

Evidence-Based Practice of Psychological Treatments: A Canadian Perspective

Report of the CPA Task Force on Evidence-Based Practice of Psychological Treatments
Canadian Psychological Association (CPA)



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Task Force on the Evidence-Based Practice of Psychological Treatments

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Preamble

In March, 2011, the CPA Board of Directors launched a Task Force on Evidence-Based Practice of Psychological Treatments to support and guide practice as well as to inform stakeholders. Psychological health and disorders are clearly a priority for many of Canada's stakeholder groups (e.g., Mental Health Commission of Canada, Treasury Board, Public Health Agency of Canada) and their effective treatment is an important priority for CPA as well.

This document operationalizes what constitutes evidence-based practice (EBP) of psychological treatment. In terms of defining what is meant by "evidence", the members of the task force were interested in a definition that was comprehensive enough to incorporate the following ideas: (1) peer-reviewed research evidence is central; (2) psychologists should be evidence-based not only in their general fund of knowledge but also in session-by-session work; (3) the process involves one of collaboration with a client/patient (rather than a top down process). Also advanced is a hierarchy of evidence that is respectful of diverse research methodologies, palatable to different groups of individuals and yet comprehensive and compelling.

Evidence Based Practice of Psychological Treatments: A Canadian Perspective is intended to support Canadian psychologists in providing treatment that is guided by the best available evidence. This document is not intended to provide a comprehensive review of the EBP literature. Rather, it defines EBP and provides a hierarchy of available evidence. This document also contains several brief case examples from various areas of practice that serve to illustrate the manner in which the hierarchy can be applied to different presenting problems and populations. A series of extended vignettes also describe the process of EBP in terms of case conceptualization, initial and ongoing assessment, treatment planning and the implementation of psychological interventions. A guide for the general public and individuals with lived experience highlights the added value that psychologists bring to the understanding, assessment and treatment of mental and behavioral health problems. Also included in this document is a list of resource materials to help professional psychologists locate reliable information regarding EBP. Finally, we end with a set of recommendations to further advance the EBP of psychological treatments.

Our intention for this document is to provide a set of guidelines that will foster interest, encourage development and promote effectiveness in EBP. We hope that the readers will find *Evidence-Based Practice of Psychological Treatments: A Canadian Perspective* useful as they seek to provide and implement the best possible psychological treatments.

David J. A. Dozois, Ph.D. & Sam Mikail, Ph.D.
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Executive Summary

- ✓ Evidence for recommending or providing treatment should stem from treatment outcome research, treatment process research, and basic psychological research.
- ✓ Before providing treatment, psychologists should first consider the hierarchy of evidence available for the treatment options under consideration.
- ✓ Psychologists should utilize the best available evidence (evidence which is highest on the hierarchy) which includes findings that are replicated across studies and that have used methodologies that address threats to validity (e.g., randomized controlled trials to address threats to internal validity; naturalistic studies to address threats to external validity).
- ✓ In cases where there may be little or no relevant treatment research, practice guidelines may be available that are based on a consensus among experts and have been determined by formalized methods.
- ✓ Psychologists should frequently and systematically monitor clients' reactions, symptoms and functioning during treatment.
- ✓ Psychologists should be prepared to alter the treatment based on data from ongoing treatment monitoring, discussions with the client, and reconsideration of the relevant hierarchy of evidence.

CPA's Definition of Evidence-Based Practice of Psychological Treatments

Evidence-based practice of psychological treatments involves the conscientious, explicit and judicious use of the best available research evidence to inform each stage of clinical decision-making and service delivery. This requires that psychologists apply their knowledge of the best available research in the context of specific client characteristics, cultural backgrounds, and treatment preferences.

Consistent with ethical codes and professional standards, evidence-based practice entails the monitoring and evaluation of services provided to clients throughout treatment (from initial intake to treatment termination and maintenance of gains). Evidence-based psychological practice also pertains to one's own professional development. This requires a commitment to continually inform and/or be informed by research evidence so as to identify and select interventions and treatment strategies that maximize the chance of benefit, minimize the risk of harm and deliver the most cost-effective treatment.

Evidence-based practice relies, first and foremost, on research findings published in the peer-reviewed scientific literature including, at a minimum, treatment process and treatment outcome research. All research methodologies have the potential to provide relevant evidence, but in examining the scientific literature preference should always be given to studies based on research methodologies that, as much as possible, control threats to the validity of the research findings. Consistent with their academic training, psychologists are expected to thoughtfully evaluate the peer-reviewed scientific literature, recognizing both the applied value and the limitations of current knowledge. A number of avenues are available for psychologists to maintain their knowledge of the relevant scientific literature, including reliance on primary studies, systematic reviews, and clinical practice guidelines.

Respect for the dignity of persons is imperative in evidence-based practice. Psychologists work in collaboration with their clients in developing and implementing their services. Psychologists have knowledge of the research literature, which forms the basis for developing treatment options that may be indicated for a client with particular characteristics. Clients have valued lived experiences including previous symptoms or treatment experiences, preferences and motivation. Communication and collaboration between the psychologist and the client is crucial to the process of achieving informed consent and reflects best practice based on current evidence.

Sources and Levels of Evidence

Evidence-based practice relies on diverse sources and levels of evidence. First and foremost, this evidence includes research findings published in the peer-reviewed scientific literature. For psychological practice, the evidence to be considered in recommending or providing a treatment should be derived from sources such as treatment outcome research, treatment process research and basic psychological research that can be applied to clinical practice (see Figure 1). Following the initiation of treatment, data should be obtained from the ongoing monitoring of clients' reactions, symptoms, and functioning, and these data should inform decisions about treatment planning, modification, completion and discontinuation.



Figure 1. Sources of evidence that inform clinical practice.

To determine the strength and relevance of research findings to their practice, psychologists should consider the hierarchy of evidence available for the treatment options under consideration (see Figure 2). Although all research methodologies have some potential to provide relevant evidence, psychologists should first consider findings that are replicated across studies and that have utilized methodologies that address threats to the validity of obtained results (e.g., internal validity, external validity, generalizability, transferability). Thus, psychologists should consider the best available evidence, highest on the hierarchy of research evidence. Evidence lower on the hierarchy should be considered only to the extent that better research evidence does not exist, or if there are clear factors that mitigate against using the best evidence (e.g., clear patient treatment preference).

Systematic knowledge syntheses are at the top of the hierarchy, as these are based on the results of multiple investigations. Systematic knowledge syntheses can include a range of methodologies, including systematic reviews, meta-analyses, meta-syntheses, realist syntheses,

narrative syntheses, and practice guidelines that systematically synthesize evidence. When systematic knowledge syntheses are not available, psychologists should refer to primary research studies based on methodologies that address threats to the value of the research findings. For example, in quantitative research, randomized controlled trials can provide evidence with strong internal validity; in treatment research, these studies are typically known as *efficacy* studies. However, it is also important for psychologists to consider the external validity of research findings, and to consider the results of studies designed to have high external validity (i.e., generalizability); in treatment research, these studies are often referred to as *effectiveness* studies. Ideally, psychologists should consider studies that have high internal validity and studies that have high external validity.

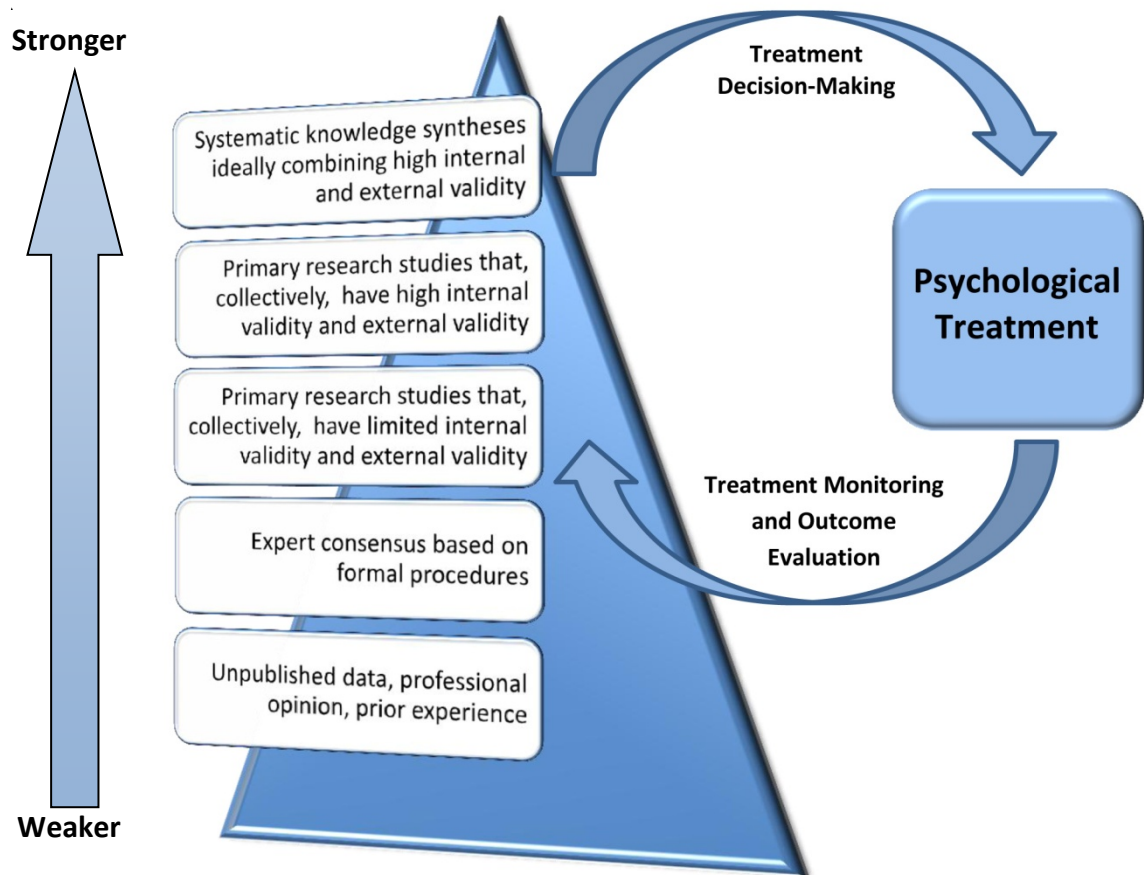


Figure 2. The hierarchy of research evidence related to clinical practice.

There is likely to be process and outcome research relevant for many of the treatments provided by psychologists, and psychologists are expected to keep current with respect to new developments in the field. In those cases where there may be little or no relevant treatment research, practice guidelines may be available that are based on a consensus among experts and have been determined by formalized methods. Additionally, other options may be

considered, although none of them are truly evidence-based. Such options are at the lowest level of the evidence hierarchy, and include unpublished practice-based data, prior clinical experience, and professional opinions not based on published research.

Regardless of the nature or strength of the evidence used to inform treatment selection and planning, psychologists should be prepared to alter the treatment being provided based on data from ongoing treatment monitoring (including both in-session and between-session client reactions and changes in symptoms and functioning). Frequently this will involve adjusting the content, sequencing, timing, or pacing of treatment elements. In some instances, this might lead to a decision, made in collaboration with the client, to discontinue the treatment and make a referral to another treatment provider. In such situations, psychologists should reconsider the relevant hierarchy of evidence in order to determine alternative options that might be appropriate for the client.

Brief Vignette Examples

The task force believed that the relevance and usability of this document would be enhanced considerably by the inclusion of clinical vignettes that illustrate the use of the hierarchy in actual clinical practice. Vignettes are commonly utilized in clinical and academic materials; they are effective teaching tools because they provide relevant, accessible and interesting examples to consider and reflect upon (Pettifor, McCarron, Schoepp, Stark & Stewart, 2010).

Task force members, Chairs of relevant CPA Sections and other psychologists were invited to submit brief vignettes of a composite case describing the use of evidence-based treatment and the application of the hierarchy. The primary objective of the brief vignettes was to illustrate the process of evidence-based decision-making and practice. Our intention was not to be exhaustive or prescriptive but rather to provide several short examples that reflect actual clinical decision-making and the process of applying EBP in psychological treatment.

The information presented in these vignettes is derived from composite and/or simulated case material which has been altered such that the parties involved cannot be identified. Any resemblance to particular individuals is purely coincidental. The information is provided for illustrative purposes only and is not intended to direct how treatment should be provided in a particular case. Practitioners are required to exercise their professional judgment when providing treatment and should not rely on the information provided other than as a learning tool.

References

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Brief Vignette Example 1: Comorbid Depression and PTSD

Cynthia, a 42-year-old woman, was referred for the treatment of depression. She was also the victim of violent sexual assaults that occurred during her adult years. Based on the results of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-IV), Cynthia met diagnostic criteria for both major depressive disorder and posttraumatic stress disorder. The Beck Depression Inventory-II (Beck, Steer, & Brown, 1996), Depression Anxiety Stress Scales (Lovibond & Lovibond, 1995) and Penn Inventory for PTSD (Hammarberg, 1992) were chosen for initial assessment and ongoing evaluation because of their excellent psychometric properties and ease of administration.

The treating psychologist was aware of Cochrane reviews and meta-analyses that supported the efficacy of cognitive-behavioral therapy (CBT) for MDD (e.g., Butler et al., 2006; Parikh et al., 2009) and PTSD (e.g., Bisson, 2009; Foa, Keane, Friedman, & Cohen, 2009) individually. The empirical literature did not, however, provide clear guidance on how to order treatment other than to document that patients with these comorbid conditions experience more severe symptomatology and greater complications than do patients with either disorder alone. Some research data did suggest that the treatment of anxiety disorders is fairly resilient to the impact

of depression, which would suggest targeting the anxiety symptoms initially. On the other hand, in this client's case, the self-report questionnaires indicated that her depression was quite severe and may have influenced the patient's motivation to carry out the exposure tasks involved in trauma-focused CBT. This information, coupled with the fact that depression was the patient's primary concern, led to the decision to target depression first. A solid case formulation was also important in determining which disorder to target first. Finally, a PsychInfo search also revealed some supportive evidence (albeit from an uncontrolled study; thus, lower in the hierarchy) that this particular comorbidity could be treated successfully by beginning with behavioral activation in early sessions and moving to exposure and cognitive restructuring in later sessions (Nixon & Nearmy, 2011).

It was hoped that starting with behavioral activation (monitoring activity and introducing mastery and pleasure-oriented experiences), with the aim of reversing the downward spiral of avoidance and negative mood, would help to increase Cynthia's energy and motivation. Therapy could then focus on monitoring, testing and modifying negative automatic thoughts and beliefs (which might also have a spill-over effect in preparing the patient for reprocessing the meaning of the past traumatic events during exposure tasks). The psychologist also decided to carefully monitor both conditions throughout the course of therapy to gauge progress and reconsider the treatment plan, if necessary. Ongoing evaluation was especially important given the lack of research that addressed the specific question of how to approach treatment for these comorbid conditions.

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Brief Vignette Example 2: Oppositional Behavior

I am about to begin treatment of an 8-year-old boy with moderate oppositional behavior. The boy's mother is a single-parent and she has indicated a willingness to be involved in treatment and an interest in learning to better handle her son's behavior. I have some expertise in the area of behavioral parenting interventions, and I know that there is evidence supporting such interventions for this type of child problem. However, the mother reports a number of depressive symptoms. I'm wondering whether the mother's depression means that I should proceed differently in treatment?

1. My professional knowledge of the nature of depression tells me this is likely to hinder treatment, but I have a quick look for recent reviews or meta-analyses to verify my sense that maternal depression predicts worse treatment progress and outcome in behavioral parenting interventions. Luckily, I have online access to the local university library and using Psycinfo helps to quickly identify the type of review I need.
2. Given this knowledge, I now need to decide how to modify my treatment based on this information. I can use the hierarchy to guide me as I look at existing databases and reviews to identify parenting interventions that specifically target maternal depression. Again Psycinfo is useful in finding such interventions, as are various websites listed by groups such as American Psychological Association's (APA) Society for Child and Adolescent Clinical Psychology. Once I find a couple of parenting programs designed and tested specifically with parents who are depressed, I need to combine this evidence/information with my clinical judgment (e.g., are the families in the reported trials similar to my client?). Throughout this process, I must also consider the needs and wishes of this particular family (e.g., can the mother afford the time or cost of a longer program?). Depending on how things go at each step, I may, at various points, need to "circle back" and try again. In sum, I can use the hierarchy to guide me in reaching an informed decision on how to proceed with the most evidence-based treatment for this family.

Obviously, there could well be other family characteristics that should also be considered in this way – cultural background, co-parenting, family support.

Brief Vignette Example 3: Mindfulness Based Cognitive Therapy (MBCT)

It is the third session for a group learning MBCT for relapse prevention in depression. Ms. M. is a 52-year-old woman with at least six past episodes of depression who was initially excited about trying MBCT. The wellness orientation, and the fact that she could take some action over and above her longstanding antidepressant regimen was very appealing to her, as was the

evidence base that MBCT works to prevent relapse. Ms. M, who is a semi-retired bookkeeper, had attended diligently and followed up on all the homework, she had done everything asked of her but hadn't yet had the results she'd wanted or expected. She tells the psychologist near the end of the session that she's really not sure what meditation is all about, and what difference it will make. She asks the psychologist, "If this works, how does it work...does it really change anything in the brain? How would you know that and can you show me some of this information to encourage me to continue?"

1. This is an important question, one for which the psychologist knows the basic literature is large and detailed, to the point of being overwhelming. A large number of factors could come into play in specific studies; the type of meditation, design of the study (cross sectional, or time series), technique of studying the brain (imaging, functional, genetic expression). Moreover, the psychologist is not an expert in neuroscience, and has to consider that the client may also struggle to understand the complexity of the basic science findings.
2. The psychologist determines that a finite amount of time can be put into this question, an exhaustive review would not be necessary, and that some summary of what he finds could be shared with the patient, and the group, at a subsequent session.
3. The ideal source for this purpose is likely to be a recent systematic review, recent is important because the psychologist is aware that the pace of research in this field is very fast, and a systematic review could summarize findings that are replicated, and sort through important methods details efficiently.
4. Because of the need for a recent high level summary, the psychologist begins with UpToDate¹ as the database of first choice and quickly finds the most recent summary of MBCT for relapse prevention.
5. Within the rationale of the UpToDate summary, he notes several citations for recent neuroimaging including a recent systematic review of neurobiological correlates.
6. Using this work, the psychologist prepares a handout, including a graphic of the brain and "points out" areas of increased functioning and structural changes that occur as people learn to meditate and presents this to the group at the next session.

