

Evidence-Based Practice: Beyond Empirically Supported Treatments

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Must the clinician choose between a practice that is strictly objective and data based and one that is purely subjective and experience based? Optimally, practitioners need to follow a model of evidence-based psychotherapy practice, such as the disciplined inquiry or local clinical scientist model, that encompasses a theoretical formulation, empirically supported treatments (ESTs), empirically supported therapy relationships, clinicians' accumulated practical experience, and their clinical judgment about the case at hand. Some shortcomings of ESTs are reviewed, and a form of evidence for psychotherapy practice is presented that entails the accumulation of systematic case studies published online. Practitioners can contribute to such a database and be guided in their practice by those cases most relevant to their clients' problems.

Mrs. T is a 42-year-old woman who is married with two teenagers and one preteen-age daughter. She is of European background and grew up abroad. On September 11, 2001, Mrs. T witnessed the second plane crash into the World Trade Center while knowing that several of her close associates were in that building for a meeting. At the time she had a very responsible human relations position in a corporation in which she did the hiring. In this role, she arranged the funeral services for two of the employees and served as the liaison for their families, taking care of matters such as insurance and death certificates. She was also an emotional support for the bereaved families.

From a few months after that time and the subsequent loss of her managerial job, she has had frequent crying spells, anxiety attacks, and a sense of despondency. She finds that her thoughts are disconnected, making her unable to focus on any task for very long. Beset by physical problems such as high blood pressure and a severe facial rash, Mrs. T has experienced chest pains and heart palpitations causing her to feel as if she were having a heart attack. Complaining of diminished libido, she has less interest in being intimate with her husband, with whom there have been increased marital tensions. Since shortly after 9/11 Mrs. T has been less involved in social activities, preferring to be by herself. Her feelings, except for grief, sadness, and irritability, have been numbed.

Mrs. T came to see me in a very distraught, tearful state despite a year having elapsed since 9/11. Referring to her experience at that time, she told me that she had learned that one of her associates was on fire when she left the building and died shortly

afterward. Mrs. T still imagines herself in conversation with the deceased employees, who were also her friends. The 9/11 events are replayed in her mind both in the waking state and in her disturbing nightmares. Mrs. T believes that she was indirectly responsible for her associates' deaths, which has been one important focus of therapy.

Because of the business downturn in New York City after 9/11, her firm decided not to do any more hiring and Mrs. T was let go. The loss of her high-paying, challenging position was a big blow to her self-esteem. Although she made an effort to find other employment, she was not successful, and she soon became unable to pursue it further because of her increasingly debilitating symptoms. Her financial situation deteriorated, made worse by her husband's losing his job as well. She first sought treatment with a psychologist a few months after 9/11, which was helpful but which she had to terminate when she no longer had insurance coverage. She also has been seen by a psychiatrist who prescribed antidepressant and anti-anxiety medications. Although Mrs. T is not yet fully recovered after 1 1/2 years of therapy, she is much less subject to anxiety and mood swings, is working part time, and is functioning better on a day-to-day basis.

Is an Empirically Supported Treatment Sufficient for Mrs. T?

For the past decade there has been a culture war raging over the value and even ethical imperative of practicing empirically supported treatments (ESTs). ESTs refer to those therapies that have been shown to be efficacious in treating specific disorders, based on the American Psychiatric Association's (1994) *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*), in two randomized controlled trials (RCTs) or in a series of single-case design experiments (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). On one side of the divide are those who advocate that ESTs be preeminent in clinicians' practice (e.g., Chambless & Hollon, 1998; Sanderson & Rego, 2000); on the other are those unwilling to cede the field to what are typically *DSM*-oriented, manual-based, cognitive-behavioral therapies (e.g., Bohart, 2000a; Levant, 2004). Mrs. T clearly suffers from

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posttraumatic stress disorder (PTSD) and probably fits other diagnostic categories as well. Is there an EST for this disorder and, if so, would it suffice to restore Mrs. T's functioning? I return to these questions after examining ESTs and the culture war between more humanistic and more scientific psychological outlooks (see Kimble, 1984).

I use the term *culture war* because the controversy taps into broad worldviews in matters psychological that divide many applied psychologists and that predate the current acrimony over ESTs. These outlooks include but are not limited to the following contrasting pairs, the first of each being the more "humanistic": subjectivism versus objectivism (Woolfolk, 1998), contextualism versus atomism (Slife, 2004), hermeneutics versus universalism (Messer, Sass, & Woolfolk, 1988; Slife, 2004), idiographic versus nomothetic (Allport, 1937), and qualitative versus quantitative method (Denzin & Lincoln, 2000). In reference to ESTs, what this amounts to is whether RCTs and experimental, single-case studies yield more useful information for practitioners than the combination of philosophical outlook, theory, other research sources, and practical experience on which most practitioners rely.

