Evidence from Within: A Paradigm for Clinical Practice

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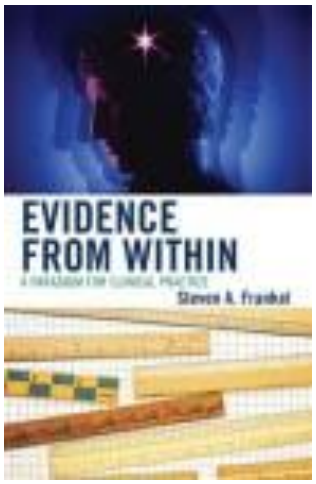

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Introduction

In this book I will review the most current information about whether psychotherapy is effective, under what circumstances, with which patients, and to what degree. In it I will take us through the evolution of a method of psychotherapy that we at the Center for Collaborative Psychology and Psychiatry believe can be used by *any* practitioner in his or her office with the real world patient population practitioners see every day. This method has been twenty years in creation. Its development began with the "three-person field" study Philip Erdberg, Ph.D. and I hatched in the early 90's, where we first used a psychologist-assessor as a consultant and included him or her as an integral member of the psychotherapy team.

The Controversy:

Bringing us to these projects was the realization that the explanation of what makes psychotherapy work is so elusive. Perhaps that observation helps explain why the practice of person-to-person psychotherapy has become so controversial.

Who is to blame for the anti-therapy wave of the 90's? In my opinion, none other than ourselves, the psychotherapists. Especially implicated, I would guess, are psychodynamically oriented therapists, including those that call themselves interpersonal, relational, and existential. Unlike our medical brethren we are late in our willingness to track and document our results, and even place our multi-modal diagnostic criteria on firmer more encompassing ground than is available from the American Psychiatric Association's Diagnostic and Statistical Manual. The result has traditionally been rampant, unsupported assertion that psychotherapy, *in whatever favored incarnation*, works, and outrageous defensive shielding of ourselves from scrutiny. An internist could never, of course, get away with that failure of accountability.

Nonetheless, in spite of the anti-therapy and pro-biology movement of the past ten or so years, holding that psychotherapists do better with cookbooks prescribing just the right formula for every step of each kind of therapy, there seems to be a renewed consensus even among some of the most hard core behavioral and biological types. These practitioners concede that psychosocial treatment is at least conditionally effective, that clinical expertise makes at least some difference in whether and how a therapy succeeds, and that contextual factors, most particularly the quality of the therapy relationship, legitimately account for a sizable part of therapy's benefit.

Of course, there are many kinds of psychotherapy with an interpersonal component. Definitions, even within a particular school of thought, tend to be non-specific with one type blending into another. Nonetheless, advocates of a particular theory and method can be close to fanatical in denouncing other types of treatment and claiming theirs is best.

All that said, whatever the value to a psychotherapy of technical orchestration, according to my observations the timing and magnitude of change in a psychotherapy is often not clearly tied to the therapist's deliberate efforts. I am referring to the seemingly impossible moves toward health that occur for the patient in a skillfully conducted psychotherapy of most any denomination. And, indeed, these shifts are often inexplicable. They seem to happen magically, following some hard to discern non-verbal map that is likely to be different in each therapy.

Still, for many of the critics of interactive psychotherapies, a formula for treatment, especially if it has been derived from and validated in randomized controlled trials, should be enough. After all, like all medical practitioners we are scientists and science strives to understand the true nature of things.

But, does it?

Thomas Kuhn in his enduring book, The Structure of Scientific Revolutions, published in 1962, traces the way views of scientific certainty have evolved. A parallel in physics was the move from a positivistic Newtonian view of events to quantum mechanics and its focus on the probability an event will take place, when and where. His conclusions are unmistakable. Gospel in one era becomes assertion or at least approximation in the next. This shift is paralleled in philosophy by the prominence of post-modernism beginning with German philosophers and sociologists late in the last century, Burger, Husserl, Heidigger, Weber, for example. Parallel are the moves to modernism and post-modernism in literary criticism (Pinsky, 1976), and to intersubjective, relational viewpoints in depth-psychology.

The Projects:

Our data from three clinical studies, with the third now in process, conducted with real patients in typical therapy offices, has allowed us to develop the method alluded to earlier in this introduction. Our first two projects each consisted of about twenty-five patients, many seen over the course of several years and most agreeing to followup for well beyond five years after the completion of treatment. All our patients have received at least part of the Center assessment protocol consisting of

clinical interviews and psychological as well as neuropsychological testing. This practice, as integrated into treatment, provides an ongoing corrective for conducting the therapy. As we have evolved our testing, retesting, and monitoring procedures, especially during the past three years, they have become more comprehensive. We are now able to follow those protocols on a more regular, albeit flexible, case-specific basis during treatment and followup. As in my past books (1995, 2000, 2007), in this book several completed cases will be discussed in detail.

We have two additional books in mind. In the first, Philip Erdberg and I will elaborate on how we do our work, detailing our continuous integration of psychological assessment with psychotherapy. Through this process we find our way in a ceaselessly changing psychological and personal environment. In the second book, we plan to present effect sizes and descriptive data from formal diagnostic assessments and reassessments of our work, having by then followed a sizable group of Center patients for several years. Our goal is get ever closer to a picture of what makes psychotherapy work, when, and with whom. We will compare our findings to those published in the literature, and comment on their statistical, clinical (effectiveness), and research value (efficacy), commenting on the advantages and limitations of office-based data.

The vehicle for the delivery of our services is an association of professionals we call the Center for Collaborative Psychology and Psychiatry. We have trained several groups of therapists in our collaborative assessment and psychotherapy techniques, and as a diagnostic and treatment center we have reached dozens of patients.