¹ UpToDate is a peer reviewed, evidence-based, information resource, available on the Internet and mobile devices.

Brief Vignette Example 4: Alcohol Dependence

Thomas, age 38, was referred by his family physician for therapy for alcohol dependence. The physician had queried Thomas about alcohol use during his annual physical. The physician had access to screening guidelines developed by the National Institute of Alcohol Abuse and

Alcoholism (NIAAA, 2007). Although very reluctant to go to a residential or group treatment, Thomas did consent to see a psychologist who specialized in addictions for assessment.

As recommended in the NICE guidelines (National Institute for Clinical Health and Clinical Excellence, 2011), the psychologist used a non-confrontational motivational interviewing approach to help Thomas identify his concerns about drinking, to resolve his ambivalence, and to explore his treatment goal. The psychologist conducted a full assessment including specific information about drinking amounts and patterns (almost daily, 7 to 10 drinks per day), level of dependence using the Alcohol Dependence Scale (ADS, Skinner & Horn, 1984, moderate high score) and the Alcohol Use Identification Test (AUDIT, Saunders et al., 1993; moderate high score), related problems including family, social, work and emotional functioning (marital issues, impatience with children, sleep and concentration problems, late and absent from work), other drug use (none except occasional cigar smoking), motivation (moderate) and self-efficacy in dealing with the problem (low). Thomas was feeling depressed but it is unclear whether he met diagnostic criteria for Major Depressive Disorder because of the concurrent drinking.

Consistent with the motivational interviewing approach, the psychologist offered Thomas feedback on his scores on the ADS and AUDIT and normative feedback on his drinking compared with other Canadians in his age range. The psychologist also offered a choice of interventions available locally that are recommended for moderate alcohol problems (NICE, 2011). These interventions included cognitive behavioural outpatient therapy, behavioural couple's therapy and intensive day treatment. The psychologist and Thomas also consulted with the physician about the need for residential detoxification (not required as he has significantly reduced his alcohol in anticipation of the assessment, no risk factors for withdrawal seizures, NICE, 2010) and the value of naltrexone medication to help minimize cravings (accepted). Thomas elected to start with outpatient cognitive-behavioral treatment with the agreement that he would attend a more intensive program if he was unsuccessful. He declined to attend SMART recovery or Alcoholics Anonymous mutual support groups, despite the suggestion from the psychologist that these can be helpful adjuncts.

The psychologist used a number of treatment manuals of evidence-based cognitive-behavioural interventions (Miller, 2004; Monti et al., 1989) to guide his sessions. He monitored Thomas' self-reported drinking on session by session bases as well as his feelings of depression. Thomas's progress was variable with some short periods of drinking but after about two months his abstinence from alcohol appeared to stabilize. As Thomas's self-efficacy improved with success, his feelings of optimism also improved.

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Brief Vignette Example 5: School Psychology

The client was a 17-year-old high school student in the first semester of Grade 11. She was referred to the school psychologist for school refusal. She was a strong student academically. In her Grade 10 year she attended until March, and then refused to attend due to fear of panic attacks. The student has had numerous panic attacks, mostly at school. She was assessed last year by a physician who prescribed both an SSRI and an anxiolytic, but the student refused to take either medication due to concerns regarding possible side effects. The school guidance counselor referred her to the local child and adolescent mental health center, but the student was reluctant to go there. The student agreed to meet with the school psychologist, as she did not want to attend sessions outside of school. There was a family history of anxiety that has not been addressed clinically. Although the father had resolved his anxiety issues independently, her mother had not addressed her problems. The student was born in Canada but her parents immigrated to Canada from Eastern Europe shortly before she was born. At the interview with the parents and the student, both parents expressed that they were 'disappointed' with their lives in Canada.

In preparing for the first session with the student, the school psychologist reviewed the diagnostic criteria for anxiety. The psychologist also reviewed the criteria for depression hypothesizing that this could be an alternative or comorbid diagnosis. In addition, the school psychologist was aware of the significance of the parents' disappointment with their current situation in Canada.

The Psychology Department at the psychologist's school board had started an initiative whereby the staff had specific training for CBT in the school environment. She was aware, through the psychology department's research, that there is substantial evidence supporting Cognitive Behaviour Therapy (CBT) as an effective intervention for childhood and adolescent anxiety disorders. As well, the Psychology Department was aware that the use of CBT in a school-based setting had a strong evidence-base. In addition, the entire student support services department recently had an in-service on school refusal treatment from one of the foremost researchers in the field. The school psychologist checked her handouts and notes from this session, and reviewed the information on CBT treatments for school refusal.

In addition, the school psychologist reviewed the research base on effects of parental mental health issues on their adolescent's mental health treatment. The school psychologist consulted both EBSCO and PsycInfo searches, as well as the National Association of School Psychologists' and the American Psychological Association's websites. The school psychologist looked for recent reviews on treatment issues with immigrants and children of immigrants. She found a great deal of information on mental health issues for recent immigrants; however, this family has been in Canada for almost 20 years. She narrowed her focus to researching effects of cultural diversity and potential effects on mental health, which gave her some ideas on how to address the parents' feelings about their move to Canada and how this affected their daughter. The school psychologist also consulted with the Board's Diversity Officer who was able to lead her to some unpublished educational research on school refusal and immigration issues.

In the Psychology Department's training sessions on CBT, specifically the Coping Cat manual, the school psychologist recalled the discussion on flexibility within fidelity of evidence-based practices. She was aware that when utilizing treatment manuals, her clinical skills, the student's needs and concerns as well as the therapeutic alliance were necessary for the implementation of manualized treatments. She read two journal articles on this topic and used them, along with the other work mentioned above, to plan her treatment approach.

The CBT approach was started with the student, based on Kendall's Coping Cat adaptation for youth (Kendall & Hedtke, 2006). Before treatment began, the student filled out several anxiety inventories, including the second edition of the Multidimensional Anxiety Scale for Children (MASC-2; March, 2012). The Children's Depression Inventory 2 (CDI 2; Kovacs, 2012) was also administered as the school psychologist was concerned about the student possibly having comorbid depression. The school psychologist also administered a diagnostic checklist as part of her clinical assessment of the student. The first treatment session was used to let the student know what was involved in the process, and how progress was going to be measured, specifically through her progress on a fear hierarchy and attendance at school. The student progressed very well as the school psychologist worked through the sessions in the Coping Cat manual. Exposure tasks were accomplished well. However, midway through the sessions, the student had a panic attack and left school. At the next session, the student felt that she had failed her treatment, but the school psychologist reframed the student's leaving school as working towards her goals, and reinforced how well she did as she returned to school the next day. The school psychologist concentrated on self-talk and exposure techniques (in vivo and

interoceptive) as a way of addressing the student's panic attacks and the student was able to work through two panic attacks at school in the next two weeks. The student's school attendance increased gradually throughout the sessions. The parent sessions went well, as the school psychologist educated them on how to support their daughter's progress and respond to their daughter when she was unwilling to go to school or experienced panic attacks. The mother also accepted a referral to a local clinic for her own anxiety.

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Brief Vignette Example 6: Rural Practice

The sole clinical psychologist in a large rural area was asked to provide consultation to the local community mental health worker (CMHW) regarding a 40 year old woman diagnosed with Major Depression. During the course of the consultation the psychologist learned that the client was first diagnosed with Major Depression approximately 3 years prior, following a negative workplace event. Since this event, the client has reported heightened anxiety (although no diagnosed anxiety disorder) and symptoms consistent with Major Depressive Disorder. Pharmacological interventions and cognitive behavioral therapy (CBT) resulted in only minimal gains. As a result, she was on disability for the past 3 years, during which time there have been multiple failed return-to-work plans. The mental health worker was seeking guidance regarding other psychological treatments but acknowledged her limited ability to provide anything other than CBT. In response to this situation the psychologist took the following steps.

1. Given the long-standing nature of the client's symptoms and limited response to CBT and pharmacotherapy, the psychologist offered to meet with the client for an initial clinical interview. Considering the client's well documented history of major depression (and anxiety) the psychologist focused more so on gaining an update on her symptoms and reviewing her prior treatment experiences. The clinical interview supported her current diagnosis. The client reported actively participating in several courses of individual and group CBT and adherence to pharmacological intervention, which was confirmed by a file review and collateral information from her CMHW. Her comments suggested she was well versed in cognitive behavioral strategies for managing anxiety and depression. However, she also reported being quite discouraged by the limited benefit she had derived from these strategies. During this initial meeting, the psychologist utilized some basic solution focused strategies (including scaling question), as she had found these helpful in her work with other depressed/anxious clients. The

client appeared responsive to this approach and agreed to meet with the psychologist and CMHW for a follow-up appointment.

2. In preparation for the next meeting the psychologist accessed the National Institute for Health and Clinical Excellence (NICE) website and reviewed the current research for solution focused brief therapy (SFBT). This information indicated some preliminary support for SFBT in the treatment of depression. Although the psychologist recognized there was more empirical support for the use of interpersonal psychotherapy (IPT) or brief psychodynamic therapy in the treatment of depression, she did not feel adequately trained to deliver these treatments.
3. During the subsequent meeting with the client and CMHW, the psychologist provided a brief overview of research findings related to psychological interventions of depression. She went over her limits of competence in this regard and explored the various treatment options, including possible risks and benefits. Given the client's geographic location her options were limited to: traveling one hour each way to an urban centre to access IPT or psychodynamic therapy, continuing her CBT with the CMHW on a once/month basis, or beginning a course of SFBT with the psychologist. The client decided to begin a course of SFBT and continue with her pharmacological treatment.
4. The psychologist began weekly SFBT sessions with the client and monitored her progress using scaling questions. The client showed improvement within 8 sessions. Although some setbacks were encountered, she continued to show improvement and was able to complete a successful back-to-work plan within a year of beginning treatment.

Brief Vignette Example 7: Depression

Based on initial referral information, the client is a woman in her 20s who has a history of depression and, apparently, has had little success with previous treatments. Based on this information, in preparation for the initial session, the psychologist did the following:

1. Reviewed DSM diagnostic criteria for all mood disorders and examined the section of the SCID-IV dealing with mood disorders. Although the psychologist frequently provides treatment for mood disorders, this review was done to minimize the likelihood of focusing too much on a specific diagnosis in the upcoming interview; it also served to lessen the impact on the psychologist's thinking of the diagnostic details associated with the three depressed clients to whom s/he is currently providing services. Also, given the history of chronic symptoms and unsuccessful treatment, the psychologist wanted to ensure that s/he explored the possibility of a bipolar disorder that may not have been identified previously.
2. Given the high level of comorbidity between mood and anxiety disorders, the psychologist also read over the anxiety disorders section of the SCID-IV in preparation for asking about possible anxiety symptoms during the interview. In light of the

comorbidity research and the client's age and gender, the psychologist also scanned the questions on eating disorders and substance abuse.

3. The psychologist selected several self-report measures that might be given to the client to complete at home before the second session. These included measures of depressive symptoms, anxiety symptoms, and a hopelessness scale (to address issues related to suicidality). If indicated by the assessment and eventual case formulation, these measures could be used subsequently over the course of services to monitor the impact of treatment.
4. Reviewed NICE guidelines for the assessment and treatment of depression. As it seemed very likely that the client may have symptoms of at least moderate severity, the psychologist decided to explore the client's openness to pursuing both psychological and psychopharmacological treatments.
5. In light of the client's history and what is known about the social context of depression, the psychologist decided to ask about the client's family and friends to determine the extent and helpfulness of her social network.

Brief Vignette Example 8: CBT for Psychosis

You are a psychologist working in a correctional institution. A 22-year-old woman has been admitted to the institution for a number of assault-related convictions. She presents as younger than her stated age with apparent intellectual deficits and cognitive challenges. She reports auditory hallucinations, in particular a female voice who commands that she hurt herself and others. Otherwise, there is no evidence of psychosis or other Axis I disorders. Her injurious behaviour toward self and others in response to "the voice" consumes a lot of resources – staff time and energy – and generates considerable anxiety among staff. In developing a cognitive-behavioural case formulation, with which you will guide and direct mental health services for the young woman, the question arises: *What do we know about the effectiveness of a cognitive-behavioural approach to the treatment of symptoms, such as command hallucinations, whether arising from psychosis or other sources?*

How to Proceed

A search of the relevant literature was conducted including PSYCINFO, MEDLINE, and the Cochrane Library. Search terms included "command hallucinations", "schizophrenia symptoms", "CBT for schizophrenia". The search generated a number of relevant articles (e.g., Birchwood et al., 2011; Chadwick Lees, & Birchwood, 2000; Crawford-Walker, King, & Chan, 2010; Lakeman, 2001; Sayer, Ritter, & Gournay, 2000).

Findings

A review of these and other articles indicated empirical support for cognitive-behavioural therapy (CBT) in the treatment of auditory hallucinations (voices), whatever the source. In particular, a review of the literature indicated promising effects for targeting individuals' beliefs

about their voices as a means of enhancing a sense of self-efficacy and reducing harmful compliance behaviour and distress. The review also indicated a lack of evidence for the use of distraction techniques in the treatment of psychotic symptoms.

Next Steps

1. Select a CBT approach such as Birchwood's Cognitive Therapy for Command Hallucinations (CTCH; see Birchwood et al., 2011).
2. Evaluate treatment efficacy with pre- and post-assessment of primary outcomes (i.e., compliance with "voice" behaviours) and secondary outcomes, including beliefs about voice's power, level of distress, changes in voice frequency and topography (e.g., loudness). The BAVQ-R could be useful here.

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Brief Vignette Example 9: Overcoming Difficulties in Treatment and the Importance of Ongoing Treatment Monitoring

The client is a woman in her mid-50's employed as a primary school teacher. Her history revealed childhood sexual abuse, dysthymia, and recurrent depression with suicidal ideation. Prior to the current referral she was participating in an outpatient program that employed dialectical behavior therapy (DBT). The referring centre stated that the patient had been progressing well in the program until the group in which she was involved began the emotional regulation module of DBT. At that point she became overwhelmed and experienced an increase in symptoms.

The current course of treatment began with a comprehensive multidisciplinary assessment. The following diagnosis was agreed upon by the assessment team:

Axis I: Major Depressive Disorder (recurrent, moderate)
Dysthymic Disorder
Adult Survivor of Childhood Sexual Abuse

Axis II: Personality Disorder NOS (Mixed personality disorder with Schizoid, Histrionic, and Avoidant traits)

Axis III: Hypothyroidism (managed with medication)
Hypertension (managed with medication)

Axis IV: Psychosocial stress associated with interpersonal conflict.

Axis V: GAF = 55

Based on results of testing and interviews, the assessment team concluded that the patient reacted to the affect regulation module of DBT because well-established defenses that had formed in response to the sexual and emotional abuse experienced in childhood had been challenged and breached.

Her depressive symptoms and agitation were of sufficient severity as to warrant immediate attention. In light of her reaction to the affect regulation module of DBT the treatment team wondered what the most optimal approach would be. It was suggested that a supportive approach combined with antidepressant medication would likely be the best starting point. A literature search was conducted using the APA Psych-Info data base and the search terms “efficacy” + “supportive therapy”. The search yielded several meta-analytic and randomized controlled studies (see below). The review affirmed the efficacy of combining pharmacotherapy with non-directive supportive psychotherapy, short-term dynamic psychotherapy (STDP) or cognitive behavioral therapy (CBT).

The treatment program employs several doctoral-level psychologists experienced in the application of CBT and STDP. Residential treatment extended for 14 weeks. The patient underwent a course of individual STDP for the entire duration of her residential stay. The staff psychiatrist prescribed Lyrica and Seroquel. She participated in a processes-oriented interpersonal psychotherapy group which met three times per week for 90 minute sessions. Mid-way through treatment she participated in group CBT in order to address an array of cognitive distortions related to self-image. Treatment progress was monitored every three weeks using the Brief Symptom Inventory (BSI), the Inventory of Interpersonal Problems (IIP), and the Working Alliance Inventory. At the end of treatment there was a marked reduction in symptoms (BSI: Obsessive Compulsive, Interpersonal Sensitivity, Depression, Anxiety), and improvement in interpersonal functioning (IIP; increased assertiveness, decreased dependence, and decreased hostility). With respect to the Working Alliance Inventory, there was gradual and steady improvement in Bond, Goal and Task scores over the course of treatment.

References

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Brief Vignette Example 10: Community Corrections

Clinical Scenario

You are a psychologist working on contract with community corrections. A 34-year-old man has been just been released from an institution for a number of domestic assault-related convictions as well as driving while impaired. He has a long history of offending including previous domestic offences, property, driving related and administration of justice offences. He did not attend treatment while incarcerated. The probation officer is asking you to provide input on the supervision and treatment plan including potential treatment services to this client. Included in the referral is a risk/need assessment which indicates that the client is high risk to re-offend and has been identified as having the following issues: antisocial personality pattern and impulsivity, pro-criminal attitudes, substance abuse, employment difficulties, and marital problems. He is regarded as unmotivated and resistant to attend domestic violence treatment and projects responsibility for his actions on his current partner and past drinking.

How to Proceed

In the correction field, the presenting problem must be viewed in context of this unique population. Evidence-based treatments for certain problems may have different outcomes for offenders (Andrews & Bonta, 2010). Therefore, it is critical the psychologist conducts the literature search with that in mind. A search of the relevant literature was conducted with the search terms “effective offender treatment” and “meta-analysis of effective correctional treatment”. The search generated a number of relevant articles which provided the background for further research and quantitative reviews on effective offender treatment (e.g., Andrews &

Bonta, 2010; Dowden & Andrews, 2000; Smith, Gendreau, & Swartz, 2009). From these articles, empirically supported effective community correctional intervention practices were consulted including Effective Practices in Correctional Services (EPICS), Staff Training Aimed at Reduced Reoffending (STARR) and Strategic Training Initiative in Community Supervision (STICS).

