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The Good Intentions Paving Company

(with apologies to Saul Bellow)

— Harry D. Corsover

While those championing Evidence Based Practice in Psychology (EBPP) may have the best of intentions, it is my opinion that the net effect on the practice of psychotherapy is and will be far more limiting and damaging than helpful.

A stated goal of the EBPP is the development of guidelines for best practice. While the risk of inappropriate use by commercial health care organizations is noted, nothing in the way of safeguards against this and other forms of misuse is provided.

Both the *2005 Presidential Task Force on Evidence-Based Practice Report* and the *Policy Statement on Evidence-Based Practice in Psychology* of 2005 mention the importance of both the clinical relevance of research and clinical utility as well as efficacy. Despite what I see as lip service to the broader context and complex considerations inherent in studying what works in psychotherapy, there has been a decided thrust to narrowly study the efficacy of manualized interventions in randomized controlled trials (RCTs). Serious concerns about the lack of applicability of such studies to the complexities of psychotherapy in the field have not been adequately addressed. The emphasis on manualized interventions continues despite the fact that factors such as the therapeutic alliance and therapist effects have shown a higher correlation than differences among treatments, and evidence that what

experienced therapists do in psychotherapy is much more similar than different (and does not necessarily adhere to a theoretical orientation or initial training). In other words, things like the person of the therapist and the interpersonal skills of the therapist make a vital difference.

As Jonathan Shedler, Ph.D. writes in an upcoming article in the *American Psychologist,*

> Empirical evidence supports the efficacy of psychodynamic psychotherapy. Effect sizes for psychodynamic psychotherapy are as large as those reported for other therapies that have been actively promoted as ìempirically supportedî and ìevidence based.î Additionally, patients who receive psychodynamic therapy maintain therapeutic gains and appear to continue to improve after treatment ends. Finally, non-psychodynamic therapies may be effective in part because the more skilled practitioners utilize techniques that have long been central to psychodynamic theory and practice. The perception that psychodynamic approaches lack empirical support does not accord with available scientific evidence and may reflect selective dissemination of research findings.

However, these factors and a psychodynamic approach in general are very difficult if not impossible to manualize and study in RCTs. It is much easier to study (and to get research approval and funding for) specific manualized interventions—even to the point of a growing number of our colleagues implying or even stating outright that such studies are science, while everything else is not. Hartz and Benson, in a New England Journal of Medicine article in 2000 ("A comparison of observational studies and randomized controlled trials"), state "a well-designed case study is just as valid as a double-blind study," and conclude "The results of well-designed observational studies do not systematically overestimate the magnitude of the effects of treatment as compared with those in randomized controlled trials on the same topic."

I am reminded of a sign that reportedly hung on the wall of Albert Einstein's office: "Not everything that counts can be counted, and not everything that can be counted counts."

I think it is fair to say that our training provides us all with a firm grounding in science, including such basic things as being able to evaluate not only the statistical results of studies, but the assumptions and definitions used as we determine the validity of results and conclusions. In that light, I offer a partial list of presuppositions underlying the EBPP movement:

1. Interventions per se are central variables determining what works in psychotherapy and are much more important to the outcome of psychotherapy than the person who is the therapist, the person who is the client or patient, and the nature and progression of the relationship between them.
2. Narrowing down a study cohort to those with a single identifiable diagnosis and the use of manualized treatment protocols (something clearly necessary in the context of such studies) does not substantially lessen the relevance of such studies to actual clinical practice—in which therapists rarely if ever see people who present with a single simple diagnosis.
3. Diagnoses, particularly as delineated in the DSM are the most useful way of determining treatment. Since this is all being done in the name of science, it is fair to deduce the following are assumptions as well:
   a. The diagnoses listed in the DSM are scientifically-derived.
   b. Diagnoses based on symptoms are the most useful way of determining what presenting problems are and the most useful way of determining treatment plans; and are more clinically useful than etiology and/or the specific patterns, basic beliefs and decisions, etc. that may not be consistent among different people with the same diagnoses.
4. Psychologists (or psychotherapists in general) treat conditions or diagnoses (vs. treating people, who are a lot more complex than that).
5. Clinical experience does not constitute empirical evidence. (Definition of "empirical" from Merriam-Webster's Online Dictionary: "1: originating in or based on observation or experience.)"
6. Randomized controlled trials are far superior to case studies as a form of research, and constitute the most important part of science.

