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Commentary

If we build it, will they come? And will they stay? Commentary on Holmes et al. "Examining patterns of dose response for clients who do and do not complete Cognitive Processing Therapy"

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ABSTRACT

Although evidence-based practice is becoming more widely accepted, the issue of patient preference has been relatively ignored. As noted by Holmes and colleagues (2019), when delivered in a community setting, Cognitive Processing Therapy (CPT) can have a relatively high dropout rate (42 % in the Holmes et al., 2019). In this commentary, issues about the conceptualization of treatment dropout as one index of patient preference are discussed. Dropout can be conceptualized as a potential reflection of poor fit between the patient and a specific empirically-supported treatment. Consideration of ways in which an empirically-supported treatment can be personalized, while remaining true to its underlying principles, are discussed using CPT as an example.

Evidence-based practice (EBP) has become the new buzz-word within clinical psychology, signifying different meanings depending upon the author. The original meaning of the term is derived from medicine (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996), wherein EBP was recognized as the integration of the best available empirical evidence, clinical expertise, and patient preferences. In many respects, this definition reflects a balanced approach to considering ways in which health care can be both standardized and personalized at the same time. Many believe that this approach to EBP is particularly applicable to dissemination and implementation efforts within mental health (e.g., Chambers et al., 2017), as it allows flexibility in adapting a scientifically-grounded intervention to a novel environment, for novel clientele, or to be implemented by novel care providers. The American Psychological Association expanded the third component of EBP to include patient characteristics, culture, and preferences (American Psychological Association & Presidential Task Force on Evidence-Based Practice, 2006), recognizing key aspects of our clientele beyond specific preferences. Notably, this definition of EBP also provides a lens through which to understand dropout from treatment.

Using a broad definition of "patient preference," discontinuing treatment prior to completion is one index of poor fit between the client's choice for mental health treatment and a specific intervention. In the Holmes et al. (2019) study, 42 % of their sample did not complete cognitive processing therapy (CPT), a rate that is high relative to the aggregate proportion of dropout reported in a recent meta-analysis of PTSD treatment (Imel, Laska, Jakupcak, & Simpson, 2013). Importantly, Holmes and colleagues explored two conceptually-driven models to determine if dropout could be understood in the context of patterns of symptom change, with poor fit noted for both the dose-effect and good-enough level models. As a take-home message, Holmes and colleagues note that clients who had the best outcomes completed all 12 sessions of CPT. The data reported by these authors are notable, as the study was conducted in a country which has publicly-funded health (and mental health) care; presumably, lack of financial resources can be ruled out as an explanation for the 42 % dropout rate.

If we conceptualize dropout from treatment as an index of patient preferences, how does our perspective change? To begin, we can understand the lack of treatment completion as a signal of poor fit between the individual and an empirically-supported treatment and not a problem anchored within the individual. Poor fit possibly can result from many factors, although research on patient preferences is somewhat limited. A meta-analysis suggests that people who were matched to their preferred therapy condition were significantly less likely to drop out of treatment and showed more positive outcomes, relative to people who were not matched to their preferences (Swift, Callahan, & Vollmer, 2011). Similar findings have been reported by Williams et al. (2016) in the United Kingdom. Swift et al. (2011) note that "preference" has been examined in the literature in one of three ways: 1) role preferences (e.g., advice-giving versus listening), 2) therapist preferences (e.g., therapist ethnicity matching with patient's ethnicity), and 3) treatment preference (e.g., CBT versus supportive therapy). Greater clarity and, perhaps, greater nuance in operationally defining

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"preference" could advance research on this important topic. For example, understanding how preferences interact with expectancies for treatment (following the first session) could deepen our understanding of these constructs and potentially help us to personalize treatment.

Moreover, Cooper, Norcross, Raymond-Barker, and Hogan (2019) highlight notable differences between mental health professionals and laypersons with respect to activity preferences during psychotherapy, with the largest differences obtained on therapist directiveness and emotional intensity. Mental health professionals preferred less therapist directiveness and greater emotional intensity, while our consumers preferred the opposite. Collectively, these studies suggest that as a field, we have just begun to dive into an understanding of what the term "patient preferences" means and its implications for treatment delivery.

CPT, the treatment used in the Holmes et al. (2019) report, could easily serve as a useful exemplar for ways to accommodate patient preferences in the delivery of an empirically-supported treatment. As an overview, CPT intends to help patients learn how to challenge and change unhelpful beliefs related to their trauma. In learning and applying the cognitive skills that undergird CPT, the individual creates a new perspective on the traumatic event and why it occurred. CPT typically begins with psychoeducation about the symptoms of PTSD, as well as provision of a working framework about the association between thoughts and emotions. In some versions of CPT, the patient is then asked to provide a written account of their worst trauma, including discussion of why they believe it occurred (the version of CPT examined in the Holmes et al. (2019) study included in this written account). Next, a series of cognitive strategies are taught by the therapist, using Socratic questioning and other process-related therapeutic skills, to help the individual gain a more balanced, realistic perspective on negative beliefs about the trauma. In the last five sessions (of 12 sessions total), CPT focuses on issues of safety, trust, power and control, esteem, and intimacy, areas that tend to be impacted by many forms of trauma. The overarching goal of CPT is to help the patient create a new understanding and conceptualization of the traumatic event so that it reduces ongoing negative effects on their current life.

In thinking about patient preference, several dimensions of CPT are potential targets for personalization. For example, CPT is designed to be completed in 12 sessions. It is possible that some patients will prefer different pacing, either a slowed down version of CPT (encompassing more sessions) or a speeded up version (encompassing fewer sessions). Galovski, Blain, Mott, Elwood, and Houle (2012) examined outcomes of CPT when the protocol was modified to be flexible, based on patient need and response to treatment. In this effort, the speed of delivering sessions was not altered but, CPT was ended according to patient response to treatment, not according to a set number of sessions. Considering dropout, 14% of patients who were initially assigned to modified CPT dropped out; for half of these cases, treatment discontinuation was related to lack of transportation or childcare, home foreclosure, need to move out of state, and imprisonment. The outcomes of the Galovski et al. trial are encouraging. Of particular utility is the approach that these investigators used for determining when to end treatment, which can become a template for dissemination of CPT into different types of care environments. A related example could involve development of guidelines for which CPT material can be repeated (if the patient has difficulty) and how to introduce the material when repeating it. Optimally, this type of guideline can explicate ways in which personalization can stay true to the principles that underlie a given intervention. Personalizing an empirically-supported treatment transcends available research on planned modification and adaption (see Wiltsey Stirman, Gamarra, Bartlett, Calloway, & Gutner, 2017). Personalizing can be studied within community care environments (see Chambers et al., 2017) and can advance dissemination and implementation efforts.

Holmes et al. (2019) have examined an important issue and their data suggest that we as a field have much to learn about patient preferences and how best to personalize (or fit) empirically-supported treatments to individuals. By expanding our view to incorporate our clients' preferences, characteristics, and culture, we increase the opportunity to impact mental health problems in a more meaningful way.

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