

Evaluating Psychodynamic-Interpersonal Therapy in Routine Clinical Practice

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Overview

- Orientation to this Panel: Background and context
 - Policy issues
 - Research
- Why Psychodynamic-Interpersonal (PI) therapy?
- Leeds PI audit and benchmarking
 - Methods
 - Results
 - Conclusions

Background: Policy

- UK NHS services commissioned in accordance with NICE guidance
- NICE guidance driven by reviews of (mainly) RCT evidence
- RCT evidence (interpreted as) supportive of CBT, almost to the exclusion of other methods

Background: Policy

- UK NHS services also driven by competing “choice” rhetoric
- Insufficient evidence re (informed) client preferences
- Therapists with non-CBT skills
 - Importance of congruence/apptitude

Background: Research

- Sources of bias
 - investigator allegiance
 - unbalanced weight of evidence
 - “winner takes all” competitive marketing culture
- Other qualifications
 - External validity: unrepresentativeness of RCTs requires complementary, practice-based evidence
 - Common factors
 - ATI findings

Acknowledgments

- Therapists
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- Data analysis
 - Jane Cahill
- Leeds Mental Health Teaching NHS Trust
- Psychological Therapies Research Centre, U of Leeds

Background: Why PI Therapy?

- Research Findings
 - Efficacy of PI in psychiatric & GI disorders
 - PI bucks negative stereotypes re science & therapy
 - Centrality of common relationship factors in treatment outcome
- Value in Training of Mental Health Professionals
 - Need for basic skills corresponding to Type A (DH '96 policy review) psychotherapy
 - Gateway to understanding psychodynamic approaches
 - Vehicle for delivery of psychodynamic concepts

Efficacy of PI Therapy of Depression (Sheffield studies)

- Sheffield Psychotherapy Projects show substantial pre-post changes, similar to those of CBT
- “2+1” study shows efficacy relative to wait-list control similar to that of CBT in sub-syndromal depression
- Bracketed with IPT in DeRubeis & Hollon’s (JCCP '99) review of EST’s for depression
- References at www.shapiro.co.uk

Efficacy of PI Therapy (Manchester studies)

- Better than TAU with IBS (Guthrie *et al* 1991 Gastroenterology **100**, 450-457)
- Reduces suicidal ideation and reported self-harm in self-poisoners as compared with TAU (Guthrie *et al* 2001 BMJ, **323**, 135-138)
- Better than supportive therapy in chronic functional dyspepsia (Hamilton *et al* Gastroenterology 2000, **119**, 661-669)
- Reduces healthcare costs relative to TAU amongst high utilizers of psychiatric services (Guthrie *et al* 1999 Archives of General Psychiatry **56**, 519-126)

PI Therapy Bucks Stereotypes

- CBT not the only empirically supported treatment
- Psychodynamic methods can be studied scientifically
- Psychodynamic therapists can learn from research
- Scientist-practitioners can do psychodynamic therapy

Common Relationship Factors

- Common factors outweigh specific treatment components by 3 to 1 in determining outcome (cf “Equivalence Paradox”)
- Relationship variables predominate amongst common factors (see J. Norcross (ed) *Psychotherapy Relationships that Work*, OUP '02)
- To improve treatment effectiveness better to optimise relationship factors than specific techniques

Training Issues

- Mental health professionals need effective relationship skills for all clinical work
- DH 1996 policy review identifies generic psychological skills applied in course of all mental health work (Type A)
- Value of demystifying psychodynamics, making it understandable and acceptable to all
- For everyday use by non-specialists, need a robust vehicle for using psychodynamics
- PI research shows it can be readily taught & learned

PI Therapy

- Therapeutic relationship as vehicle for understanding and modifying interpersonal problems, viewed as primary in origins of depression
- Negotiating style, language of mutuality
- Metaphor to enhance immediacy of affect in "here and now"
- Hypotheses based on PI concepts, tentative, to aid understanding, not revealed truth

