Commentary on The Case of "CG:" Balancing Supportive and Insight-Oriented Psychodynamic Psychotherapy with a Client Undergoing Intense Life Stress

Placing Psychotherapy Case Studies within the Framework of the APA Evidence-Based Practice in Psychology (EBPP) Model

CAROL D. GOODHEART [a,b]

[a] Independent Practice, Princeton, New Jersey .
[b] Correspondence concerning this article should be addressed to Carol D. Goodheart, 114 Commons Way, Princeton, New Jersey. Email: carol@drcarolgoodheart.com

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ABSTRACT

The American Psychological Association Report of the Presidential Task Force on Evidence-Based Practice delineates Evidence-Based Practice in Psychology (EBPP). The model provides a broad-based framework that allows for the placement of psychotherapy case study outcomes in a systematic, evidence-based context, complementing the results of group-based efficacy studies. This Commentary introduces the EBPP model and suggests ways in which use of its principles could enhance Karen Riggs Skean's case of CG.

Key words: Evidence-Based Practice in Psychology (EBPP); psychoanalytic therapy; supportive versus insight-oriented therapy

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Karen Riggs Skean (2005, this module) has done a thorough job of presenting the case of CG according to her psychodynamic theoretical orientation. It is apparent the patient was functioning poorly at the outset and was in significant distress, and he improved considerably over the course of the treatment. The therapist emerges on the page as a thoughtful, caring, patient, insightful, and conscientious professional. The case appears to represent many good practices in current psychodynamic therapy conducted in a non-research context, and it seems an excellent model as the first psychodynamic case of this *PCSP* journal, with its comprehensive format. My comments and questions are directed toward improving the utility of the case studies generally as the *PCSP* case study database grows. First, I introduce Evidence-Based Practice in Psychology (EBPP), as described in the Report of the Presidential Task Force on Evidence-Based Practice (American Psychological Association, 2005). This model provides a sufficiently broad-based framework to place psychotherapy case study outcomes in a systematic, evidence-based context, and complement the results of group-based efficacy studies. Second, some selected implications of the EBPP model for the case of CG are explored.

EVIDENCE-BASED PRACTICE INPUT FOR CASE STUDIES

In August 2005, the Council of Representatives of the American Psychological Association (APA) adopted the policy statement recommended by the Task Force on Evidence-Based practice as policy for the organization, and it received the Report that explains the basis and provides the references to support the policy recommendation. The Task Force, which I chaired, expects the report will serve as the basis for further publications and will be informative for members, legislators, the public, and those who fund health care services and research. The Task Force was comprised of 18 psychologist scientists and practitioners from a wide range of perspectives and traditions. All Task Force members shared the core value of delivering the best possible care based on the best available evidence. They reached consensus on the definition and important principles that guide a scientifically informed clinical practice in psychology.

The Task Force began with a definition of evidence based practice adapted from Sackett, Straus, Richardson, Rosenberg & Haynes (2000) by the Institute of Medicine (IOM, 2001) in its influential report *Crossing the Quality Chasm: A New Health System for the 21st Century*: "Evidence-based practice is the integration of best research evidence with clinical expertise and patient values" (p. 147). The APA Task Force definition of EBPP that has been adopted by APA closely parallels that definition: "Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of the patient's characteristics, culture, and preferences" (American Psychological Association, 2005, p.5). The components of research, clinical expertise, and patient factors are amplified as follows.

Best research evidence comes from "scientific results related to intervention strategies, assessment, clinical problems, and patient populations in laboratory and field settings as well as to clinically relevant results of basic research in psychology and related fields" (American Psychological Association, 2005, p. 7). Research needs to balance both internal and external validity in order to be useful for practice. Because different research designs are needed to answer different types of questions, the Task Force endorsed multiple types of research evidence (e.g., efficacy, effectiveness, cost-effectiveness, cost-benefit, epidemiological, treatment utilization studies), all of which contribute to effective psychological practice. Among the sources of research evidence are systematic individual case studies involving both quantitative and qualitative process and outcome data, such as those associated with *PCSP*.

