Research and Practitioner Decision Making

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Practices are the activities engaged in by people to achieve a goal. The goal of psychotherapy is to assist people in improving the quality of their lives. Often improving quality of life involves helping people gain relief from distressful and hampering symptoms; on other occasions (e.g., positive psychology), it involves supporting people to achieve personal empowerment and the actualization of their potentials. Although there is general agreement among clinical psychologists on the goal of psychotherapy, there is a lack of agreement on which activities can best lead to achieving that goal with the individuals served by psychotherapy practitioners.[1]

Practical knowledge (know-how) is knowledge about what to do to achieve a goal. People develop a fund of practical knowledge during their lives about how to accomplish daily tasks. They draw on various sources in the development of their practical knowledge. They come to know how to accomplish various things through personal trial and error, through imitating others' successful actions, through testimonies about what works from parents, friends, and authorities. In our culture, the most reliable and authoritative source of how-know is generally held to be science. Those who practice science have performed experiments that demonstrate what works best to accomplish a specific task. By extension, the source for what works best in achieving the goal of psychotherapy would the scientific reports of experiments which have demonstated which activities or therapists' behaviors are most effective in relieving hampering symptoms or in promoting actualization of a person's potential. Deciding what to do for psychotherapists would involve a process of consulting the research literature. Then, to accomplish the desired goal, therapists would engage in the activities described in the literature.

Although this process of deciding what to do to accomplish something works well if one is trying to accomplish a task when working with materials and physical objects, it works less well in deciding what to do when working with people. People have emerged properties (see Clayton, 2004) that are less determinate in their responses to environmental happenings and engagements with others. Their responses are informed by their personal histories and by the

[1] I am a licensed psychologist in the United States' state of California and a faculty member in a stateside university psychotherapy training program. The focus of this chapter is on the development of the relationship between practitioners and researchers in the United States. The funding of psychotherapy by insurance and managed care companies in the United States creates a distinctive context in which the relationship has been played out.
This chapter is focused on the practice-research relationship that holds among psychology researchers and psychologists who engage in psychotherapy practice. Professionals from other disciplines also practice psychotherapy; for example, licensed clinical social workers, Marriage and Family Therapists, and School Counselors.

context and sequence in which things happen. They are capable of producing unique and unpredicted responses to similar happenings. Thus, the same therapist's actions will often produce a different response and have different effects on different individuals and on the same individual at different times. Because of these human qualities that therapists experience in their work with people, therapists have argued that deciding what to is not simply a matter of directly applying research generated know-how to the therapy situation.

Research and Practice

A rift between members of a discipline who render direct services and those who engage in research activities appears in a number of fields. Beutler et al. (1995) cites references to this rift in the literature of dentistry, nursing, education, surgery, and horse training. He notes that the practice-research spilt occurs across disciplines "is so pervasive that in some realms of study, separate disciplines have evolved" (p. 985). The discipline of medicine is differentiated from the disciplines of biology and physiology; the discipline of engineering from physics, and education from educational psychology. Even within disciplines a distinction between the practice and the research of the discipline is maintained; for example, applied and theoretical physics, and performance and theory of music. He concludes:

> In virtually every discipline in which the usual access to knowledge is through the scientific method, scientists [researchers] have lamented that practitioners are inadequately trained, are insensitive to the value of scientific findings, and fail to read the right journals. Conversely, practitioners are dismayed because scientists [researchers] offer too little, are consumed by irrelevant questions, and fail to appreciate the knowledge that arises from practice. (p. 985)

As with other disciplines, the practice-research division of labor appears within the discipline of psychology. Psychology began as an academic research, not applied, discipline and research has been retained as its primary function. Introductory college psychology textbooks display the breadth of the areas of psychological research. However, practices of applied psychology have also developed. In 1896, Lighter Witmer formed the first psychological clinic; and in the next decades applied psychologists engaged in vocational testing, diagnostic testing, evaluation of attitudes, etc. In the early decades, applied psychology was thought of as bringing research into the field; that is, applying research findings in practice situations (Zedeck, 2003). In these early decades, there was little evidence of a rift between the researchers and the practitioners who applied the research.

