

***Commentary on Story of "Hope":
Successful Treatment of Obsessive Compulsive Disorder***

The Case of Hope: "Evidence-Based Practice" (EBT) in Action

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ABSTRACT

The fascinating case of Hope as described by one of our senior independent practitioners, Paul Clement (2007), illustrates in a superb manner the integration of evidence-based practice (EBP) into the realities of clinical practice. This commentary presents an analysis of Clement's implementation of EBP in the context of the American Psychological Association's statement on EBP in psychology (APA 2006). Strengths evident in the treatment of this case, as well as shortcomings currently endemic in our profession, are described with a focus on choice of psychological interventions, non-specific factors, and assessment. Finally, this case, representing as it does the "facts on the ground" in the practice of psychotherapy, raises issues about the role of this activity in emerging national healthcare systems and a proposed distinction between "psychological treatments" and "psychotherapy"

Key words: evidence-based practice (EBP); assessment; psychotherapy; psychological treatments

The story of Hope is cast by the distinguished psychotherapist, Paul Clement (2007), as a typical case from his practice who happened to have an exemplary outcome. More importantly, this case is presented as an example of how a clinical psychologist conducting psychotherapy independently can incorporate the newly outlined ideas of evidence-based practice (EBP) into independent practice. Clement succeeds admirably. There is no question that he has achieved the specific objectives of EBP in a manner that represents the current state of the art in our field. But it is also clear that the field itself has much to achieve before EBP can be more systematically and universally practiced as illustrated by a few shortcomings in this case report. In addition, Clement's case of Hope raises additional questions about how we conceptualize what we do, where psychotherapy will fit within our emerging national health care system, and the future of practice. In this commentary I will briefly address each of these issues with the caveat that this commentary represents my own speculations on likely future directions in our field.

THE COMPONENTS OF EVIDENCE-BASED PRACTICE (EBP)

EBP is one of those ideas that comes along occasionally and takes the world by storm. Although some of the tenets of EBP have been around for decades, it is only in the past 10 years that EBP has been formally identified as a systematic method of delivering clinical care (Institute of Medicine, 2001; Sackett, Strauss, Richardson, Rosenberg &, Haynes, 2000).

Since that time the "tipping point" (Gladwell, 2000) for EBP has clearly occurred, and healthcare policy makers and governments around the world have collectively decided that the delivery of healthcare, including behavioral healthcare, should be based on evidence. Fulfilling this mandate comprises the goals of EBP. Some countries around the world, particularly where healthcare is a nationally coordinated endeavor, are more advanced in achieving these goals than others. For example, the National Health Service (NHS) in the United Kingdom employs over 5,000 clinical psychologists (British Psychological Society, 2004). Approximately 5% of new clinical psychologists take their first jobs in either the NHS or in the clinical psychology training programs that feed the NHS. In 2001 the NHS began investing over three million pounds to advance the goals of EBP in the context of behavioral health care. The target was coordinated assessment and psychological intervention for behavioral problems. This initiative was based on the demonstrated effectiveness of psychological treatments in clinical trials and the growing evidence of the generalizability of these interventions to front line clinical settings (Barlow, 2004). Anticipating a sizable gap between supply and demand for psychologists, the British Psychological Society, working in conjunction with the government, recommended that the annual growth of clinical psychology programs (which are fully supported by the NHS) should be increased 15% each year over the near term, and that the wages of such psychologists working for the NHS should be increased to better reflect their new responsibilities.

In the United States, the President's New Freedom Commission on Mental Health made the principle recommendation of their final report to

advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation (and) improve and expand the work force providing evidence-based mental health services and supports. (2003, p. 25).

Most recently, the American Psychological Association (APA) adopted as policy a report describing EBP in psychology and encouraging wide adoption of the notion of basing principles of psychological practice on evidence (APA, 2006).

Despite these recent pronouncements and reports, wide confusion remains on the definition of EBP and the implications of EBP for the day-to-day clinical work of psychologists and related mental health professionals. At least three related concepts, presented in Table 1, can be identified that describe a somewhat different set of activities, although the terms are, mistakenly, used interchangeably at times.