These dichotomies are overdrawn insofar as not every psychologist falls neatly on one or the other side of the divide. In addition, alternatives now available for practitioners to draw on for an empirically oriented practice are studies on *empirically supported relationships*, or ESRs (Norcross, 2002). The ESR literature focuses on people, not disorders, namely, the role of the therapist, the client, and their interaction in contrast to the ESTs' emphasis on techniques and treatment packages. For example, three general elements of the therapeutic relationship that have been shown to correlate with therapy outcome are the quality of the therapeutic alliance, therapist empathy, and agreement and collaboration around goals.

In addressing this culture war as it pertains to the practice of psychotherapy, I first review shortcomings of ESTs in an effort to demonstrate that their wholesale adoption by practitioners is not warranted—although neither should they be ignored. In doing so, I summarize and update some arguments that I have presented elsewhere (e.g., Messer, 2001a, 2002). In the hope that we have arrived at a point at which the battle has exhausted both sides and some form of a truce, if not peace agreement, is possible, I discuss two helpful ways of viewing the researcher–clinician divide. These offer a viable middle ground for the practitioner interested in evidence-based practice (the now preferred and broader term than ESTs). They include Peterson's (1991) disciplined inquiry model and Stricker and Trierweiler's (1995) concept of the local clinical scientist. The case of Mrs. T is then revisited to demonstrate the importance of going beyond ESTs in clinical practice. The article points to some promising uses of the pragmatic case study method that may also contribute to narrowing the gap between research and practice, science and humanism. Finally, implications for practice are spelled out.

Some Shortcomings of ESTs

Randomized Clinical Trials: The Gold Standard?

Luborsky et al. (1999) examined 29 RCTs comparing one therapy with another and found a correlation of .85 between research-

ers' therapy allegiance and outcome. That is, there was a very substantial association between the researcher's preferred therapy model and the therapy that was more successful. It emerged despite the fact that differences in efficacy between the therapies were rather small and clinically insignificant to begin with. Because behaviorally oriented researchers carry out the great majority of research on ESTs, differences that are found between cognitive–behavior therapy (CBT) and other therapies may be due to researcher allegiance (in essence, a type of "experimenter bias") rather than to a feature specific to the behavioral ESTs. For example, it may be the case that researchers' theoretical persuasion leads to their favorite therapy being administered in the studies with more fidelity and enthusiasm than those with which it has been compared.

The RCTs on which ESTs are based are problematic in certain other respects. A case in point is Westen and Morrison's (2001) meta-analysis of high-quality RCTs of panic disorder, generalized anxiety disorder, and depression. Most of the treatments were cognitive–behavioral ESTs. They found a high exclusion rate from clinical trials for all three disorders: "two thirds of patients who present for treatment of the disorder are excluded, and the more patients excluded and the more stringent the exclusion criteria, the more successful the treatment" (p. 884). Could it be that ESTs are based on rather select patient samples? If patients with comorbid disorders (e.g., both a *DSM-IV* Axis I and Axis II disorder) are frequently excluded, to what extent is the research on which ESTs rest truly applicable to clinical practice where such patients are not typically refused treatment? On the other hand, somewhat reassuring in this connection are results reported by Shadish, Matt, Navaro, and Phillips (2000) that there is a high degree of similarity between the research samples and those seen in clinical practice. Similarly, Stirman, DeRubeis, Brody, and Crits-Christoph (2003) found that 80% of the outpatients treated in the community would have been eligible for at least one published RCT—although it should be noted that 58% of these patients had the *milder* diagnoses such as adjustment disorder or dysthymia, which are poorly represented in the psychotherapy outcome literature. Apparently, the verdict is still out on the issue of the generalizability of ESTs to normative practice.

Of equal concern is Westen and Morrison's (2001) finding that for depression and generalized anxiety disorder, the average patient maintains a mild but clinically significant level of symptoms after treatment with an EST. Furthermore, only 40% of these patients who undertake these treatments (which include the drop-outs) gain from them. Of the patients with depression who completed treatment, the number who improved and remained improved after 1 to 2 years was about 37%. If the patients who began treatment but did not complete it are included, the improvement rate at 2 years is only 27%. Data for panic disorder are more encouraging but not outstanding: Half of those patients who completed treatment can expect to remain improved at 2 years. Comparable data for generalized anxiety disorder are not available. Note, too, that somewhere between one quarter and one half of patients treated for these disorders seek further treatment within 12–18 months, and half do so within 2 years.

