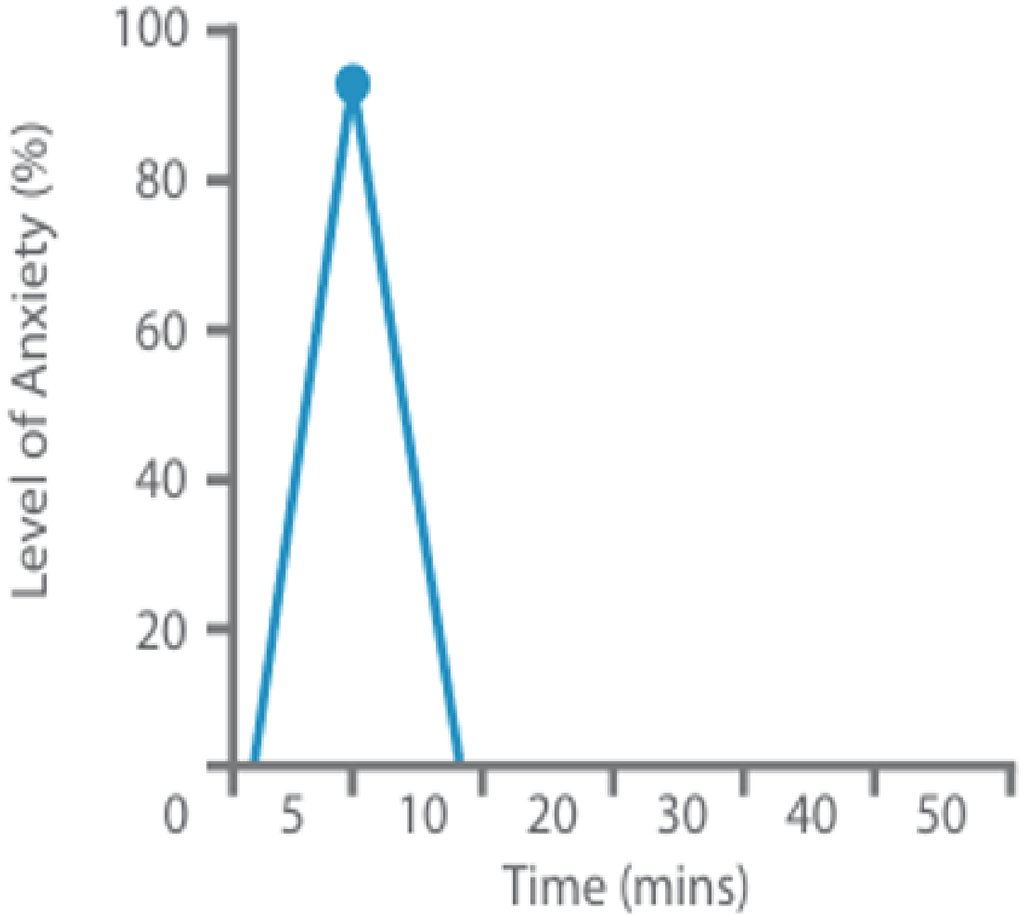
Explanation of thinking biases and need for objective evidence

Behavioural experiment – keep track of how many people I pass outside the home, and if anyone tries to confront me or shouts out that they’ve seen me