The first concept in Table 1 is "empirically supported treatments" (ESTs). Specifying ESTs is a nomothetic process that involves identifying those specific interventions, such as drugs and psychological treatments in behavioral health care, with evidence for their effectiveness for

certain identified problems or diagnoses. Much of this evidence comes from the methodological gold standard for identifying ESTs, randomized clinical trials (RCTs). This concept is “nomothetic” because these RCTs are based on the average response of a group of people with the target problem or diagnosis when treated by the identified EST, usually compared to some good alternative. As Clement points out, these trials are often subjected to meta-analyses demonstrating not only the superiority of one treatment or another over alternative treatments, but also the “effect size” of these treatments as typically applied to large groups of patients.

A second concept in Table 1, also alluded to by Clement, is “clinical practice guidelines” (or “best practice” algorithms, or some similar descriptor). These are also nomothetic products that refer to a coordinated series of assessment and treatment strategies with a recommended sequence of application. Thus, a clinical practice guideline for substance abuse (Anton et. al., 2007), for example, recommends initial diagnosis and formulation to identify and specify the problem followed by particular assessment strategies that lead, in turn, to “first line” treatments. The guideline also has many different options (represented as branches) for patients with unique presenting characteristics, or for patients who do not respond to first line treatments. Failure to respond to a first line treatment leads to recommendations for treatment enhancement or wholesale switching to secondary treatments. Nevertheless, these efforts are still nomothetic, since the data base supporting the construction of these guidelines is also derived for the most part from large group studies wherein this information is developed.

The third concept in Table 1 is evidence-based practice itself, which differs from the previous two concepts in that it is idiographic. That is, it is focused on the individual patient. As such, the APA Presidential Task Force report (2006) defines a series of activities that would comprise evidence-based practice and enable practitioners to administer the best care available to an individual patient (or group of patients) under their care.

Having considered the three different products of EBP, we can now examine how the case of “Hope” matches up to these newly developed principles. To begin, it is helpful to consider two related statements from the APA document on EBP (APA, 2006).

Some patients have a well defined issue or disorder for which there is a body of evidence that strongly supports the effectiveness of a particular treatment. This evidence should be considered in formulating a treatment plan, and a cogent rationale should be articulated for any course of treatment recommended. (p. 278)

And, in another statement

There are many problem constellations, patient populations, and clinical situations for which treatment evidence is sparse. In such instances, EBP consists of using clinical expertise in interpreting and applying the best available evidence while carefully monitoring patient progress and modifying treatment as appropriate” (p. 278).

For the case of “Hope,” Clement begins with a detailed intake assessment accompanied by a more objective problem checklist and self-report inventory to assist in gathering information and in formulating the nature of any psychopathology that might be present. As a result of this

intake interview he found that Hope did, in fact, have several well-defined disorders that pointed to a particular psychological treatment, in this case obsessive compulsive disorder (OCD). She also presented with a specific phobia (flying), panic disorder, and problems with nightmares all of which were somewhat less severe at presentation than the OCD.

It is increasingly common in many practice settings to ascertain a principal diagnosis (as well as any additional diagnoses) at the outset based solely on agreement among the clinician and the client on which problem is the most distressing and interfering at this point in time. In this case the principal diagnosis was OCD, but there were a number of additional problems and complaints that also rose to the level of meeting criteria for a diagnosis. To treat the OCD, Clement expertly employed the psychological treatment with the most evidence for effectiveness, exposure and ritual prevention, along with cognitive work separating the rational from emotional nature of Hope's understanding of the connection between her rituals and what happens to others (Franklin & Foa, in press) He also introduced some calming procedures, which are always a good idea with patients with a variety of anxiety disorders as long as they do not become additional vehicles for avoiding the important therapeutic work of processing the negative affect. Clement made sure this was the case, since he used relaxation to reduce general tension and anxiety rather than as a strategy to avoid negative affect (which, as a faulty emotional regulation technique, has the paradoxical effect of increasing negative affect and associated symptoms, such as obsessional thoughts [Campbell-Sills & Barlow, 2007]). Utilizing calming techniques and cognitive restructuring, Clement also attacked the problem of separation anxiety that occurred when Hope's husband was away on business.

One of the myths of utilizing ESTs is that this activity implies picking up a treatment manual and rather mindlessly administering it to the patient in some kind of a rote fashion. Nothing could be further than the truth. Empirically supported treatment programs are meant to be skillfully integrated into the treatment process while attending to the idiosyncratic presentation of the client, a skill that is fully evident in Clement's treatment of Hope. But this "skill" begins with deciding whether to use the EST or not. Thus, the APA statement notes that evidence for the appropriateness of the empirically supported treatment should be considered in formulating the treatment plan. But it is very possible that there could be some reasons that exposure and ritual prevention might not be the most appropriate treatment. Two of the most obvious of these would seem to be the patient's unwillingness to undergo the treatment due to a preference for medication, or particular cultural or religious beliefs.