This Book:

Why is this book necessary? Why not replace interpersonal psychotherapy with behavioral treatments? Aren't biological treatments the wave of he future? The answer is that neither is enough. Peoples' behavior is made of more than cognitive schemas, and, at least at this point, psychopharmacology is only in the early stages of its development and any psychiatrist can attest to the hit and miss quality of psychopharmacological treatments. Moreover, life is just more exciting than all that. Human relationships supported by both thought and emotion are complex. It is a cliché by now that the human mind cannot be fully replicated by a computer. Anyway, who would want it to be? What then would we do about the surprise and discovery which make life, and indeed psychotherapy, so exhilarating and promising?

Chapter One
Orientation

How certain can a psychotherapist be about the value of the therapy he or she is delivering? Will the treatment be effective and will it last? Forget the overly-technical for the moment. To a point the question can be boiled down to the simple notion of whether or not the treatment is working. Progress can be measured and tracked using a variety of tools ranging from the patient's verbal report, to self-assessment inventories, to more complex psychological tests. So, what exactly then is our problem?

First, we need to target something. But, how do you categorize the patient's difficulties, especially since psychological complaints tend to be so personalized? How, also, do you know what parts of the problem to focus on and in which order? Then, we need a reliable and practical method for delivering help and assessing whether it is effective. This line of thinking raises the question of the reliability of your procedures for monitoring progress. And what do you do about the time and cost required to do this work, and whether it can be carried out in the office?

Psychotherapy Under Siege?

Psychotherapy, as it has been traditionally practiced, is under siege. As implied in the above paragraphs, it is frequently criticized as too costly, too inefficient, and generally lacking in clinically cogent and practical means for following change, keeping the therapist accountable for the therapy's outcome. The sad reality is that these allegations are often heavy with truth. They describe a clinical procedure based in subjectivity and frequently bolstered by assertion. By reference to our projects and the literature on psychotherapy, this book attempts to address these deficiencies. It encourages therapist and patient to ask the hard questions about the nature of treatment. How, if, and when it works. What exactly is psychotherapy? What accounts for therapeutic change? When in the therapy exchange should the therapist act and in what ways (Frankel, 2007)? When, how, and, to what extent should psychotherapy be used with a particular patient? What kind of therapy or alternative treatments are most appropriate with a particular patient? What amount and kinds of change are being sought and can reasonably be achieved within the scope of the patient's resources and the therapist's capability? Attempting to grapple with these complexities, this book presents a model for psychotherapy practice that incorporates techniques for planning, orchestrating, and following the changes sought by the patient. These techniques have been selected so they can be readily used by office-based clinicians.

Yes, in most types of psychotherapy, whether delivered by a psychiatrist or a practitioner without medical training, the patient and therapist interact in a disciplined way, attempting to understand and ameliorate the sources of the patient's distress. When studied meticulously, this interaction can be described and nodal points bounding change can often be identified and studied (see, for example, Hilsenroth, 2007, Jones and Pulvos, 1993; Lambert, M., 2007, Luborsky, 1984; Luborsky and Crits-Cristoph, 1990; Watson and Rennie, 1994; Weiss, 1993). The progression sought may be concrete and easily measured, as when the patient graduates from school or advances professionally, or its character and magnitude may elude objectification. However, limiting these determinations is the personalized nature of the patient's report and the therapist's observations of that change. The fact is that the patient's and therapist's appraisals are always riddled with subjectivity, biasing their clinical impressions and expectations in the direction of what they would like to find or think they see [see Weinberger and Westen (2004) for a comparison of this source of error with that associated with formal psychological assessment]. It is also difficult to prove that an observed change in the patient is due to, rather than simply correlated with, the work of the therapy. Events in life, developmental influences, and other peoples' contributions, for example that of family and friends, may have played the greater role in creating the change.

To understand whether and how a psychotherapy is working none of these factors are irrelevant, making research on psychotherapy a challenging, if not ultimately imperfect endeavor. Sorting out this network of interacting influences is the purvey of process-oriented research on psychotherapy (Jones and Pulvos, 1993; Silberschatz, 2005). Its complexity and the probability that its meticulous pursuit would undoubtedly deflect us from our clinical duties, however, makes outcome our criterion for the study from which the observations and recommendations in this book are derived. Outcome also guides us in selecting useful and cost-effective methods of appraising change in therapy.

In all our cases a second opinion by another clinician, a psychologist-assessor, is obtained as part of our treatment procedure, an arrangement we call "the three-person field." The therapist and patient have access to the psychologist-assessor throughout their work together. In addition to providing formal testing data, this person serves as a consultant to the therapy. In adult cases the psychologist-assessor routinely administers the following assessment instruments: (1) during the initial assessment and then once every eighteen months the Rorschach and usually the Thematic Apperception Test (TAT), (2) every six months: the Personality Assessment Inventory (PAI), the Symptom Check List 90 (SCL 90), the Neuropsychological Impairment Scale (NIS), and any other tests or self-report inventories, such as the Hamilton or Beck Depression scales, that provide information about problem areas of specific concern for that patient. (3) A running

account of the patient's problems is kept on a biweekly or monthly basis using the brief clinical status check lists provided by the Target Complaint and Goal Attainment questionnaires.

The instruments named have been carefully selected for clinical relevance as well as the accuracy and scope of the information they provide. Our impression is that for most patients this assessment sequence can be repeated on schedule without creating an undue financial burden and an unwelcome disruption in the therapy. Further, while testing provides diagnostic information and evidence of effectiveness, it is also incorporated in and contributes to the therapy dialogue and is likely to play a part in the changes that result (Finn, 2007; Finn and Fischer, 1997; Fischer, 1994 and 2000)

During the initial evaluation and throughout treatment, consultations with specialists are also sought as needed. Any specialty pertinent to the mental health field, including education, psychopharmacology, genetics, neurology, and general medicine may be enlisted.