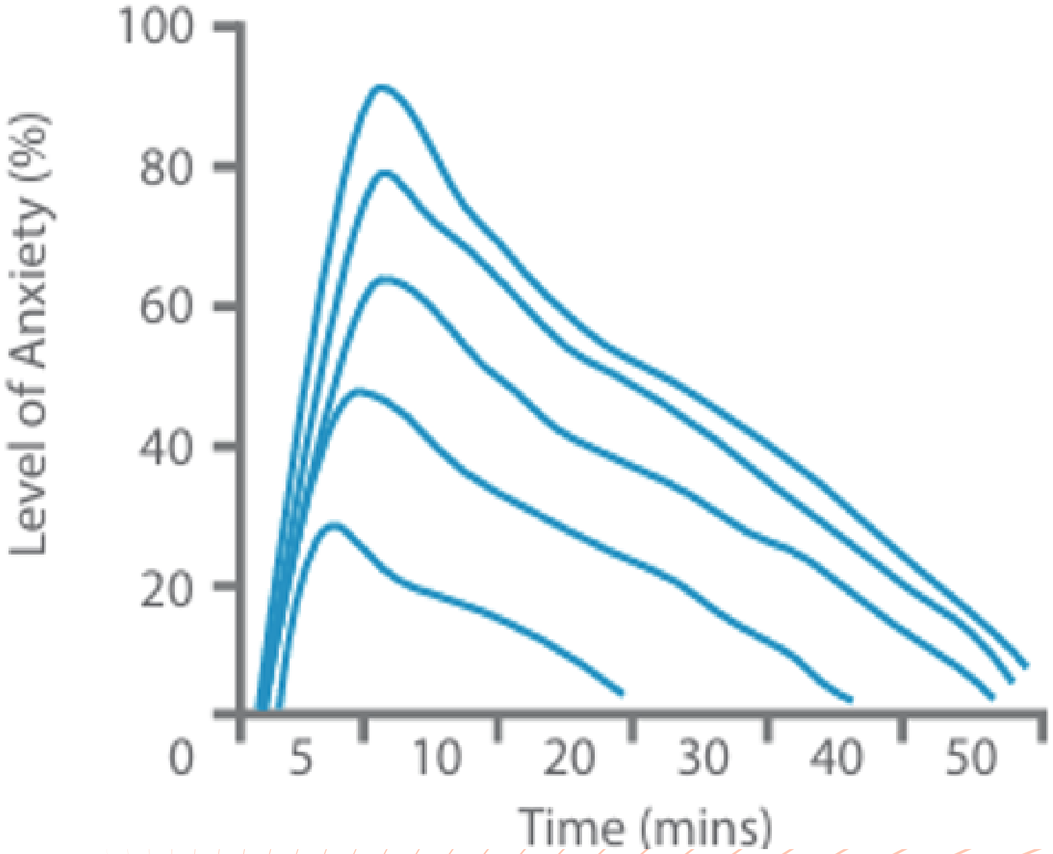
# Case Example

## Rationale for Exposure and Habituation

**Vicious cycle of anxiety and avoidance**




**Breaking the vicious cycle with exposure and habituation**



# Case Example - Graded Exposure

To be effective, exposure needs to be:

**(1) frequent (2) repeated, and (3) prolonged (4) without distractions**

**Graded Exposure Practice Record**

SUDS = Subjective Units of Discomfort Scale (i.e. how anxious / uncomfortable you feel doing a particular task). Rate each task using the scale below:

0 — Completely relaxed

100 — So anxious you can hardly bear it

| Step to practice from Exposure Hierarchy | Start SUDS rating | SUDS after 5 mins | SUDS after 10 mins | SUDS after 15 min | SUDS after 20 min | SUDS after 25 min | SUDS after 30 min | SUDS after 35 min | SUDS after 40 min | SUDS after 45 min | SUDS after 50 min | SUDS after 55 min | SUDS after 60 min | SUDS after 65 min |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sit inside the front door, with the front door open | 70 | | | | | | | | | | | | | |
| Sit on the front doorstep with the front door open | | | | | | | | | | | | | | |
| Sit/stand/walk outside in the front garden | | | | | | | | | | | | | | |
| Walk up and down the road, to the first corner and back | | | | | | | | | | | | | | |
| Walk across the road and into the park, to the far side of the park and back home | | | | | | | | | | | | | | |

# Case Example

## Log book of behavioural experiments

Alongside Graded exposure and habituation, Amy also kept a log book of evidence from her behavioural experiments

**Log book** of evidence to test the belief that: "Someone will recognise me and they'll confront me in public" ("Theory A")

Alternative: "No-one would recognise me from a childhood photograph. People I pass on the street will be busy with their own lives" ("Theory B")

How I will test Theory A: Go out, with my hood down and my head up. I will look directly at people I pass and check what they are looking at.

| Date & time | Location | Number of people passed (including cars, pedestrians & cyclists) | Any shouting / confrontations? What did you notice? | Which theory does this evidence support? |
|---|---|---|---|---|
| Tues11.30am | Walked down the road to the corner and back for 25 minutes Hood off, head up | 15 | No People were just busy with their own lives | Theory B No-one recognised me |
| Weds 2.05pm | Walked across the road and around the park for 30 mins Hood off, head up | 11 | No People were walking their dogs or sitting and talking | Theory B No-one recognised me |