Psychology had followed the pattern of other disciplines in the creation a division of labor in which some (primarily situated in the academy) served as researchers, developing the body of knowledge, and others (primarily working in the field) served as practitioners, applying the developed body of knowledge. Practitioners were to limit their practice to applying the findings developed by academic researchers. Because practitioners were the appliers, not creators, of knowledge, they had lesser standing than the researchers who actually developed knowledge. The activity of scientific research produced knowledge of laws and general

principles that were to be translated into techniques for use by practitioners in specific situations.

Practitioners were to be trained in research so that, as consumers of research, they could read the research journals and keep themselves up to date on the latest findings produced in the academy. They were not to trust as reliable the experiential understandings that they derived from their practice. These understandings, which were derived from trial and error or anecdotal experience, had not yet been tested by the rigorous methods of science and were not considered appropriate to guide the practitioners' actions and interventions. Practice based on personal experiences was unsystematic and was held to produce unpredictable results.

Research and Psychotherapy

This standard model of practitioners as simply the appliers of research generated knowledge began to disintegrate when a significant number of psychologists started to engage in the practice of psychotherapy with adults in the 1950s. Psychotherapy had been exclusively a medical practice delivered by medically trained psychiatrists. Its roots were in Freud's psychoanalysis, not in the application of psychological research, and knowledge about its practice was drawn from the literature written by Freud and the subsequent developers of analytic therapies. The decades after WWII brought an increased need for psychotherapy services for returning veterans. Psychologists were requested to fill this demand. The United States Veterans Administration set up programs to train psychologists to deliver psychotherapy services. As social attitudes toward seeking psychotherapy for problems of living changed, the demand for psychotherapy services increased further and more psychologists became engaged in its practice.

Previously psychologists had been engaged in the applied tasks of counseling and providing support. However, this work had been primary with children and was not considered the same as psychotherapy. "Witmer was an interventionist, but probably no one would have called him a psychotherapist" (Routh, 1996, p. 246). Engagement in psychotherapy was a new practice for psychologists. There was early conflict between the psychiatric and psychological practitioners of psychotherapy. Insurance payment for psychotherapy could only be given to medical psychiatrists; however, as psychological practitioners gained in numbers they acquired independent state licensing and achieved direct payment from insurance companies and the right to commit patients to hospitals. Once involved in psychotherapy, psychologists advanced new theories about its practice; for example, Rogers' client-centered therapy, Beck's cognitive-behavioral therapy, and behavioral therapy, which was the direct application of psychological stimulus-response learning theory (see Reisman, 1991).

In the beginning psychotherapy training for psychologists was conducted in clinics outside the academy. Those who would become psychotherapy practitioners would first complete their academic training in general or developmental psychology and then, on the model of psychiatric training, receive post-doctoral training in psychotherapy in clinics. However, a significant change occurred, beginning in the late 1940s, when the academy initiated their own training programs to prepare graduates as practitioners. The 1949 Boulder conference

proposed a model for psychology programs to train practitioners. Programs were to combine training in research as well as its practice applications. Psychologists, unlike practitioners in other disciplines, would be researchers as well as appliers (Raimy, 1950). The model aspired to produce practitioners who would engage in research. However, in practice, academic training focused on research training rather than training in practice (Peterson, 1991; Stricker & Cummings, 1992). A 2005 survey supported that training in research remains the primary emphasis in academic counseling psychology programs (Ramesh, 2005).

As psychologists entered the practice of psychotherapy in larger numbers and the academy engaged in their preparation, academic researchers turned attention to the study of psychotherapy. Eysenck's (1952) negative evaluation of the effects of psychotherapy brought a research response that sought to demonstrate its effectiveness, and Rogers began a research program on the effectiveness of certain therapist actions on client responses during the process of psychotherapy (Hill & Corbett, 1993). Nevertheless, the rapprochement between research and practice of psychotherapy hoped for in the Boulder training model did not hold.