Clinical expertise competencies identified by the Task Force include:

> a) assessment, diagnostic judgment, systematic case formulation, and treatment planning; b) clinical decision making, treatment implementation, and monitoring of patient progress; c) interpersonal expertise; d) continual self-reflection and acquisition of skills; e) appropriate evaluation and use of research evidence in both basic and applied psychological science; f) understanding the influence of individual and cultural differences on treatment; g) seeking available resources (e.g., consultation, adjunctive or alternative services) as needed; and h) having a cogent rationale for clinical strategies. Expertise develops from clinical and

> scientific training, theoretical understanding, experience, self-reflection, knowledge of research, and continuing professional education and training. It is manifested in all clinical activities, including but not limited to forming therapeutic alliances; assessing patients and developing systematic case formulations, planning treatment, and setting goals; selecting interventions and applying them skillfully; monitoring patient progress and adjusting practices accordingly; attending to the individual, social, and cultural context; and seeking available resources as needed (e.g., consultation, adjunctive or alternative services) (American Psychological Association, pp. 10-11).

The IOM component of patient values was expanded by the Task Force to include a patient's characteristics, culture, values, and preferences.

> Available data indicate that a variety of patient-related variables influence outcomes, many of which are cross-diagnostic characteristics such as functional status, readiness to change, and level of social support (Norcross, 2002). Other patient characteristics are essential to consider in forming and maintaining a treatment relationship and in implementing specific interventions. These include but are not limited to a) variations in presenting problems or disorders, etiology, concurrent symptoms or syndromes, and behavior; b) chronological age, developmental status, developmental history, and life stage; c) sociocultural and familial factors (e.g., gender, gender identity, ethnicity, race, social class, religion, disability status, family structure, and sexual orientation); d) current environmental context, stressors (e.g., unemployment or recent life event), and social factors (e.g., institutional racism and health care disparities); and e) personal preferences, values, and preferences related to treatment (e.g., goals, beliefs, worldviews, and treatment expectations). Available research on both patient matching and treatment failures in clinical trials of even highly efficacious interventions suggests that different strategies and relationships may prove better suited for different populations (Groth-Marnat, Beutler, & Roberts, 2001; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Gamst, Dana, Der-Karaberian, & Kramer, 2000, Norcross, 2002) (American Psychological Association, 2005, p.15).

The goals of EBPP seem congruent with the goals of *PCSP*, namely, to publish systematic case studies that are rooted in the specifics of individual clinical practice while at the same time based on the latest empirical research and scholarly theoretical development. Also, it is important to point out that discussions about EBPP take place in a larger social context. The evidence-based practice movement is a growing public policy trend toward greater accountability and cost containment in health care services for all of the health professions. Like it or not, this larger context is having a major effect on psychology practice and the ways in which psychologists assess, treat, and report on their patients (Tanenbaum, 2005).

Disagreements concerning the relative importance of different aspects of EBPP have been plentiful and heated in the discipline (e.g., Crits-Christoph, Wilson, & Hollon, 2005; Fishman, 1999; Wampold, 2001; Westen, Novotny, Thompson-Brenner, 2004, 2005). What appears to underlie the controversies are fundamental philosophical differences between adherents of the medical drug model of psychotherapy based on specific ingredients as tested in randomized controlled clinical trials (e.g., Nathan & Gorman, 2002) and the contextual model of

psychotherapy based on common factors in well-established therapies (e.g. Wampold, 2001; Norcross, 2002). No one can know with certainty the optimal balance of the positivistic empiricism of the specific ingredients model on the one hand, and the contextual model's attention to the client's subjective experiences and needs, the therapist's characteristics and activities, and the therapeutic alliance and endeavor, on the other. As a result, psychologists would do well to pay attention to the lessons that can be learned from *both* of these perspectives (Goodheart, in press).

Most practitioners are practical integrationists (Lambert, Bergin, & Garfield, 2004). They cull and use evidence without subscribing to specific hierarchies about which evidence is most important because usefulness varies widely depending on the clinical context of the individual case; and thus practitioners seek information from a broad range of empirical research, from the literature of reasoned theories and consensus and diverse forms of knowledge, from the fruits of clinical observation and inquiry, and from clients' contributions, responses, and progress (Goodheart, in press). The endeavor of psychotherapy is a complex multilayered interpersonal enterprise, with both scientific and humanistic foundations. When psychotherapy is understood in this way, it seems clear that multiple strands of evidence and resources are necessary for effective practice.