And a crucial one:

7. The state of our scientific knowledge about psychotherapy is sufficiently advanced to be used to delineate "validated" treatments, and to be used to develop treatment guidelines.

It would take far more space than this column allows to elaborate on each of the assumptions above and to discuss the challenges they pose to EBPP. To my knowledge, not one of the above assumptions is based in science. I do not agree with a single one of them, and I am sure I am far from alone in this. Not only does that *not* make me/us "anti-science," or describe us as ignoring science (as is often charged when we object to the current state of EBPP), but I think it reflects a higher level of adherence to science than those who treat RCTs

as "the gold standard" in determining what works in psychotherapy. If a study's assumptions are questionable or false, then the results are questionable, if not invalid. While I am not assuming that everyone will disagree with each of the presuppositions listed above, I do think it is crucial that these tacit assumptions and their implications for EBPP are carefully examined.

As far as I'm concerned, the gold standard is my clients' informal and formal evaluations of whether and to what extent they got what they came for. And when our work together is successful and efficient, nobody who has not met and worked with my clients is in a position to tell me what I should have done. At best, RCTs can offer one piece of the puzzle, and perhaps be as useful as the relevant experience of an esteemed colleague. (I know such thinking is almost demonized by those who worship at the altar of what they consider to be science or what they narrowly define as scientific, but I stand by this both as a clinician and as someone highly trained in and who has taught scientific thinking and the scientific method.)

The dangers of treatment guidelines are not just potential. In fact, the down sides—unintended consequences—have already appeared and show no signs of diminishing. One example, which occurred on the Division 42 email list years ago, was a statement by a very well-known colleague that any psychologist who did not use "empirically validated treatments" (the phrase used at that time) before employing any other intervention was acting "unethically." We already know how easy it is for any state board or plaintiff's attorney to find a colleague willing or even eager to opine that another therapist's behavior was "below the standard of care." Statements such as this provide all the ammunition anyone so inclined would need to punish any of us who do not tightly adhere to some list of "approved" treatments.

Another example, and one even more troubling, is how in one agency, therapists were told that the only approved treatment for trauma is Trauma Focused Cognitive Behavior Therapy (TFCBT), and they were not allowed to use any other form of treatment, even if research-based. The criterion? Having a a level A SAMHSA (Substance Abuse & Mental Health Services Administration) rating. In other words, a government-sponsored listing—National Registry of Evidence-based Programs and Practices (NREPP)—that uses a complex application process was being used to limit allowable treatment. Two psychologists resigned their positions at this agency for this and other related reasons.

Our guidelines and policy statement may include "The treating psychologist determines the applicability of research conclusions to a particular patient. Individual patients may require decisions and interventions not directly addressed by the available research. The application of research evidence to a given patient always involves probabilistic inferences. Therefore, ongoing monitoring of patient progress and adjustment of treatment as needed are essential to EBPP."

None of this keeps agencies, third party payors or anyone else from using existing lists as if they were the definitive criterion for determining allowable or reimbursable interventions. At best, treatment guidelines will apply to those clustered around the mean. Are we to sit idly by while therapists are put in the position of having to defend their choice of approaches "not directly addressed by the available research," or while colleagues have to choose between the best interests of patients and their jobs?

We would not accept a therapist's behavior when it clearly harms the client. Why should our standards be any lower when it is a group of psychologists, or even the APA Council of Representatives bringing harm to psychologists and the practice of psychology (regardless of their good intentions)?

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Everybody gets so much information all day long that they lose their common sense.

— Gertrude Stein

Getting information off the Internet is like taking a drink from a fire hydrant.

— Mitchell Kapor

A successful marriage requires falling in love many times, always with the same person.

— Mignon McLaughlin