Findings

A review of these and other articles indicated empirical support for cognitive-behavioural therapy (CBT) and Motivational Interviewing for clients who are resistant to attend treatment for criminal behaviours. In particular, a review of the literature indicated promising effects of cognitive-behavioural treatment with specific focus on attitudes, values and beliefs and other criminogenic needs that support a variety of criminal behaviours. In addition, the articles provided guidance on specific 'responsivity' factors to consider when providing services to unmotivated and resistant criminal justice clients.

Next Steps

1. Begin with Motivational Interviewing techniques to enhance client engagement and motivation for change targeting both substance abuse and aggression. Collaboratively engage with client to identify "change goals" related to offending and use CBT to target specific cognitions associated with substance use and aggression and provide opportunities to learn alternative strategies.
2. Evaluate treatment efficacy with pre- and post-assessment of stages of change measures (e.g., University of Rhode Island Change Assessment), criminal attitudes (e.g., Criminal Sentiments Scale), hostility, and dynamic risk measures (e.g., Level of Service/Case Management Inventory).

References

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Brief Vignette Example 11: Anxiety and Depression Following a Workplace Accident

A 36-year-old construction worker was referred by an insurance agency for treatment of anxiety and depression secondary to a workplace accident. An initial open-ended interview revealed that the client had fallen 60-feet from a worksite escaping death only because his safety harness caught at the last moment. His primary complaints were panic attacks when he attempted to return to the worksite, nightmares and intrusive images of the fall and depressed mood. He also reported financial concerns and marital discord related to being off work. After

discussing the situation, the client and psychologist decided that that client's accident-related anxiety, cognitions, and avoidance were the most pressing issues and were fueling his depression, financial, and marital problems.

1. Prior to the first session, the psychologist had briefly reviewed Canadian references on forensic aspects of psychological injuries (e.g., Koch, Douglas, Nicholls, & O'Neill, 2005). to refresh the psychologist's knowledge of potential litigation and compensation issues that can arise in cases involving workplace injuries so that the client's best interests could be served.
2. The psychologist's initial impression was of an anxiety disorder, possibly posttraumatic stress disorder (PTSD) complicated by depression-related demoralization and anhedonia, and financial and relationship stress. The psychologist was aware that forensic/compensation decisions often hinge on formal clinical diagnoses. Therefore, the psychologist consulted online databases (Psychinfo, Pubmed, Uptodate) for reviews of assessment procedures. Although the literature pointed to the Clinician Administered PTSD Scale (CAPS) interview as the gold standard for PTSD diagnosis, the psychologist had to weigh the time demands of the CAPS, its narrow focus, and the need for immediate intervention. The psychologist discussed the demands and potential importance of formal assessment with the client, and they decided to proceed with the CAPS. Keeping in mind the danger of confirmatory bias, the psychologist also administered sections from the Structure Clinical Interview for Diagnosis (SCID-IV) to assess a broader range of anxiety and mood disorders.
3. The psychologist used the same websites to select several self-report measures of anxiety, depression, and pain for the client to complete. The psychologist decided to monitor the client's marital situation to determine if referral for specialized treatment was needed.
4. To arrive at a treatment plan, the psychologist consulted the American Psychological Association Division 12 website on evidence-based treatments for PTSD and depression (<http://www.div12.org/PsychologicalTreatments/treatments.html>). The psychologist also did a quick web search via PsychInfo and Uptodate for recent treatment reviews and recommendations. The psychologist discussed the psychological and pharmacological options with the client, and they decided to begin with an evidence-based, trauma-focused psychological treatment. The psychologist supplemented that treatment with techniques shown to be effective with depression.

References

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Brief Vignette Example 12: Ambivalence for Change in Bulimia Nervosa

Ms. S is a 25-year-old woman who seeks outpatient treatment from a psychologist for bulimia nervosa, purging subtype. Online published guidelines (e.g., APA and NICE clinical guidelines for eating disorders) and meta-analyses of treatment studies published in peer-reviewed scholarly journals recommend cognitive behavioural therapy (CBT) as the most well-researched, evidence-based treatment for bulimia nervosa. Following an online search, the psychologist finds a highly-cited CBT treatment manual for eating disorders. After four sessions, Ms. S has learned about normal eating, thought monitoring, and challenging distortions. She has started eating somewhat more normally and is able to challenge many of her unhelpful thoughts about eating, weight, and shape. The therapist then introduces the concept of behavioural exposures (e.g., eating high calorie foods) as a way to test hypotheses and for habituation. In the fifth session, Ms. S tells her psychologist that she has gained three pounds since starting therapy and is terrified of gaining any more weight. She says she is fine with challenging her thoughts and eating more regularly, but she absolutely refuses to start eating "risky foods" (i.e., high calorie foods). Despite the psychologist's attempt to engage in the client in cognitive restructuring around the over-importance of weight and shape, the client refuses to participate in key behavioural CBT techniques, so the therapist explores other options.

1. The psychologist reviews scholarly literature (e.g., book chapters, peer-reviewed journal articles) on the nature of ambivalence in eating disorders. Research reveals that it is extremely common to encounter strong resistance to change among clients with an eating disorder. The psychologist realizes that this client lacks the readiness to change that would be necessary to successfully implement CBT.
2. The psychologist finds a few published randomized controlled trials involving eating disorders and several trials involving other mental disorders (e.g., anxiety disorders, substance use) showing motivational interviewing to be an effective intervention for engaging treatment-resistant clients and for facilitating change. The psychologist's approach to psychotherapy is then guided by the principles of motivational interviewing, including maintaining a strong therapeutic rapport, conveying a non-judgmental stance, developing empathy, and rolling with resistance.
3. As the client works through her ambivalence about recovery, her willingness to participate in behavioural exercises improves. The psychologist is then able to return to CBT techniques that the client is willing to do (i.e., slightly less anxiety-provoking behavioural exposures), as a way to work up to more challenging ones.
4. The therapist moves between adherence to the action-oriented CBT protocol for eating disorders and client-centred work around enhancing motivation when resistance arises. To maximize the effectiveness of this approach, the psychologist seeks regular support and peer consultation from a colleague who works in an established hospital treatment program for eating disorders.

5. The psychologist reviews published, peer-reviewed natural and treatment outcome studies, which reveal that there are no known predictors of spontaneous recovery of bulimia nervosa and that treatment is often lengthy. Psychotherapy with Ms. S continues for over a year and the psychologist tracks progress over time, noting periods of waxing and waning motivation and several episodes of partial relapse. The psychologist's knowledge of theory and research on ambivalence and its role in eating disorders helps to reduce frustration for both the client and the psychologist, and keeps the client engaged in the process of treatment.

Extended Vignette Examples

The purpose of the extended vignette examples is to illustrate the process of being evidence-based in one's assessment, conceptualization, therapeutic planning and treatment implementation. As noted earlier in this document, clinicians are expected to practice in an evidence-based manner and have an ethical and professional responsibility to provide the best treatment for a particular client based on the research evidence available. As such, clinicians should utilize the hierarchy of research evidence to determine which approach to treatment is optimal (and to revisit this hierarchy when necessary). The vignettes that follow assume that this decision-making process has already taken place.

A variety of therapeutic approaches are efficacious for unipolar depression and dysthymia (Australian Psychological Society, 2010; Beck & Dozois, 2011; Goldman, Greenberg, & Angus, 2006; Hollon, Thase, & Markowitz, 2002; Leichsenring & Leibing, 2007). Utilizing the same basic case example, three vignettes focus on evidence-based assessment, case formulation, treatment planning and implementation from cognitive therapy, emotion-focused therapy and brief psychodynamic psychotherapy approaches. A separate case is used to illustrate evidence-based reasoning from an interpersonal psychotherapy perspective. Research findings published in the peer-reviewed scientific literature including treatment outcome research, therapy process research and basic research that can be applied to clinical practice are highlighted to demonstrate the process of evidence-based practice and the thoughtful evaluation of the peer-reviewed scientific literature. The inclusion of different treatment protocols in response to the same basic clinical presentation is meant to underscore the reality that in many instances, the literature supports the efficacy of several treatment approaches. In such cases what is important is that clinicians' decisions are guided by the best available evidence combined with their existing skill base.

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Cognitive Therapy Evidence-Based Case Example: Dysthymia

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I. INTRODUCTION

The practice setting for this case illustration is a sole private practice in which there is limited third-party payment for psychological services. The clinical decisions around assessment, case formulation and treatment are informed by these contextual limitations. Thus assessment was limited to three one-hour sessions and had to be highly selective, focusing on symptom presentation directly relevant for treatment decisions. A fifteen session course of individual weekly cognitive therapy (CT) was offered in a collaborative but highly focused, goal-directed manner.

II. CASE DESCRIPTION

Mary was a 25-year-old third year university undergraduate majoring in computer science. She was the oldest child of a working class family and the first to attend university. Her father was a welder and her mother worked in a fish processing plant. She had a younger brother still living at home who had irregular seasonal employment and an undiagnosed substance abuse problem. Her youngest sister was still in high school but struggled because of a learning disability. Mary's father had a long history of alcohol abuse and her mother had been on SSRIs for years due to recurring bouts of major depression. Recently her parents had separated, which was a devastating experience for Mary. Her family had always struggled financially because of her father's occasional periods of unemployment.

Mary described her childhood as a lonely and isolated experience. She had few friends and was repeatedly teased and bullied throughout because of her obesity. In middle school she developed one close friend but this friend moved away when she entered Grade 10. She was often in trouble at school because of poor attendance. Throughout her adolescence, Mary dieted without much success because of junk food binge eating. She spent most of her high school alone, playing videogames, reading and working on Facebook. She was the first in her family to enter university but she has wandered from one major to the next, with no real goals in mind. She has had to take time off university because of several depressive episodes and so her grades have suffered. She continues to have few friends and shares an apartment with three other students she barely knows. She has dated only once and admitted to some confusion about her sexual orientation. She spends most of her day alone, either trying to catch up on assignments or watching TV.

Mary expressed the conviction that she has no reason for living and that her future looks empty, lonely and useless. She rarely feels happy and thinks she has been depressed most of her life. She struggles to get out of bed in the morning, often missing her morning classes. She stays up until 2:00 or 3:00 am, eating, watching TV or surfing the Internet because she can't get to sleep. She expressed little interest in her daily activities and felt tired most of the day. She rarely eats a regular meal but tends to "graze" on highly processed foods. Lately she has gained more weight. She avoids looking at herself in the mirror because of self-loathing and she expressed a strong wish to die. In fact Mary has made a couple of suicide attempts, involving an

overdose of medication and one attempt at cutting her wrists. Each time she has called her mother asking for a reason to live and expressing her intent to kill herself. This has allowed her family to intervene and get her to the local hospital ER.

Mary has received mental health treatment almost continuously over the past 10 years. She has been tried on numerous antidepressants with little effectiveness. She has had intermittent psychiatric care and a two week period of short-term inpatient treatment. She has seen numerous mental health counselors and 1-2 psychologists with minimal effect. At the time of referral, Mary had weaned herself off all medication but was drinking on weekends and using cannabis daily. She agreed to another round of psychological treatment sessions but expressed doubt that it would be effective. She felt destined to live a life of misery. Mary felt the only solution was to end life itself, and for once attain peace of mind.

III. DIAGNOSIS AND CASE CONCEPTUALIZATION

Clinical Assessment: After taking a life history and record of past treatment, Mary was administered selected modules from the Structured Clinical Interview for DSM-IV (SCID-IV) based on her primary symptom presentation that included extreme negative self-evaluation, hopelessness, suicidality, social isolation, sleep disturbance, inactivity and lack of interest. This included the SCID-IV life event and screening questions, major depression, and dysthymia modules as well as several self-report symptom measures such as the Beck Depression Inventory (BDI-II), Beck Anxiety Inventory (BAI), Hopelessness Scale (HS) and 21-item Depression Anxiety Stress Scale (DASS). In addition a conjoint session was held with Mary and her parents to obtain corroborating information about her childhood adjustment, history of suicidality, and past treatment regimen.

Clinical Decision: *The decision was made to focus primarily on assessment of depressive symptomatology given the case history, with a secondary evaluation of anxiety based on the high comorbidity between anxiety and depression (**basic research evidence:** Brown, Campbell, Lehman, Grisham & Mancill, 2001). The SCID-IV screening questions assessed other symptoms, and this was supplemented by further questioning to assess for pathological worry, substance use behavior and thought disorder. The validity and reliability of the BDI-II, HS, and DASS-21 for the assessment of depression are well-established (**high validity primary research or review:** Antony, Bieling, Cox, Enns & Swinson, 1998; Beck, Brown, Berchick, Stewart & Steer, 1990; Dozois & Dobson, 2010). In addition the SCID-IV has moderate inter-rater reliability for the assessment of depression (**high validity primary research:** Lobbestael, Leurgans & Arntz, 2011). Given the client's history of suicide attempts, the Scale of Suicide Ideation was considered but not administered because currently she only had thoughts of death that have been present for several years, the last suicide attempt was months ago, and she expressed a low level of suicide intention or wish to die (**prior clinical experience evidence**).*

Mary had a BDI-II Total Score of 21, BAI Total Score of 6, HS Total Score of 18, and DASS scores of 24, 4 and 10, respectively, on the Depression, Anxiety and Stress subscales. The BDI-II and DASS-Depression scores fell within the moderate to severe depressive symptom range (**high validity primary research-** Beck, Steer, & Brown, 1996; Lovibond & Lovibond, 2004) and the HS

Total Score indicates a heightened degree of negative expectancy about the future consistent with elevated depression and suicide potential (**high validity primary research:** Beck & Steer, 1988; Beck, Brown, Steer, Dahlsgaard, & Grisham, 1999). Scores on the BAI and DASS Anxiety and Stress subscales were in the nonclinical range, indicating a relative absence of anxious symptoms. The SCID-IV Screen revealed presence of possible generalized anxiety, panic attacks, substance abuse (cannabis), and binge eating. However, further questioning revealed that the panic attack episodes were associated with episodes of great emotional upheaval culminating in a suicide gesture. Mary indicated that these bouts of intense emotion did not really frighten her and she had not changed her behavior in order to avoid them. Furthermore she had not had one of these episodes for several months and so it was decided not to include these as a primary treatment target (**professional opinion**). As well, further inquiry revealed that the pervasiveness and duration of worry was not sufficient to meet criteria for pathological worry or GAD (**basic research evidence:** see Dugas & Robichaud, 2007). The psychologist decided to treat Mary's depression before working on her cannabis abuse since this might increase the eventual success of a drug rehabilitation treatment program (**systematic review:** Baker, Hides, & Lubman, 2010).

Mary failed to meet diagnostic criteria for a current major depressive episode on the SCID-IV. She denied depressed mood or loss of interest that lasted at least two weeks "most of the day nearly every day". The longest she reported feeling consistently depressed was 5-7 days, followed by 1-2 good days. It is likely that she had 1-2 past major depressive episodes during her transition to high school and then again after her parent's separation. However she did meet criteria for every diagnostic symptom of dysthymia (i.e., *DSM-V Chronic Depressive Disorder*). She reported feeling sad or depressed more days than not since middle childhood. Certainly there had been times when her depression intensified and she became highly suicidal, but she was never completely asymptomatic even at the best of times.

Diagnostic Formulation: Based on the assessment findings, the following diagnosis was formulated. Axis I Primary- dysthymia; Axis I Secondary - substance abuse (cannabis); Axis II- borderline personality disorder features; Axis III - obesity, hypertension; Axis IV- academic problems, deficit peer network, inadequate finances; Axis V - GAF score = 45 (current)

Case Formulation: Several factors identified during the assessment were considered critical in accounting for the etiology and persistence of Mary's chronic depression (dysthymia). Beck's cognitive model of depression was the theoretical framework that informed the case formulation (**basic research:** Beck, 1987; Clark & Beck, 1999; **clinical review:** Beck & Dozois, 2011). Various elements of the formulation were characterized as distal vs. proximal factors (**basic research:** Ingram & Price, 2010) and categorized as cognitive, behavioral, social or biological variables. The emphasis placed on developing a case formulation that leads to treatment goal-setting and planning is a critical feature of cognitive therapy (**clinical manuals:** Kuyken, Padesky & Dudley, 2009; Persons, 2008).

Various **cognitive proximal factors** were considered responsible for Mary's chronic depression. Mary struggled daily with negative self-evaluative thoughts such as "no one likes me", "what's

the use in trying”, “why bother trying”, “I’m such a loser”, “I can’t stand myself”, “I’m so fat and ugly; everyone looks at me with disgust”. These thoughts were triggered by a variety of daily experiences such as trying to get out of bed in the morning, eating meals by herself, trying to make herself study, watching TV alone on Friday night, etc. In addition, she had negative thoughts about her future (e.g., “My future is lonely and empty”, “I’ll never amount to anything”, “I have nothing to contribute; my life is useless”) and her personal world (e.g., “I’m a burden on my family”, “Everyone in my life is so screwed up”, “I hate computer science”). Thus an important element of Mary’s chronic depression was the presence of the negative cognitive triad described in the cognitive model (**clinical manual:** Beck, Rush, Shaw & Emery, 1979). **Proximal behavioral contributors** to Mary’s depression included a disruptive and chaotic sleep routine, poor class attendance and study habits, limited physical exercise, excessive engagement in distracting activities (i.e., videogames, Facebook), compensatory binge eating, reliance on cannabis, and avoidance of social settings. Her extensive avoidance of social and goal-directed activities resulted in an entrenched loneliness and sense of personal ineffectiveness (**clinical manual:** Dimidjian, Martell, Addis, & Herman-Dunn, 2008). **Proximal social factors** included absence of peer interaction, overreliance on her mother for friendship, moderate fear of negative peer evaluation, social skills deficits, and lack of assertiveness. The **proximal biological factors** were obesity, frequent bouts of shortness of breath, sleep apnea, and constant fatigue and lethargy.

Several **distal factors** were identified that resulted in a heightened vulnerability for depression. Mary had a strong genetic diathesis for depression, with major depression extensively on her mother’s side and substance dependence in her father’s family (**basic research:** Forty, Zammit, & Craddock, 2008). Several childhood and adolescent disruptions occurred including her father’s binge drinking, periods of unemployment, bullying at school, parent’s separation, peer rejection, and loneliness. From this Mary formed **enduring beliefs or schemas** that “She was flawed and had no value as a human being”, “No one could possibly like her”, and “There is no sense trying because she will ultimately fail”. These vulnerability schemas encompassed both interpersonal or dependent and autonomous or self-critical aspects of depression (**basic research:** Beck, 1987; Blatt & Zuroff, 1992).

