Evidence-based Practice and the Endeavor of Psychotherapy

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Many of us who are clinicians want to broaden the discussion of evidence-based psychotherapy. We want to move beyond the basics of the easy to measure efficacy studies, and into a more complex realm. In today's climate, it is a challenge for practicing psychologists to balance the needs to develop and maintain a personally effective therapeutic voice, translate multiple streams of evidence into meaningful interventions, offer safe and confidential therapeutic relationships, and practice in the real world. Disparate voices carry conflicting messages about the need for psychotherapy and its' costs, worth, components, allowable interventions, and effectiveness. These forces, both within the discipline of psychology and outside in the health care system, compete for supremacy and the attention of clinicians.

It is important for clinicians to join in the discussion and to share information on practices that contribute to good results for patients. Our discipline needs a bidirectional, not a one-way, conversation between clinical scientists and clinical practitioners. Our academic colleagues are giving us information daily about specific treatments and elements of the therapeutic relationship that work. We need to give them information about the problems we identify in our communities, the ways we approach those problems, and the outcomes.

This article gives an overview of our knowledge about psychotherapy: the *endeavor* of psychotherapy, the *evidence* we use for its underpinnings, and the *resources* we turn to for guidance in the absence of hard research findings.

EVIDENCE

What do we mean when we talk about evidence? The foundation for psychology is science, of course. The practice of psychology is built upon that base, although clinicians are faced also with problems that go beyond what the research has yet been able to describe, measure, or ameliorate.

The Institute of Medicine defines Evidence-Based Practice as: "the integration of the best research evidence with clinical expertise and patient values." [1] The APA document, Criteria for Evaluating Treatment Guidelines, integrates the same three components: empirical research, clinical judgment and expertise, and acceptability to the patient. [2]

Most knowledgeable psychologists support this kind of broad scientific definition for psychotherapy. There are, however, some who would like to minimize or eliminate the roles of clinical observation and judgment and patient values. That is a mistake, if one considers the nature of psychotherapy and the resources available that contribute to its success.

ENDEAVOR

Psychotherapy is first and foremost a human endeavor. It is messy. It is not solely a scientific endeavor, nor can it be reduced to a technical mechanistic enterprise. We do not yet know what is curative in psychotherapy. But we have some leads. We have a significant body of scientific evidence for the treatments of specific kinds of distress and clusters of symptoms, and we have a significant body of research concerning the importance of the therapeutic relationship. The triumvirate of factors that contribute to psychotherapy outcome is: the patient's personal factors (e.g. motivation), the therapist's personal factors (e.g., capacity for empathy), and the interventions offered. Keep in mind that specific techniques contribute only 5% to 15% to outcome. [3] Therapist effects are greater than treatment effects. [4] People get a substantial benefit from psychotherapy and no one modality is shown to be better than all the others. [5] We know that suffering is a part of the human experience, and we know that psychotherapy is effective in easing that suffering, no matter how you define it! Both the effectiveness and the efficacy research show that result.

Psychotherapy is a rich process. It is an attempt to reach understanding, ease pain, solve problems, and find meaning, within the context of a trusting relationship. Our patients want to be heard and understood. They want respectful help in obtaining relief, making sense out of their experiences and improving their lives. Each wants to be treated as a whole person, not a diagnosis or a case. Research findings are a necessary and vital part of psychotherapy, but they are not all of psychotherapy. The language of treatment manuals gives only a narrow and tightly structured view of the human condition. It is like

looking at a landscape with a flashlight. The flashlight illuminates the dark, but it does not show the entire field. We need additional tools as well, in order to function clinically. The scientific experiments are predicated on control and the ability to manipulate the variables under consideration. Real world psychotherapy involves working in the face of a few variables one can control, and with the knowledge that there are many one cannot. This is where clinical experience, judgment, and the ability to use creative combinations and adaptations of interventions come into play. They widen the view, from the flashlight view to the broader field.

Psychotherapy draws on many theories, including behavioral, cognitive behavioral, family systems, feminist, humanistic, psychodynamic, and cultural competency orientations. Perhaps not surprisingly, different patients make different theories look good, depending on the 'fit' in language and world view between the person seeking help and the person providing it. In practices and clinics across the country, underlying theories may differ but experienced clinicians look quite similar. They offer proven interventions, a solid therapeutic relationship, and a shared expectation with the patient for a positive outcome. Good clinicians borrow from each other and borrow what works. Some psychotherapy related theories contain constructs that are easy to isolate and measure; some do not. There are very few differences among bona fide therapies, widely practiced over time, that have a coherent theoretical structure and a research underpinning. [4,6] We need to remember that treatments not researched easily or sufficiently yet may be every bit as valid as those that lend themselves to ready measurement. Conversely, we need to discard any treatments that have been shown to do harm or be of no benefit.