The APA Task Force concluded that " ongoing monitoring of patient progress and adjustment of treatment as needed are essential to EBPP" (American Psychological Association, 2005, p. 18). In principle, if therapists are able to document good outcomes, including outcomes that compare favorably to established outcome base rates where they exist, therapists should be able to select freely from among the many well-established and coherent guiding theories and methods of psychotherapy. Some (although not all) important meta-analytic reviews that have compared different psychotherapies have found little general difference among treatments (e.g., Lambert & Ogles, 2004; Wampold, 1997). Although the most frequently researched theoretical approaches to psychotherapy are the behavioral and cognitive-behavioral models, the psychology literature includes many other widely recognized theories of personality, psychopathology, and health, as well as other theoretically based principles and aims for psychotherapy – such as psychodynamic, family systems, humanistic, interpersonal, feminist, cultural competency, and integrative paradigms. Many intervention methods are employed by good clinicians and theoretical blending that borrows techniques across traditions is becoming increasingly common (Goodheart, in press). Thus the main criterion in judging the effectiveness of a therapy case should be outcome, not the particular intervention orientation or methods per se.

APPLICATIONS TO THE CASE OF CG

If we take this discussion of EBPP as a point of departure, what questions might we ask and what comments might we make about the case of CG?

Research. Most of the citations for the CG case are theoretical in nature, rather than research based, and few are recent. The author's case would be strengthened if she included

more empirical and more recent research. Although it is less extensive than the research on CBT, there is certainly a body of empirical research applicable to psychodynamic approaches (e.g., Bateman & Fonagy, 2001; Bradley, Heim, & Westen, 2005; Fonagy, 2000; Luborsky, Popp, & Barbarer, 1994). Similarly, there is strong evidence available for the importance of supportive aspects of therapy. It would be particularly persuasive to anchor this case in research related to the therapeutic alliance and to the importance of other therapeutic relationship factors (see Norcross, 2002 for a review). Skean might also want to make the link between her approach, the success of the case, and the common factors research, some of which overlaps with relationship factors (e.g., Bickman, 2005; Wampold, 1997). Finally, as more and more case studies are published in journals like *PCSP*, authors like Skean will have more numbers of relevant case studies to which to link their work.

Clinical expertise. Clinical competence is difficult to demonstrate directly in print. However, an author can bring the reader into the therapeutic dyad by giving examples of pivotal moments, by telling us exactly what she said and did. For example, an author can tell us that the patient said *w* suddenly or showed *x* consistently over many sessions, and in response the therapist said *y* or did *z* (or *initiated a* or *b* because she knew patients with a particular pattern will be likely to respond well to it) -- and this was the therapist's rationale for her actions. Or the therapist might describe how the patient did *c* immediately or *d* in the next session and *e* over time; and which patient-therapist interactions were one-time events and which were repeated over time. Skean provides a number of good examples of these processes. She also demonstrates clinical competencies identified by the Task Force through her description of the case formulation, her interpersonal expertise, the referral for a medication evaluation, and other elements.

Also, generally it will make all cases more accessible if authors attempt to find common language for their actions across differing orientations (Goldfried, 1995). For example, techniques can be described simply and accurately as clarification, interpretation, non-directive support, problem solving, education, homework, referral for consultation, and the like. Skean does a good job of avoiding jargon, describing and explaining the therapy in English that is accessible to those outside her particular theoretical orientation. It may be worth noting that many readers from other orientations will recognize the terms transference and countertransference, but not really understand their meaning, or how integral these constructs are to therapeutic relationship patterns, or how to identify a transference or a countertransference reaction.

Case formulation can be grounded in the research literature, as well as in the specific clinical material (see Eells, 1997). The formulation can be strengthened by the use of operationalized guideposts that cross theoretical orientations, such as the Diagnostic Statistical Manual (American Psychiatric Association, 2002), which Skean employed to good effect. Another guide is a promising functional classification system, the International Classification of Functioning, Disability, and Health (ICF; World Health Organization, 2001). APA and WHO collaborated on the development of a procedure manual and guide for applying the ICIDH-2

(American Psychological Association and World Health Organization, 2003). This system is designed to work in real world clinical settings with differing assessment techniques, such as psychometric measures, clinical interviews, direct observations, and self-report.