These studies suggest that there is reason to be cautious about the claimed virtues of ESTs, or any therapy for that matter. Nathan (2001) speculated that longer continuation of psychosocial treat-

ments for these disorders, as is often the case for treatment with medication, might yield better results. Generally speaking, the results of short-term therapy (15–25 sessions) are quite good at termination and up to 1-year follow-up (e.g., Anderson & Lambert, 2001), but it may be that long-term therapy is needed to maintain long-term gains, especially for the more severe mental disorders.

Validity of Non-EST Therapies

The fact that some therapies have been shown to be efficacious in RCTs does not mean that others are invalid. Meta-analyses (Smith & Glass, 1977; Wampold et al., 1997) and meta-analyses of meta-analyses (called mega-analyses, e.g., Grissom, 1996; Luborsky et al., 2002) have found very few differences among those therapies referred to by Wampold (2001) as *bona fide*. By this term, he means therapies that have a firm theoretical structure, have been practiced extensively over time, and have a research foundation even if this foundation does not include the RCTs as defined by the Task Force on Promotion and Dissemination of Psychological Procedures (1995). Psychodynamic therapy, client- or person-centered therapy, and family or couples therapy are all *bona fide* by this definition. Given the results of the meta-analyses, it is very likely that *bona fide* therapies will be found as helpful as the current ESTs for many diagnostic disorders and nondiagnosable problems, although this remains to be proven. By my count, 41 of the 49 ESTs listed by the Task Force update (Chambless et al., 1996) are either behavioral or cognitive-behavioral, but when direct comparisons with other *bona fide* therapies have been made in the meta-analyses mentioned above, typically the behavioral or cognitive-behavioral therapies have not been found to be more efficacious. These analyses are not cited in the approved EST lists because the meta-analyses are often conducted on studies that have not targeted one specific *DSM*-based disorder. In such studies, diagnostic groups such as adjustment disorders, major depression, and anxiety disorders have been combined, which has disqualified them. Therefore, it is not the case that the non-CBT therapies are without any type of empirical support for their efficacy.

Even in those instances in which there was an advantage to the behaviorally based ESTs, closer inspection has revealed this to be incorrect. Wampold, Minami, Baskin, and Tierney (2002), for example, meta-analyzed therapies for depression and found CBT to be superior to the noncognitive and nonbehavioral therapies. When they separated the latter therapies into two groups—those that were *bona fide* treatments and those that were not (such as supportive counseling with no theoretical framework)—the superiority of CBT turned out to be an artifact of including non-*bona fide* therapies in the comparisons. In other words, CBT was not significantly more beneficial than noncognitive and nonbehavioral treatments that were *intended* to be therapeutic rather than merely serving as a convenient control group for the researchers' favored therapy.

Process and Outcome Criteria for ESTs Versus Other Therapies

On another front, there is a mismatch between the nature of the treatment emphasis of ESTs and those therapies that are not cognitive-behavioral. The latter, including such approaches as

psychodynamic, experiential, and existential, focus more on the *process* of therapy compared with CBT, which sets its sights more directly on presenting problems and *outcomes* per se (Gold, 1995). Stated differently, in CBT the aim is to modify the psychiatric disorder or its symptoms as directly and efficiently as possible. The process-oriented therapies, on the other hand, view symptomatic changes as occurring indirectly through exploration of emergent themes, schemas, or unconscious motives and beliefs. They seek to resolve complex intrapsychic conflicts, personality difficulties, or interpersonal maladaptive patterns through insight and affective experience in the therapy. Therapists encourage a process that leads patients to an awareness of their potential for self-direction rather than focusing them along more preset lines in accordance with the guidelines of a manual or specific technique. There is a process of discovery and meaning-making to help enrich the patient's self-experience and awareness. Outcome criteria used are different, too, encompassing variables not directly tied to presenting symptoms and *DSM-IV* categories, such as attainment of insight, a sense of agency, a firmer identity, higher self-esteem, a greater recognition and better handling of feelings, greater ego strength and self-cohesion, and increased pleasure and serenity in living life (McWilliams, 1999).

Process therapies tend to emphasize the competence, skill, and personal qualities of individual therapists and their impact on the therapeutic alliance more so than specific techniques or ingredients such as cognitive reframing or anger management that are characteristic of the ESTs. These therapist and therapist-client variables are sometimes referred to as common factors that cut across the different therapies. Here is a brief summary of the empirical findings regarding these two kinds of variables (Messer & Wampold, 2002):

Common factors and therapist variability far outweigh specific ingredients in accounting for the benefits of psychotherapy. The proportion of variance contributed by common factors such as placebo effects, working alliance, therapist allegiance and competence are much greater than the variance stemming from specific ingredients or effects. (p. 23)

(For specific empirical studies documenting this conclusion, see Wampold, 2001.)