It might also have been the case that the patient did not meet criteria for a well-defined issue or disorder. In other words, the diagnosis and formulation did not point clearly to a specific empirically supported treatment program. In this case EBP would have the clinician choose what combinations of procedures might be most appropriate among the available range of psychological procedures (possibly combined with medications) based on the clinician's best judgment. This judgment would be based on a deep working knowledge of psychopathology and intervention. The clinician would then begin to engage in careful ongoing assessment to monitor progress. Such was the case in addressing the problems of Hope's dreams and nightmares. Relying on procedures developed from positive psychology as well as clinical experience, Clement devised some strategies currently without quantitative evidence for effectiveness that

could, nevertheless, be interpolated from existing research as likely to provide the desired therapeutic effect. This was, in fact, the result with Hope. We will return to this issue below.

NON-SPECIFIC FACTORS IN THERAPY AND EBP

Clement also recognizes the importance of "non-specific" factors, such as expectancies of the patient and the nature of the therapeutic alliance. A recent question in psychotherapy research that is raised by this case has to do with the relative contribution of therapeutic techniques and non-specific factors to overall change. This has been a contentious issue with a few proponents on one side purporting that techniques make little or no contribution to outcome and that non-specific factors are responsible for the majority of therapeutic change when it does occur. A few individuals from the other end of the continuum would suggest that therapeutic techniques are the only thing that matters, and that the therapist can be removed from the equation in favor of automated, interactive, web-based therapy (to take one example) or other forms of "telehealth" derived from an algorithm. As in most of these contentious arguments where extreme positions are staked out, the truth seems to lie somewhere in between.

To examine this issue in the context of the present case, a number of studies suggest -- as noted above -- that exposure and ritual preventions for adult OCD is one the most powerful psychological procedures available to us (Nathan & Gorman 2002). Recent analyses of large, multi-site clinical trials summarized in Figure 1 (Huppert, Franklin, Foa, Simpson, & Barlow 2007) indicate that this treatment procedure accounts for up to 60% of the variance in overall change.

Thus, Dr. Clement was obviously exactly on target in choosing the psychological treatment that he did. As is evident in Figure 1, a substantial percentage of the variance in outcome in the treatment of OCD is due to therapist factors, which is quite representative of these types of analysis. One must remember that these analyses are based on large clinical trials with numerous therapists all trained to a very high "gold standard" in the administration of these treatments. That fully 0 – 20% of the variance was due to therapist qualities is actually quite surprising in this regard, but again, fairly representative. In this particular analysis, another 35% of the variance can be attributed to the variety of individual differences and other external influences that are present in any therapy situation. Based on analyses such as these and as represented in Figure 2 (Huppert et al., 2007), our best estimates indicate that specific therapeutic techniques may contribute between 10 and 60% of the variance across a variety of disorders, with from 0 - 20% due to "non-specific," therapist effects, and 30 - 70% accounted for by the random situational variations and individual differences that make up the richness of clinical experience.

Note that in earlier meta-analyses (e.g., Wampold, 2006) of the relevant research data, more generic models of contributions to outcome that de-emphasize the power of techniques or interventions seem to have missed the effects of specific treatments and their interactions with specific disorders. They have done this by collapsing analyses across both treatments and disorders and by including in their analyses some studies in which there were no diagnosed disorders per se. In fact, as forthcoming analyses currently in preparation will show,

results of interventions would be expected to differ and do differ as a function of the nature of psychopathology. Few clinicians would treat someone with a specific phobia or schizophrenia with the same interventions on the assumption that the intervention was of little importance. Similarly, analyses of single factors such as therapist or therapeutic alliance are likely to miss complex interactions with clients or presenting problems that comprise the essence of psychotherapy. These analyses are complex and will yield quite different results on the contribution of various therapeutic factors to change based on the nature of the disorder or problem as well as specific interactions with technique, therapist, and client.

Thus treatment procedures, relationship factors, and other "non-specifics" are clinically important in therapy, as astutely noted by Dr. Clement.