Other possible guideposts include psychometrically validated multi-symptom and multi-problem instruments such as the Symptom Checklist 90-Revised ("SCL-90," Derogatis, 1994); the Treatment, Evaluation, and Management instrument ("TEaM," Grissom, Lyons, & Lutz, 2002); the Outcome Questionnaire 45 ("OQ-45," Lambert, Burlingame, Umphress, Hansen, Vermeersch, Clouse, & Yanchar, 1996); and the Shedler-Westen Assessment Procedure ("SWAP," Shedler & Westen, 2004). A description of alternative diagnoses and formulations, as Skean employed, is important and such considerations act to mitigate tendencies toward the common heuristics and biases in judgment to which all human beings are subject, including psychotherapy practitioners and researchers (Garb, 1999).

Many therapists, regardless of orientation, offer educational information about psychotherapy as a meaningful intervention. In her case study, Skean reports that "the second kind of intervention which showed evidence of working was to respect the client's defenses, to time what was said in a way that could be heard, and to give him as much control as possible, what Pine (1985) refers to as 'acceptance/rejection rights' over any intervention." This material seems to speak wisely to the need for tact and timing and for allowing the patient to assimilate information and change at his own pace.

Patient characteristics. The third leg in the three-legged stool of evidence-based practice is the patient's characteristics, culture, values, and preferences. Providing these details in a written case study has to be weighed against the need to protect the client's confidentiality. In terms of personal characteristics, there is no reference to CG's ethnocultural background, although his eyesight is included and seems to be a distinguishing personal attribute with strong emotional resonance for him. Some additional information that I believe would have enriched the case, assuming it would not have compromised confidentiality, includes: the quality of the patient's current relationship with his mother, and whether the early attachment to her was sufficiently secure to build upon for satisfactory adult functioning in relationships; the client's relationship with his sisters now; more on the client's real relationship with the author as well as the transference relationship, including implications for the client's capacities for relationships with women. His relationship patterns with men, especially authority figures, were more clearly documented.

Collaboration on goals between patient and therapist is a central tenet of EBPP. The description sounds as if Skean implicitly decided on goals in CG's case based on her understanding of his pressing needs, although given Skean's sensitivity there may have been more collaboration than is communicated, as trust was established during the psychotherapy process.

Quantitative monitoring. Finally, Rigg-Skean's case involves no quantitative monitoring of the psychotherapy process, for perhaps two reasons. First, given the exceptional concerns of CG and his persistent questions about confidentiality, it is not clear whether he would have agreed to complete paper-and-pencil instruments, at least at the outset of the psychotherapy. Second, the case was not conducted in a setting where outcome measurement is routine. Nevertheless, it is likely that such measurement will become the norm within a very short time, and it is already expected in many settings.

Quite apart from any requirements by insurers and managed care companies (and their potential mismanagement of the outcomes issue), there are more positive reasons to institute a formalized, but simple, feedback mechanism that generates outcome-related data, such as that developed by Lambert and his colleagues (Lambert & Archer, in press; Lambert, Harmon, Slade, Whipple, & Hawkins, 2005). These researchers report on efforts to improve psychotherapy outcomes by monitoring treatment and providing feedback to clinicians to guide ongoing treatment. This is especially valuable when the patient is not responding to treatment or is getting worse, which was a factor in Lazarus' (2005) case of "Ben," published earlier in *PCSP*. Specifically, in earlier research, Lambert and Ogles (2004) reported that 5-10% of the patients in their sample deteriorated during treatment, and 15-25% showed no measured benefit. In more recent research, Lambert and his colleagues (Lambert & Archer, in press; Lambert et al., 2005) demonstrate that in most cases deterioration can be reversed with monitoring, feedback, and clinical support tools. Further, they found that although a good percentage of patients show some improvement in 10 sessions, a sizable percentage require more sessions – some up to 50 – to obtain optimum success, which is why psychotherapy should not be restricted to arbitrary short term limits. Finally, Lambert and Archer found that characterological and interpersonal problems respond more slowly to treatment than symptoms, supporting the length of treatment for the case of CG.

Skean's case of CG makes a welcome contribution to the published literature on systematic case studies of psychoanalytic psychotherapy. As mentioned above, while there presently exists a small but identifiable literature on accumulated psychotherapy case studies (Miller, 2004), it is expected that this literature will expand considerably as new psychotherapy case study journals like *PCSP* and *Clinical Case Studies* (Hersen, 2002) develop. When systematic case studies include measurement of their outcomes, the framework of EBPP helps to highlight their knowledge value and thereby to stimulate their continuing creation. As these case studies grow in number and variety, they will become an increasingly important source of scholarship to which future case study authors can link their work.

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