The ideal of an applied psychology that brought research into the field for application was not realized in the psychologists' practice of psychotherapy. Barlow (1981) reported:

> At present [1981], clinical research has little or no influence on clinical practice. This state of affairs should be particularly distressing to a discipline whose goal over the last 30 years has been to produce professionals who would integrate the methods of science with clinical practice to produce new knowledge. (p. 147)

Several years later Morrow-Bradley and Elliott (1986) reported that in their survey of psychotherapists, who were members of the Psychotherapy Division of the American Psychological Association, they found that only 10% reported that research articles were their primary source of information about what to do. What practitioners said was most useful was their ongoing experience with clients.

Beutler et al. (1995), however, in a survey conducted a decade later, reported approximately half of the psychotherapists responding to the survey said "that they find research writings to be useful and that they regularly incorporate these findings into their daily work" (p. 989). Beutler et al.'s survey expanded the notion of interest in research beyond directly reading academic journal articles to include secondary literature, conferences and workshops. Nevertheless, the survey indicated there is a "research apathy" among half the clinicians surveyed, it suggested that therapists have more interest in research than many academics believe.

There is a complex relationship between what researchers say about "what works" in psychotherapy practice and what therapists do in their practice. The complexity stems from various dimensions in the research-practice relationship. (a) Some of the complexity stems from the differences in subcultures within which researchers and practitioners operate. (b)

Some of the complexity stems from the notion that researchers speak with a single voice about how practice should be conducted. (c) Some stems from the different levels in which the idea of application can be understood. That is, does application mean administering specific manualized treatment protocols that have been experimentally verified, does it mean following general treatment strategies supported by research, does it mean being guided by principles of change that have achieved reinforcement from research, or does application mean being a local researcher who makes situated decisions based on the values intrinsic to scientific thinking.

The rest of this chapter will explore the dimensions within the complexity of the research-practice relationship and how it has played out historically. The relationship has not been static and was significantly affected by a change in the way payment for psychotherapeutic services occurred in the 1990s. Prior to that time, as the Barlow (1981) and Morrow-Bradley and Elliott (1986) studies cited above show, there was little interaction between the researchers and practitioners of psychotherapy. After that time, with the advent of managed care, came a demand for research that documented the cost-effectiveness of psychotherapy. The type of research carried out to meet this demand produced a somewhat antagonistic interaction between researchers and practitioners. In the past several years, new research more supportive of insights of practitioners has emerged and has lessened the tension in the relationship. Both researchers and practitioners have the best interests of the clients served as their motivation. Both sides of the relationship employ their own skills and values to bring about what is best for clients. But at times they disagree on how to accomplish this. Perhaps, some level of tension between researchers and practitioners is to be expected.

Research

Research is a product that is the outcome of the practice of research. It is the result of human effort and is intended to be a true or correct description of the properties of entities and the relationships that hold among these entities. Psychotherapy research is a product intended to describe the effects of psychotherapists' actions on client responses and therapy outcomes. The issue between researchers and practitioners is about what role researcher finding should play in the practice decisions psychotherapists make when actually engaged in working with a particular client.

The Researchers

As practitioners receive training in how to conduct psychotherapy practice, so researchers receive training in how to conduct research. Research training is almost exclusively given in university programs. The academic degree that designates competence in research is the Ph.D. (the Doctor of Philosophy). Traditionally, psychologists who practice psychotherapy have received training as researchers and earned the Ph.D. degree before entering practice. In recent years, an alternative type of academic training for psychologists intending to enter practice has been established. This training emphasizes training in clinical skills with less emphasis on training in research skills. Programs offering this kind of training grant a practice degree, the Psy.D. (Doctor of Psychology).

Researchers of psychotherapy are primarily graduates of Ph.D. programs and are housed in academic communities. Their primary employment is as university teachers and researchers (Beutler et al., 1995). They are most often housed in departments of psychology, although some in departments of education. They have a somewhat detached place within these departments because of their placement in graduate programs devoted to training clinical and/or counseling practitioners. Nevertheless, as employees of universities their promotions and status is determined by the prestige of the research journals in which they publish and by the number of peer-reviewed articles they have produced. When they first enter university teaching, they go through a six year probationary period after which time they are considered for promotion to tenure. The probationary period is used by the university to determine the capacity of the candidate to produce publishable research. The capacity is demonstrated by the candidate's actual publication of a sufficient number of peer-reviewed published articles. Although the level of teaching skill is also considered in promotion, it is mostly a secondary importance.

