Not All Treatments are Equal: Re-Conceptualizing Treatments that Cause Harm

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Introduction

• What are **Evidence-Based Treatments (EBTs)**? (Lilienfeld, 2007)

“[L]ists of treatments that have been found in controlled trials or systematic single-case designs to be efficacious for specific disorders”
Introduction

• Purpose/Rationale of EBTs:
  • APA Division 12 Task Force (Rosen, & Davison, 2003)
  • Bridging the gap between researchers and practitioners
  • “Dodo Bird” verdict: “all treatments are equal/effective”
  
  FALSE!

• There are treatments that are not only ineffective, but can also be harmful

• Identifying harmful treatments is only the first step; identifying mediators is a logical progression (Lilienfeld, 2007, p. 54)
Statistics on PHT

- “10% of clients seen in therapy experience deterioration effects or get worse due to therapy” (Lilienfeld, 2007)
- “Results of randomized clinical trials show that 5-10% of patients deteriorate or get worse, and about 35-40% do not benefit from therapy” (Lambert, 2007)
- “28% of 181 practicing psychologists across America were unaware of negative effects in psychotherapy” (Boisvert, C at Rhode Island Center for CBT & Faust, D at Brown University Medical School)
Treatments could be harmful!

- If the treatment is ineffective, it can be harmful.
- Receiving no treatment can sometimes be better than receiving an unknowingly harmful treatment.
Purpose & Rationale

I. Explore *why* Potentially Harmful Treatments (PHTs) are used

II. Discuss *strengths and limitations* for developing a list of PHT

III. Propose *an alternative approach* for conceptualizing effective/harmful treatment
Lilienfeld’s (2007) Definition of PHTs

Three Conjunctive Criteria

I. **Deterioration** & **decelerated rate** of improvement in clients or others

II. Harmful effects are **enduring** and not short-term

III. Harmful **effects replicated** by independent investigative teams
Some PHT are widely administered

- Hypnosis and guided imagery: uncovering child sexual abuse in female clients (Polusny & Folette, 1996; Poole, Lindsay, Memon, & Bull, 1995)
- Critical Incident Stress Debrief (CISD): aftermath of the September 11) (McNally et al., 2003)
- Facilitated communication (FC): 200 schoolchildren in Whittier, California alone (Rubin & Rubin, 2005)
- Drug Abuse & Resistance Education (DARE) Programs: About half of all U.S. local school districts (MacKillop et al., 2003)
If it’s harmful, why use it?

- **Belief Perseverance**: Firmly held beliefs are resistant to contradictory evidence.
- **Disposition Bias**: May attribute client deterioration to individual-difference variables instead of therapeutic factors (e.g., DARE).
- **Alleviation is bliss?** Decelerated improvement is hard to notice (often still viewed as effective therapy).
- **Best intentions undermined**: Overestimate the prevalence of negative effects without treatment (e.g.: CISD).
Assessing and Understanding Treatments

- Treatments as **monolithic** vs **multicomponent**

- Consideration of components of therapy

- Comparison to a clear standard
  - Direction of change
Utility of Assessing Components

- Uncover extraneous or harmful components
- Promote improvement

![Graph showing the utility of assessing components with three lines representing Effective Treatment, Natural Change, and Harmful Effect over time.](image-url)
Practical Application

• Already happening
• May be particularly useful in clinical settings
• May avoid situations that lead to defensiveness
Is it **eclecticism**?

**Eclecticism**
- Pick and choose based on assumptions
- No clear means of assessment
- High burden on clinician

**Component Approach**
- Identify and apply effective components
- Clear means of assessment based on component
- Low burden on clinician