Treatment Goals: Based on the case formulation, Mary and her therapist collaborated in the development of the following prioritized list of treatment goals. The order and relative importance placed on these goals was largely determined by the client, although there was input from the therapist in directing treatment efforts to goals that would have the most impact on Mary’s depression and had the greatest likelihood of success (**clinical manual;** Leahy, 2010).

- 1) Improve academic performance so she finally graduates
- 2) Reduce daily fatigue and persistent feeling of exhaustion
- 3) Reduce loneliness and boredom; have even a little social life
- 4) Eliminate suicidal thoughts (i.e., wanting to die)
- 5) Lose weight
- 6) Have a more healthy diet

- 7) Be more hopeful, optimistic about the future
- 8) Learn to like myself; have confidence in myself

IV. TREATMENT PLAN

Clinical Decision: *Mary was offered 15 sessions of cognitive therapy for depression. Treatment progress was evaluated at the beginning of every session by reviewing a Therapy Session Report the client completed as part of the homework assignment. The report assessed changes in negative and positive affect, negative cognitions, certain key behavioral indicators of daily functioning, homework compliance, global ratings of treatment progress, and possible agenda items for the next session (primary research [outcome] - sessional measure based on Improving Access to Psychological Therapies [IAPT]; see Richards & Borglin, 2011). In addition, every 5 sessions more extensive questions focused on the continued frequency and intensity of the case formulation variables, progress towards treatment goals, and re-administration of the BDI-II and HS. Cognitive therapy is considered one of the most efficacious treatments for depressive disorders, including dysthymia (systemic knowledge syntheses [meta-analyses]: Butler, Chapman, Forman, & Beck, 2006; Parikh et al., 2009; primary research studies [RCTs]: DeRubeis et al., 2005; Hollon et al., 2005). Fifteen sessions is the approximate length of treatment cited in the RCTs and it also fits with the client's health insurance coverage.*

Treatment Goal #1 (Sessions 4-6). *Mary wanted to work on improving her academic performance because she was beginning the second term of her third year and was already falling behind. Poor class attendance and an inability to study were major contributors to poor academic performance. It was decided to first target Mary's sleep difficulties that were a major cause of missing classes and daily fatigue that made it difficult to study. Clinical Decision: Stimulus control therapy was offered to improve Mary's sleep hygiene (primary research: Morin 2004; Morin & Azrin, 1987; meta-analysis: Morin, Culbert, & Schwartz, 1994). Maladaptive sleep-related behaviors were identified and corrective homework assigned. For example Mary was asked to keep a sleep log, to maintain regular sleep hours, eliminate daytime naps, and restrict bedroom activities to sleep. Mary was inconsistent in making these sleep adjustments. It was discovered that negative expectancies were undermining her efforts. Mary expressed doubts about the intervention, stating "I don't see how this will help my depression" and "I need to take naps because I feel so exhausted". Clinical decision: Cognitive restructuring was introduced to correct Mary's doubts and negative expectancies. Thought records, evidence gathering, cost/benefit analysis, and generate alternative beliefs were utilized within-session, as well as empirical hypothesis-testing homework assignments were given to test Mary's belief that "nothing will help the depression" and "I need to nap because I'm exhausted" (primary research [process]: see Dobson & Dobson, 2009).*

To improve class attendance, a behavioral contingency was developed to ensure Mary woke up by 8:00 am so she could attend all her scheduled classes for that day. Mary would set two alarms and ask her roommates to encourage her to be awake by 8:00. In addition she would shower (an enjoyable activity), eat a light breakfast, and walk to school. If she completed this schedule 3/5 days, Mary would reward herself by going home for the weekend or to the movies with a roommate (2 high pleasure activities; primary research [process]: Dimidjian et al., 2006).

The therapist reviewed Mary's sleep log and daily activity record to evaluate the success of these interventions at modifying sleep behavior and class attendance (**primary research [process]**: Lacks & Morin, 1992). As well, the Therapy Progress Report was reviewed each week. Progress was evident by improved class attendance and a more consistent bedtime routine. Homework compliance was inconsistent and so the therapist focused on beliefs about homework that threatened Mary's treatment progress. In addition, greater emphasis was placed on collaboration when assigning homework to increase compliance. Session 6 concluded with Mary agreeing to seek help with her poor study skills from the university counseling center.

Treatment Goal #4 (Sessions 7-8). At session 7 Mary reported better class attendance, more sustained focus on her academic studies, and continued improvement in sleep. It was decided to shift the therapy focus to another treatment goal. Mary wanted to work on weight reduction but after negotiation with the therapist, she agreed to focus on hopelessness, suicidal thoughts and a general negative expectancy. It was important to re-negotiate the next treatment goal because the therapist had concerns about lingering suicidality, the improbability of weight loss success given Mary's longstanding battle with obesity, and the benefits of introducing a more cognitive focus to the treatment. After agreeing on hopelessness as a treatment target, Mary was asked to report on a recent experience of heightened despair about her future. She easily remembered last Friday night when she was once again alone in her apartment with nothing to do. She had an overwhelming feeling of discouragement that she rated as 85/100 and lasting 2-3 hours. After probing questions, Mary revealed that she was thinking "No one likes me", "I'm alone again", "Everyone has someone but me", "I'm destined to go through life alone and miserable". Mary rated her belief in the statement "I'm destined to live my life alone and to be miserable" as 90/100. ***Clinical Decision:*** Beck's cognitive restructuring was employed to target Mary's hopelessness which was based, in part, on her belief that she will be alone the rest of her life (**clinical manual:** Beck et al., 1979; J.S. Beck, 2011). The therapist and Mary recorded times when she was alone and miserable and then wrote down times when she was not alone; for example occasions when she had one friend in high school, times with her family, and the short time intervals at university when she is with other people. Mary was introduced to the concept of cognitive errors; that her belief she will be alone the rest of her life is an example of the "fortune-telling" error. The therapist and Mary worked on constructing an alternative, more adaptive belief such as "I'm often alone because I tend to avoid my peers and make no effort to be with others". An action plan was developed that involved some basic, practical steps Mary could take to become more connected with her peer group (**self-help manual:** Greenberger & Padesky, 1995). Homework consisted of implementing the plan, recording the outcome and testing her negative thoughts "I'm will always be alone and miserable".

In session 8, the therapist reviewed the previous homework assignment and the "making friends action plan" was re-evaluated and refined. ***Clinical Decision:*** Given Mary's limited social skills and avoidant tendencies, it was considered important not to overemphasize social relations as a source of life satisfaction and hopefulness. Thus session 8 shifted focus to other potential sources of Mary's negative expectancy of future misery – her tendency to focus exclusively on the failures and deficiencies in her life. Learning to practice gratitude and

compassion toward others is often deficient in individuals prone to depression (clinical manual: Gilbert, 2009). This session also focused on attending to the positive aspects of Mary's life; of things that she has accomplished and that suggest her life may not be as miserable as she thinks. The therapist introduced the concepts of compassion and gratitude to counter occasions of feeling self-pity and misery. Mary was asked to recall times in her life when others showed compassion toward her and how it made her feel. The therapist brainstormed with Mary the positive aspects of her life that could be associated with gratitude. The client found this exercise extremely difficult because all she could think about were the failures and deficiencies in her life. To assist in this exercise Mary agreed to do a homework assignment in which she would conduct a survey of the Internet and ask family members for examples of simple acts of compassion. In addition, Mary agreed to keep a diary of daily experiences for which she could be grateful. The rationale for these exercises was to counter Mary's heightened self-focused attention (**primary source:** Pyszczynski & Greenberg, 1987) and her deficient processing of positive self-referent information (**primary source:** Dozois & Beck, 2008).

Treatment Goals #2, 7 & 8 (Sessions 9-14). The remaining 6 therapy sessions focused on Mary's low energy, pessimism and lack of self-confidence. Therapy focused on increasing Mary's daily activity level to improve her physical fitness, breaking tasks into more manageable steps, improving her dietary intake, and eliminating daytime naps. More cognitive restructuring focused on testing her automatic negative attributions and future expectancies and replacing with a more balanced, realistic evaluation of her immediate future prospects. Finally in-session and homework assignments targeted Mary's continual negative self-talk that undermined her academic and interpersonal efforts. She was encouraged to document instances where she had some success and examples of making progress in overcoming lifelong habits of procrastination, avoidance and failure. By session 14, Mary was recounting examples of daily accomplishments that gave her more self-confidence and hope for the future. Her BDI-II score had declined to 14 and HS to 9. Her Therapy Progress Report indicated that she was having fewer bouts of dysphoria and more positive thoughts about herself and her future. As well she was interacting more with her peers, had started a diet and exercise program and reported no suicidal ideation. Mary reported that she was making progress in her treatment goals and for the first time felt that therapy had made a real difference in her life.

Relapse Prevention (Session 15). The final session was devoted to relapse prevention. Mary was warned that she would continue to have days of depressed mood and automatic negative thoughts of self, world and future. A plan was formulated on what to do when feeling down (**clinician manual:** Antony, Ledley, & Heimberg, 2005; Bieling & Antony, 2003). As well, the therapist focused on strategies for countering Mary's tendency to avoid others and spend too much time alone. It was agreed that a follow-up session would be booked for 3 months to review Mary's progress. The therapist also provided contact information so that Mary could arrange an appointment if she felt like she was slipping in her battle against depression.

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Emotion-Focused Therapy Evidence-Based Case Example: Dysthymia

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I. INTRODUCTION

The practice setting for this case illustration is a private practice. Assessment took place during the initial clinical interviews and measures were given selectively following the second interview based on the presenting symptoms, life history, and past treatment history. Post-session measures, as well as mid-and post-treatment measures were also given. An initial sixteen to twenty four sessions of individual Emotion focused therapy (EFT) with integration of interventions from different approaches, where indicated, was recommended.

II. CASE DESCRIPTION

Mary was a 25-year-old third year university undergraduate majoring in computer science. She was the oldest child of a working class family and the first to attend university. Her father was a welder and her mother worked in a fish processing plant. She had a younger brother still living at home who had irregular seasonal employment and an undiagnosed substance abuse problem. Her youngest sister was still in high school but struggled because of a learning disability. Mary's father had a long history of alcohol abuse and her mother had been on SSRIs for years due to recurring bouts of major depression. Recently her parents had separated, which was a devastating experience for Mary. Her family had always struggled financially because of her father's occasional periods of unemployment.

Mary described her childhood as a lonely and isolated experience. She had few friends and was repeatedly teased and bullied throughout because of her obesity. In middle school she developed one close friend but this friend moved away when she entered Grade 10. She was often in trouble at school because of poor attendance. Throughout her adolescence, Mary dieted without much success because of junk food binge eating. She spent most of her high school alone, playing videogames, reading and working on Facebook. She was the first in her family to enter university but she has wandered from one major to the next, with no real goals in mind. She has had to take time off university because of several depressive episodes and so her grades have suffered. She continues to have few friends and shares an apartment with three other students she barely knows. She has dated only once and admitted to some confusion about her sexual orientation. She spends most of her day alone, either trying to catch up on assignments or watching TV.

Mary expressed the conviction that she has no reason for living and that her future looks empty, lonely and useless. She rarely feels happy and thinks she has been depressed most of her life. She struggles to get out of bed in the morning, often missing her morning classes. She

stays up until 2:00 or 3:00 am, eating, watching TV or surfing the Internet because she can't get to sleep. She expressed little interest in her daily activities and felt tired most of the day. She rarely eats a regular meal but tends to "graze" on highly processed foods. Lately she has gained more weight. She avoids looking at herself in the mirror because of self-loathing and she expressed a strong wish to die. In fact Mary has made a couple of suicide attempts, involving an overdose of medication and one attempt at cutting her wrists. Each time she has called her mother asking for a reason to live and expressing her intent to kill herself. This has allowed her family to intervene and get her to the local hospital ER.

Mary has received mental health treatment almost continuously over the past 10 years. She has been tried on numerous antidepressants with little effectiveness. She has had intermittent psychiatric care and a two week period of short-term inpatient treatment. She has seen numerous mental health counselors and 1-2 psychologists with minimal effect. At the time of referral, Mary had weaned herself off all medication but was drinking on weekends and using cannabis daily. She agreed to another round of psychological treatment sessions but expressed doubt that it would be effective. She felt destined to live a life of misery. Mary felt the only solution was to end life itself, and for once attain peace of mind.

III. DIAGNOSIS AND CASE CONCEPTUALIZATION

Clinical Assessment: In an initial session Mary was met with empathic listening to create a bond and an alliance. Mary's life history and past treatment history were obtained. In addition, she was questioned about her motivation for seeking treatment at this time as well as her goals for therapy. After the second clinical interview, based on reported symptoms of anxiety, depression, and suicidal ideation, Mary was given the following self-report symptom measures: the Beck Depression Inventory (BDI-II), Beck Anxiety Inventory (BAI), Beck Hopelessness Scale (BHS), and the Outcome Questionnaire (OQ) 45 (Lambert & Hawkins, 2004).

Based on her high score on the BHS in the severe range indicating a high degree of hopelessness and what she reported in the first session, a more intensive clinical risk assessment was merited. Mary in the first meeting expressed the conviction that "she has no reason for living and that her future looks empty, lonely, and useless," and she reported that "the only solution was to end life itself, and for once attain peace of mind." As well, she expressed "a strong wish to die" and had reported making a few past suicide attempts. Given her reported suicidal ideation, past suicide attempts, and the fact that she was socially isolated as she lives with roommates "she barely knows" and spends most of her time alone, the clinical assessment involved a focused suicide risk assessment involving three components: 1) acquiring information related to Mary's risk factors, protective factors, and warning signs of suicide; 2) collecting information related to Mary's suicidal ideation, planning, behaviors, wishes, and intent; and 3) making a clinical formulation of suicide risk based on this information. An in-depth clinical interview that focuses on suicidal ideation, suicidal behaviors, and intent is able to give the best validity of impending suicide (Shea, 2009).

The therapist's clinical opinion (based on a thorough interview and clinical experience) following the suicide risk assessment was that Mary was not found to be at imminent risk. The

following clinical variables contributed to this: Protective factors: she had called family in the past following all her suicide attempts and upon questioning Mary indicated that her past attempts were cries for help and now that she is going to give therapy another try she felt that she was not at risk for self-harm while she was in treatment. Planning and intent: Mary revealed no specific plan to hurt herself, and the nature of her ideation is presently more passive. If she does not make progress on treatment goals following a course of therapy then suicide risk should be re-evaluated given that Mary may feel more hopeless if she does not make therapeutic progress.

Mary had a BDI-II Total Score of 21, BAI Total Score of 6. The BDI-II scores fell within the moderate depressive symptom range. Scores on the BAI were in the nonclinical range, indicating a relative absence of anxious symptoms. The interview revealed presence of panic attacks, substance abuse (cannabis), and binge eating. However, further questioning revealed that the panic attack episodes were associated with episodes of great emotional upheaval culminating in a suicide gesture. Mary indicated that these emotional attacks did not really frighten her and she had not changed her behavior in order to avoid them. Furthermore she had not had one of these episodes for several months and so it was decided not to include these as a primary treatment target. Mary's depression appeared to be the major concern. She reported feeling sad or depressed since middle childhood. Certainly there had been times when her depression intensified and she became highly suicidal, but she was never completely asymptomatic even at the best of times. Given her presenting picture Mary's depressive symptoms were found to meet the DSM-IV criteria for Dysthymia. She did not meet diagnostic criteria for a current major depressive episode as she did not report depressed mood or loss of interest that lasted at least two weeks "most of the day nearly every day". The longest she reported feeling consistently depressed was 5-7 days, followed by 1-2 good days. Based on her self-report, it is likely that she had 1-2 past major depressive episodes during her transition to high school and then again after her parent's separation. However she did meet criteria for every diagnostic symptom of dysthymia (i.e., *DSM-V Chronic Depressive Disorder*).

Biological factors were obesity, frequent bouts of shortness of breath, sleep apnea, and constant fatigue and lethargy. The clinician inquired if Mary had had successful treatment for sleep apnea, and when she reported she was not being treated for it because she could not tolerate the C-PAP machine, it was strongly recommended that this be followed up with immediately with her sleep specialist as the symptoms of sleep apnea include: obesity, depression, fatigue and lethargy, and in severe sleep apnea, high blood pressure. Given that Mary has all these symptoms as well as sleep apnea, it was a priority for her to be followed up medically as sleep apnea could be a major contributing factor to her physical and emotional symptoms.

Diagnostic Formulation:

DSM diagnosis is not viewed as a central aspect of an EFT treatment as it is not viewed nearly as important to guiding treatment as is the case formulation which follows, but it was thought to be helpful to assess Axis I on the DSM given the refractory nature of Mary's depressive symptoms, and is done in EFT in complex cases or when past treatments have been

unsuccessful. Based on the assessment findings in the initial interviews, the following diagnosis was formulated. Axis I Primary – dysthymia; Axis I – Secondary – substance abuse (cannabis). The other axes were not formally assessed; however, a thorough clinical interview revealed features of borderline personality disorder. In addition, Mary’s health history revealed that she suffered from obesity, hypertension and sleep apnea. Her social history indicated that she had academic problems, lacked a good peer network, and had inadequate finances. Mary’s documented history and clinical interview showed that she was currently functioning below average in her life.