Consistent with the author's described paradigm for psychotherapy are the requirements of any thoughtfully practiced medical science. No physician would defend a treatment without clearly articulated criteria for diagnosis and progress. Second opinions are the rule in general medicine. Medical tests and radiological imaging are always used to confirm and expand upon a diagnosis. Why, then, have we as psychotherapists been willing to forgo rigorous accountability in our clinical work? After all, the patient's well-being is in our hands and deserves as much attention and respect as when he is treated for a medical illness. By incorporating practical ways therapist and patient can follow their work and by encouraging them to be meticulous in devising and revising their definition of psychotherapy so it fits that particular case, the therapist and patient begin to address these deficiencies.

I am not overlooking the fact that most psychotherapists present at least some of their clinical work to a consultant or in case-oriented conferences. In both of these situations, however, the case material presented may neither be verbatim nor capture the non-verbal, contextual dimension of the therapy interaction. More to the point, there is rarely a person outside of the therapist and patient who gets to experience the patient directly.

Our Three Projects

50 case studies, from two earlier projects, and already about 30 additional cases from the current one, provide the data upon which this model has been developed (1995, 2000, 2007). The Center for Collaborative Psychology and Psychiatry, in all its incarnations, was the vehicle for the ongoing development of this practice. The

essence of this method, *collaborative psychology,™* was devised by the author and is described in his three books. C*ollaborative psychology™* emphasizes the centrality of the authenticity and strength of the therapeutic relationship. In this model, psychotherapy is a two-way process. The therapist and patient provide feedback to each other so they can re-adjust their methods and goals as the patient's clinical requirements change.

Introducing a third party, a psychologist-assessor, into the therapy assures that two perspectives in addition to the therapist's and patient's will continually be available (Finn and Fischer, 1997; Finn, 2007; Fischer, 1994; Fischer, 2000). These contributions come both from the psychologist-assessor's clinical impressions and the findings of his or her psychological or neuropsychological assessment. This approach is collaborative from two vantage points. First, the therapist and patient provide feedback to each other, progressively modifying their shared and private views of the key factors in their work. Their impressions are supported by the measures of therapeutic progress provided by the assessment inventories, as well as the self-report questionnaires completed separately by patient, family, and therapist. The second level of collaboration is between the psychologist-consultant and the therapist and patient, individually and jointly. Further discussion of this collaborative assessment and treatment method will be found in chapter 5.

The Center for Collaborative Psychology and Psychiatry was designed for the purpose of providing treatment according to this model. We communicate with other centers using similar principles, most particularly the Center for Therapeutic Assessment in Austin, Texas headed by Stephen Finn, Ph.D., and with the group working with Constance Fischer, Ph.D., Professor of Psychology at Duquesne University in Pittsburgh, Pennsylvania.

Regarding those involved in this project, Diane Hannah Engelman, Ph.D. is my co-director at the Center for Collaborative Psychology and Psychiatry. She is trained and certified in neuropsychology and psychological assessment. She has years of experience as a psychotherapist and has a specialty in psychological aspects of medical illness. Philip Erdberg, Ph.D. has been my co-investigator in all three of these projects. George Silberschatz, Ph.D. has been our trusty consultant. Together with Phil he contributes his expertise in research design and execution. Phil is also a core associate of the Center. His expertise includes psychological testing and he co-authored a major book on the Rorschach test with the late John Exner, Ph.D. Paul Gilbert and I are trained and board certified general and child psychiatrist as well as psychoanalysts. By virtue of training and experience, we, together with Phil who also has training in psychoanalysis, are well equipped to understand the traditional requirements of in-depth psychotherapy.

What can psychotherapy offer?

Begin with the question of what psychotherapy can really offer. Faith in the process doesn't mean much when your ten year old daughter says no one likes her, or when you find yourself feeling stuck in a marriage or job that feel stale. In these situations you need results. In both cases, the initial visits to a therapist are likely to be reassuring. After all, if you have done your homework, that person probably came highly recommended and has years of experience. And, at times we all need reassurance.

Not likely to be apparent at the time of the first encounter are the therapist's personal and professional limitations and biases. How, for example, do you know he will actually deliver? Why in the world, given the little you know about his background and personal life, would you trust that he is able to empathize with or even understand your dilemma?

Let's say you are depressed and the therapist is intolerant of worry and inaction. How well will that therapist comprehend what you need? How impatient will he be if you procrastinate about following his recommendations? While therapists are generally thoughtful and well-intentioned, this one might not believe in the coddling you think you need, or, alternatively, he or she may be too sympathetic for your tastes. In brief, the comforting presence you encounter when you first meet a therapist is likely to cover a personality as complicated and sometimes as private and unpredictable as yours. No doubt, training and discipline help the therapist sift through and regulate his responses, choosing those he believes will be most constructive at the moment. Still, interpersonal reliability will at best be a product of a collaborative process in which you and the therapist get to know each other, in some ways intimately. Its limits will be set by such informal factors as the events in both of your lives, the ways you both intuitively gauge and track the therapeutic alliance, and even the way you both feel about fees.

Several sessions later, your absolute certainty about the therapist may begin to wear thin. That's lucky, in a way, since you might instead have spent several months or even years in therapy before taking your doubts seriously.

But, then, maybe it's you. Maybe the therapist is on track and simply pushing you to your limit. Your impression is that he is off-base and yet to benefit from this therapy you may need to tolerate his unwelcomed observations. Like in the Ken Kesey play, One Flew Over the Cookoo's Nest, it is hard, maybe impossible, to tell who is crazy in a case like this, yourself or the therapist. This dilemma is an old one, elaborated years ago by R. D. Laing (1959) and Thomas Szasz (1961).