A common factors or contextual approach (Frank & Frank, 1991; Wampold, 2001) does regard specific types of therapeutic interventions as necessary to the conduct of therapy, but their purpose is conceptualized quite differently than in the EST literature. The purpose of such specific ingredients or techniques is to construct a coherent treatment—be it cognitive-behavioral, psychoanalytic, existential, or otherwise—that therapists believe in and that provides a convincing rationale to clients. Furthermore, these specific ingredients cannot be studied independently of the healing context and atmosphere in which they occur.

In terms of clinical practice, the medical model on which ESTs are based says, "Seek a therapist who uses techniques with demonstrated ability to alleviate your condition," whereas the contextual (common factors) model advises, "Seek an interpersonally competent therapist who uses a treatment approach you find compatible with your worldview." The former puts more reliance on the value of targeted treatment ingredients, and the latter more on the personal qualities of the therapist and the fit between the

client's and therapist's worldviews as expressed in a theoretical orientation.

Two Models of Clinical Practice

The Disciplined Inquiry Model

Does the clinician have to choose between ESTs and ESRs, between a scientific and humanistic practice, and between reliance on nomothetic findings and the idiographic richness of the individual case? I do not believe so. Because of the complexity and contextual features of each applied case, psychologists can only practice responsibly by drawing on knowledge available from many sources (e.g., Goodheart, 2004). What is the relationship, then, between science and practice, and how does this bear on evidenced-based practice?

Figure 1 illustrates Peterson's (1991) disciplined inquiry model (see also Fishman, 2001). The first step is assessment of the client, which is based on a theory or "guiding conception." The assessment is then used by the practitioner to create a specific formulation of the client's situation, frequently involving a reframing of the issues the client initially presented. Most relevant for the issue of evidence-based practice, the assessment and formulation also rely on clinicians' knowledge of relevant empirical research and their mental storehouse of similar cases. There are now several empirically supported assessment approaches that are applicable to the formulation of individual clinical cases. These include, for example, the core conflictual relationship theme, cyclical maladaptive patterns, and cognitive-behavioral case formulation using functional analysis (Eells, 1997). All of these provide an empiri-

cally supported framework leading to specific kinds of interventions. Note that disciplined inquiry is a pluralistic model insofar as it can accommodate multiple, empirically supported approaches. In other words, the evidence-based clinician is not constrained by empirical findings to one practice orientation only.

A formulation typically leads to a treatment plan for action. Here, too, research findings are relevant for both selecting a treatment and conducting it. Such research can include the ESTs. Is there an EST that is targeted to the client's problem, and can it be administered within the theoretical approach guiding the practitioner? This is much more likely to be the case for the therapist who is cognitively or behaviorally oriented. However, as noted earlier, there are other kinds of empirical findings to draw on besides ESTs. It behooves practitioners of all theoretical stripes to know what client and therapist factors, for example, have been shown to correlate with therapy outcomes because these are often more useful than diagnosis (Clarkin & Levy, 2004). It is true that the link between cause and effect is not as strong in correlational findings as it is in RCTs, because the latter include a comparison or control group. Correlational data, however, do have evidentiary standing by virtue of their pointing to an association between two variables.

For example, there is strong empirical evidence that the therapeutic alliance has a significant, reliable, albeit modest, relationship to outcome (Martin, Garske, & Davis, 2000). In a review of therapist characteristics and techniques that enhance the therapeutic alliance, Ackerman and Hilsenroth (2003) found the following personal attributes of the therapist to be important: being flexible, honest, respectful, trustworthy, confident, warm, interested, and