Case Formulation: Emotion-focused therapy (Greenberg Rice & Elliott 1993, Greenberg & Watsons 2006), which has been found to be an effective treatment of depression (outcome research: King et al., 2000; Goldman, Greenberg, & Angus 2008; Watson, Gordon, Stermac, Kalogerakos & Steckley, 2003; meta-analyses: Elliott, Greenberg, Watson, Timulak & Freire in press; Elliott, Greenberg, & Lietaer, 2004) was the theoretical framework that informed the case formulation and treatment due to the similarity between dysthymia and depression. From a research perspective, the processes that have been shown to predict good outcome in EFT can be summarized as: Making narrative sense of moderately aroused emotions that are deeply experienced and reflected on in the context of an empathically attuned relationship with a good working alliance. This involves approaching rather than avoiding emotions, as well as accepting, tolerating, regulating and symbolizing emotion in awareness. These factors predict good therapeutic outcome (Goldman, Greenberg, & Pos, 2005; Missirlian, Toukmanian, Warwar, & Greenberg, 2005; Pos, Greenberg, Goldman, & Korman 2003; Pos, Greenberg, & Warwar, 2009; Watson, McMullen, Prosser & Bedard, 2011; Watson & Bedard, 2006; Watson & Geller, 2005). In addition, other processes shown to predict outcome are: Processing aroused emotion in a *mindfully aware manner*, and *changing emotion with emotion*, by moving from secondary to primary emotion, and from maladaptive to primary adaptive emotions. In this latter emotion transformation sequence the client moves from high distress (anxiety, hopelessness, despair) through maladaptive emotions such as fear of isolation and shame of inadequacy, to acknowledging unmet needs and feeling deserving of them. Accessing primary maladaptive emotions leads to the healing adaptive emotions such as assertive anger at invalidation, self-compassion towards one’s own suffering and grief at what has been lost or was missing (Auszra, Greenberg, 2008; Herrmann & Greenberg 2008; Greenberg, Auszra & Herrmann 2007; Pascual-Leone, & Greenberg, 2007).

An EFT approach to case formulation involves following the client’s core pain and using this as a guide to the development of a focus on underlying determinants that are generating the presenting concerns. Clients’ presenting problems, or symptomatic distress, are seen as manifestations of underlying emotion-schematic processing difficulties. The client’s core painful experiences are articulated as such feelings as a deep fear of abandonment or a shame-based sense of unworthiness. The essence of formulation involves following the client’s most painful or poignant experience and using this to guide toward the core emotion scheme. In addition, markers of in-session problematic states are identified to light the way for the best interventions to help gain access to the maladaptive core scheme.

Case formulation with Mary thus involved a process diagnostic approach of following her most painful experience and having this act as a compass that guided the therapy toward her core feelings of shame, worthlessness, sadness, and fears of lonely abandonment. At the same time the therapist listened for markers of in-session emotional processing difficulties such as self-criticism and unresolved feelings toward significant others to guide interventions that will help access her underlying maladaptive emotions to open them to transformation. The first phase of therapy involved collaboratively developing a focus on her core maladaptive painful emotions, developed from past traumatic and painful experience, underlying her dysthymia and her other difficulties and symptoms. In addition to identifying the core painful self-organization a narrative was developed as to how these core emotions connected to her symptoms and compensatory behaviours.

As noted earlier, Mary's father had a long history of alcohol abuse and her mother had been on SSRIs for years due to recurring bouts of major depression. This had left Mary as anxious with many feelings of abandonment, shame and a core insecure sense of self. Recently her parents had separated, which was a devastating experience for Mary. Her family had always struggled financially because of her father's occasional periods of unemployment. There were many ruptures in the attachment bond with her parents in childhood and adolescence, including her father's binge drinking, periods of unemployment, her parent's separation, and experiences of painful humiliation through bullying at school, peer rejection, and loneliness. From the latter Mary formed core maladaptive emotional responses that left her feeling like she was flawed and had no value as a human being and that no one could possibly like her. These vulnerabilities left her feeling both insecure and inadequate, encompassing both the self-critical and dependent self-organization shown to be central aspects of depression (basic research: Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1982). Both of Mary's parents had been completely emotionally unavailable to her; her mother due to her depression, and her father, due to his alcoholism. Furthermore, given that Mary's siblings had problems that were already taxing her parents, as her youngest sister had a learning disability and her brother had an undiagnosed substance abuse problem, Mary felt extra pressure to not burden her parents with her emotional needs. Consequently, very early on Mary's experience was that her feelings and needs were not important as she did not receive emotional validation from her parents, and as a result she shut herself down emotionally and became disconnected from her emotional needs. As is common in children of alcoholics, Mary felt a strong sense of burden and over responsibility to fix the dysfunction in her family, and to make sure that she did not add to her parents' unhappiness. Her inability to fix the family dysfunction and make her parents happy, contributed to her sense of failure, powerlessness, and hopelessness. As Mary did not receive validation or support, and, consequently, did not learn how to soothe herself emotionally, eating, drinking, and using cannabis were ways that she tried to regulate herself emotionally.

Formulation first involved the development of an alliance. The collaborative aspects of the alliance involve agreement on goals and perceived relevance of tasks (Bordin, 1994; Horvath & Greenberg, 1989). Developing collaboration is helped greatly by the speed, clarity and sureness with which the therapist can capture Mary's chronic enduring pain. This is enhanced by a special type of listening involving therapeutic presence and empathic attunement to affect. The

therapist made psychological contact with and conveyed a genuine understanding of Mary's internal experience (Rogers, 1951; 1957; Norcross, 2011). This led to a strengthening of the bond as well the development of a treatment focus - to work on resolving her painful feelings. A narrative was constructed which helped Mary and the therapist develop an understanding of how her core feelings of shame and fear of rejection/abandonment, lay beneath her difficulties and how these dreaded emotions related to her symptoms and to the behavioral manifestations of her underlying painful emotions, such as her bingeing, substance abuse, and social avoidance.

Various **emotional processing factors** were considered as being involved in Mary's chronic depression. First, it was observed that Mary struggled daily with primary shame based feelings of worthlessness, feeling unlovable, and she had a strongly contemptuous self-critical voice ("I'm so fat and ugly; everyone looks at me in disgust", "I'm such a loser", "I can't stand myself"). In addition, she was lacking resilience as she was collapsing into secondary hopelessness (Whelton & Greenberg, 2005) as indicated by her comments, "what's the use in trying", "why bother trying". Her secondary hopelessness was activated by failing to engage in a variety of daily experiences such as trying to get out of bed in the morning, eating meals alone, trying to make herself study, or watching TV alone on Friday night. Thus, an important element of Mary's chronic depression was her core maladaptive schematic processing based on shame as well as fear and the sadness of lonely abandonment which led to self-organizations of feeling worthless and basically insecure. Many of her problematic behaviors such as her disorganized sleep routine, poor class attendance and study habits, engagement in distracting activities (i.e., Videogames, Facebook), and avoidance of social settings were viewed as being secondary symptoms of underlying core feelings of shame and fear which when transformed will lead to reduction in anxiety and avoidance. The binge eating, reliance on cannabis, and the drinking were Mary's way of trying to regulate these painful feelings of worthlessness, and abandonment. Her avoidance of social contact and of goal-directed activities were seen as results of her attempts to regulate the painful affect she had in social situations and feelings of incompetence/inadequacy evoked by difficulties she faced when she engaged in goal directed behavior. The ensuing loneliness and failure to get things done were seen as secondary consequences of her efforts to regulate her affect by avoidance, substance use, as well as exacerbating feelings of worthlessness and aloneness.

Treatment Focus: Formulation and intervention in EFT are, in the final analysis, inseparable and they span the entire course of treatment. They also occur constantly at many levels. In EFT, there is no discrete initial formulation or assessment phase. The therapist, rather gets to know the client over time, but never comes to know definitively what is occurring in the client. Formulation thus never ends.

As we have said, a defining feature of EFT is that it is process diagnostic (Greenberg et al., 1993) rather than person diagnostic. Thus, it is clients' manner of processing, in-session markers of problematic emotional states, core emotion states and co-evolving therapeutic themes are attended to as ways of helping to develop a focus on underlying determinants. Although Mary was diagnosed as dysthymic, this in itself is not the necessary information to help form a

treatment focus. The focus depends much more on the establishment in therapy of an understanding of the person's core pain and the underlying determinants of this pain. People's current momentary states and accompanying narratives reveal what troubles them. Therefore, in a process diagnostic approach there is a continual focus on the client's current state of mind and current emotional problem states. The therapist's main concern is one of following the client's on-going process and identifying markers of current emotional concerns, more than developing a content-based picture of the client's enduring personality, character or core pattern or beliefs.

In formulating a focus the therapist therefore attends to a variety of different in-session markers. Markers are client statements or behaviors that alert therapists to various aspects of clients' current self-organization that offer opportunities for specific types of intervention that will help lead to underlying determinants of the presenting problem. It is the client's presently felt experience that indicates what the difficulty is, and indicates whether problem determinants are currently accessible and amenable to intervention. The therapeutic focus is always subject to change and to development and process diagnosis of in-session problems states always acts as a major means of focusing each session. Interventions at markers all work to access core emotions schemes. The markers are entry points into the underlying self-organizations involved in a client's difficulties.

IV. TREATMENT PLAN

Clinical Decision: Mary was offered 16-24 sessions of emotion-focused therapy for depression. Treatment progress was evaluated every session based on session questionnaire measuring self-reported progress and changes (Watson & Greenberg 1998) and every second session on the Outcome Questionnaire (OQ 45; Lambert, & Hawkins 2004) which measures progress on Symptom Distress, Interpersonal Relationships and Social Role.

Following the formation of a therapeutic bond by the third session, whenever a marker of self-criticism arose in the sessions and it seemed appropriately related to a core concern a two-chair dialogue was suggested. In the first dialogue Mary initially collapsed into hopelessness. The therapist remained empathically affirming, understanding how resigned she felt. With the therapist's empathic attunement and inquiring into what she needed Mary was able to access a tiny bit of resilience and self-assertion saying she needs support, not condemnation from her own critical voice. With this new experience of staying with and facing her hopelessness she begins to enter into a deeper state of her underlying loneliness and shame. This emotional state is highly painful and is a marker of anguish so the therapist suggests a shift to a self-soothing dialogue in which she is asked if she can soothe the loneliness and pain of the wounded child experience. This is a new experience of accessing compassion and developing capacities to validate, regulate and soothe herself emotionally. At the end of the session meaning was created relating her self-criticism to both her feelings of depression and her academic performance. Dealing with her painful feelings and ways to soothe herself outside of the sessions is discussed. This included first paying attention to her breathing whenever she felt distressed and then going to an emotionally soothing place in her mind (which had been done in the session and involved her walking along a quiet forest path) as well as going swimming in

a local center which she found soothing. Research on resolving self-critical conflicts and unfinished business has shown that processes of both enacting her negative voice or image of the negative other leads to accessing the core maladaptive self-organization and that processing this leads to accessing the unmet need and to a sense of being deserving of having had that need met (Greenberg, & Webster, 1982; Greenberg, Warwar & Malcolm, 2008; Greenberg, & Malcolm, 2002). This process leads to the emergence of a more adaptive emotional response and this pattern of emotion from secondary through primary maladaptive to adaptive predicts good outcome (Hermann & Greenberg, 2008, Pascual-Leone & Greenberg, 2007).

Work in further sessions accesses some of her unfinished business with her parents. Over the course of treatment, repeated evocation of Mary's core maladaptive emotions leads Mary, with the help of her therapist's validation, to acknowledge her unmet need for support and validation and to reclaim a sense of entitlement to having that need met. This leads to more adaptive emotions to the past situations which transform her maladaptive emotions. As she feels better about herself and develops a stronger sense of self, she begins to change the way she thinks and behaves. At about session 16, treatment progress will be evaluated and depending on therapeutic progress, the therapist and Mary will discuss either: ending therapy, continuing therapy, or maintenance sessions.

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Psychodynamic Psychotherapy Evidence-Based Case Example: Dysthymia

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I. INTRODUCTION

The practice setting for this case illustration is a private practice. Assessment took place during the initial clinical interviews and measures were given selectively following the second interview based on the presenting symptoms, life history, and past treatment history. Post-session measures, as well as post-treatment measures were also given. An initial sixteen to twenty four sessions of Time Limited Dynamic Psychotherapy (TLDP) was recommended.

II. CASE DESCRIPTION

Mary was a 25-year-old third year university undergraduate majoring in computer science. She was the oldest child of a working class family and the first to attend university. Her father was a welder and her mother worked in a fish processing plant. She had a younger brother still living at home who had irregular seasonal employment and an undiagnosed substance abuse problem. Her youngest sister was still in high school but struggled because of a learning disability. Mary's father had a long history of alcohol abuse and her mother had been on SSRIs for years due to recurring bouts of major depression. Recently her parents had separated, which was a devastating experience for Mary. Her family had always struggled financially because of her father's occasional periods of unemployment.

Mary described her childhood as a lonely and isolated experience. She had few friends and was repeatedly teased and bullied throughout because of her obesity. In middle school she developed one close friend but this friend moved away when she entered Grade 10. She was often in trouble at school because of poor attendance. Throughout her adolescence, Mary dieted without much success because of binge eating, mainly on high carbohydrate food. She spent most of her high school alone, playing videogames, reading, and on Facebook. She was

the first in her family to enter university but she has wandered from one major to the next, with no real goals in mind. She has had to take time off university because of several depressive episodes and so her grades have suffered. She continues to have few friends and shares an apartment with three other students she barely knows. She has dated only once and admitted to some confusion about her sexual orientation. She spends most of her day alone, either trying to catch up on assignments or watching TV.

Mary expressed the conviction that she has no reason for living and that her future looks empty, lonely and useless. She rarely feels happy and thinks she has been depressed most of her life. She struggles to get out of bed in the morning, often missing her morning classes. She stays up until 2:00 or 3:00 am, eating, watching TV or surfing the Internet because she can't get to sleep. She expressed little interest in her daily activities and felt tired most of the day. She rarely eats a regular meal but tends to "graze" on highly processed foods. Binge eating tends to occur several times a week, late at night when her room mates are asleep or out. Lately she has gained more weight. She avoids looking at herself in the mirror because of self-loathing and she expressed a strong wish to die. In fact Mary has made a couple of suicide attempts, involving an overdose of medication and one attempt at cutting her wrists. Each time she has called her mother asking for a reason to live and expressing her intent to kill herself. At these times, her family intervened and got her to the local hospital ER.

Mary has received mental health treatment almost continuously over the past 10 years. She has been tried on numerous antidepressants with little effectiveness. She has had intermittent psychiatric care and a two week period of short-term inpatient treatment. She has seen numerous mental health counselors and 1-2 psychologists with minimal effect. At the time of referral, Mary had weaned herself off all medication, but was drinking on weekends, binge eating several times a week, and using cannabis daily. She agreed to another round of psychological treatment sessions but expressed doubt that it would be effective. She felt destined to live a life of misery. Mary felt the only solution was to end life itself, and for once attain peace of mind.

III. DIAGNOSIS AND CASE CONCEPTUALIZATION

Clinical Assessment:

The clinical assessment included a clinical interview and psychometric evaluation. The goal of the assessment was to rule out problems that required immediate intervention such as suicidal intent, and problems that may require a medical consultation such as sleep apnea. For psychotherapy, the assessment was geared toward developing a psychodynamic case formulation that included understanding attachment needs and functioning, defense mechanisms, and core relational patterns. Developing a psychodynamic case formulation is key to defining a focus for time limited dynamic psychotherapy (TLDP; Luborsky, 1984; Strupp & Binder, 1984).

Suicidal intent was assessed with Mary by an in depth clinical interview that focuses on suicidal ideation, suicidal behaviors, and intent (Shea, 2009). Given Mary's difficulties with sleep and the common co-occurrence of sleep apnea and obesity (Trakada, Chrousos, Pejovic, &

Vgontzas, 2007), Mary was referred to a medical specialist at a sleep lab in order to assess for possible sleep apnea. She completed the Personality Assessment Inventory (PAI; Morey, 2007). The PAI is a psychometrically sound measure that has a number of scales that assess validity of the responses, symptoms such as depression and anxiety, personality features such as borderline features and antisocial behaviors, substance abuse issues, treatment readiness, and interpersonal style. Mary also completed the Experiences in Close Relationships Scale (ECR; Brennan, Clark, & Shaver, 1998), a self-report scale of attachment that assesses interpersonal style and affect regulation strategies along dimensions of attachment avoidance and attachment anxiety. Finally, the interviewer conducted a clinical interview that asked questions about early family interactions, social and romantic relationships, common emotions that Mary feels, how she copes with these emotions and with distress, and the quality of her current relationships. The goal of the interview was to guide the case formulation that will also define Mary's Core Relational Patterns (CRP; Strupp & Binder, 1984) and to describe Mary's predominant defense mechanisms. The latter was aided by the interviewers' knowledge of the Defense Mechanisms Rating Scale (DMRS; Perry, 1990). The DMRS has received good empirical support in psychotherapy research (Perry & Henry, 2004). During the interview, the clinician also asked diagnostically oriented questions to assess for DSM-IV (APA, 1994) diagnoses. Although not used in this example, two other methods of assessment might be helpful to psychodynamic case formulation. First, psychodynamic researchers have found the Shedler-Westen Assessment Procedure - 200 (SWAP-200; Westen & Shedler, 1999) to be a valid and reliable interview assessment Q-sort method to assess personality functioning relevant to psychodynamic therapy (Blagov, Bi, Shedler, & Westen, 2012). Also, attachment states of mind can be assessed by the Adult Attachment Interview (AAI; Main, Hesse, & Goldwyn, 2008).

The PAI indicated that Mary responded in a straightforward and consistent manner and so the profile was valid. She had elevated score on the following scales: Depression scale (T=70), and Drug Problems scale (T=70), and moderate elevations on the Suicidal Ideation (T = 65) and Borderline (T = 65) scales. The interpersonal scales suggested moderately low Warmth (T = 40) and very low Dominance (T = 35), suggesting a tendency to be interpersonally distant as well as passive in relationships. The PAI Self Concept profile (Morey, 1996) suggested low self-esteem and self-confidence, a tendency to be highly self-critical. The Treatment Rejection scale score (T = 55) indicated potential problems with motivation to enter psychotherapy. The Aggression Scale subscales profile suggested that she might experience a moderate amount of anger (Aggressive Attitude T = 60) but is unlikely to direct this outward (Verbal Aggression and Physical Aggression scales T < 50). Critical items that Mary endorsed indicating suicidal ideation were followed up by the interviewer.

The ECR indicated a moderately elevated Attachment Anxiety scale score (1 SD higher than non-clinical samples) and a very elevated Attachment Avoidance scale score (2 SD higher than non-clinical samples; non-clinical sample data from Shaver, Schachner, & Mikulincer, 2005). These suggested a prominent interpersonal style in which she may dismiss the importance of relationships but still may experience underlying dependency needs. Affect regulation is likely predominantly characterized by cutting off emotions, avoidance, with occasional hyperactivation of emotions if under greater stress.