PSYCHOLOGICAL ASSESSMENT IN EBP

In addition to considering the evidence for intervention procedures, an aspect of EBP that is at least as important (if not more important) is ongoing assessment (Barlow, 2005). The APA (2006) notes the importance of "carefully monitoring patient progress and modifying treatment as appropriate" (p.278). Unfortunately, clinicians of all stripes have not been very good at this, reflecting the standards in the field where appropriate strategies for ongoing assessment are undeveloped. Clement, however, did choose an objective instrument for monitoring progress that goes over and above the typical informal clinical assessment ("How was your week?"). Using this instrument he evaluated progress three times during treatment, after the 14th, 69th, and 103rd sessions. As noted, this is far better than what most of us do these days, but is probably not adequate to pick up various ups and downs in patient progress that would provide important information for fine-tuning or even changing ongoing treatment strategies.

For example, the objective assessment procedures recorded a drop in effect size somewhere between session 14 and 69, but this is a long period of time. It would have been more informative to have a more convenient, user-friendly, ongoing measure of progress to pick up changes in psychopathology weekly or even daily that could then be related in a more functional way to life events or interventions. Of course the therapist is always doing this informally as did Clement, but applied psychological science has long proven the value of objective assessment, and this is the reason it is strongly recommended in the APA statement.

The emerging field of evidence-based assessment notes the importance of adapting assessment techniques (a) so that they are appropriate to the target problem at hand, and (b) so that they can be administered in an ongoing fashion in order to observe functional relationships between treatment, environmental events, and outcome (Barlow 2005a). This is very much a change from previous clinical strategies in which psychological assessment procedures most often consisted of an initial, standardized battery of psychological tests targeting personality traits, skills, abilities, and generalized profiles of strengths and deficits in functioning. As a standardized battery, this effort is not necessarily directed towards further elucidating the patient's specific presenting problem, but rather -- in the best case scenario -- provides a one-time snapshot of more generalized trait-like issues.

Perhaps the best example of this is the MMPI (Butcher et. al., 1990), which is designed and normed for general administration without initial consideration of presenting psychopathology. Furthermore, the MMPI is "empirical" in the generation of various profiles. Nevertheless, while the goal of the MMPI and similar standardized tests is obviously to identify patterns of psychopathology, these patterns are for the most part idiosyncratic to individual tests and have not been tied in a satisfactory way to either systems of nosology or to systematic treatment recommendations. Rather, this is left to the discretion of the individual clinician and therefore has varied widely. New assessment strategies, on the other hand, are designed to be fully integrated with an in-depth consideration of presenting psychopathology and accompanying levels of impairment that reflect our most advanced knowledge of these conditions. These strategies, in turn, are closely linked to existing treatment options with the expectation that progress will be monitored in each of the crucial domains to the point of outcome. These trends are also occurring in medicine as exemplified in recent work on care for cystic fibrosis (Gawande, 2004).

In addition, in frontline clinical settings, the focus on optimal assessment will increasingly require efficiency and cost-effectiveness. In these settings we will be looking for the briefest, most feasible, and most user-friendly instrument or strategy with sufficient reliability and validity to get the job done. Clement, acting as a responsible clinician, made the best choice he could in this regard based on what was available. But fortunately for practitioners everywhere, more sophisticated, psychometrically sound, and user-friendly choices for comprehensive screening and repeated ongoing assessment are on the way (for example, Krauss, Seligman, & Jordan, 2005).

In summary, the process of evidence-based practice can be collapsed into five steps as represented in Table 2. Step 1 is the immediate initiation of ongoing monitoring of psychopathology or other targets for change. Once that has begun, in Step 2 the clinician is in a position to continue with diagnosis and case formulation. Following adequate formulation, the clinician can then in Step 3 match the patient's problems to the nomothetic EST data base and make the appropriate choice of treatments (or combination of treatments). The therapist is then in a position in Step 4 to decide on the appropriate treatments based not only on the presenting psychopathology and diagnosis, the case formulation, and available treatments, but also on patient characteristics and other local factors. Finally, utilizing ongoing monitoring procedures, in Step 5 the therapist will continually analyze progress and make clinical judgments on the functional relationships in non-responsive or deteriorating cases in order to make appropriate changes. It is very clear in this case study that Clement anticipated the APA (2006) statement of EBP by following every one of these suggested guidelines.