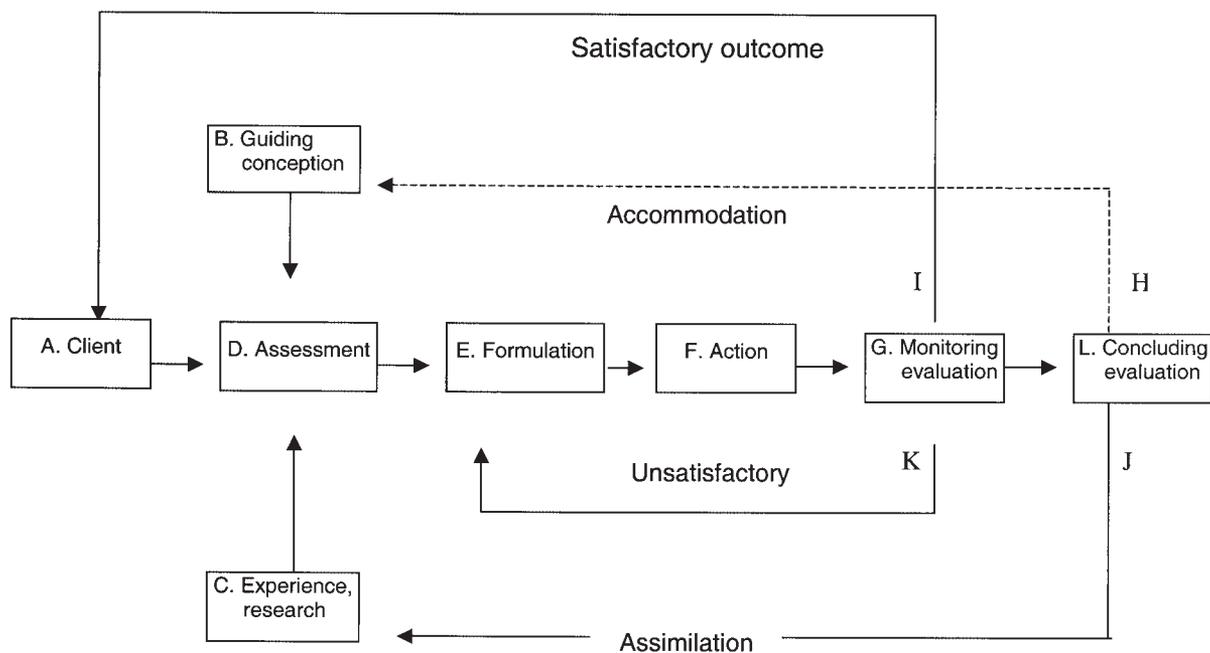


Figure 1. Professional activity as disciplined inquiry. From "Connection and Disconnection of Research and Practice in the Education of Professional Psychologists," by D. R. Peterson, 1991, *American Psychologist*, 46, p. 426. Copyright 1991 by the American Psychological Association. Adapted with permission. (See also Fishman, 2001.)

open. Apropos of techniques, the following kinds of intervention contributed positively to the alliance: exploration, reflection, noting past therapy success, accurate interpretation, facilitating the expression of affect, and attending to the patient's experience. The findings were not specific to only one kind of therapy, although there were few studies that included CBT. Knowing these findings should help therapists maximize their chances of preventing drop-outs and enhancing outcomes.

Finally, a monitoring evaluation is conducted that, in practice, is most typically based on a discussion between client and practitioner of what has been accomplished. Testing may be used as part of a more formal evaluation. If either client or practitioner considers the outcome insufficient and expects further efforts to lead to greater improvement, the case may be reformulated and new interventions attempted either by the same or another practitioner. If both the client and the practitioner consider the outcome satisfactory, the client's needs are met and the therapist proceeds to termination and a concluding evaluation. The case then becomes part of the psychologist's accumulated repertoire of clinical experience, which influences how future cases are treated. Results that differ from expectations may require a change or accommodation of the guiding conception.

The Local Clinical Scientist

Parallel to the disciplined inquiry model, Stricker and Trierweiler (1995) proposed the term *local clinical scientist* to describe the mode of practice of a scientifically oriented psychologist. A local clinical scientist is one who "brings the attitudes and knowledge base of the scientist to bear on the problems that must be addressed by the clinician in the consulting room" (p. 995). In supporting the synergy between science and practice, they cited Flexner's (1925) comments on medical education:

At bottom the intellectual attitude of the two are—or should be—identical: Neither investigator nor practitioner should be blinded by prejudices or jump to conclusions; both should observe, reflect, conclude, try, and, watching results, continuously reapply the same method until the problem in hand has been solved or abandoned. (p. 4)

They stressed that it is just as unscientific to apply presumably generalizable empirical findings (read, ESTs) to a local situation where they do not quite fit (e.g., Mrs. T) as to ignore them when they do. Understanding a local situation is at least as important as knowing something about clients or techniques in general.

Along these lines, note the similarity of the following two statements from leading educators of applied psychologists who differ in theoretical orientation:

Local clinical scientists amass whatever [scientific] data are relevant, combine these with the observations of the immediate setting and with experience gathered from years of local practice and put it all together in the service of providing assistance to those in need. They become Sherlock Holmes of the consulting room: learned and astute observers, consummate logicians, and effective agents in the local situation. (Stricker & Trierweiler, 1995, p. 998)

Nevertheless, hope for distinctive, closely specifiable, demonstrably effective, dependably generalizable methods of treating all the conditions that clinicians encounter seem out of the question. Variations

among disorders are too great, variations in treatment are too often required, and the responsibilities of practice require that the unique specifics as well as the common features of every case be thoroughly examined, fully described, and managed to the greatest possible benefit of each client. (Peterson, 2004, p. 204)

Of course, both models need to be subjected to their own disciplined inquiry and empirical test.