By using the DMRS to aid in assessing defense mechanisms, the interviewer found that Mary tends to use disavowal defenses predominantly. That is she tends to keep unpleasant or unacceptable stressors, impulses, ideas, affects out of awareness by denial of these experiences. At times she may use action defenses when she cannot keep the affect away, such as acting out, passive aggression, or turning against self during which she may be self-destructive.

Diagnostic Formulation:

In terms of DSM-IV diagnoses, Mary meets diagnostic criteria for Dysthymia, Substance Abuse, and Binge Eating Disorder (BED: technically, in DSM-IV BED is classified as an Eating Disorder Not Otherwise Specified, but will be classified as a full diagnosis in DSM-5). The interview (based on Shea's [2009] criteria) did not indicate immediate risk for suicide. Mary had current fleeting suicidal ideation, but no immediate intent, and no plan. This was consistent with Mary's score on the PAI Suicidal Ideation scale, and with her responses to follow-up questions regarding PAI critical items that she endorsed. However, the therapist made note to periodically monitor her potential for suicide.

Case Formulation:

As indicated, the key element to TLDP is the case formulation which provides the dynamic focus for the therapy. TLDP has substantial research support both in terms of effectiveness and efficacy (Shedler, 2010), including specifically for depressive disorders (Taylor, 2012). TLDP is used here as an umbrella term to refer to a group of psychotherapies that all have psychodynamic models as their frame. These approaches tend to have a number of elements in common including an understanding that: (a) psychological development across the lifespan has an ongoing and cumulative impact on who we are and how we function; (b) sometimes behaviors, feelings and thoughts are caused by unconscious feelings or needs (i.e., that they act on people but may remain temporarily out of awareness); (c) unmet relational needs (perhaps associated with attachment issues) can lead to negative affect; (d) people may have conflicts between how they feel and how they perceive themselves to be, which may cause them discomfort or distress; and (e) that people engage in defense mechanisms (i.e., automatic and consistent means of coping with unpleasant internal experiences) to cope with unconscious feelings, needs, and conflicts that are distressing. Also fundamental is the notion of transference. That is, that people engage in similar dynamic patterns across relationships, including in the therapeutic relationship, which have their origin in early attachment relationships (for an accessible introduction to contemporary psychodynamic concepts, see Shedler, 2005). Understanding these elements, how they affect current relationships, and changing how one copes and behaves in current relationships, including the psychotherapeutic relationship, are key to effective psychodynamic psychotherapy. Each of these aspects of psychodynamic theory is supported by a body of basic and applied research spanning several decades (see Andersen & Przybylinski, [2012] for a review of research on transference; Cramer [2002] for a review of defense mechanisms research; Levy, Ablon, & Kachele [2012] for a compendium of reviews of psychodynamic psychotherapy research; and Westen [1998] for a review of basic research of psychodynamic constructs).

For Mary's case formulation we used Strupp & Binder's (1984) CRP model. This model has many similarities to Luborsky's (1984) Supportive-Expressive Psychotherapy that relies on the Core Conflictual Relationship Theme (CCRT) method. The CCRT method has been used to provide a valid operationalization of transference concept and its components (Luborsky, Chrits-Christoph, & Mellon, 1986). Components of the CRP model (Strupp & Binder, 1984) include: (a) Acts of Self – the individual's wishes, feelings, thoughts, and actual behaviors in relationships including defenses; (b) Acts of Others – how others in an individual's life behave toward them; (c) Expectations of Others – an individual's assumptions or predictions about how others are expected to behave, and these expectations are often based on previous experiences with others including attachment relationships; and (d) Introject – the internalization of repeated patterns of behaviors characterized by the interplay among Acts of Self, Acts of Others, and Expectations of Others into a self-definition or self-concept. It is often the Introject that maintains the pattern of behaviors, so that one's self concept becomes an aspect of a self-fulfilling prophecy.

It is important to note that the case formulation based on a CRP model is not a fixed entity, but will be modified with more interactions and more feedback from Mary especially in the early phase of therapy. The case formulation will be shared with Mary early on, and she will collaboratively develop the formulation with her therapist. Further, Luborsky (1984) encourages therapists to use a socialization interview with new clients to orient the client to how psychotherapy will work and what to expect (for an example, see the Appendix in his book). Such an approach of collaboratively developing a focus and of discussing the goals and tasks of therapy also helps to develop and maintain an empathic connection with clients. Research has indicated that this will improve the therapeutic alliance (Hilsenroth, Cromer, & Ackerman, 2012).

Mary's *Acts of Self* are, in part, characterized by wishes for a close relationship with her parents and perhaps with her mother in particular. She also likely has wishes for close relationships with peers as well. However, at the same time she isolates herself from peers and likely maintains at a distance from her mother, except when very distressed. Although individuals with attachment avoidance appear to dismiss relationships or to seek solitude, research with infants and adults consistently shows that these individuals use these secondary avoidant attachment behaviors to protect themselves from further loss and disappointment (see Wallin, 2007, for review). Mary's predominantly dismissive and avoidant attachment pattern likely developed as a way of defending herself against further disappointment and the potential for further abandonment. This avoidance was commonly achieved through disavowal level defenses, such as denial, in which Mary keeps unpleasant or unacceptable stressors, impulses, ideas, affects out of awareness (Perry, 1990). The avoidance behaviors and defenses extend into some of her symptomatic behaviors including binge eating, substance abuse, and excessive internet use to cope with negative affect, i.e., sadness and anger (see Ansell, Grilo, & White, 2012, for related research on binge eating). One can speculate, given her PAI interpersonal scales profile, that her passivity co-occurs with interpersonal coolness and an angry attitude that she directs inward. Anger could not be easily expressed in her family because her parents were not

available or overwhelmed with other demands. So Mary learned early on to keep anger to herself. The inwardly directed anger likely fuels her depressive affect. A therapist can expect that Mary will be initially distant, inwardly angry, and passive in psychotherapy.

Acts of Others in Mary's interpersonal world suggest that others typically have been not available to or interested in her. Recall that her mother has a history of depression, her father has struggled with alcoholism, and her troubled siblings likely required a greater proportion of the available attention. This set the stage for a lonely and isolated childhood. Her family tends to become more active in her life when she is in crisis (i.e., she becomes suicidal and reaches out to her parents). Peers were hostile and abusive when she was growing up, and so any needs she had for closeness were not likely met by friendships. Currently, her peers, including roommates, keep their distance, and she has dated only once. One could speculate that new potential friends, keep their distance because of her apparent coolness, isolation, and moderately angry attitude. That is, her current behaviors may help to create the context for future isolation and unhappiness.

Mary's *Expectations of Others* is that they will not be available, will hurt her, or will disappoint her. Mary has a lot of experience with others disappointing, hurting, or abandoning her, and so it is not surprising that she might go into any new relationship, including a therapy relationship, with these expectations. In fact, Mary has already indicated that she is not hopeful that therapy will be helpful, which one can translate into: "My therapist won't be there for me, might hurt me, or will leave me."

Mary's *Introject* is a product of the interaction of her Acts of Self, the Acts of Others, and her Expectations of Others. She experiences herself as damaged and worthless likely because of a long history of attachment losses and disappointments. Her view of herself, as well as inwardly directed anger, fuels her depressive affect, and her highly self-critical attitude. Both of these will sap her of energy, make her more passive, and further her social isolation and avoidance. As a result, others, especially new potential relationships, may keep their distance, which will reinforce her expectations of others as uncaring, and her sense of self as worthless. In this way, the CRP is complete, and largely driven by a self-critical depressive experience (Blatt, Quinlan, Chevron, MacDonald, & Zuroff, 1982).

Treatment Focus:

As indicated, the dynamic focus is a key element to TLDP. In this example, Mary's CRP becomes the focus of her treatment for depression. Because of the time limited nature of TLDP, the therapist must develop the case formulation early and maintain a focus on the CRP. The therapeutic relationship becomes an important element in TLDP for two reasons. First, the therapeutic alliance is known to be related to positive outcomes in psychotherapy and so developing and maintaining an alliance is important (Horvath, Del Re, Fluckiger, & Symonds, 2011). As indicated earlier, developing a CRP in collaboration with Mary will go a long way to establishing a collaborative relationship in which both therapist and client agree on the focus and on the method of therapy. Second, if correct the CRP will characterize the transference relationship (Luborsky et al., 1986). The changing of the CRP by will be accomplished by: (a)

allowing the CRP to emerge early on in the therapeutic relationship and discussing this with Mary; (b) encouraging Mary to see the therapeutic relationship differently from what she expects; (c) encouraging her to identify when she is denying distressing affect or thoughts that might occur, especially anger and sadness toward attachment figures; (d) supporting Mary to behave differently in therapy by allowing herself to be vulnerable with her feelings (i.e., not avoiding or denying her feelings) and allowing the therapist to be caring and empathic (i.e., not dismissing of the relationship); and (e) helping her to generalize these new behaviors and expectations to relationships outside of therapy, and to internalize these new experiences into an altered and less critical introject.

IV. TREATMENT PLAN

Clinical Decision:

Mary was offered 16 to 24 sessions of TLDP to treat her depression by focusing on altering her CRP. After the assessment sessions, Mary and her therapist had one or two sessions in which they discussed the nature, goals, and tasks of the therapy, including the CRP formulation. The Outcome Questionnaire – 45 (OQ-45; Lambert & Hawkins, 2004) was administered pretreatment, every fourth session, and at posttreatment to assess general symptoms and functioning. The Working Alliance Inventory short form (Hatcher & Gillaspy, 2007) was also administered every fourth session. Consistent feedback to therapists about client functioning has been shown to improve outcomes and reduce client deterioration (Lambert & Shimokawa, 2011). Mary was seen by a female therapist who was about 20 years older.

In the first phase (session 4 to 6) the therapist and Mary worked together to identify the CRP by examining relationship episodes described by Mary. The goal was to have Mary describe in her own words her relationship patterns and to use these episodes to populate the Acts of Self, Acts of Others, Expectations of Others, and Introject relevant to her CRP. Another goal was to have Mary realize how ubiquitous the CRP and denial of affect was in her life. Although reluctant at first, the therapist's gentle persistent and empathy regarding Mary's ambivalence about the usefulness of therapy resulted in Mary eventually seeing how pervasive these relational and dynamic patterns were in her life.

In the second phase (sessions 6 to 16) Mary and her therapist examined Mary's actual or anticipated reactions to her wish and needs for closeness and security from others. Through this process Mary learned that her fears that others would hurt, disappoint, or abandon her were rooted in early attachment relationships. She also learned that her means of coping (i.e., by remaining distant, avoidant, denying, and dismissing) resulted in eliciting from others the very responses she feared (e.g., her roommates were distant). Mary and her therapist also discussed several instances in which Mary expected her therapist to be uncaring or critical (i.e., aspects of the transference based in early experiences with Mary's mother). At these times, Mary felt most sad and pessimistic about therapy, and her WAI scores following those sessions tended to drop. Mary's therapist took a highly empathic and understanding stance when she encouraged Mary to talk about her sadness and underlying anger toward the therapist. They discussed how the therapist's behaviors were different from what Mary expected based on her experience with her parents. For example, her parents were often unavailable to her, and Mary

felt required to keep her feelings to herself. Expressing sadness and anger in a safe therapeutic context provided some relief to Mary. She began to approach peers, including one of her roommates, whom she found “interesting”. She tentatively became more social. She also reported feeling better about herself and more optimistic as her peers responded positively to her overtures.

During the third or “termination” phase (sessions 16 to 20), the therapist focused more specifically on the upcoming conclusion of therapy. This was a difficult phase for Mary, as it re-awakened issues of abandonment for her. However, the therapist encouraged Mary to see this as another opportunity to challenge her CRP (e.g., that the therapist was uncaring), that Mary’s self-worth remained intact despite this ending, that she can use what she learned about herself in therapy to create more meaningful and fulfilling relationships, and that her unhappiness was not inevitable as evidenced by the changes she made.

Certainly, Mary still had a number of issues to work on at the end of TLDP. Her drug use and binge eating decreased significantly, but she often felt drawn to these means of coping especially when stressed or when she felt sensitive to a disappointing interpersonal event such as with her family. Her mood and sleep improved and she was much less self-critical. The OQ-45 confirmed this by showing consistent improvements over time to post treatment. Mary still struggled with her academic options and was now considering leaving computer sciences to explore other fields that interested her. She still remained unsure about her sexual orientation, but this did not distress her. She was still, at times, angry and disappointed that her family relationships did not meet her wishes for closeness and security, but she was more open about her feelings about this, and was coming to the conclusion that she may need to rely on future peer and romantic relationships to meet some of these needs.

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Note to the Reader: The case below is somewhat different from the other three vignettes described above. Part of the rationale for this is that IPT is not presently considered an "evidence based" treatment for dysthymia. There is also insufficient evidence for the efficacy of IPT for substance abuse problems. As such, the case below describes evidence-based decision making in the assessment, case conceptualization and treatment of depression.

Interpersonal Psychotherapy Evidence-Based Case Example: Depression

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I. INTRODUCTION

The practice setting for this case illustration is a university-affiliated psychiatric hospital. The patient was referred for the treatment of depression with interpersonal psychotherapy (IPT), a time-limited (usually 12-16 sessions), empirically supported treatment for depression. The assessment was conducted over the first three sessions and included a diagnostic evaluation and psychiatric history. The psychiatric history included a semi-structured interpersonal inventory to assess the quality of the patient's social network and patterns of communication and to determine which of the four IPT domains (grief, role transition, role disputes, interpersonal deficits) is the critical precursor to the depressive episode and should be the focus of treatment. The middle phase of treatment (sessions 4-11) focused on resolving the interpersonal stressor linked with the depressive episode and the final phase of treatment (sessions 12-13) focused on consolidating treatment gains and relapse prevention.

II. CASE DESCRIPTION

Ruby is a 42-year-old Caucasian married woman who works as an immigration lawyer. She is a partner in a small firm with four other lawyers. Her husband of seven years works as an administrator for a bank. The couple has no children. Ruby was referred by her family physician for psychological treatment of depression. This is her first contact with a mental health practitioner.

Ruby reports that she has felt depressed for several months and that these feelings have worsened in the past six weeks prior to coming to the assessment. She also complains of frequent crying spells, decreased capacity for enjoyment, fatigue, poor concentration and trouble falling asleep. Her fatigue and impaired concentration are affecting her ability to perform at work, making her feel overwhelmed and guilty. Her appetite is diminished and she has lost weight. She reports feeling more irritable than usual and vents her anger at her husband and other people she is close with. She does not report suicidal ideation although at times she feels weary of life. Her family doctor suggested a prescription for an antidepressant but she is reluctant to take medication because she is trying to become pregnant.

Ruby reports that she started feeling depressed shortly after a failed trial with in-vitro fertilization (IVF) and her doctor's recommendation that she stop treatment because her chances of becoming pregnant are low. Ruby and her husband Michael have been trying to conceive for the past five years. After a year of unsuccessful attempts to conceive spontaneously they consulted a fertility specialist. Both underwent a battery of tests and

diagnostic procedures and the cause of infertility was eventually determined to be female factor. Their struggle with infertility included various ovulation-enhancing drugs, six rounds of intrauterine insemination and four trials of IVF. The IVF trials were especially demanding and stressful as well as financially draining. Ruby reports that although she felt disappointed and sad many times after failed attempts to conceive, these feelings never lasted more than a week and she was always able to bounce back and remain hopeful that she would eventually become pregnant. This time the depressed mood is unshakable and she feels a profound sense of loss and despair. She blames herself for not becoming pregnant and sees herself as a failure.

Although Ruby and Michael had agreed to stop infertility treatment after the fourth IVF trial, Ruby recently decided she wants to undertake a fifth trial at a clinic in another city that boasts a high success rate with IVF. Her husband Michael wants to stop treatment and move on with their lives. The experience of infertility treatment has been emotionally draining for him and he feels that they have done everything they possibly can to get pregnant. He accepts that they cannot have a biological child and is comfortable with the idea of being childfree or even adopting. Although Ruby is sensitive towards her husband's feelings and recognizes that her odds of becoming pregnant with IVF are low, she is unable to abandon the idea of having a biological child and is ambivalent about adoption. She is afraid that if she doesn't try one more time she might regret her decision in the future. Ruby reports that while she and Michael are able to talk about their differences in an open and respectful manner, the disagreement about whether or not to continue with fertility treatment has created some tension in their relationship. Ruby's husband feels she has become consumed with getting pregnant and that it has taken over their lives. Ruby readily admits that her struggle with infertility has changed her and she has increasingly lost sight of all the positive aspects of her life. Ruby's mother and two close friends who are aware of her condition have also urged her to stop treatment and move forward. They worry about the risks of IVF and long-term effects of fertility drugs on her health as well as the psychological burden of continuing treatment for her and Michael. Although Ruby knows they have her best interest at heart, she cannot help feeling hurt that they don't understand her desire for pregnancy.

Social and Developmental History.

Ruby is the youngest child of a sibship of two. Birth and milestones were normal. She grew up in a close and loving family and recalls a happy childhood and uneventful adolescence. Her parents were supportive and sensitive to her needs and encouraged her to be independent and responsible. Her mother is a retired school teacher and her father is a semi-retired corporate lawyer. Both are in good health and active in their community. Ruby's parents came from large families and she recalls her mother always planning parties and family gatherings at home. Ruby always looked forward to these family events and hoped to carry on this tradition when she had her own children. Although Ruby has a good relationship with both parents, she is especially close with her mother whom she describes as nurturing, a good listener and an incredible support. Ruby's older brother is a college professor who lives in the United States with his wife and 8-year-old son who is autistic. She reports that although her brother and his wife are great parents, raising their son has not been easy. Her relationship with her brother is satisfactory and they speak regularly by telephone and see each other during holidays. As far as

she knows none of her family members has been treated for psychiatric problems but her brother became quite depressed after learning about the diagnosis of his son.

Ruby describes herself as a “good girl” who excelled academically and was involved in many extracurricular activities. She had a healthy self-esteem growing up and never engaged in risky behaviours or got into trouble. She completed her undergraduate degree with distinction and graduated the top 10% of her law class. After completing law school she was offered a position at a prestigious law firm and quickly established a reputation for being a hard worker, ethical, reliable and a good team player. She reports being performance-oriented and having high expectations for herself but does not feel she is a workaholic. She has always been a sociable person and enjoys spending time with family and friends.

