

The Logotherapy Evidence Base: A Practitioner's Review

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Why A Practitioner's Review?

Why do we need a practitioner's review of the logotherapy evidence base? Isn't this something we should leave to the researchers? The fact is, simply, in the United States we can no longer afford to.

Mental health care in the United States is undergoing rapid change of a magnitude not seen since the passage of the community mental health act in the 1963. Therapists need to be aware of the role of government regulation of healthcare, the therapy industry, and of the regulation of the third-party payors, that is, private and government insurance companies, who pay for the cost of treatment.

As a result of these sweeping changes, psychotherapists of all types are being held to account for the quality and outcome of their work. The survival of psychotherapy itself in the new healthcare landscape will depend on data – solid, empirical data on the effectiveness of the treatments applied *and* on the clinical outcomes achieved *at the level of individual therapists*. In other words, not only must treatments have a clear empirical base, individual therapists must be able to demonstrate solid clinical outcomes. This is sometimes called practice-based evidence.

Third party payors are moving from the fee-for-service model to an outcomes-based payment model. This means that in the near future, a therapist may get paid, not for providing an hour of logotherapy, but for achieving a desired outcome – however that outcome may be achieved. Moreover, the better skilled a therapist is at delivering the desired outcomes, the more that therapist will be paid to provide the service. Someone and I may provide the same service, but if that someone achieves better results than me, then that someone will get paid more for doing the same work.

In fact, this payment model for a limited target population begins in Kansas on July 1st of this year as part of the Affordable Care Act, popularly known as Obamacare.

In brief, government regulators and payors, whether private insurance companies or government agencies, want – and will pay for – improved care at lower costs.

Practitioners will need to demonstrate sound clinical outcomes.

Clients will demand improved quality of life.

These outcomes are defined in the United States by the National Outcome Measures. They are:

1. Decreased morbidity
2. Decreased mental illness symptomology
3. Increased employment or return to school
4. Decreased criminal justice involvement
5. Increased stability in housing
6. Increased access to services (service capacity)
7. Reduced use of psychiatric inpatient beds
8. Increased social supports/social connectedness
9. Client perception of care
10. Cost effectiveness
11. Use of evidence-based practices

Logotherapy holds significant promise for growth in the new healthcare landscape. This presentation will compare the published empirical evidence for the efficacy of logotherapy to evidence-based practice guidelines in the United States. The interpretations are my own based on my point of view as a logotherapist who intends to advocate for the efficacy of logotherapy with state government and with third-party payors. I will describe, from this point of view, what we know, what we need, and where we stand. I will conclude with details of an emerging Kansas Initiative.

A Note of Caution

We must take care not to confuse the term evidence-based practice as synonymous with practices that have strong research backing. An evidence-based practice is not defined as such by researchers, but defined by government, third-party payors, or other professional bodies. As such, it is a function of politics and economics more so than actual research. As we will see, it is necessary to “apply” to become an evidence-based practice. It does not just “happen” based on published research. This, of course, is also a mechanism to control costs by reducing the range of treatments to only the most cost-effective.

There is another side of the evidence-based practice debate - a body of research that stresses the therapeutic factors related to outcome. Consistent findings over many years demonstrate that differences among the various therapy models do not translate into differences in therapy outcomes. In fact, the preponderance of the evidence suggests that no meaningful differences exist among the various schools and forms of therapy.

Having said that, and perhaps because of it, it is good to know that the law defining evidence-based practice in Kansas is fairly broad. I will not burden you with reading the entire statute, but will simply draw your attention to the fact that the legal text offers a range of possibilities, depending upon the current state of the research. Scientific evidence is considered first, followed by other factors.

The legal definition of scientific evidence, seen here, is also broad. In general, in Kansas, an evidence-based practice may fall anywhere on this five-point scale:

1. Controlled clinical trials
2. Observational studies that demonstrate a causal relationship and partially controlled observational studies
3. Uncontrolled clinical series
4. Professional standard of care
5. Expert opinion

The definition of the American Psychological Association is also rather broad, as you see. *Evidence-based practice in psychology* (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.