# Case Example

## Outcome

After about 10 sessions, Amy progressed to walking independently to a local park closer to the town centre, where her mum worked

She then had a setback; her sister became unwell and needed looking after at home. Amy was the family member given this responsibility

Amy found it difficult to continue with the Graded exposure therapy homework. We tried problem solving but she didn't feel able to continue with regular therapy homework while she was looking after her sister

We agreed that Amy could contact me when she felt ready to allocate regular daily time to therapy homework

# Case Example - Dissociative Disorder

*All identifying details have been fully anonymised

Sue*, a 41-year-old woman with a diagnosis of
DSM-5 Dissociative disorder, anxiety, and depressive symptoms

Brief background

- History of adverse childhood event – bullying at school
- Period of anxiety and low mood during adolescence
- Worked full time, lived with supportive partner, no children
- Several incidents of bullying at work – criticised and shouted at by manager in front of colleagues, manager then left
- Brief dissociative episodes started – temporary loss of conscious awareness of surroundings and passing of time

Rationale for focus on Dissociative disorder

Tackle dissociative symptoms first, depressive symptoms likely secondary, then address any trauma related symptoms

# Case Example

## Diagnostic & Statistical Manual, Fifth Edition (DSM-5) Criteria for ‘Dissociative trance’

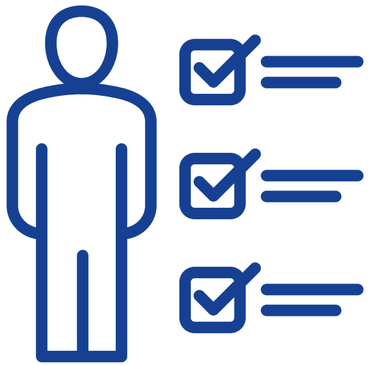
Episodes of sudden narrowing or loss of awareness of immediate surroundings

During these episodes, unresponsive to external stimuli

May involve minor stereotyped movements, and / or transient paralysis, and / or loss of consciousness

Not occurring as part of an accepted cultural or religious practice

# Case Example - Assessment



- Had three brief “collapses” at work, involving brief loss of consciousness and muscle control. Work colleagues alarmed.
- Partner very anxious.
- Occurred in situations where Sue felt more anxious at work, e.g. before work deadlines and a presentation in a meeting
- Medical & neurological causes assessed for and excluded
- Reduced social contact, started to work from home all week
- Dissociative episodes continued, 1-2 times a week, Sue would sit down when she felt onset, so no further collapses
- Avoiding work colleagues, avoiding socialising
- Partner supportive but worried, social life increasingly restricted
- Other co-existing symptoms – Major depressive disorder
- Outcome measures - Frequency of dissociative episodes, PHQ-9

# Case Example

## Therapy Goals & Agreement

Sue accepted that her collapses were due to psychological causes.

Very motivated to gain control of dissociative symptoms

Wanted to start going in to work again. Had enjoyed work and social events with colleagues in the past, wanted to return to this

Agreed 16 sessions, to focus on understanding, reducing frequency of dissociative episodes, and gaining control over them. Then gradually returning to work and social events with colleagues

## Shared Psychological Formulation

Developed shared understanding that dissociative episodes likely started due to episodes of bullying at work – reminded Sue of bullying at school

Explained that dissociation is part of a continuum of normal human experience – ranging from ‘day dreaming’ to loss of consciousness