Psychotherapy Involves Two Human Beings

Like it or not, to connect with a person, especially when one of them is fragile, requires another human being. To be sure, technical expertise helps, but how does a therapist catch on to the subtle nuances of a patient's problems without major contributions from intuition and empathy? How does that therapist know what to do and say, and when to make his statements? And, what goes into the elusive quality called clinical judgment?

Given that the interactive aspect, the human piece, of a psychological or psychiatric intervention can rarely entirely replace the technical, however, how reliable is the therapist's clinical judgment? What can the therapist promise? The variables predicting the fate of any interaction are complex and interrelated. Among the factors determining the course of a psychotherapy are clinical expertise, empathy, and concern, all at least partially subjective.

For a closer look at these issues take Dori, who was 26 at the time this story begins. Dori had graduated from an excellent college, but after a near debacle in her life was forced to return to her parents' home to work in a temporary job doing clerical work in a large corporation. Following graduation from college two years previously she found work as an assistant account executive at a prestigious advertising agency. At that point she planned to go on to business school, following in the footsteps of her mother who was a successful businesswoman.

What a disaster. Uncharacteristically, Dori rapidly became muddled and inefficient in her work, grasping for straws to correct and explain her failures. After six months she was fired from her job, and was forced to return to her parents' home in despair, her self-esteem shattered.

Here's where Dori met Thea, a therapist chosen by her mother. Always confident and impressively clad in an expensive suit, Thea was a sure thing. Thea's covert message was clear: listen, follow my lead, and be careful not to think too much. In essence, Thea advocated a system of thought control and meditation. Hungry for relief, Dori complied. And, indeed, she felt better each time she saw Thea. No medication was prescribed.

But, Thea misfired. The unwritten rule in that treatment was apparently that Dori never question Thea's authority. Implied was that the wisdom Thea imparted was all that Dori needed to reestablish a healthy frame of mind. Little consideration was given to helping Dori become self-sufficient. For example, Thea never considered having Dori contribute to the cost of the treatment. Thea's fee was shockingly high, but that didn't get questioned either. All these omissions were overlooked by both Dori and her parents since Dori remained in so much

emotional distress. Tragically, however, three years later when Dori was ready to enter a doctoral program in public health, she again crashed into a depression, this time worse than the original one. Now it was the fear of again failing that was responsible.

Nonetheless, Dori was intent on going to graduate school. In spite of her near paralysis, she decided to move to a distant city to attend a university that offered her a generous grant. Here's when Dori met Wanda, a psychiatrist who was willing to prescribe medication, and seemed refreshingly thoughtful and generous. Right from the beginning Wanda, who was unmarried and childless, treated Dori like a daughter. Then, when Dori required more time and patience from Wanda as her world seemed to spin out of control, Wanda became punitive. The problem was that Dori was overwhelmed by the fear she would fail to meet the demands of graduate school and became increasingly dependent on Wanda for reassurance.

In fact, the more anxious Dori became the more medication Wanda prescribed: at first Prozac up to 80 mg. a day, then Tegretol stopping at 1200 mg. a day, and finally Geodon building up to 120mg a day. While Wanda was at first sympathetic and even maternal with Dori, she apparently had her own needs that by inference she hoped Dori would meet. Hence, the ever increasing dosing of medication, most likely Wanda's way to biologically quell Dori's anxiety and demands. This tension continued to build for months, making Dori feel ever more desperate. Then, finally and sadly, it was terminated when Wanda fired Dori telling her she had a "histrionic personality disorder," a problem of a magnitude Wanda said she would not be able or willing to treat.

At this point Dori was in her second year of public health graduate school. She lived in a drab apartment in a large city far from her hometown. She was progressively feeling psychologically damaged, unappealing, and, given the hit she had recently sustained to her self-esteem, despairing about ever amounting to anything professionally.

And then, voila! Suddenly as if by magic everything began to change for Dori. This time the initial mover was not a psychotherapist.

Out of necessity Dori moved to a new, cheaper but, as it turned out, distinctly friendlier neighborhood. She now had a little extra money to spend and plenty of people in their late twenties to keep her company. Her public health graduate school experience also took a distinct turn for the better. Her courses finally began capture her imagination.

Ultimately, as critical or even more important to her current sense of well-being than these life changes, is the fact that Dori soon entered treatment with another

psychiatrist, this time an intuitively-gifted behaviorist. But this therapist seemed to understand Dori, and maintained the boundaries Dori required to use the therapy for her own needs. Apart from cutting back on Dori's medications, the psychiatrist made direct and practical recommendations to Dori. While not as emotionally complex as Wanda, this psychiatrist, Dr. Crane, had her feet on the ground. She told Dori enough about her own life to make Dori comfortable but not burden her. Dr. Crane confided to Dori's relief that she was happily married, had three children she loved and admired, thus assuring Dori that she had no personal needs for Dori to fulfill through the psychotherapy.

At this point, remarkably, one year post-Wanda, Dori is thriving. She has a bevy of friends, and has entered an internship in public health, a path she is confident will lead to an ideal career. She is dating again, and is beginning to feel normal for the first time in several years. She speculates that when she can afford to she would like to try in-depth psychotherapy. She still hopes that she will find the perfect therapist, but knows that such a person may not exist.