In many "research universities," half of a faculty member's work load is assigned to research production and half to teaching. Faculty members are expected, or at least encouraged, to receive grant funds for research from government agencies and private foundations. Those who are granted these funds are held in high regard and can use the funds to reduce their teaching obligations.

The Body of Knowledge

It is the responsibility of researchers to develop a profession's body of knowledge. A modern profession is expected to be supported by a scientifically generated body of knowledge. Researchers who study psychotherapy are engaged in producing a body of knowledge for the profession of psychotherapy. A profession's body of knowledge consists of all the "truths" it has accepted as accurately describing the objects of its field and the relationships that exist among these objects. Researchers conduct studies to produce evidence for "knowledge claims" that they propose for admission into their discipline's body of knowledge. A profession's body of knowledge is located in its journal articles, scholarly treatises, and dissertations. It is compiled in its disciplinary indexes, such as PsychINFO. Writers of literature reviews and textbooks gather together and synthesize parts of a discipline's body of knowledge to make it more accessible to readers. A discipline's body of knowledge is not static or merely additive. "Truths" previously admitted are sometimes removed. For example, phrenology was once part of psychology's body of knowledge. Thus, some of the "new truths" proposed for admission are that the "old truths" are wrong and should be discarded.

The decision on what gets admitted to a body of knowledge is made by the "community of scholars." The "community of scholars" is an idealized concept that includes all the recognized scholars in a field. In practice the function of the "community of scholars" is performed by journal editors, reviewers, and dissertation committees. Proposals for new knowledge are submitted to these groups for their review and approval. The reviewers' duty is to evaluate proposed additions to the body of knowledge and decide what is to be admitted and what is to be rejected. They are to judge whether or not the proposed new knowledge

claim can pass the muster of the knowledge criteria of the discipline. It is the task of those who are proposing the new knowledge to demonstrate that their "new truth" is worthy of inclusion.

Much of a discipline's research activity does not produce knowledge claims that get admitted into its body of knowledge. In many cases the activity does not produce knowledge claims that are statistically significant and, thus, are not usually submitted for review. In other cases, submitted articles are not judged acceptable for publication by reviewers. The more prestigious APA journals accept less than 10% of the research submitted to them. Thus, much of the practice of research does not result in a published outcome. The criteria for admission to a discipline's body of knowledge undergo historical changes. For example, Wundt's use of data from colleagues trained in reporting subjective changes through introspection would likely not be acceptable in many contemporary mainstream journals. New journals are begun to provide a place for research designs that are not acceptable to main-stream journals; for example, *Qualitative Research in Psychology*.

Researchers suggest that practitioners should read more primary research articles as a means for translating research into practice (Beutler et al., 1995). However, the format of the research report is designed to allow reviewers to judge the validity of the submitted knowledge claim, not to communicate the results to practitioners. The audience for the conventional report is the expert reviewers who decide on the validity of the knowledge claim and its purpose is convince the community of scholars that the proposed new knowledge is worthy of inclusion in the discipline's body of knowledge. The conventional format is not designed to communicate the knowledge claim to practitioners, but to communicate its validity to reviewers. The introduction, method (including sample, instrumentation, and procedures), results, and discussion format was designed to report behavioral research in a succinct manner (Bazerman, 1987). It is not surprising that practitioners, whose interests focus on the usefulness of knowledge claims, do not find the conventional format of the reports a useful means for showing the significance of the research for practice (for example, Morrow-Bradley & Elliott, 1986).

After WWII the practice of psychotherapy by psychologists began to mushroom. The assumption was that if this many people were using the service, it must be producing valued results. However, in 1952, Eysenck (1952) published an article questioning the effectiveness of psychotherapy, compared to the mere passage of time, in producing client change. Psychotherapy researchers responded by producing articles that attacked the credibility of Eysenck's research (A. E. Bergin & Lambert, 1971) and that produced evidence of the general benefits of psychotherapy. A meta-analysis of this research (Smith & Glass, 1977; Smith *et al.*, 1980) summarized the array of research that supported the position that psychotherapy was effective.