It also contains an important word of caution. “It is important not to assume that interventions that have not yet been studied in controlled trials are ineffective. Specific interventions that have not been subjected to systematic empirical testing for specific problems cannot be assumed to be either effective or ineffective; they are simply untested to date. Nonetheless, good practice and science call for the timely testing of psychological practices in a way that adequately operationalizes them using appropriate scientific methodology.”

An Evidence-Based Practice in Psychology may fall anywhere on this three-point scale:

1. Sophisticated empirical methodologies, including quasi-experiments and randomized controlled experiments or their logical equivalents
2. Systematized clinical observation
3. Clinical opinion, observation, and consensus among recognized experts representing the range of use in the field

However, the experience in Kansas is somewhat different. The University of Kansas maintains a list of evidence-based practices that are only those programs operated by the University of Kansas. Clearly, they don't feel that they can speak for practices that they themselves do not operate. These University of Kansas evidence-based practices are offered at costs out of the reach of many community mental health centers; however, state government turns to the university for guidance on evaluating programs. The end result is many centers are left offering sound traditional psychotherapy services, but services that Kansas may not consider to be evidence-based. For this reason, the mental health centers in Kansas have argued that a national list should be the standard when negotiating with third-party payors in our State.

The national list suggested comes from the United States Substance Abuse and Mental Health Services Administration, or SAMHSA.

SAMHSA is:

1. An agency within the United States Department of Health and Human Services

2. Maintains a National Registry of Evidence-based Programs and Practices (NREPP)
3. Recognizes 329 EBPPs at last count
4. Publishes general information about the intervention
5. Describes the research outcomes
6. Rates the quality of research and readiness to disseminate
7. Provides a pathway for inclusion in the database

Here is an example of a SAMHSA evidence-based practice listing.

We won't go through the details, but the example, Mindfulness-Based Cognitive Therapy, likely has some points that could be similar to an imagined logotherapy listing.

We note the specific outcomes that the intervention is shown to achieve. Specific populations and geographic areas are noted. There is a bit of history and summary of key findings, followed by disclosure of funding sources. Adaptations and adverse effects or contraindications are given. Here you will see there are none. The full listing then goes on to give the most relevant research bibliography supporting the entry.

What Do We Know?

So, what do we know?

What is the evidence base of logotherapy? If we were to apply to SAMHSA to be recognized as an evidence-based practice, what would we claim as outcomes? By my count, the most well documented findings of relevance to logotherapy are the following:

1. A positive correlation exists between meaning and measures of well-being and coping.
2. An inverse correlation exists between meaning and a diagnosis of mental illness.
3. When mental illness does occur, an inverse correlation exists between meaning and symptom severity.

Other well-documented findings are:

1. An inverse correlation exists between reasons for living, or purpose in life, and suicidality.
2. An inverse correlation exists between meaning and a diagnosis of substance use disorders.
3. A positive correlation exists between meaning and health.

Emerging findings include:

1. Meaning in life is positively correlated with occupational functioning.
2. An inverse correlation exists between meaning and criminal or antisocial behavior.

3. Meaning in life is positively correlated with social functioning.

All of these findings would clearly be of great interest to a government or third-party payor interested in improving the health of a population in a cost-effective way. These findings represent significant strengths for the flourishing of logotherapy in the current healthcare environment. That is, IF the findings can be made available in a persuasive way to government and third-party payor decision makers.

What Do We Need?

However, there are some gaps. What do we need? Missing in my review is clear evidence of the following:

1. Studies to demonstrate that LTEA increases the perception of meaning in life. (This would seem to be an assumption, but it is not an assumption that has been clearly demonstrated in controlled studies. I found only two. Granted, I may have missed some studies, but ideally there would be many of these and the matter would be clearly established).
2. Studies to demonstrate that LTEA increases meaning in life equal to or better than other methods that purport to increase meaning in life.
3. Studies that demonstrate LTEA leads to positive clinical outcomes (such as the National Outcome Measures) regardless of the influence of meaning. (That is, the therapist's understanding of what is happening in logotherapy at the theoretical level need not be objectively true for the treatment to be effective. Our note of caution regarding therapeutic factors mentioned earlier is relevant here).