Lastly regarding Table 2, it should be noted that the steps in the table are consistent with the logic of Peterson's (1991) "Disciplined Inquiry" model of clinical practice that underlies this *Pragmatic Case Studies in Psychotherapy (PCSP)* journal. Specifically, as listed on the PCSP home page, the sequence of practice stages in Disciplined Inquiry include "Assessment of the Client's Problems, Goals, Strengths, and History" (see Step 1 in Table 2); "Case Formulation and Treatment Planning" (see Steps 2, 3, and 4 in Table 2); and "Therapy Monitoring and Use of Feedback Information" (Step 5 in Table 2).

DISTINGUISHING "PSYCHOTHERAPY" AND "PSYCHOLOGICAL TREATMENTS"

Finally, it is noteworthy that, much to the surprise of both the therapist and the patient, treatment took more than two and half years and lasted 103 sessions. Based on the extremely valuable process notes kept by Dr. Clement, he is able to detail what was addressed in each session providing an illuminating and accurate description of the nature of psychotherapy today. We learn from this that in addition to successfully addressing the client's anxiety-based psychopathology in the form of conditions like OCD, panic, nightmares, and separation anxiety, other issues important to the client's well being were also addressed. In fact, considerable therapeutic time was devoted to what could be categorized as general problems in living, and the holy grail of the pursuit of happiness.

Specifically, two of the goals worked on include "facilitating Hope's becoming more aware of her personal assets as a source of calmness and contentment"; and increasing her "connections with herself," with the aim of generating a more accurate and comprehensive view of herself as an impressive, achieving young woman. In addition, more practical issues were addressed, such as career directions; dealing more successfully with some overbearing parents (addressed in parts of 16 sessions); handling uncertainties in her husband's career (focused on during 18 sessions); dealing with logistical problems and job seeking due to her citizenship status; and facing ambiguities in her marriage. Clement notes that his role in handling uncertainties regarding where Hope's husband's career might lead them to relocate, and related issues "was mostly to listen with understanding to her thoughts, feelings, concerns, and preferences and to accept her as she was." Once again, my point of describing these activities, admirably detailed by Clement, is that they are a common part of long-term psychotherapy, including my own (yes, I do long-term therapy on occasion!). But they raise an issue I have addressed previously on the relationship of this type of effort to the remediation of identifiable psychopathology (Barlow, 2004; 2005b; 2006).

The question is: Will "psychotherapy" be integrated into our emerging national healthcare system in this country or not? The objections by policy makers over the years to including psychotherapy have in part been due to the long-term growth and adjustment-oriented features of the psychotherapy process. This has been the principal reason for the lack of parity between physical and behavioral healthcare plans (along with prejudice and stigma). In fact, "psychotherapy" is such a heterogeneous activity at this point in time that the term has lost its ability to communicate our activities. Elsewhere (Barlow, 2004; 2005b; 2006), I have suggested that it would resolve and clarify our objectives to delineate at least two kinds of psychotherapy.

The first would be "psychological treatments" that are clearly compatible with the objectives of our healthcare system in that the goal is to address pathology as laid out in current, officially accepted nosological systems.

The second would be an equally valuable undertaking, which we could term "psychotherapy," which would primarily address problems in adjustment and growth that are not necessarily related to pathology. I have suggested that these two activities would not be

distinguished on theory, technique or even evidence, but on the problems addressed. In this case, we see that Clement uses the latest psychological research from positive psychology to address problems in living as well as long-term adjustment and growth issues. It seems likely (to me) that positive psychology will provide the theoretical and empirical underpinnings to an evidenced-based approach to adjustment and growth (Seligman, 2002). In this context, one could make an argument that in addressing problems in living, Clement is promoting positive psychological skills that might prevent redevelopment of future psychopathology, or conceivably prevent relapse. But there is as of yet no evidence of this, and these arguments have not been particularly persuasive to healthcare policy makers. Needless to say, future research pursuing such evidence would seem a high priority for the field.

So the question remains, will "psychotherapy" (as I define it here) be a part of our healthcare system going forward, and can we reasonably expect health insurance to pay for these kind of activities? There is no mention in Hope's case of how fees were handled for her 103 sessions, and insurance regulations currently vary so widely from state to state in the United States that it would be impossible to guess. But in many of these long-term cases, self-pay has been the modal economic arrangement.