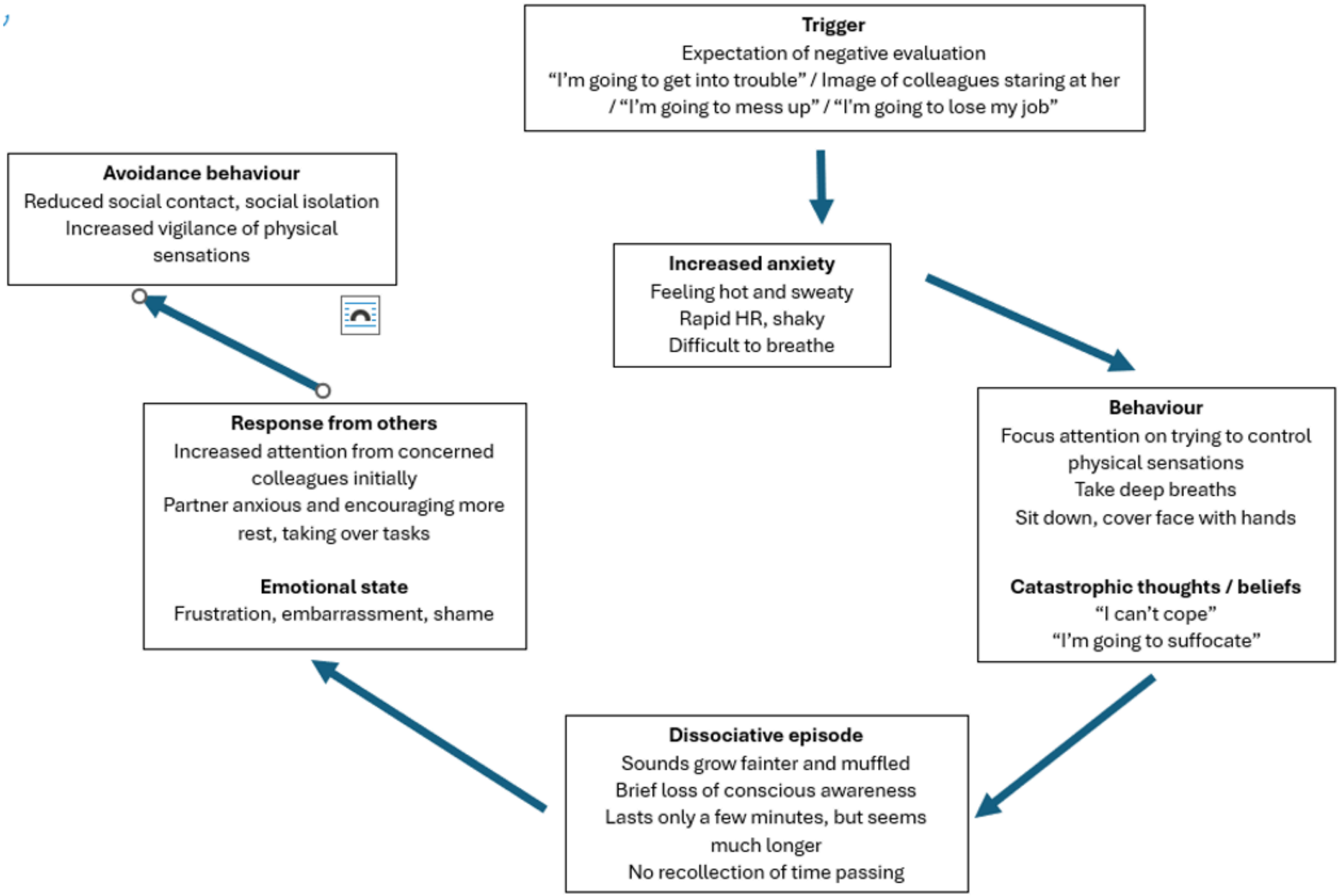
Psychoeducation on the ‘Fight Flight and Freeze’ response

Beliefs and behaviours associated with seizures may be maintaining rather than resolving them

# CBT Strategies

- Validated the impact of dissociative episodes and previous attempts to cope
- Pros and cons of current coping strategies
- Could see current strategies were ineffective, willing to try a different approach
- Discussed impact of responses of other people – alarm and worry make symptoms worse
- Dissociative episode diary – Sue able to recognise early warning signs
- Psychoeducation on physical symptoms of anxiety in ‘Fight, Flight & Freeze’ response – these are uncomfortable but not dangerous
- Breathing techniques – Paced breathing, diaphragmatic breathing
- Introduced distraction and refocusing (focusing outwards, bridging object, physical / mental activity)
- With Sue’s agreement, joint session with partner to share new approach
- Graded exposure (overcoming avoidance) and problem solving
- Addressing unresolved trauma & preparing for ending

# Case Example



**Thank you for joining us.**

**Do you have any questions?**