Before going on let's catalog the influences that were instrumental in Dori's more recent progressions and regressions. (1) It is likely that Thea was too unreflective and sure of herself to recognize that she was on the wrong track with Dori. She also missed Dori's need for both antidepressant and mood-stabilizing medication. (2) Wanda, next, took advantage of Dori's search for a caretaker to meet Wanda's own needs. When that misfired she gave Dori a damning diagnosis and tried to contain Dori's growing desperation with ever-increasing doses of medication. Finally, she fell into an even worse transference-countertransference trap by actually becoming the agent of failure for Dori. This episode repeated Dori's experience at the advertising agency during her first post college year, and dismissal from treatment was precisely the outcome Dori most feared. (3) In contrast to miscalculations by two therapists who were sure of themselves, Dr. Crane's reducing Dori's medication, practical suggestions, and appreciation of Dori's age-appropriate need for autonomy were helpful. She directly supported Dori's finding an exciting career track and making friends in a strange city. Dr. Crane was also perceptive. She was the first therapist to make the incisive observation that Dori's success in her career might be tantamount to an assault on Dori's father who had given up his own promising career to go into business with his own faltering father. She also used cognitive retraining techniques to curb Dori's self-deprecation which by then had become obsessive. By that time Dori was plagued with images of becoming a bag-lady and could rarely get this prospect out of her mind.

Does Psychotherapy Work?

Why is this the place to start an examination of the literature? Read the up-to-date research on what makes psychotherapy work. The conflicting claims about this subject are neatly documented in the debates in Norcross, Beutler, and Levant's edited book, "Evidence-based Practices in Mental Health" published by the American Psychological Association Press (2006), and in the newest edition of Bergin and Garfield's, Handbook of Psychotherapy and Behavior Change edited by Michael Lambert (2004). These authors, even in their presumably dispassionate reviews of the debates in the literature, may implicitly favor either what Bruce Wampold (2001) calls the "contextual model" or the "medical model" as applied to psychotherapy. In fact, it would seem unreasonable to expect each to be entirely without a point of view and for that bias to be completely absent from his volumes.

The medical model in psychology and psychiatry, according to Wampold, "differs from the medical model in medicine primarily because in psychotherapy the effects due to 'specific' therapeutic ingredients and to incidental, 'contextual' factors are both psychological, creating conceptual as well as empirical ambiguities" (p. 15). Wampold's medical model, as I understand his use of the term, includes all structured aspects of psychotherapy falling under the behavioral heading, from setting treatment goals to prescribing specific interventions such as the homework and the hierarchical planning of interventions. The complementary model he describes, "emphasizes the contextual factors" (p. 23) as they contribute to engagement in psychotherapy. The "contextual factors" cited by Wampold begin most prominently with the therapeutic relationship. Referring to Frank and Frank (1991), he also mentions hope engendered by the therapist, new learning experiences, a sense of mastery created by the therapist's interventions, and the opportunity for the patient to practice new attitudes and forms of behavior (Frank and Frank, 1991).

There is a bewildering assortment of interactive psychotherapies from which to choose. Whatever else each accomplishes they all presumably deliver some form of contextual support. Among them are the traditional Freudians, Freudian dissidents such as Carl Jung (1913) and Melanie Klein (1957), neo-Freudians like Fromm (1970) and Horney (1937), inter-personalists beginning with Sullivan (1953), client-centered therapists, and relational psychotherapists. Generally the theories advocated are based on clinical observation, not hard data (Luborsky et al., 1999). Added, to this list are more structurally oriented theoreticians such as Aaron Beck (1976) and the behaviorists. There are also master clinicians like Marsha Linehan (1993), the researcher-clinician who created Dialectical Behavioral Therapy, who have supported their theories with helpful but limited research.

I suppose the lack of specificity inherent in the contextual model is OK, as far as it goes. According to that viewpoint therapists from most schools of thought should be helpful to their patients if they pay meticulous attention to their personal requirements and are caring. Further, every decent therapist *knows* that he or she frequently gets results, often results that last. Manualized protocols prescribing standardized interview and remediation procedures just aren't human, and the subject matter therapists deal with, like it or not, is human. Prominent among the commentaries arguing this point is that by Westen, Novotny, and Thompson-Brenner (2004).

Still, every practitioner, no matter how liberated, also wants objective guidelines and reassurance of achieving results. To this end there is safety in procedures derived from studies involving *randomized controlled trials* (RCTs). This experimental condition seeks to give every participant in a clinical trial an equal chance of being assigned either to the control or treatment category. Meeting this requirement makes it likely that there will be comparability between control and therapy groups and that the findings will be meaningful. One prominent case of practice guidelines developed from research using RCTs is *empirically supported treatment* (ESTs) (Chambless et al., 1996; Chambless and Hollon, 1998, and Nathan and Gorman, 1998). Empirically supported treatments are defined by the American Psychological Association Task force on Promotion and Dissemination of Psychological Procedures (1995) as, "treatments shown efficacious in randomized clinical research trials with given populations." The demonstration of treatment efficacy used in the formulations of ESTs usually involves randomized clinical trials in which interventions are applied to diagnosed cases and analyzed against a comparison condition, for example, a waiting list or an alternative treatment.

There is every reason to pay close attention to ESTs and their implications for technically improving the practice of psychotherapy. For a typical example of the way ESTs are used constructively see Maruish (2002), Essentials of Treatment Planning. This manual leaves plenty of room for clinical judgment, even though it is written as a guide for managed care. However, formal research designs employing RCTs also have deficiencies. For example, RCTs typically exclude many of the patients clinicians are likely to encounter in their offices since characteristically between 40% and 70% of the applicants are refused participation (Westen, Novotny, and Thompson-Brenner, 2004, p. 650), controls may be lacking or inadequate (Lambert, 2004, pp. 16-43), or the assessment instruments used may be validated and normed on populations different from one's own. Evaluators and judges may be relatively unskilled or biased through their adherence to a particular model of treatment. Measures are often too limited or non-specific to be clinically very meaningful. Typical is the study of 327 subjects by Beutler et al. (1991), who in spite of their sophistication as researchers determined outcome of cognitive,

experiential, and self-directed therapy using the Beck Depression Inventory, the Brief Symptom Inventory (an abbreviated version of the SCL 90 R), The Hamilton Rating Scale for Depression, the Barrett-Lennard Relationship Inventory, and the Working Alliance Inventory. None of these measures is either broad or deep reaching.