Ruby’s peer relationships during childhood and adolescence were good and she remains close with several high school friends and cousins who she sees on a regular basis. She also developed good peer relationships at university and law school and although she does not currently see these friends regularly, she maintains contact via email and social media. Once a year a group of friends from law school meet for a weekend retreat at a spa to catch up and bond. She reports having a good relationship with colleagues at work and occasionally socializes with them.

Ruby dated during high school and had a few casual relationships while she was an undergraduate student at university. Her first serious romantic relationship was with a graduate student she met during her first year at law school. The first two years of the relationship were great and they talked about living together in the future. However, after her boyfriend completed his degree he accepted a position abroad for three years. They tried to sustain the relationship at a distance but Ruby missed the closeness they had and after a year they mutually decided to break up. Her second serious relationship was with a successful businessman 10 years her senior. She met him at the wedding of one of her cousins and there was an instant bond between the two. She describes him as kind and caring and she was deeply in love with him. They married two years after they met and planned to start a family once Ruby was more established in the law firm she worked at. Sadly, her husband was diagnosed with cancer shortly after they married and died within a year of being diagnosed. Her husband’s diagnosis “hit her like a ton of bricks” and the first year after his death was difficult and she missed him terribly. The support of her family, close friends and colleagues as well as attendance at a support group for bereaved spouses/partners helped her with the grieving process.

Ruby met her current husband, Michael, at a fund raising event for cancer research. A mutual friend introduced them. It had been two years since the death of her husband and she felt ready to move on and find love again. She found Michael attractive, fun, generous and easy to talk to. He comes from a large Italian family and like her is close with his family. Ruby enjoys socializing with Michael’s family and has developed a close friendship with his older sister, although she finds his parents somewhat intrusive. After dating for a year they agreed to live together and married a year later. Having children was an important life goal for Ruby and she

stopped using contraception within a few months after they married. They bought a house in a neighborhood with lots of children and schools and Ruby resigned from the prestigious law firm she worked at to work at a smaller firm that offered her more flexible working arrangements so she could spend more time with her children. Although she is content at her firm, she regrets buying the house and feels like an “outsider” in her neighborhood. It is painful for her to see pregnant women and couples with babies and young children and she feels excluded when friends, family and colleagues talk about their experiences with pregnancy, childbirth and childrearing. She describes infertility as a marginalizing and isolating experience.

Medical History.

During her evaluation for infertility she was diagnosed with endometriosis. Otherwise her medical history is unremarkable. Ruby does not smoke, use drugs and has one or two glasses of wine on the weekends. She exercises regularly and takes yoga classes twice a week for stress management. Ruby states that since she has been trying to get pregnant she has been diligent about maintaining a healthy lifestyle. She is not currently using any prescription medication and discontinued fertility drugs after her last failed IVF trial.

III. DIAGNOSIS AND CASE CONCEPTUALIZATION

DSM diagnosis and assessment of severity of depressive symptoms are central aspects of IPT. In the initial session Ruby was administered the Structured Clinical Interview for DSM-IV (SCID-IV; First, Spitzer, Gibbon, & Williams, 1997) to assess current and past Axis I disorders as well as the 17-item clinician-rated Hamilton Depression Rating Scale (HAM-D; Hamilton, 1960) and self-report Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996). A detailed review of Ruby’s depressive symptoms and their duration, severity and impact on functioning revealed that she clearly met DSM-IV-TR criteria for a major depressive disorder. She obtained a score of 22 on the HAM-D and 20 on the BDI-II, suggesting moderately severe depression. There was no evidence that her depressive symptoms were related to use of fertility drugs since she had stopped fertility treatment several months prior to the intake assessment. Although she experienced profound sadness following the death of her first husband, there was no evidence of delayed or distorted grief reaction. Moreover, none of the periods of depressed mood she experienced after other failed attempts to conceive met diagnostic criteria for major depression. There was no history of suicide attempts or non-suicidal self-injurious behavior. The SCID-IV did not reveal any other current or past Axis I disorders. The psychiatric history did not reveal any Axis II disorders, although Ruby did present with some mild obsessional traits.

Clinical Decision: *In addition to reviewing current depressive symptoms, the diagnostic interview included a review of past depressive episodes, including interpersonal precipitants and consequences of the depression and symptom management. If Ruby presented with a history of recurrent major depression, this would have informed the treatment plan and the therapist might have considered maintenance IPT following acute IPT treatment to reduce relapse risk (Frank, 1991). A comprehensive review of concurrent Axis I and Axis II disorders was needed to clarify whether IPT was the best treatment for this patient. Depression can be complicated by the presence of comorbid disorders and research suggests that chronic depression, presence of an anxiety disorder, substance abuse, and certain personality disorders (e.g., borderline or*

avoidant personality disorder) predict poor antidepressant response to IPT (Parker et al., 2006; Ravitz, McBride, & Maunder, 2011). In patients with comorbid conditions, the therapist might consider adjunctive pharmacological interventions, modifications of IPT to address comorbid issues, or use of alternative treatments that “fit” both the depression and the comorbid disorder.

Diagnostic Formulation.

Based on the assessment findings, the following diagnosis was formulated. Axis I: Major Depression; Axis II- rule out obsessional traits; Axis III- Infertility; Axis IV: Mild tension with interpersonal supports; Axis V- GAF score=55.

Ruby was provided with the diagnostic formulation and told that depression is a medical illness that is not her fault. She was given the “sick role” which helps alleviate feelings of guilt or shame patients may have about their inability to function in different roles due to depression. The therapist compared her depression to other debilitating medical illnesses and offered the following analogy: “If you broke your leg you wouldn’t expect yourself to run a marathon.” (Weissman, Markowitz, & Klerman, 2000). Ruby was encouraged to take a few days off work if needed and if this was not possible to at least reduce her workload. She was also encouraged to ask her husband to take over some of the responsibilities at home so she could rest and focus on recovering from her depression. Psychoeducation about depression and its treatment is an important element of IPT. Ruby was reassured that depression is a treatable illness and there was every expectation she would recover with treatment. The therapist discussed various therapeutic options including medication, psychotherapy and their combination as well as the advantages and disadvantages of different therapeutic approaches.

Clinical Decision: *IPT involves a medical model of illness and is therefore easily combined with medication if needed. While combined treatment can produce more rapid relief of symptoms than monotherapy there were several reasons why IPT alone was considered appropriate for Ruby. This was her first depressive episode, the intensity of her neurovegetative symptoms was not considered severe enough to interfere with her ability to engage in therapy, and her suicide risk was low. Further, Ruby was reluctant to take antidepressant medication because she was trying to conceive and patient preference is important in treatment decision making. Although Ruby was also a good candidate for cognitive behavior therapy (CBT), another empirically supported intervention for major depression, the link between her failed attempts to get pregnant and onset of depressive symptoms made her particularly well suited for IPT. IPT focuses specifically on interpersonal events as a primary point of intervention, while at the same time recognizing the role of genetics, biochemical, developmental and personality factors in causation and risk for depression (Weissman et al., 2000; Stuart & Robertson, 2003). The main goals of IPT are to alleviate depressive symptoms by facilitating resolution of the interpersonal “crisis” and improve social adjustment and functioning. Another factor that made Ruby a good candidate for IPT was her high level of social functioning and secure attachment pattern. Depression that occurs in the absence of a life event and this is primarily associated with interpersonal deficits and high attachment avoidance is less responsive to IPT and may fare better with another type of intervention such as CBT (Stotsky et al., 1991; McBride et al., 2006).*

Interpersonal Formulation

After reviewing the interpersonal and social context of Ruby's current depressive episode, it is clear that Ruby's depression is linked with the loss of reproductive health and her life plan to have her own genetic children. Although Ruby is aware that her odds of getting pregnant are low and that there are health risks associated with continuing infertility treatment, she feels stuck and the decision to stop treatment and move forward is agonizing. A review of Ruby's interpersonal world reveals a solid network of social supports and she has a history forming secure and enduring attachments with others. She reports having a good relationship with Michael, and despite their current disagreement about the next step in their quest for parenthood, she feels secure in their relationship and has always felt loved and supported by him. In some ways, she feels their struggle with infertility has strengthened their bond. Ruby also describes a close relationship with family and friends and is able to appropriately seek support and share her experience with infertility with them, although more recently she feels they do not fully understand the magnitude her loss. She feels her struggle with infertility has affected some relationships over the years due to her avoidance of child-centered occasions. While she has always enjoyed family gatherings, these too have become more difficult and she often feels awkward when extended family and family-in-law question her and Michael about their childlessness. On a few occasions, her parent-in laws have made comments she felt were not supportive, leaving Ruby feeling upset for days. Ruby acknowledges that her depressed mood has also affected her relationships, especially with Michael. She is more withdrawn than usual and more negative and irritable which she reports is unusual for her.

Clinical Decision: *Construction of an interpersonal formulation in the assessment phase of IPT is an important tool that links the depressive episode to recent life events and helps the therapist determine which of the four interpersonal problem areas is most salient to the onset and maintenance depressive symptoms and should be the focus of the remainder of treatment. The short-term nature of IPT leaves little room for error in formulating the case and choosing the wrong focus could potentially contribute to poor outcome as each interpersonal foci has a different set of goals, strategies and therapeutic techniques (Markowitz & Swartz, 1997; Ravitz et al., 2011). In the case of Ruby, the therapist formulated the case as a role transition, a difficulty in dealing with the loss of healthy reproductive self and experience of pregnancy, childbirth, and raising her biological children. Although Ruby also reported some tension in her relationship with her husband because of their recent disagreement to continue with treatment, interpersonal disputes was not a focus of therapy because the disagreement with her husband was more recent and not linked with the onset and maintenance of her depressive symptoms. Additionally, Ruby described an open and respectful dialogue between her and Michael regarding their disagreement and overall she was satisfied with the relationship. Complicated grief was not a focus of therapy because there was no evidence that Ruby's current depressive disorder was linked with the death of a member of her social network. Finally, interpersonal deficits were ruled out because Ruby has an extensive and supportive social network.*

At the end of the third session, the interpersonal formulation was reflected back to Ruby and the therapist explicitly linked her depression to the role transition of being infertile. The therapist stated "The inability to conceive is a significant loss for you as bearing your own

children has always been part of your life plan and identity. We call this a role transition. Despite all your efforts to conceive your body is not responding as planned, leaving you feeling out of control and helpless. Your inability to conceive has also affected your interactions with others and this too contributes to your feelings of depression. You describe infertility as an isolating experience and feel awkward and unhappy in social situations that remind you of your childlessness. While you acknowledge that the chance of becoming pregnant is remote, the decision to stop treatment is difficult because this would mean giving up on your dream to have a biological child. Although the loss of this dream is painful, the situation is not hopeless and you have options that would be important to explore. As you find a way to adjust to the role transition, your mood should improve". The interpersonal formulation resonated with Ruby and she agreed to proceed with IPT and attend an additional 10 weekly sessions.

Treatment plan.

Clinical Decision: *Following the initial assessment phase, IPT includes a middle phase in which the therapist and patient explicitly focus on resolving the interpersonal stressor and a termination phase which includes consolidating treatment gains, relapse prevention and discussion of additional treatment if full remission is not achieved. Consistent with IPT guidelines for working with role transitions (Weissman et al., 2000; Stuart & Robertson, 2003), the therapist and Ruby collaboratively established the following goals: 1) mourning the loss of reproductive health and the biological child she may never have, 2) navigating the decision to stop treatment, 3) exploring alternatives such as adoption or a childfree lifestyle; 4) reducing feelings of isolation from the "fertile world" and learning how to manage the infertility in her interactions with friends, family, neighbors and colleagues; and 5) increasing comfort in her new role (i.e., a childless woman). At the beginning of each session, the therapist monitored Ruby's depressive symptoms and explicitly linked changes in her mood with social and interpersonal events that occurred during the past week. In addition, during the course of treatment the therapist attended to the therapeutic alliance established during the assessment phase of treatment, maintained the therapeutic focus, and presented a reassuring, supportive and hopeful stance. The main IPT techniques the therapist used in this case were non-directive exploration, encouragement of affect, clarification, communication analysis, and behavior change techniques.*

In the initial middle sessions the therapist encouraged Ruby her to express painful feelings about her inability to conceive and unfulfilled wishes and dreams of experiencing pregnancy, giving birth, breastfeeding and raising children she and Michael created. Ruby talked with sadness about how she was "depriving" Michael of a biological child and her parents of a "healthy" grandchild, how angry and inadequate she felt when relatives would ask her why she and Michael have no children, and how excluded she felt when her friends, family and colleagues would talk about their children. Although Ruby felt her husband, parents and some close friends were supportive she often kept her feelings to herself because she knew how badly they felt for her and she didn't want to burden them with her pain. Ruby felt that talking about her loss in the context of a supportive therapeutic relationship made her feel better and that it also helped her put the role loss in better perspective. Ruby was encouraged to talk

more candidly about her feelings of loss with her husband and other key supports as this too would help improve her mood.

At the same time Ruby and the therapist explored her feelings about stopping fertility treatment and what this would mean to her. Ruby was afraid she would regret her decision to not undergo one more IVF trial and that stopping treatment would mean having to finally face the loss as it was not possible for her to conceive without reproductive assistance. Yet she also recognized that terminating medical therapy was the best decision considering her history of treatment failures and low odds of succeeding with future trials. The therapist and Ruby discussed the advantages and disadvantages of continuing infertility treatment and impact this would have on her physical and emotional well-being and relationship with Michael. Ruby talked about how she made all the decisions about fertility treatment and that Michael went along with whatever she decided because he loved her and wanted to support her in any way he could. She confessed that she did not always consider how her unrelenting pursuit of pregnancy affected him and that it was unfair of her to demand that he endure another trial that would likely end in failure. The therapist encouraged Ruby to continue negotiating treatment options with Michael and find a decision both of them could be happy with. By the eighth session Ruby indicated that she felt emotionally prepared to stop treatment and to her surprise felt a tremendous sense of relief after the decision was made. Her mood had improved significantly and she reported improvement in other depressive symptoms and interpersonal functioning. The therapist noted that while this was a difficult decision to make, Ruby's ability to mourn and move beyond the loss of her dream of having biological children had a positive effect on her mood.

Throughout the next several sessions Ruby and the therapist explored other options for parenthood. Ruby expressed a reluctance to adopt a child because this too would be a stressful and uncertain process. Additionally, not knowing the adopted child's genetic background and the birth mother's pre- and postnatal care scared her. She talked about how stressful it has been for her brother to raise an autistic child and she did not want to risk adopting a child with serious physical or mental health problems. The therapist acknowledged and validated Ruby's concerns, but encouraged her to research and explore this option with Michael further before making a final decision. The therapist then shifted the discussion to what life would be like without children if she and Michael eventually opted not to adopt. Ruby mentioned that while the idea of childlessness is very painful she was beginning to feel more optimistic that her life could be happy and meaningful without children. She recently had dinner with a friend from law school who was also involuntarily childless and Ruby was impressed by how satisfied and fulfilled her friend was with her life. The therapist and Ruby continued to discuss this option and whether there might be advantages to remaining childless. In the following session Ruby mentioned how she and Michael had been talking about their future and that both were feeling more positive with the notion of being a childless couple.

During the course of therapy Ruby talked about her feelings of isolation from the fertile world and how she wanted to develop strategies to manage her emotional response to being around pregnant women and child-centered events. Ruby indicated that she felt terrible whenever she

declined an invitation to attend a baby shower, christening, or birthday party of the child of a close friend or relative and she worried about alienating these important members of her social network. The therapist encouraged Ruby to attend these events if she felt up to it and that it was okay to have an “exit plan” if she felt too upset and needed to leave the event early. Towards the end of therapy Ruby agreed to attend the christening of the son of Michael’s close friend and while it was difficult to participate in the event, she noted the intensity of her emotional distress was markedly diminished and she was able to stay at the event until the end. The therapist helped Ruby explore other ways she could maintain regular contact with friends with children and encouraged her to expand her network of friends to include more childless friends and couples she and Michael could socialize with. Finally, the therapist used role-play to help Ruby respond more effectively to insensitive and intrusive questions about her childlessness. Although these questions continued to bother her she felt more skilled in responding to them.

The final two sessions focused on consolidating treatment gains, relapse prevention and discussing feelings about ending therapy. At the end of treatment, Ruby’s score on the HAM-D was in the normal range (≤ 7), her score on the BDI was 6, and she showed good functioning in all areas (GAF=90). The therapist and Ruby agreed that additional sessions were not necessary but that they would set up an appointment in six months to assess how things were going. At the follow-up visit treatment gains were maintained and Ruby had recovered from her depression. Ruby mentioned that after considerable reflection she and Michael finally decided that adoption was not the right choice for them, and although she still has periods of sadness when she is reminded of her loss, there is finally closure on this issue and she feels content in her life without children.

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Getting the Best Psychological Help: Your Guide to Seeking Effective Psychological Treatment

If this is the first time you are looking for psychological help, you may be feeling a little overwhelmed by choices and decisions. Here are some guidelines to help you obtain treatment that is based on the best available research and clinical evidence.

What is effective psychological treatment?

Psychologists are trained to draw on research to guide their professional practice. This approach is referred to as Evidence-Based Practice. Evidence-Based Practice allows psychologists to use the best available information:

- To select assessment and treatment methods that have been deemed effective in addressing specific conditions.
- To help you to fully engage in a collaborative relationship with your therapist.
- To help you actively participate in the therapeutic experiences that enhance good outcomes.
- To monitor treatment progress and outcome.
- To adjust their approach if the treatment isn't working optimally.

Why is it important that my psychologist is using Evidence-Based Practice?

- The use of Evidence-Based Practice means that the treatment approach suggested for you is based on research indicating that the type of treatment works for people who have problems or conditions like yours. It provides a type of quality control.
- Treatment approaches that are part of Evidence-Based Practice are guided by a coherent and systematic theory, methodology and science.
- Evidence-based practice encourages full and open communication between you and your psychologist throughout treatment. It ensures that you are informed about the evidence supporting your treatment and about your treatment progress.

How do I select a psychologist who follows Evidence-Based Practice?

- Psychologists are expected to provide information about the treatments they offer.