Psychotherapy is an art as well as a science. It is a fluid, mutual, and interactive process. Each participant shapes and is shaped by the other. Good clinicians respond to the nuances of language, both verbal and bodily expressions. They are masters of tact and timing, of when to push and when to be patient. They know the spectrum of disruptions that can occur in a working alliance and are versatile and empathic in their reparative responses. They are creative in finding paths to understanding, in matching an intervention to a need. There are powerful examples of the uses of metaphor, music,

movement, art, and sand play in psychotherapy, as successful appropriate therapeutic tools and interventions.

Psychotherapy is complex. Our patients' biological predispositions, personalities, preferences, developmental level, and psychological functioning intertwine with their life circumstances and stressors. Most psychotherapy patients, the great preponderance, have cross diagnostic issues and comorbid conditions. Dual diagnosis is common. Even within one diagnostic category, the level of functioning varies widely. We have to tailor treatments individually for patients such as the following, all of whom are patients from my practice and meet the criteria for major depression: the self mutilative woman with a borderline personality disorder, who is depressed; the man lashing out at his work clients and on probation for his bad temper, who is depressed; the withdrawn tearful mother and mid-level manager, whose husband is a cocaine addict with bizarre behavior that is frightening their children, who is depressed; and the elderly man with cancer and suffering great losses, who is depressed. We know that individually tailored interventions can be as much as 100% more effective than standardized ones. [(7)]

RESOURCES

Where do clinicians turn for guidance to make decisions and treatment choices for psychotherapy? Psychologists use a combination of tools to do meaningful and effective psychotherapy. We use research evidence where it exists, modify it where necessary, and create new interventions in the field on a case-by-case basis (often by combining accepted techniques from different areas in novel ways). We seek feedback and guidance from *multiple* sources on how it is working and how we can improve it. Where the research evidence is spotty, we draw upon evidence from our clinical experience and expertise.

Here in a brief list are some of the sources of guidance valuable to clinicians:

1. *Doctoral Training Program and Internship*

Graduate school is where psychologists learn the theories and the research, and get their first practical training in psychotherapy. It is a humbling experience to learn publicly, in front of one way mirrors, supervisors and fellow students, how to do an intake, build an alliance, develop working hypotheses about a patient, make a diagnosis, offer trial interventions appropriate to the person and the situation, appraise the response, continue

or change course, and come to a mutual agreement on a treatment plan, goals, and termination. And that is just the beginning. It is also the initiation into a practitioner work ethic that values openness about one's work and builds in an ongoing expectation of feedback.

2. *Observation*

Observation, both in session and over time, is a powerful tool. It includes four types of observational skills: objective (from the outside), participant (including awareness of the reciprocal effects on observer and observed), subjective (empathic and intuitive), and self (self-examination). [8] A therapist functions as a finely tuned instrument and thinking person, not as a technician following a script. What do I hear and see; how do I understand it; how am I reacting to it and to this person? Related to observation, there is a useful distinction between generalization and stereotyping: A generalization is a starting point, which indicates common trends, but further inquiry is needed to discover if the hypothesis or conclusion being reached is appropriate to a particular individual. A stereotype is an ending point, one in which no further attempts are made to discover if the person fits the hypothesis. [9] Being observant and keeping an open mind, an attitude of scientific inquiry, are ways that clinicians use to keep a cautious eye on their own judgments. They allow us to add knowledge and rein in a tendency toward errors that can lead to breaks in the alliance and lead to misunderstandings and treatment failures. Problems in the generalizability of treatments based on the efficacy literature can be overcome by using local observations and local solutions. The term "Local Clinical Scientist" has been introduced to describe practitioners with these kinds of observational and scientific attitude skills. [10]

3. *Experience*

Clinicians turn frequently to their own experience for guidance. Faced with a difficult or murky psychotherapy situation, clinicians sort through their own experiences and expertise for a way to move the treatment forward. Often this process is associative, rather than a linear process. What have I learned about this in the past; what might be affecting my judgment, what am I missing, why does this patient keep reminding me of another person, what should I do now? For example, how can I bind this patient's anxiety sufficiently so that she will not run out the door? Under time pressure such as this, we

must draw on our store of experiences in the moment, knowing we can read, consult, and think more about it later. It is called clinical judgment. Sometimes we make mistakes, but then we also learn from them and add to our expertise that is learned from experience.

In addition to clinical experience, there are other kinds of experiences that may have a significant impact on the success or failure of psychotherapy. These include self-knowledge, gained in a personal psychotherapy or other avenues of introspection and personal growth, and broad life experience that enriches the general knowledge and wisdom brought to the psychotherapy endeavor.

4. *Patient report*

Patients are a primary source of information about how psychotherapy is progressing. An attuned clinician gains valuable feedback about improvements or setbacks that are taking place outside of the treatment room in the patient's everyday life. Patients tell us when things are going better or worse at work or in relationships; they tell us they are sleeping or eating differently; they tell us they feel better or worse or not their old selves yet. But, attuned clinicians also know that patients have a tendency to be agreeable and tell us what we want to hear. We know it is important to be alert for signs of patient disengagement or distance, in order to address the issue that is being hidden.

5.*Third Party Report*

It is not only the patient who gives feedback to the clinician, but it may be a spouse or parent who contributes observations about changes in the patient. Under some particular circumstances, it may be the patient's physician, attorney, or employer.