PI Therapy

- Positive client-therapist bond, not compromised by challenges
- Client-therapist relationship as microcosm of primary relationships, readily available source of data on problems and of hypotheses to build understanding and change
- *e.g.*, attachment theory => hypotheses re client responses to experienced or feared loss

Methods: Sample

- 67 routine GP or psychiatrist referrals for therapy in secondary (CMHT) or tertiary (specialist psychotherapy) setting
- 17 men, 50 women
- Minimal inclusion criteria beyond suitability for therapy
- Exclusion criteria: primary referrer diagnosis of psychosis, substance misuse or organic impairment

Methods: Therapists

- 4 experienced mental health nurses with prior training in counselling or psychotherapy
- Trained and supervised in PI by David Shapiro as a group
- 2 male therapists in specialist service saw 29 & 18 clients, respectively
- 2 female therapists in CMHTs each saw 10 clients

Methods: Therapy

- PI therapy ranging from 16 to 25 sessions, median 17 sessions, each session about 50 minutes
- Data collected on 57 completers and 10 non-completers of an agreed course of PI therapy

Methods: Measures

- Inventory of Interpersonal Problems (IIP42; Barkham *et al.*, 1996)
- Beck Depression Inventory (BDI-II; Beck *et al.*, 1996)
- Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM; Evans *et al.*, 2000)

Methods: Ethical Issues

- Audit project formally registered with Trust's clinical audit department
- All clients received information leaflet about treatment and signed consent for data to be used anonymously for clinical audit as described in the leaflet, including publication

Methods: Data Analysis

- Check distributions, outliers, of pre- and post-therapy data
- Benchmarking pre-therapy scores
- Missing data: Last Observation Carried Forward
- Pre-post changes *t*-tests & ESs (diff/pre-SD)
- Benchmarking pre-post changes
- Group differences
- Indices of reliable & clinically significant change for CORE-OM & BDI-II

Methods: Benchmarks

- Sheffield studies comparing PI with CBT
- Westbrook & Kirk (2005) CBT in routine practice
- Leach *et al.* (2004) routine service data
- Barkham *et al.* (2005) multi-site pre-therapy CORE-OM

Results: Pre-Therapy

- No differences by gender, treatment setting, or individual therapist
- No outliers
- Pre-therapy scores on all measures similar to, or more severe than, other clinical samples

Results: Pre-Post

Scale	Pre mean (SD)	Post mean (SD)	<i>p</i>	Effect Size
IIP	1.84 (0.58)	1.56 (0.56)	.002	0.57
BDI-II	30.66 (11.86)	20.05 (15.77)	.000	0.89
CORE-OM	20.3 (6.2)	14.5 (8.8)	.000	0.93

Results: Pre-Post IIP Subscales

Subscale	Pre-	Post-	<i>p</i>	ES
H sociable	2.32 (1.07)	1.93 (1.10)	.002	0.42
H assertive	2.14 (1.09)	1.97 (1.20)	.077	0.23
H supportive	1.05 (0.99)	0.99 (0.84)		0.12
H involved	1.51 (0.99)	1.33 (1.07)		0.19
Too aggressive	1.60 (1.11)	1.36 (0.99)	.041	0.23
Too open	1.53 (0.90)	1.52 (0.78)		0.00
Too caring	2.14 (0.93)	2.01 (0.99)	.033	0.24
Too dependent	1.95 (0.84)	1.92 (0.91)	.024	0.27
Over-inv. attach.	2.10 (0.85)	2.01 (0.87)	.053	0.24
Under-inv. attach.	2.07 (0.93)	1.86 (0.95)	.098	0.24

Results: Pre-Post CORE-OM Subscales

	Pre-	Post-	<i>p</i>	ES
Well-being	26.0 (9.5)	18.9 (11.9)	.00	0.75
Problems	24.6 (8.1)	17.1 (10.4)	.00	0.93
Functioning	21.2 (7.7)	15.8 (9.5)	.00	0.70
Risk	4.9 (5.2)	3.9 (5.5)	.15	0.19

