

Evidence-based Practice and the Endeavor of Psychotherapy

(Short Version)

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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. 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.

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. 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.

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 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. There are few differences among bona fide therapies, widely practiced over time, that have a coherent theoretical structure and a research underpinning. ^(4,6)

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 are creative in finding paths to understanding, in matching an intervention to a need.

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. 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

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. The training period 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.

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. 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.

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.

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

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.

7. Continuing Education

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*

Most clinicians probably do not read the journal articles that do not contain applications of research to clinical problems. 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.

10. *The Patient's Impact*

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, based on a somewhat limited but growing body of empirical research that shows its effects on treatment. ⁽⁹⁾ It helps us all to recognize the impact of working in psychotherapy with people who are distressed and may be quite disturbing.

11. *Outcome Assessment*

This may be a formal or informal process used for guidance. More clinicians seem to use informal evaluations at the end of psychotherapy than use formal methods, although that is changing. 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. We can also use our outcomes to show the world psychotherapy works, as we have known all along.

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.**

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