Add to the above list of imperfections frequently encountered with RCTs, restrictions in time allocated to followup and the lack of adequate controls often reflecting budgetary restrictions. These shortcomings obviously limit the long-term value of such studies. Also, except for the more qualitative psychodynamically informed studies, formal research on the efficacy of psychotherapy tends to be about treatments lasting no more than 18 months and often for much shorter periods. Also, the psychosocial modality used in these studies tends to be limited to cognitive behavioral treatments (CBT).

Followup for these studies tends to be carried out for a year or two, and only rarely for longer than five years (Wampold, 2001; Westen, Novotny, and Thompson-Brenner, 2004). Limited duration followup may miss the protracted resolution of or exclude reappearances of the targeted condition. Episodes of these generally recurring psychological conditions may repeat over a person's lifetime or at least for substantial portions of it. Also, pathological entities often change in character over time, as, for example, is the case when major depression develops into a bipolar disorder in a person's mid-twenties. In part because of these considerations, realistic longitudinal studies with adequate followup are difficult and expensive to design and execute.

In addition, the data obtained on followup is generally paltry, consisting of self-report questionnaires, telephone conferences, or a few periodically administered face to face interviews at each followup. The most widely used self-report inventories for followup, for example the Symptom Check List 90 (SCL 90), consist of a limited range of questions about symptoms. They usually fail to incorporate complex or overlapping symptomatic constellations. Also, these inventories often cover a range of concerns not accurately reflecting those the therapist and patient are likely to be focusing on in their treatment.

Roth and Fonagy (2005, p. 18) discuss the virtues and limitations of different hierarchies of evidence according to their susceptibility to bias (p. 18). Choices range from RCTs, to randomization without controls as may be found in single case designs (p. 25), to cohort studies where groups of patients are allocated to specific treatments. Then, there are retrospective studies where patients with similar outcomes are grouped and differences accounted for. Least rigorous are reports using clinical impressions. The authors believe that within this category single-case studies, where the patient is his own control, may become more

relevant in time. Single case studies are convenient to carry out, inexpensive, and can be office-based. Clearly the more rigor introduced into the study, the more artificial the treatments offered. The challenge for us, and for practitioners in general, is to develop ways to optimize treatment to meet a patient's unique requirements without sacrificing flexibility. Research derived guidelines, such as those contained in ESTs may only do part of the job. Also, it needs remembering that a patient's requirements often shifts throughout treatment making superfluous an EST that was originally useful (Frankel, 2000 and 2007).

In the controversy about the applicability of RCTs and, in turn ESTs, for clinical work, serious doubts are raised about the general applicability of EST guidelines. Witness Stein, Lehrer, and Stahl's representative work, Evidence-Based Psychopharmacology (2005). Judging from this volume, much that is currently accepted as standard biological treatment for psychiatric disorders is as yet technically unsubstantiated. Nonetheless, there is no scarcity of ESTs listing when and how to use these drugs in treatment. As one of many examples, I was surprised to learn, that lithium carbonate is the only mood stabilizing drug whose efficacy for mania has been adequately substantiated in clinical trials. Nonetheless, there are a raft of other drugs that are commonly used for the treatment of mania even though they have been subjected to fewer and less definitive studies than lithium. Many, including valproic acid and antiepileptics such as carbamazine have plenty of support from clinical practice for their value in the treatment of mania. The newer mood stabilizing antiepileptic lamotragine is also used in the treatment of mania, although it seems to be uniquely effective in the treatment of bipolar depression.

More disturbing are comments such as those by David Healy (2005) a British psychiatrist. He views the reputation for specificity that many psychotropic drugs have earned as products of manipulation by the pharmaceutical industry. He uses SSRI antidepressants as an example. His opinion is that the central psychotropic action of these drugs is on anxiety, not depression. Nonetheless, they have been marketed as antidepressants. Also, except for their side effect profiles the SSRIs are no more effective for depression than the older tricyclic antidepressants, and in fact the tricyclics may be more effective than the SSRIs with a subgroup of depressed patients (Nierenberg, A., 1994; Shatzberg, A., Cole, J., DiBattista, C., 2005, pp. 109-111).

In summary, the nature and efficacy of interactive psychotherapy, the identity of who should receive it, the impact of the therapist's training and ideology, and the effect of the sensitivity with which psychotherapy is delivered on outcome are critical areas for research. However, currently, there isn't even a consensus about which modality, medication, behavioral treatment, or interactive psychotherapy is most appropriate for what problems (Pinquart, Duberstein, and Lyness, 2006) This

generalization holds for the treatment of most disorders, including those involving "garden variety" depression and anxiety.

Still, the argument between supporters of the contextual model and those who ascribe to the alleged certainty of the medical model and attribute therapeutic superiority to particular pharmalogical and interpersonal interventions, carries on and that debate is cogently documented in the above cited work by Norcross, Beutler, and Levant (Eds), 2006. This book contains a balanced compilation of positions that reassuringly has been published by the American Psychological Association Press.

Certainly, any temptation to reflexively dismiss procedures derived from randomized controlled trials, such as empirically supported treatment protocols, as too rigid to be clinically applicable or as not representative of ordinary clinical populations is self-defeating [Hollon, S., 2006, In: Norcross, Beutler and Levant (eds.), pp. 96 - 105; Chambless and Ollendick, 2001; and Ollendick and King, 2006, In: Norcross, Beutler and Levant (eds.) Evidence-Based Practices in Mental Health, pp. 308 - 317]. It is hard to imagine that selectively incorporating evidence-based treatments in our procedures would do anything less than augment the non-specific effects that are always working in a well-executed psychotherapy (Goebel-Fabbri, Fikkin, and Franco, 2003; Lambert et al., 2003; Westen, Novotny, and Thompson-Brenner, 2004). In fact, it makes sense that these measures, when used thoughtfully, should noticeably improve psychotherapy outcome.