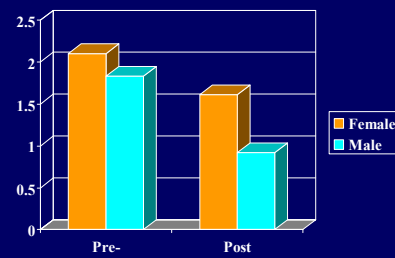
Benchmarking Pre-Post ES: BDI-II

Study	All clients	Above cut-off	'Severe'
Leeds PI	0.89	1.18	1.97
SPP1 PI	1.83		
SPP1 CB	1.77		
SPP1 both	1.77		
SPP2 8PI			1.76
SPP2 16PI			3.12
SPP2 8CB			2.40
SPP2 16CB			2.44
Westbrook CBT	0.67	1.15	2.10

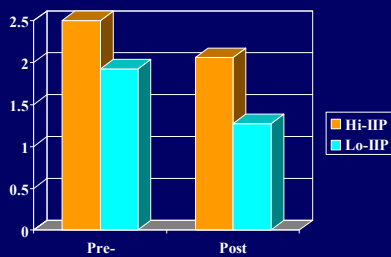
Benchmarking Pre-Post ES: CORE-OM

Sample	Pre-	Post-	ES
Leeds PI	20.3 (6.2)	14.5 (8.8)	0.93
Stiles <i>et al.</i> full sample	17.4 (6.5)	8.5 (6.3)	1.36
Stiles <i>et al.</i> CBT	16.9 (7.0)	8.1 (6.4)	1.27
Stiles <i>et al.</i> PDT	17.6 (6.3)	9.9 (6.8)	1.23
Stiles <i>et al.</i> PCT	17.6 (6.6)	8.9 (6.1)	1.32

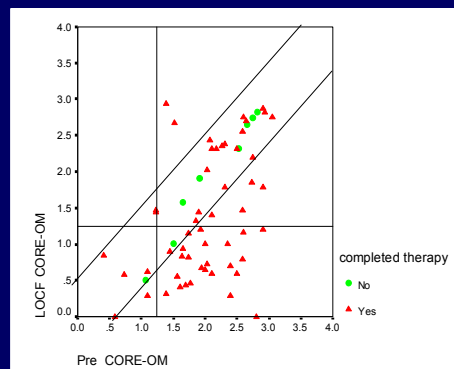
Gender Effect on CORE-OM



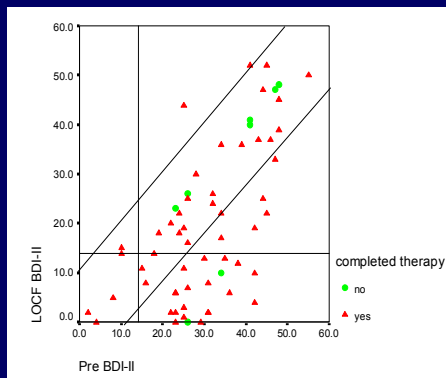
Pre-R_x IIP Effect on CORE-OM



Jacobson Plot: CORE-OM



Jacobson Plot: BDI-II



CORE-OM Jacobson Benchmark Leach *et al.* 2004

	PI data %	Leach <i>et al.</i> %
No reliable change	37	38
Reliable improvement	58	58
Reliable improvement only	18	16
Reliable & clinically significant change	40	42
Reliable deterioration	5	3

Summary of Findings

- Clients were at least as severe as those in other clinical settings and research studies
- Gains were substantial (*e.g.*, 40% reliable and clinically significant change)
- Gains were comparable to those achieved in other settings, but, in common with other non-research data including for CBT, less favourable than obtained in research

Limitations

- Client population could be better specified
- Work done in a “near-research” setting (*e.g.*, trainer a researcher, one therapist has a research doctorate) so may still overestimate effects

Conclusions

- “Winner takes all” promulgation of CBT likely underestimates the contribution of other research-based therapies to effective practice
- Client (and therapist) choice of non-CBT methods can be encouraged