6. *Consultations and Peer Discussion*

Consultation with peers and senior colleagues is a staple activity for clinicians. Many of us belong to ongoing peer case discussion groups for most of our careers. Regular consultations and case discussions shed light on our thinking and broaden our perspective. They push us to talk about cases that are puzzling, or not going well, or that may have one aspect that is bothersome or unique. Group consensus may not always be correct, but it is a valuable tool. Also, in listening to others' cases, we learn new methods, new ways to solve problems, and get a better picture of our own blind spots.

7. *Continuing Education*

There are many kinds of learning that may fall under this heading. Some programs are skill based, such as a workshop that teaches specific techniques for use with pain patients. Some programs might better be characterized as focused on attitude and growth, such as the "Difficult Dialog" workshops held at the APA Multicultural Conference last year.

8. *Professional Literature*

Some people have said that clinicians don't read once they leave graduate school. It may be true that many do not read the journal articles that do not contain applications of research to clinical problems. However, they do read books of clinical relevance to their practices. And they value the journals that are most helpful to clinicians, such as Professional Psychology: Research and Practice, and the Clinicians Research Digest.

9. *Internet*

Clinicians have benefited greatly from Internet access that did not exist when some of us started practice. From our offices we can gain needed information quickly, without taking time away from practice to go to the nearest university or medical school library. Recently, a colleague told me she suspected that a patient's hand tremors were a side effect of the anti-depressant medication she was taking. The psychologist was able to confirm the symptom as a known side effect, online within 5 minutes, and arrange for the patient to see her prescribing physician, who subsequently changed the prescription.

10. *The Patient's Impact*

Working with the patient's impact on the therapist, as source of guidance, requires quite a lot of sophistication. However, for experienced and competent clinicians it is an opportunity to gain information not obtainable by other methods. This variable in the therapeutic relationship was described first in psychoanalytic theory, as countertransference. It is an important psychotherapy phenomenon and is recognized now across other theoretical orientations as well. Countertransference is a complex topic, with a somewhat limited but growing body of empirical research that shows its effects on treatment. [(11)] It benefits us all to recognize the impact of working in psychotherapy with people who are distressed and may be quite disturbing.

Like everyone else, clinicians have deeply held personal attitudes, as well as idiosyncratic responses that affect the way they relate to patients. What good is a treatment manual when the clinician is disgusted by a sight, a smell, or story; is anxious

about being seduced, assaulted, or sued; is distracted by going through a divorce or caring for a dying parent; is only dimly aware of biases against women or men or ethnic minorities or people with disabilities; what good if the clinician identifies closely with the patient's situation; or needs desperately for the patient to follow the treatment plan in order to feel successful; or can't deal with the patient who is too distancing or who craves intimacy. How flexible is the therapist able to be, how tightly controlled? Will a treatment manual be used as a defensive shield? Or will the clinician face the impact of the therapeutic relationship in all its subtleties? The kinds of responses I have just mentioned, which clinicians try not to reveal, are typical and informative. They guide us to explore further our own personal issues *outside* of the therapy relationship. It is important to learn how to manage our own negative personal reactions and keep them from interfering with treatment. On the other hand, with self-understanding and expertise, these reactions can also be translated into positive therapeutic interventions. They can point the way toward an exploration of what is going on in the room that is pertinent to the patient's treatment. Recognition of the patient's impact and the use of that information as a clinical resource is much more therapeutic than trying to ignore the behavior and sticking to the session plan. The exploration allows the patient to put thoughts and feelings into words, instead of less than aware actions.

11. *Outcome Assessment*

More clinicians seem to use informal evaluations at the end of psychotherapy than use formal methods, although that seems to be changing now. It is quite straightforward to ascertain information about global improvement and symptom reduction. It can be harder to tease out the multiple variables, and their relative weightings, that have contributed to the result. Outcome measures are an excellent source of guidance for clinicians and a wonderful reinforcement for work well done. Over time, a perceptive clinician using a familiar set of measures can gain a clearer picture of his or her practice, warts and all. Perfect outcomes are rare in the realm of psychotherapy, but we can all work at improving the weak areas and building on the strengths. We can also use our outcomes to show the world psychotherapy works, as we have known all along. I think the best ammunition we have, in a world that often doubts the value of psychotherapy, is to

continue working up to our capacities in trying to help our patients/clients, and then to measure the results and pool our outcome data.

CONCLUSIONS

Clinicians need and prize evidence. We learn over time to use evidence and guidance without subscribing to artificially constructed hierarchies about which evidence is most important, because usefulness varies widely. Our "best practices" are built on a foundation of **empirical research, comprehensible and reasoned theories, clinical observation and expertise, and our patient's values, contributions, and responses.**

I often ask critics of the broad psychotherapy framework, who would you seek out as a therapist for yourself in a terrible crisis, or send your ill parent, or distressed child to see? I think people want a psychologist who brings to the treatment: science, clinical expertise and empathy, broad experience, and a high level of appreciation for the ambiguities and strengths of the human condition.

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