Bringing the nay-sayers and advocates together may be the notion that in spite of adherence to a manualized treatment protocol, a practitioner needs to make his own judgment of when and how a particular technical measure should be introduced into a psychotherapy. This judgment is always based on the subjective data of clinical impression tempered by experience and empirical evidence. The evidence I am referring to includes facts about the patient's current life reported by the patient and at times other informants, the patient's history including information about possible genetic factors, a medical examination, self-report questionnaires, and psychological testing. Add to this list the technical information to which the practitioner has access and his sometimes vast clinical experience. Further, in making moment to moment decisions the clinician cannot help but rely on his judgment about what the patient can hear and tolerate at any given moment. In this spirit Sackett et al. (2001) suggest that the, "Best research evidence refers to relevant research from the basic health and medical sciences, but especially from patient centered research and patient values." He goes on to define clinical expertise as including the "(cumulative) ability to use clinical skills and past experience…" (p. 147).

It is noteworthy that the relationship between training in the use of treatment manuals and competence in their application needs further study as does the impact of manualization on the outcome of these treatments as they are carried out in the real world of psychotherapy (Addis, 1997 and 2002; Castonguay et al., 1999; Kennedy, Regehr, Rosenfeld et al., 2004; Levant, 2004). The American Psychological Association's publication called Criteria for Evaluating Treatment Guidelines (2002), fully acknowledges the complex challenge of flexibly meeting a patient's idiosyncratic needs while maintaining the rigorous standards for efficacy and effectiveness that might be achieved through manualized instruction. It is interesting that in two of the few studies on the topic, less experienced therapists appeared more successful at learning to use treatment manuals than more experienced therapists, presumably since they were less set in their ways and less resistant to be retrained (Henry et al., 1993; Sendell et al., 2006).
By the same token, these therapists might have been less capable of clinical depth than seasoned clinicians. Note, these studies simply need to be regarded as suggestive since each involved a small number of participants and relied on limited data for its conclusions.

As mentioned earlier, a noteworthy alternative to research based on RCTs are single case designs, potentially conducted by clinicians themselves. This single-participant research (Chambless and colleagues, 1998, Barlow and Hayes, 1979, Morgan and Morgan, 2003) is essentially qualitative, relying on data obtained about a single patient in on-going psychotherapy rather than from a cohort of patients (Hill and Lambert, 2004). Here the patient is his own control, and the work and its outcome is assessed serially. While single-participant protocols are promising for office-based research, needed at this point are designs that clinicians are willing to embrace and use in their offices. To date, most office-based treatment monitoring is restricted to self-assessment questionnaires, and these have limited depth and validity.

Probing the Controversy Through My Own Experience

As a fully trained general and child psychiatrist, with seven post graduate years of training in psychoanalysis, and a marvelous clinical upgrade at my first job at Children's Psychiatric Hospital at the University of Michigan, I figured I had it down. My work had to be superior to that of lesser trained professionals. How else could it be? After all, for what had I spent those uncountable hours and so much money on tuition, supervision, and missed practice income, anyway?

So, here, let me tell you about my first consultation group, and then the second, third, and fourth. In order to expand the reach of the Center for Collaborative Psychology and Psychiatry we needed therapists trained in our collaborative model. To begin with, a group of six psychologists, social workers, and MFTs

were recruited. Needless to say I got to know the work of these practitioners intimately. And, I was amazed, completely unprepared, for the lesson I was to learn. These therapists were for the most part mature people who had returned for training after another career or raising children. Almost to a person they were smart and self-reflective, and more than able to seek and hear others' appraisal of their work. They were not inflexibly wedded to theoretical models, as so many of my highly trained colleagues became. And, most important, they strived, asked questions, and generally were impressively successful with their patients.

Most telling about the impact of this experience on me is the before and after. Before this experience there were only a few select colleagues to whom I would refer. These mostly were people I had worked and studied with over years. Almost all were psychoanalytically trained or had been heavily exposed to depth psychology. Now, after four years, I have a bevy of people I trust and can work with clinically. I like, respect, and always learn from them. Of the current group, one is Jungian, another has specialty training in behavioral techniques, and another prefers to work with families.

This testimony appears to support what Norcross, Wampold, and others like them report. Whatever else these psychotherapists delivered, in a general sense they got it right. They were meticulous, caught onto their patient's deeper needs, and most often responded helpfully. Given their different theoretical orientations, their work with patients is a confirmation that the basic requirements for a psychotherapy are human, "contextual" (Wampold, 2001). My first three books examine these interpersonal factors in depth. The rest of what goes into optimizing the results in a psychotherapy, the specific factors as they work with the contextual, is the subject of this book.

Back to Dori

To repeat an earlier point, while several contextual factors affecting outcome in psychotherapy have been identified, I believe no one is fully clear about exactly how each of these general factors work to effect personal change. That they are important to therapeutic success is intuitively reasonable. But beyond the intuitive, what then? Dori's work with Dr. Crane is a case in point.

Dori knows she was helped by Dr. Crane. But how did Dr. Crane manage to have such a profound impact on her? According to Dori, within a few months of working with Dr. Crane her mood and confidence lifted beyond her wildest expectations. Apart from changing Dori's medications by eliminating Carbamizine and Geodon and lowering the dose of Prozac, what specific factors explain why Dr. Crane succeeded when two other therapists had failed so dismally? Dori says that following the unexpected failure of her psychotherapy with Thea she learned to be skeptical, to automatically screen expert advice for utility and authenticity.