Research during the period up until the mid-1990s did not, in the main, focus on the differences among therapy approaches by comparing the effectiveness of one approach against the others. Training program introduced students to a variety of therapeutic theories

(for example, psychodynamic, humanistic, existential, behavioral, and cognitive). Which approach or combination (eclectic or integrative) of these theories therapists would choose to use in practice was considered to be a matter of personality and personal decision.

Having established the overall efficacy of psychotherapy outcomes, researchers turned to the study of the processes within psychotherapy that brought about the positive outcomes (Hill & Corbett, 1993). The advent of audio recording made possible the close examination of client changes as they occurred within psychotherapy sessions. The generally accepted conclusions from the research carried out during this period were summarized in the 4th edition of Bergin and Garfield's *Handbook of Psychotherapy and Behavioral Change* (1994).

First, it was generally accepted that psychotherapy, on the average, was effective, and was more effective than placebo control groups. In fact, there was more research on the effectiveness of psychotherapy than on any medical treatment (Messer, 1994). Second, on the average, there appeared to be no general difference in effectiveness among the different approaches to psychotherapy that had been studied. That is, research had generally supported the approximately equivalent effectiveness of the cognitive, behavioral, psychodynamic, and humanistic therapies that hade been researched. This particular finding has been called the "dodo bird" verdict, based on *Alice's Adventures in Wonderland* in which the dodo bird judges a race and proclaims that everyone has won and all must have prizes. But Bergin and Garfield gave a cautionary note to this conclusion by noting that there were at that time varying estimates that over 250 to 400 different therapy approaches were in use, and many of these approaches had not been researched.

Another set of findings was that the biggest contributor to the successful outcome of therapy is the client (40% of the outcome variance). The second biggest contributor was the therapeutic relationship (30%). Techniques and differences among therapy approaches only contribute 15% and 15% were unaccounted for (Lambert, 1992).

Another finding was that psychotherapy was not equally effective for all problems or for all clients. Generally, it was shown to be effective for anxiety, depression, marital problems, and various types of specific behavioral problems. It was not generally shown to be effective for schizophrenia (although it was shown to be helpful with selected subsets of schizophrenics), and it was at best only modestly successful, if at all, with substance abuse problems and various kinds of antisocial behavior.

Research up to the mid-1990s generally confirmed what therapists were learning from experience. Researchers were not arguing that their findings implied that therapists should change the way they practiced. However, by the middle of the 1990s, under the pressure of a change in the way payment for psychotherapy services were paid for, the relation between a set of researchers and practitioners became antagonistic.

The Advent of Managed Care

In the United States, it was usually the case that payment for health care services, including psychotherapy, was done by insurance companies. Premiums were paid to an insurance company (usually by employers for their employees). When a service was rendered by psychotherapists, they would submit a bill to the clients' insurance company. Clients themselves determined when they needed psychotherapy services and could choose which licensed therapist would deliver the service to them. What was done in the sessions was unexamined by the insurance payers. It was left up to the professional judgment of the therapist as to how best to conduct the sessions with clients. Many insurance companies would pay for up to twenty sessions per year. This method of payment was an indemnity or fee-for-service system.

At the beginning of 1990s, under competition from foreign manufacturers, American business began a corporate belt tightening. Downsizing and re-engineering led to layoffs of many workers, including white-collar middle managers. Corporate hierarchies were leveled and production was outsourced, often to foreign workers. American industry was in a period of cost-containment and re-examination of ways in which costs could be reduced. One of the costs that had grown out of control was the health insurance costs employers paid for their employees. Health care costs were rising at over three times the rate of inflation and they had come to consume over 14% of the United States' gross national product.

Several federal administrations had attempted to address the problem of rising health care costs, but had not succeeded. A national debate on health care reform occurred during the 102nd Congress (1993-1994). Various proposals were considered, including a Canadian style of government run health care as well as a cost control system administered by the national government. Both plans were designed to cover the health care costs for every citizen. However, neither of the plans became law. Instead, the insurance companies were mandated to reduce the nation's health care costs.