Going forward, healthcare systems are going to want to know what is being treated and what objective measures are in use to monitor outcomes. And very clearly, as we have seen from recent developments, various interested parties are going to have to fight tooth and nail to get even recognized patterns of psychopathology included under reimbursement schemes. For example, at the current time, panic disorder and obsessive compulsive disorder are included under some reimbursement schemes as severe mental illnesses while generalized anxiety and specific phobia are not. Note also the recent controversy on whether morbid obesity should be included as a reimbursable illness under Medicaid. Most people would recognize the well-established risk factors to health from obesity and say it should be included. But policy makers note the enormous costs of paying for treatments of obesity when only a subset will suffer medical consequences. Parity schemes vary from state to state, but the real political and economic issue is how many recognizable psychological diagnostic conditions will be included, not whether insurance should cover all problems in living (Newman, 2007).

It seems to me that, going forward, we will need to delineate in some way these two approaches. Psychological treatments should be placed firmly within in our emerging healthcare system so that psychologists and other mental health practitioners can be fully reimbursed as they should be for remediating psychopathology. But for those noble, distinguished, and traditional efforts to enhance the process of living and the quality and value of relationships as well as to promote adjustment and personal growth, we might have a clearly delineated, second approach termed "psychotherapy."

I am aware that this is a controversial proposal and that this dichotomy is overly simplistic. In Clement's expert hands he integrates this kind of care for Hope in a holistic fashion that produced an excellent outcome. But it does seem to me that it is time we come to grips with the issue of whether we wish to be healthcare practitioners, fully included in emerging national healthcare plans, with all of the economic consequences of that practice, or whether we wish to follow the path of helping people work out how to live and love. If we want to be both,

as most of us are now, how can these activities can be integrated in today's healthcare environment in a manner that would permit full inclusion of mental health practitioners in national health schemes with unqualified parity? Ideally, every citizen would have access to both resources; but from a policy point of view, it simply will not happen given fiscal restraints in our emerging national healthcare system. Going forward, health practitioners, particularly mental health practitioners, need to be aware of these issues to proactively insure that the benefits of both psychological treatments and psychotherapy are as widely available as possible.

In the meantime we have this superb case study from Dr. Paul Clement as a reaffirmation that the goal pursued by all of us can be achieved. The resolution of human suffering and the enhancement of human functioning is why we all went into this field, and our disagreements simply revolve around how best to do it. Dr. Paul Clement comes very close to the ideal.

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Table 1: Three Concepts Used in Evidence Based Practice

- ***Empirically supported treatments***
(nomothetic focus on intervention strategies)

 - ***Clinical Practice Guidelines***
(nomothetic focus on disorder or problem)

 - ***Evidence-based practice***
(idiographic focus on patients or recipients of services)
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Table 2. The Process of Evidence-Based Practice

1. ***Ongoing monitoring of pathology or other targets for change***

 2. ***Diagnosis and case formulation***

 3. ***Match patient's problems to nomothetic, empirically supported treatments (ESTs) data base***

 4. ***Based on psychopathology and patient characteristics, make inferences on possibly effective interventions***

 5. ***Functional analysis on non-responsive, deteriorating cases***
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Figure 1. Treatment Procedures vs. Therapist Factors: Adult OCD

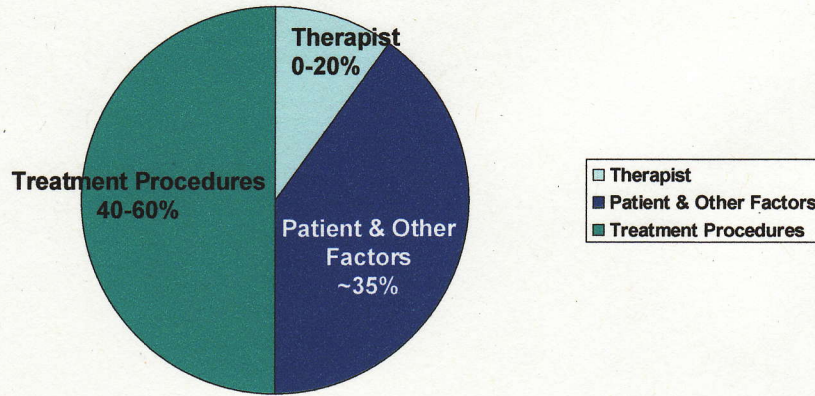


Figure 2. Treatment Procedures and Relationship Factors: Depending on Disorder and Treatment