She says her experience with Wanda was downright traumatic. In contrast, apparently Dr. Crane provided some or all of the general ingredients deemed by Hilsenroth (2007), Luborsky et al. (1985), and Norcross (2002) to be necessary for psychotherapy to work. According to Dori, (1) Dr. Crane emanated reassuring personal attributes such as warmth and intelligence (the therapist's personal qualities). (2) The therapist-patient relationship with Dr. Crane was solid (the therapist-patient relationship). (3) Dori was a willing subject (patient qualities). (4) Dr. Crane was apparently sure of herself and was clearly experienced and competent with her craft (the therapist's skill). (5) Dr. Crane had few overt doubts about the value of the help she offered, yet she could readily incorporate Dori's needs and views with her own so they made sense to Dori (the therapist's belief in the treatment he or she is providing and its underlying theoretical propositions).

On the side of specificity, Dori says that Dr. Crane knew a lot about managing in a strange city as a young adult. Among her recommendations was that Dori move to a more appropriate neighborhood. Using her cognitive-behavioral skills she taught Dori practical ways to manage her by now obsessive worries about failure. Added was Dr. Crane's psychologically astute commentary about Dori's unconscious fears of harming her father through her professional success.

But, Dr. Crane's skills in the general and specific categories named were certainly not powerful enough to explain how she could have cut so deeply into Dori's despair. Just as a magician pulls rabbits out of a hat, Dr. Crane pulled life out of what at that time was an emptying vessel. There is no doubt that she did it. But how? Apparently Dr. Crane's inviting Dori to participate in her own thought process, rather than simply insisting she follow worshipfully as Thea had, was helpful. According to Dori, Dr. Crane is brilliant and perceptive. That she believed Dori could join her in this process and succeed apparently helped set standards for the changes Dori needed to make. Dr. Crane's allowing Dori to prove to herself incrementally that she could do the job probably made the work more convincing for Dori and may have encouraged her to carry on. And, then there are the more nebulous qualities called *clinical skill and judgment*. Apparently, Dr. Crane had plenty of both.

The Bottom Line

Psychotherapy is always a complex mixture of general-contextual and specific-technical factors. Even though comprehension is achieved at one point, therapist and patient still will probably not be certain of *exactly* how to explain and sustain their success (Frankel, S., 1995, 2000, 2007). This perspective is consistent with the emphasis on subjectivity of the relational school of psychotherapy (Aron, L., 1991, 1992, 1996; Hoffman, I., 1998). It was foreshadowed in the late nineteenth and early twentieth century by philosophers such as Heidegger and Husserl (see, Smith, B. and Smith, D., 1995) and sociologists such as Max Weber (see, Gerth,

H. and Mills, C., 1946) and Alfred Schultz (see, Wagner, H., 1970 and Garfinkel, H.,1967). This therapeutic stance reflects the hermeneutic, anti-structural, anti-positivist view that all observations, whether or not called scientific, reflect the observer's subjectivity infused interpretation. It casts doubt on the persistent truth-value of any set of observations and the procedures derived from these. ESTs would then be seen as trustworthy for as long as they remained clinically valid in a particular psychotherapy. However, one would expect them to falter in their ability to guide and predict over time, necessitating that the EST procedures be modified or abandoned.

Comprehending how a psychotherapy is working is always elusive. As soon as the therapist, and the therapist and the patient together, achieve clarity about what exactly is troubling the patient and what he needs therapeutically, obscurity begins to creep in. The solution to their diagnostic and progress monitoring puzzle, at first seeming within reach, begins to fade. The above considerations notwithstanding, it would be terribly self-defeating for therapist and patient not to seek to identify the principles guiding their work. This is where the sequential assessment procedure we use at the Center for Collaborative Psychology and Psychiatry for making diagnostic determinations and monitoring progress comes in.

Making Psychotherapy User Friendly

Lest the reader find this viewpoint discouraging, it would be surprising if the topic of whether reliable guidelines for the practice of a psychotherapy are achievable was less complex and elusive. Understandably, clinicians and researchers seek simplicity and clarity. But, just think how dull life would be if the human mind could be reduced to a few concrete, semi-stable parameters.

Nonetheless, we are faced with the exciting and daunting task of finding a methodology for assessment and monitoring of psychotherapy patients that not only works but can be used by psychotherapists in the offices. It may be worth remembering at the outset that for years people have benefited from psychotherapy, a statement that is supported by the findings by Smith, Glass, and Miller (1980); Wampold (2001); and the reviews in Lambert (2004). The first step in finding our way within this subjective and technical maze is to explore the issue of making a reliable diagnosis.

A New Paradigm?

My purpose in writing this book and at the Center for Collaborative Psychology and Psychiatry is to establish a *new paradigm* for practicing psychotherapy. In this vision, the therapist, of whatever discipline, thinks like a physician. He takes responsibility for delivering a therapy that is most likely to be productive and is not

wasteful of the patient's time or money. While fully aware of the human, subjective fabric our work, he is impatient. The patient has come in with an ailment and the therapist is responsible for fixing it. Knowing the literature really does count, since this field is anything but static. Similar is the therapist's willingness to consult with others when he reaches the limit of his knowledge or when the treatment begins to fail.

In the next chapter we look at the research on which factors, specific and non-specific, are likely to be most helpful in conducting a psychotherapy. Then on to the complexities of making a diagnosis, and from there to how we do our work with adults and children at the Center for Collaborative Psychology and Psychiatry. Then to our initial clinical study and our method of delivery at the Center.

Welcome along.

About Steven Frankel

Steven A. Frankel M.D. has been a practicing psychiatrist for over thirty years. A graduate of Yale University Medical School, he is certified by the American Board of Psychiatry and Neurology in both general and child psychiatry as well as by the American Psychoanalytic Association. He is an Associate Clinical Professor at the University of California Medical School. He is the founder and director of The Center for Collaborative Psychology and Psychiatry in Kentfield, CA.

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