If, in fact, applied psychologists need to know the specifics about individual cases and not only generalized group findings, what kinds of methods and sources of data might supplement and even improve on evidence from traditional group designs, process–outcome correlations, and Client \times Technique interactions? One answer is intensive case studies that strive to preserve a scientific attitude even if the traditional level of control and ability to generalize is much less than in RCTs. The point made by advocates of these methods, however, is that they are better suited to the exigencies of practice than are the RCTs, and that through the accumulation of such cases lawful trends can be discerned. This will also be a vehicle to study the effectiveness of the disciplined inquiry and local clinical scientist models.

Revisiting Mrs. T

Before I describe some new, scientifically based approaches to the case study, let us return to the case of Mrs. T. Is there an EST that is suitable for her? Not exactly. The PTSD treatments that are considered "probably efficacious" typically pertain to combat veterans or to the aftermath of sexual assault. In addition, many PTSD studies apply only to treatment that takes place soon after the trauma (Litz, Gray, Bryant, & Adler, 2002). Therefore, one difficulty with ESTs, which tend to rely on *DSM-IV* diagnoses such as PTSD, is that they may not fit the case at hand very well. Nevertheless, the empirical psychological research on the treatment of anxiety and specifically PTSD points to two important treatment factors: anxiety management and exposure, whether real or imagined (Keane & Barlow, 2002). I used these principles in helping Mrs. T come to face and start to master the 9/11 trauma. Incidentally, as Keane and Barlow pointed out, it was Pierre Janet and Sigmund Freud who most influenced these CBT approaches to PTSD, so that it was not difficult for me as an "assimilative" psychodynamic therapist to adapt them to the therapy. (Assimilative integration refers to the incorporation of techniques or perspectives from one mode of treatment into one's "home" therapy; Messer, 2001b).

Although these procedures were of some help to Mrs. T, they were only partially successful. A primary question that arose in my mind was why her symptoms had persisted so long and with such virulence. Was there something more to it than a natural, human response to disaster? Why did she feel so very responsible for the fate of her employees who were simply going about their business in a usual way? After all, she did not deliberately send them to their death and was only "responsible" to the extent that she had hired them and made the case for keeping one of them on when the boss wanted to let her go.

When I asked Mrs. T to tell me what came to mind about her feeling responsible for the employees' demise, she informed me that she had long believed that she possessed magical powers, that

she was, in her words, “a small deity.” I asked her for examples of what she meant. In response, she told me how she is able to locate objects even years after others have lost them simply by holding something of theirs in her hand. As another example, on three separate occasions she had heard a knock on the door although no one was there and knew instantly who in the family had died.

It became clear to both of us that her sense of specialness (or grandiosity) had played an important role in her slow recovery from the trauma. If she could foresee the future, she posited, why had she not prevented her associates from going into the World Trade Center on that fateful day? When I pointed out to her that her excessive guilt over their deaths was closely linked to her belief in her special powers, she responded ruefully that if she were more humble she might not be suffering so much. This dynamic also helped her to understand that her sadness was not related only to the 9/11 losses but also to the diminution of her secret sense of being extremely powerful and special. At first, she experienced this revelation as a considerable narcissistic blow (to use the language of self psychology). With further exploration and reflection about this unusual feature of her personality, her narcissism diminished to some degree as she became more accepting of herself as just an ordinary mortal. This also helped her to recognize her own role in her strong reaction to 9/11. Although this insight caused her grief, it also produced relief at its exposure in a safe therapeutic setting.

In brief, other features of the therapy included my encouraging expression of her mixture of feelings about her marital relationship and her coming to the realization that she no longer wanted the kind of high-powered job she once enjoyed. That job had meant giving up what she now saw as precious time with her growing children and having too little time for herself and her husband. (For a fuller account of Mrs. T’s therapy in which I drew on the four “visions of reality”—tragic, comic, romantic, and ironic—see Messer, in press). The point to be made here is that an EST, while of some help in this case, could not by itself cover other ground that truly mattered to this woman. Hers was not a case of pure or even typical PTSD, as is true of many cases that are dually or triply diagnosed and multifaceted. In fact, the complexity of people’s lives is not readily captured by diagnoses altogether. There are many pieces to this case that, to be treated optimally, call for knowledge of ESTs, conceptualization and recognition of narcissism, a degree of assimilative integration, and at least some of the relationship qualities listed above that contribute to a therapeutic alliance.

What are the new methods available that are designed to capture the formulation, process, and outcome of a therapy in a way that preserves the important features that I just illustrated with the case of Mrs. T? I discuss this in the next section.