- This information might include what you can expect from the treatment, the likelihood of success and how you can best manage your condition.
- It is perfectly legitimate, indeed very sensible to ask “does the research support the use of this method to address my particular concerns?”
- If the research evidence related to your concern does not yet exist or is not sufficiently strong, the psychologist should be able to provide a coherent rationale for the approach they have suggested and also to describe alternative approaches for you to consider.
- If there are any risks associated with use of that approach, the psychologist is expected to be able to outline these and explain them fully so that you are in a position to make a fully informed decision about the service that you are receiving.

What is treatment monitoring and why is it important?

- Psychologists using Evidence-Based Practice may ask you to periodically complete questionnaires or keep track of symptoms and life events over the course of your treatment.
- The results allow the psychologist to determine if treatment is yielding the expected result. This is very similar to a physician asking a patient with high cholesterol to undergo periodic blood tests in order to ensure that the cholesterol medication they have prescribed is having the desired effect.
- Monitoring also allows **you** to get an objective picture of whether treatment is working. Change can occur in small steps and monitoring allows you to see small changes more clearly.
- If the monitoring indicates that treatment isn’t working, then you and your psychologist can discuss what may be impeding treatment and what can be done about it. Together you may decide that another approach should be tried.
- It is important to note that treatment can take a while to produce effects, therefore you will want to give the treatment a reasonable try. You and your psychologist can discuss how long is reasonable.

Evidence-Based Practice in psychology is in keeping with the general movement in all health professions toward offering treatments that are based on research evidence. Physicians, nurses, social workers and other health professional organizations are all working to encourage Evidence-Based Practice.

Various professional organizations have developed guides to psychological treatments supported by evidence. Links to these websites are below.

Canadian Psychological Association (CPA)

The CPA has a number of fact sheets available that provide information on different problems and conditions: <http://www.cpa.ca/psychologyfactsheets/>

Helpful websites about treatment

<http://www.cpa.ca/public/>

<http://www.abct.org/Public/?m=mPublic&fa=WhatIsEBPpublic>

<http://www.apa.org/divisions/div12/cppi.html>

Helpful websites for child treatment

<http://www.effectivechildtherapy.com/>

http://www.kidsmentalhealth.ca/professionals/interventions_and_research.php

Resources on Evidence-Based Practice (for Practitioners)

Canadian Psychological Association (CPA)

The CPA has a number of resources for practitioners. These can be found here:

<http://cpa.ca/practitioners/resourcesofinterest/>

Ordre des psychologues du Québec (OPQ)

The OPQ publishes a number of guidelines for intervention. These can be found at:

<http://www.ordrepsy.qc.ca/en/documentation-et-medias/guides-frameworks-and-guidelines.sn>

The OPQ also publishes a series on science and practice, which can be found at:

<http://www.ordrepsy.qc.ca/en/documentation-et-medias/integrating-science-and-practice.sn>

American Psychological Association (APA)

The APA publishes guidelines for practitioners, including for intervention with specific populations: <http://www.apa.org/practice/guidelines/index.aspx>. See also <http://www.apa.org/practice/resources/evidence/children-report.pdf>

Division 12 (Clinical Psychology) of the APA maintains a list of research-supported treatments for different conditions: <http://www.psychology.sunysb.edu/eklonsky/division12>

Division 29 (Psychotherapy) on psychotherapy provides resources for evidenced based practice:

<http://www.divisionofpsychotherapy.org/tag/evidence-based-practice/>

Division 53 (Society of Clinical Child and Adolescent Psychology) provides information on empirically supported treatment options for different child and adolescent mental health symptoms and disorders:

http://effectivechildtherapy.com/sccap/?m=sPro&fa=pro_ESToptions

Division 54 (Pediatric Psychology) provides links a list of references regarding evidence based treatments: <http://www.societyofpediatricpsychology.org/evidence/>

EBMsources

EBMsources includes a list of websites that provide evidence-based clinical information, including in mental health. It is available in French and in English:

<http://www.ebmsources.fmed.ulaval.ca>

The Cochrane Library

The Cochrane Library provides summaries of systematic reviews for various conditions, including in mental health: <http://www.cochrane.org/reviews>. See also:

<http://www3.interscience.wiley.com/cgi-bin/mrwhome/106568753/HOME>

The Campbell Collaboration (C2)

C2 prepares, maintains and disseminates systematic reviews in education, crime and justice, and social welfare. <http://www.campbellcollaboration.org/>

National Institute for Clinical Excellence

NICE produces systematic reviews and practice guides, including for practitioners in mental health: <http://www.nice.org.uk/guidance/index.jsp>

Social Care Institute for Excellence

SCIE produces different guidelines related to intervention including, for example, guidelines for intervention with children and adolescents who deliberately self-harm:

<http://www.scie.org.uk>

NHS Clinical Knowledge Summaries

CK Summaries provides evidence-based information and guidelines for the common conditions managed in primary, including for mental health issues: <http://www.cks.nhs.uk/home>

Guidelines Advisory Committee and the Center for Effective Practice

Until 2010, GAC and CEP (<http://www.effectivepractice.org/>) reviewed and endorsed practice guidelines: <http://www.gacguidelines.ca>

Scottish Intercollegiate Guidelines Network

SIGN produces evidence based practice guidelines, which can be found at:

<http://www.sign.ac.uk>

National Guideline Clearinghouse

The NGC is a U.S. based search engine dedicated to clinical practice guidelines:

<http://www.guideline.gov>

The Institut national d'excellence en santé et en services sociaux

INESSS produces evidence based guidelines. These will soon include guidelines for mental health issues: <http://www.inesss.qc.ca>

TRIPDataBase

TRIPDatabase is a search engine for clinical evidence in support of clinical practice:

www.tripdatabase.com

The Child and Adolescent Mental Health Services Evidence Based Practice Unit

The Unit is part of University College London (UCL) and the Anna Freud Centre. It provides a summary of the evidence regarding treatments for various child disorders:

http://www.ucl.ac.uk/clinical-psychology/EBPU/publications/pub-files/drawing_on_the_evidence_booklet_2006.pdf

The Ontario Children's Mental Health webpage

The webpage provides information on evidence-based practices:

http://www.kidsmentalhealth.ca/professionals/interventions_and_research.php

Health Evidence

Health Evidence has a searchable library of research evidence. <http://health-evidence.ca/>

Agency for Healthcare Research and Quality (AHRQ)

AHRQ has a number of evidence reports pertaining to practice and intervention in mental health. <http://www.ahrq.gov/clinic/epcindex.htm>

Recommendations to the CPA Board of Directors

Canadian Code of Ethics

The Values Statement accompanying Principle I of the Canadian Code of Ethics (Respect for the Dignity of Persons) states “Rights to privacy, self-determination, personal liberty, and natural justice are of particular importance to psychologists, and they have a responsibility to protect and promote these rights in all of their activities. As such, psychologists have a responsibility to develop and follow procedures for informed consent, confidentiality, fair treatment, and due process that are consistent with those rights (Canadian Psychological Association, 2000, p.8). Contained within Value I are several standards addressing the issue of informed consent.

✓ **The EBP task force recommends that Standard I.17 be expanded to read:**

I.17 Recognize that informed consent is the result of a process of reaching an agreement to work collaboratively, rather than of simply having a consent form signed. ***This includes ensuring those receiving services from psychologists are apprised of available evidence-based treatment options and the psychologists’ ability to provide those services effectively and efficiently*** (Canadian Psychological Association, 2000, p. 9).

The Values Statement accompanying Principle II of the Canadian Code of Ethics (i.e., Responsible Caring) states “A basic ethical expectation of any discipline is that its activities will benefit members of society....Therefore, psychologists demonstrate an active concern for the welfare of any individual, family, group, or community with whom they relate in their role as psychologists” (Canadian Psychological Association, 2000, p. 15). The statement underscores the importance of developing and using methods that will maximize benefit while minimizing potential harm to recipients of psychological services. Implied in this statement is the centrality of relying on empirical evidence to guide case formulation, treatment planning and clinical intervention.

- ✓ **The EBP task force concludes that this section of the Canadian Code of Ethics would be strengthened by the addition of a direct statement recommending that ethical psychological practice is guided by empirical evidence and use of the evidence hierarchy.**

Suggested wording could be:

II.21 Strive to provide and/or obtain the best possible service for those needing and seeking psychological service. This may include, but is not limited to, selecting interventions that are relevant to the needs and characteristics of the client *that are evidence-based and guided by the evidence hierarchy*, and that have reasonable theoretical or empirically-supported efficacy in light of those needs and characteristics (Canadian Psychological Association, 2000, pp. 16-17).

Accreditation Standards

The Accreditation Standards for Doctoral and Internship Programs in Professional Psychology (Canadian Psychological Association, 2011) stipulate that “Training in the practice of psychology includes a range of assessment and intervention procedures and is not restricted to a single type. Although programmes may emphasize different theoretical models and skills, students need to become familiar with the diversity of major assessment and intervention techniques in common use and their theoretical bases. Programmes must include training in evidence-based interventions as well as training in more than one therapeutic modality” (p. 21). This standard serves as an essential foundation for EBP for developing professional psychologists.

- ✓ **The EBP task force recommends that the accreditation panel consider expanding this standard to include instruction and training in evidence-based decision-making that is guided by use of the evidence hierarchy.**

Standard II.9 of the Canadian Code of Ethics states that psychologists “[k]eep themselves up to date with a broad range of relevant knowledge, research methods, and techniques, and their impact on persons and society, through the reading of relevant literature, peer consultation,

and continuing education activities, in order that their services or research activities and conclusions will benefit and not harm others.” (Canadian Psychological Association, 2000, p. 16)

Dissemination of Evidence-Based Practice Methods

- ✓ **The EBP task force recommends that the Education Directorate, Practice Directorate, and Science Directorate of CPA take steps to disseminate the findings and conclusions of the EBP Task force and look for opportunities to sponsor or provide continuing education workshops, seminars, and symposia to psychologists in EBP and EBP decision making. The annual convention of the Canadian Psychological Association and annual meetings of Provincial and Territorial Psychological Associations and Societies can serve as vehicles for these sessions.**
- ✓ **Dissemination to the general public and other professional audiences should also be considered. The Task force recommends that the “Getting the Best Psychological Help” Guide be distributed widely for display in offices of other health care providers (e.g., General Practitioners and Specialists, Chiropractors, Hospital waiting areas, and various consumer-based groups such as the Canadian Cancer Association).**
- ✓ **The task force also recommends that the guide for individuals with lived experience (i.e., Getting the Best Psychological Help: Your Guide to Seeking Effective Psychological Treatment) be posted on the CPA Psychology Works web page.**
- ✓ **The task force recommends that various versions of this guide also be developed to target specific segments of the community (youth, various ethnic and cultural groups).**

Continuing Education

- ✓ **The EBP task force recommends that the CPA Sections offering or sponsoring CE activities at the annual convention, or as stand-alone workshops, ensure that these offerings reflect EBP and EBP decision-making.**

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Appendix A: The Task Force Process and Deliberations

As part of the incoming CPA President's 2011-2012 mandate (see Dozois, in press, 2012), the Board of Directors voted in favour of a motion (March, 2011) that the CPA establish a task force on the evidence-based practice of psychological treatments which reviews the literature, generates a set of criteria and develops a position statement regarding the optimal integration of research evidence into practice. The board believed that it was important for CPA to develop its own position on evidence-based practice in psychology to support and guide practice as well as to inform stakeholders. Psychological health and disorders are clearly a priority for many of Canada's stakeholder groups (e.g., Mental Health Commission of Canada, Treasury Board, Public Health Agency of Canada) and their effective treatment is an important priority for CPA as well.

Rationale

Key objectives in clinical psychology include the generation of treatment-relevant scientific knowledge and the application of this knowledge to the development of effective interventions for mental and behavioral health problems (Baker, McFall, & Shoham, 2008; Kazdin, 2008; Lilienfeld, 2010). Such objectives arise from a growing recognition in the field that the practice of psychological treatments should be based on valid evidence regarding which approaches to intervention are most likely to be successful. Although there is controversy regarding what constitutes "evidence", the vast majority of psychologists favour the idea that they should practice in a manner that is evidence-based.

Commissioned by Division 12 (Clinical Psychology) of the American Psychological Association (APA), the Task Force on Promotion and Dissemination of Psychological Procedures published its 1995 report, which listed treatments considered to be either well-established or probably efficacious according to a standard set of criteria (e.g., Chambless et al., 1996). These criteria were also adopted by the Clinical Section of CPA in their task force report, *Empirically Supported Treatments in Psychology: Implications for Canadian Professional Psychology* (Hunsley, Dobson, Johnston, & Mikail, 1999a, 1999b).

The APA's criteria for empirically supported treatments elicited both enthusiasm and controversy. Although there was excitement about the recognition of "effective" psychological treatments there were also myriad concerns. For example, some psychologists have argued that the type of research deemed necessary to produce supportive evidence for a treatment is incompatible with schools of psychotherapy outside of the cognitive and behavioural framework (Bryceland & Stam, 2005; Stuart & Lilienfeld, 2007). There was also criticism that although randomized clinical trials are considered the "gold standard" for psychotherapy outcome research the generalizability of their findings to actual clinical practice is limited (but see Hunsley, 2007; Hunsley & Lee, 2007). Others criticized the preponderance of CBT treatments that, for lack of a better term, "made the list" (e.g., Westen & Morrison, 2001). Still others contend that manualized treatments fail to address the complexities of clinical practice.

More recently, the APA established a task-force on evidence-based practice in psychology that attempted to acknowledge multiple types of research evidence. The wording of the policy states that, “Evidence-based practice in psychology is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA, 2006, p. 273; also see Spring, 2008).

Unfortunately, the APA task force did not operationalize what constitutes “evidence.” in this policy. Rather, it “identified a continuum of data sources available to clinicians, from uncorroborated clinical observations through meta-analyses of the results of RCTs” (Stuart & Lilienfeld, 2007, p. 615). The task force also said little about the need for ongoing idiographic evaluation of one’s clinical cases. Current debate in the literature focuses not on whether it is necessary to utilize research findings but on *how* research findings should be incorporated into clinical interventions.

It is important to point out that evidence-based practice is a process by which the best evidence available is used to make optimal clinical decisions (see Hunsley, 2007). Although some psychologists mistakenly equate evidence-based practice with empirically-supported therapies, the two are not synonymous. There are, in fact, many ways to provide evidence-based treatment (e.g., by focusing on effectiveness trials and naturalistic studies or by emphasizing evidence-based *procedures* and principles of practice). Clinical practice should be evidence-*informed* but it does not need to be evidence-*driven* (Bohart, 2005). Similarly, research should be informed by practice to ensure that the discipline and profession are providing evidence for treatments that respond to the kinds of problems that clients bring to psychology practitioners.

The Work of the Task Force

The CPA Task Force on Evidence-Based Practice of Psychological Treatments was co-chaired by Drs. David J. A. Dozois and Sam Mikail. The task force was populated during the summer and began its work in September, 2011. Task force members (11 in total) were chosen to represent a variety of research, practice, knowledge-translation, consumer and community perspectives. There was also good representation from different theoretical orientations, including interpersonal, emotion-focused, cognitive-behavioural and psychodynamic perspectives. The task force members met a total of 12 times from September, 2011 to November, 2012 (11 teleconferences and 1 face-to-face meeting). Considerable work was also conducted via email correspondence, the use of Dropbox™ (to download documents and articles pertaining to EBP), and in various subcommittees.

The task force produced an initial draft document that operationalized what constitutes evidence-based practice of psychological treatment (both a definition of evidence and a hierarchy of available evidence). In terms of defining what is meant by “evidence”, the members of the task force were interested in a definition that was comprehensive enough to incorporate the following ideas: (1) research evidence is central; (2) psychologists should be evidence-based not only in their general fund of knowledge but also in session-by-session work; (3) the process involves one of collaboration with a client/patient (rather than a top down process). The next step involved establishing a hierarchy of evidence that was respectful of

diverse research methodologies, palatable to different groups of individuals and yet comprehensive and compelling.

At this point, the task force was interested in obtaining feedback on these core elements prior to completing its next steps. The consultation process involved an online survey and was completed on April 15, 2012. Input on the initial document was sought from CPA members who practice or have an interest in psychological treatments. Various organizations (e.g., ACPRO, CCPPP, CRHSPP) were also contacted for their feedback. The Chairs of the following CPA Sections were also contacted to respond to the consultation document: Aboriginal, Addictions, Clinical, Clinical Neuropsychology, Counselling, Criminal Justice, Family, Health, Psychoanalytic, Psychologists in Education, Rural and Northern, Sport and Exercise and Traumatic Stress.

A total of 51 responses to the consultation document were received. In general, the task force's statements were very well received. Most respondents were enthusiastic and positive about the definition and levels of evidence. The feedback was considered carefully by the task force members during subsequent teleconferences and a revised version of the evidence statement and hierarchy was then generated.

The task force believed that the relevance and usability of the document would be enhanced considerably by the inclusion of clinical vignettes that illustrate the use of the hierarchy in actual clinical practice. As such, the task force members generated a series of brief vignettes that illustrated the process of EBP and solicited vignettes from various CPA Sections. Chairs of various CPA Sections were invited to submit a brief vignette of a composite case describing the use of evidence based treatment and the application of the hierarchy. Our intention was not to be exhaustive or prescriptive but rather to provide several short examples that reflect actual clinical decision-making and the process of applying EBP in psychological treatment. A compilation of several such cases was then included in the final manuscript. Section Chairs were informed that, although the document would be authored corporately, their contribution would be acknowledged in the final manuscript in the list of contributors.

Individual experts were also invited to contribute an extended vignette that outlined the process of being evidence-based in one's practice within a particular therapeutic modality. Specifically, these contributors were asked to illustrate an evidence-based approach to assessment, case-conceptualization, goal-setting and treatment planning and implementation.

Task force members also worked to put together a brochure that is oriented toward the public and highlights the importance of evidence-based practice and the value of psychological interventions. A list of resources to help professional psychologists locate reliable information regarding EBP was also compiled. Finally, a set of recommendations was created to further advance the EBP of psychological treatments

Although important, this work serves merely as a springboard for further development and dissemination. We hope that this will be a "living" document of sorts that will continue to be up-dated, resourced and energized by the CPA Board and Head Office staff.

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Appendix B: List of Vignette Contributors

A number of individuals worked hard to contribute clinically-relevant, interesting and thought-provoking vignettes that illustrate the process of being evidence-based in one's practice. We would like to acknowledge your hard work and thank you for your important contributions.

Contributors to the Brief Vignettes

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