Inclusion of studies demonstrating these factors would improve the position of logotherapy enormously.

Where Do We Stand?

So, where do we stand with what we currently know? In comparing the research on logotherapy with the National Outcome Measures we see that there is evidence to believe that logotherapy leads to:

1. Decreased morbidity (as reflected in the inverse relationship between meaning and suicidality)
2. Decreased mental illness symptomology
3. Decreased criminal justice involvement (mediated not only by studies on criminality but also in the arena of substance abuse, an illegal activity. Not enough studies were published in the area of criminality to make my short list, but this is an emerging finding).
4. Reduced use of psychiatric inpatient beds (via reduced symptomology and decreased suicidality)
5. Increased social supports and social connectedness (again, this is an emerging finding).

If we were to submit logotherapy to SAMHSA, how would we fair? Where are our strengths and weaknesses?

We will answer this question specifically with respect to the “Quality of Research” and the “Readiness to Disseminate” measures.

Where are we in terms of our “Quality of Research?” This is where I think we would fall on the variables that compose this measure. As I interpret it, we:

1. Have good reliability
2. Have good validity
3. Have done little or no work on Intervention Fidelity. That is, how do we know that the way I practice logotherapy in Kansas is similar to how it is practiced in Austria? Or Australia? Or Japan? Someone could, in theory, advocate nihilism and still call it logotherapy. Such unmonitored variation in training weakens research results on logotherapy when taken to government or third-party payor reviewers.
4. Have had few studies that really address any missing data. I recall seeing one in my review and, perhaps, it is a rare event.
5. Have not extensively explored confounding variables in several studies.
6. Have demonstrated consistently the appropriateness of analysis in most studies.

Where are we in terms of our “Readiness of Dissemination?” That is, if a practitioner wanted to start a logotherapy initiative, where would we stand on this measure? In my opinion, we:

1. Have limited materials available for implementing a program. That is, there are multiple materials available, but they would need to be modified to form a consistent treatment program.
2. Have limited training resources and technical assistance. There are multiple training resources, to be sure, mostly consistent, but somewhat outdated, in the English-speaking world. Consistently of training worldwide is not clear, and technical assistance is available, as far as I know, only from the Vienna Institute with limited personnel.
3. Finally, no quality assurance procedures are available.

So, the two biggest barriers to the successful initiation of a logotherapy program in the current healthcare environment are:

1. Lack of Intervention Fidelity
2. Lack of Quality Assurance (recall, outcomes will be measured and paid for at the level of the individual provider)

It is no surprise that these were key issues of concern for the Vienna Institute following the 2012 Future of Logotherapy Congress.

A Kansas Initiative

However, enough material and clinically significant outcomes are available to begin an initiative that can deliver logotherapy to a broad population, with sound clinical outcomes, and that can build in fidelity and quality assurance as part of its program. To that end, I want to tell you a little bit about how I envision the Future of Logotherapy in Kansas.

The Kansas Initiative has local (state-level), national, and global objectives.

At the State level:

Phase 1:

With the support of the Association of Community Mental Health Centers of Kansas, a white paper is being prepared for submission to the Kansas Department of Health and Human Services demonstrating the likelihood that LTEA is effective in achieving a range of National Outcome Measures. This will be completed in the second half of 2014.

I have already received good technical assistance from the Association of Community Mental Health Centers, an organization with many years of experience in gathering data from the various mental health centers across the State and using those data to lobby for specific mental health goals in the State Legislature.

Phase 2:

Once the backing of the Department of Health and Human Services is acquired, one of the Managed Care Organizations under contract with the State will be approached to provide funding for a pilot program in LTEA to demonstrate its ability to achieve National Outcome Measures. LTEA in this form will likely be offered free of charge as a "Value Added Benefit" by the funding Managed Care Organization.