Intensive Case Study: The Practitioner’s Friend

The Pragmatic Case Study Method

Fishman (1999, 2001; Fishman & Messer, 2004) has proposed that the basic unit of knowledge in applied psychology—whose ultimate purpose is to improve the condition of individuals, groups, families, organizations, or communities—should be the individual case. His *pragmatic case study method* (PCSM) refers

to systematic, largely qualitative case studies that are focused on practical results. The case study has a venerable history in psychology, especially in psychoanalysis, but has been widely criticized for the many sources of bias that reduce its utility as a basis for a cumulative psychological science (e.g., Messer & McCann, in press; Spence, 1993). Fishman has argued that two features of his method mitigate these concerns. The first is that in the PCSM the case presentation is neither fragmentary, as in the use of case vignettes, nor free flowing according to the preferences of the author, but has a specified structure, one in fact that follows Peterson’s disciplined inquiry model described earlier. This model has the virtue of being developed on the basis of empirical studies of how effective professionals in diverse fields actually operate (e.g., Schön, 1987). That is, the model possesses ecological validity. In addition, the PCSM method has the potential to reduce therapists’ reporting bias, such as their overemphasis on more recent versus earlier information. It does so by encouraging systematic, reflective processing of audiotaped material or extensive progress notes and collecting quantitative feedback from client questionnaires. This process would help alleviate cognitive bias, which experimental studies have shown to affect clinical judgment (Garb, 1998).

A pragmatic clinical case would be written up with the following headings: Case Context and Method, The Client, Guiding Conception With Research and Clinical Experience Support, Assessment of the Client’s Presenting Problems and Goals, Formulation and Treatment Plan, Course of Therapy, Therapy Monitoring and Use of Feedback Information, and Concluding Evaluation of the Therapy’s Process and Outcome. To situate the case normatively, one may also use standardized, quantitative, client- or therapist-completed measures. Fishman (1999, 2001) described each of these sections in considerable detail, although the specifics of the method are still evolving to accommodate diverse theoretical approaches to case write-ups. For example, the Assessment and Formulation sections describe the process of integrating contextual information about the patient with the results of the assessment. This would be carried out within the framework of the guiding conception, leading to a formulation of the client’s problem and an individualized treatment plan. One of the sources for such case write-ups could be a database of the individual client case studies that make up the samples in RCTs because the kind of data collected lend themselves to this format (Fishman, 2001).

The common framework for case write-ups sets up the second major feature of the PCSM that is designed to help create a cumulative science of cases. Although one cannot generalize from a single case study, the collection of many such cases allows for inductive generalizations to other, similar settings. This can happen by organizing case studies with similar presenting problems and intervention approaches into searchable databases, akin to legal databases used by lawyers and judges. As the number of cases increases, so does the probability that selected cases in the database will be contextually and pragmatically relevant to a new target case. This approach requires the use of online capacities in the form of a peer-reviewed, case-based journal, in which accumulating case studies form a searchable database. My colleagues (Dan Fishman, Ron Miller, Peter Nathan) and I have developed such a journal. Titled *Pragmatic Case Studies in Psychotherapy* and encompassing both case studies and articles on case study

method, it will be edited by Daniel Fishman and published jointly by the Rutgers University Libraries and the Rutgers Graduate School of Applied and Professional Psychology. One of the advantages of such a journal is that it makes it much more possible for practitioners to contribute to the literature than has been the case to date. (The journal is located at the following Web site: <http://pcsp.libraries.rutgers.edu>.) Another specific, related approach that falls under the umbrella of PCSM follows.

Hermeneutic Single-Case Efficacy Design

This is an approach to assessing the outcome of psychotherapy that goes beyond the general findings of RCTs (Elliott, 2001). It tries to delve more thoroughly than do RCTs into the question of which aspects of therapy a client found most helpful. The rationale for the hermeneutic single-case efficacy design (HSCED) is that traditional measures of therapy outcome are neither penetrating enough nor specific enough to individual cases to yield a sufficiently nuanced picture of what has changed and why. HSCED attempts to use quantitative and qualitative information to create a rich case record, which provides direct and indirect evidence for the causal influence of therapy on client outcome. In other words, it relies on thick description (Geertz, 1973) rather than controlled research design, and interpretive rather than experimental procedures (Elliott, 2001). The method is referred to as “hermeneutic” because, in Elliott’s words, “it attempts to construct a plausible understanding of the influence processes in complex, ambiguous sets of information about a client’s therapy” (p. 317).

How does one make a reasonable case for claiming that a client probably improved and that therapy was probably the cause? Elliott (2001) stated two conditions: There must be one or more pieces of positive evidence linking therapy to observed client change, and there must be indications that plausible nontherapy explanations are insufficient to explain the change. Typically the method calls on client, therapist, and researcher input. Examples of the positive evidence for change are the following: (a) The client explicitly attributes change to therapy, (b) the client describes helpful aspects of therapy linked to change, and (c) examination of the weekly data reveals covariation between in-therapy processes and week-to-week shifts in client problems. The combination of weekly measures of “helpful aspects of therapy” and client difficulties or goals provide the necessary information to make such inferences.

There are also stringent criteria by means of which the researcher attempts to refute these claims and to argue that therapy outcome is due to nontherapy events, which gives this method a scientific cast. The following are some examples: (a) The changes are negative, irrelevant, or trivial; (b) the changes are due to statistical artifacts or random error; (c) the client wants to make the therapist feel good or tries to justify ending therapy, or (d) life events outside therapy. After these data are collected, it is necessary to interpret and weigh them as they may conflict with each other. This requires an integration of the data and a determination of where the weight of the evidence lies. One interesting addition to this method that has been put into practice is having a panel of affirmative and skeptic teams evaluate the evidence and present the case for and against change. A research jury makes the final determination (Bohart, 2000b). Elliott and his colleagues are cur-

rently preparing an extended example of such an adjudicated HSCED. (For another, related approach to single-case studies, see Schneider’s, 2001, multiple-case depth research model.)

Implications for Practice

The culture war between proponents of ESTs and other forms of treatment has been useful in bringing to the fore various arguments and counterarguments about what the scientific practice of clinical and counseling psychology can and should be. The issue need not be framed so starkly as science versus humanism or the use of evidence versus clinicians’ subjectivism and clinical judgment. ESTs, for example, provide one kind of relevant data on which clinicians can rely, but they are not and cannot be the sole source of evidence-based practice. As I have tried to demonstrate, both from the literature and in the case of Mrs. T, there are serious limitations to ESTs at the same time as there are other sources of scientific and not-so-scientific evidence available to clinicians, all with their own strengths and limitations that are just as crucial to daily practice. They can, at the very least, complement ESTs to provide sound evidence-based treatments. ESRs are one such source of evidence, as are the effects of the interaction of clients and techniques and process–outcome correlational data more generally, which it behooves clinicians to know.

Regarding future development, systematic, in-depth collections of case studies, which can include both qualitative and quantitative information, hold considerable promise. One need not be a researcher to contribute to this literature (see <http://pcsp.libraries.rutgers.edu>). All such sources of data can be brought to bear on practice within the framework of the disciplined inquiry and local clinical scientist concepts. These models are the most inclusive and pluralistic ways of conceiving of evidence-based practice available and can encompass the results of many extant psychotherapy research strategies. Examples include research on the efficacy of therapy (from RCTs in the lab) and its effectiveness (outcomes in the field), process research (especially process–outcome relations and client by treatment interactions), and pragmatic, hermeneutic, and in-depth case studies. As practitioners, we cannot manage without nomothetic *and* idiographic data, findings based on quantitative *and* qualitative method, and a mixture of scientific *and* humanistic outlooks, which are psychology’s dual heritage.

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New Editors Appointed, 2006–2011

The Publications and Communications Board of the American Psychological Association announces the appointment of seven new editors for 6-year terms beginning in 2006. As of January 1, 2005, manuscripts should be directed as follows:

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- *Journal of Abnormal Psychology* (www.apa.org/journals/abn.html), **David Watson, PhD**, Department of Psychology, University of Iowa, Iowa City, IA 52242-1407.
- *Journal of Comparative Psychology* (www.apa.org/journals/com.html), **Gordon M. Burghardt, PhD**, Department of Psychology or Department of Ecology & Evolutionary Biology, University of Tennessee, Knoxville, TN 37996.
- *Journal of Counseling Psychology* (www.apa.org/journals/cou.html), **Brent S. Mallinckrodt, PhD**, Department of Educational, School, and Counseling Psychology, 16 Hill Hall, University of Missouri, Columbia, MO 65211.
- *Journal of Experimental Psychology: Human Perception and Performance* (www.apa.org/journals/xhp.html), **Glyn W. Humphreys, PhD**, Behavioural Brain Sciences Centre, School of Psychology, University of Birmingham, Edgbaston, Birmingham B15 2TT, United Kingdom.
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- *Rehabilitation Psychology* (www.apa.org/journals/rep.html), **Timothy R. Elliott, PhD**, Department of Psychology, 415 Campbell Hall, 1300 University Boulevard, University of Alabama, Birmingham, AL 35294-1170.

Electronic submission: As of January 1, 2005, authors are expected to submit manuscripts electronically through the journal’s Manuscript Submission Portal (see the Web site listed above with each journal title).

Manuscript submission patterns make the precise date of completion of the 2005 volumes uncertain. Current editors, Warren K. Bickel, PhD, Timothy B. Baker, PhD, Meredith J. West, PhD, Jo-Ida C. Hansen, PhD, David A. Rosenbaum, PhD, Patricia G. Devine, PhD, and Bruce Caplan, PhD, respectively, will receive and consider manuscripts through December 31, 2004. Should 2005 volumes be completed before that date, manuscripts will be redirected to the new editors for consideration in 2006 volumes.