With State approval, this could be rolled out in 2015, the final year of the current contracts that the State of Kansas has with its current Managed Care Organizations. Achieving the National Outcome Measures is specified in the State contract and so the Managed Care Organizations will be eager to demonstrate their progress as they negotiate for contract renewal.

They will be especially interested because of statistics like this. The suicide rate in Kansas (and, likewise in other states) has increased by about 30%. Kansas is currently investigating whether the rise in the suicide death toll is directly related to the decrease in funding for the community mental health center system.

Phase 3:

Once the pilot program demonstrates the ability to achieve National Outcome Measures, such as a reduction in the suicide rate, the LTEA program could be initiated Statewide through a "Train the Trainer" model that would require dozens (at minimum) licensed

psychotherapists to be trained in the LTEA program model as developed in the pilot program. The LTEA program would then be offered throughout the well-organized and politically active network of community mental health centers in the State of Kansas. The pilot program is likely to be a one- or two-year program to gather the necessary data. This means that a “Train the Trainer” model with fidelity and quality assurance could begin as early as 2017.

Phase 4:

With the achievement of National Outcome Measures demonstrated in the State of Kansas through the LTEA Train the Trainer program, and with the backing of the Association of Community Mental Health Centers of Kansas and the Kansas Department of Health and Human Services, the LTEA program model may be made available to the National Council for Behavioral Health to be replicated as an evidence-based practice across the United States.

The National Council for Behavioral Health functions on the national level much like the Association of Community Mental Health Centers of Kansas, and the Association itself is a member of the National Council. The National Council is on the forefront of developing evidence-based practices, working toward and achieving SAMHSA recognition of those practices, and then providing mechanisms for intervention fidelity and quality assurance on the practices so developed. Their initiatives were instrumental in developing the behavioral health portions of the Affordable Care Act.

Phase 4 would require, initially, dozens and, eventually, scores or hundreds of LTEA Trainers monitored for fidelity and quality assurance to offer National Council workshops and seminars across the United States, training hundreds of logotherapists. Assuming success in the first three phases, this initiative could begin as early as 2019. With additional data gathered by the National Council, LTEA would then likely be added to the National Registry of Evidence-based Programs and Practices with relative ease.

An example of this is the Mental Health First Aid program, developed in Australia and adapted for the United States. Two people, a nurse and a professor, started this program with only a loose leaf binder as training material. In only 13 years, it has become the leading prevention program in the United States and over 150,000 people have been trained in the approach, in the United States alone, using the Train the Trainer model. That is, a National Council member trains and certifies me and other instructors, and then I train others. So, I can use what I’ve learned from the success of this National Council evidence-based program and apply it to the Kansas Initiative.

Also, as you can see, the mental health center where I work has trained 120 people in Mental Health First Aid, though now it is 142, of those 150,000. And we are small, rural center. Imagine if all those people had been trained in logotherapy!

At the global level:

Government and private payor sources are motivated by the ability to demonstrate improved care at reduced costs. The empirical evidence base of LTEA supports the notion that LTEA does provide improved care with speed and efficacy that can lead to reduce costs. However, data must be provided that demonstrate this to payor sources.

I propose, as part of the Kansas Initiative, to establish a secure, online portal for logotherapists and existential analysts around the world to report their individual clinical outcomes.

In this, we would be replicating the same type of data collection activities that have been used in Kansas to successfully demonstrate the effectiveness of the Kansas mental health center system.

These data will be made freely available in aggregate form to members of the initiative for use in their own countries, states, or regions to support the ability of LTEA to produce recognized clinical outcomes.

The online portal might also be used to collect international sample data during the course of the development of new LTEA measures.

Logotherapists and Existential Analysts wishing to participate can contact me. The online portal will be developed during the second half of 2014 if enough interest is generated.

I hope to be able to report significant success with the Kansas Initiative at the next Future of Logotherapy conference in 2016.

Thank you for your attention. We now have some time for questions and comments.