The insurance companies replaced the old indemnity policies, which simply paid for procedures according to policy limits. They adopted a process of examining claims so as to allow payment only for procedures they determined were medically necessary. This meant that decisions about what treatments patients needed and who should deliver the treatments was moved out of the hands of the providers and given to utilization review boards set up by the insurance companies. That is, the insurance companies themselves took over the management (or micro-management) of the delivery of health care. Within the mandate to control costs, the purpose of health care was reduced from assisting patients to retain optimum recovery to doing what was medically necessary for patients to return to a functional level on the job, in school, or as part of their families.

All health care providers—physicians, dentists, rehabilitation therapists, etc.—were affected by these changes in health care financing. Among those most affected were psychotherapists. Insurance companies suspected that much of what was being paid for in psychotherapy did not meet the criteria of medical necessity but was simply designed to help people grow or

improve. The insurance industry did not hold that helping people achieve self-actualization or deal with problems of living (DSM's V codes) was part of their mandate. Although people go through periods of psychological distress, such as anxiety and nervousness, their conditions didn't sufficiently impair their lives to any great extent. They were still able to "love and work," just not as effectively as they might. Thus, psychotherapeutic care was only required when a person was too dysfunctional to work or perform activities of daily living (ADLs).

Insurance companies began to argue that the development of anti-depressant drugs, anti-anxiety drugs, and other pharmacological treatments for psychological systems were more cost-effective for those with psychological systems than psychotherapy. Under the threat of replacing psychotherapy with drug treatments, psychotherapy researchers turned to demonstrating the efficacy and cost-effectiveness of psychotherapy. The demonstration was undertaken in terms set up by the managed care systems and in the context of medical treatment. The government Food and Drug Administration (FDA) had determined that the between group experimental research design was required to establish the efficacy of drug treatments. The design consisted of randomly assigned subjects to two groups—a treatment group and control and control group, and a double blind process in which the treatment group received the active drug and the control group an inert drug or placebo. Neither those administering the drug nor those gathering the data were to know which subjects were receiving the active drug. If there was a statistically significant difference in the mean scores of the two groups, the conclusion could be made that the drug was effective.

Use of this design by psychotherapy researchers meant that the treatment had to remain stable across subjects. In order to accomplish this, the treatments were manualized and therapists delivering the treatment in an experiment were trained not to deviate from the manualized treatment instructions. Control groups received drug treatments, alternant therapy, or no treatment. Psychotherapy research could not achieve a true double blind because the therapists delivering the treatment knew that they were not delivering a placebo. Therapies that yielded a statistically significant difference in the reduction of diagnosed symptoms were determined to have efficacy. Only those therapies were considered worthy of payment from managed care systems. In 1995, the APA Division of Psychotherapy identified 18 treatments that had been determined to be efficacious by the FDA mandated design. A therapy that had passed the between group test was called an Empirically Validate Therapy, which was later changed to Empirically Supported Therapy or EST.

The motivation of psychotherapy researchers at this time was to demonstrate to those who funded health care, by using the research methods designed for drug treatments, that certain psychotherapy methods were worthy of payment. Their purpose was to save psychotherapy from being removed from the health care payment system. Although the research concluded that some tested procedures were efficacious, the findings were interpreted by advocates of ESTs to imply that only ESTs were effective. These researchers proposed that it was ethically questionable to engage in the use of untested therapies. The debate heated up between those who held that the ESTs were the only legitimate means to achieve clinical success and the vast majority of practicing therapist using traditional methods. The EST advocates argued that

clinicians should only be trained in ESTs and that other forms of treatment are "less essential and outdated" (Calhoun *et al.*, 1998, p. 151). They accused clinicians of self-serving subjective beliefs about the value of their work when employing untested therapies.

Practitioners responded with critiques of the limitations and errors in the EST research. They noted that relapse rates among clients treated with ESTs was high and that psychological distresses were not as malleable as proposed by the advocates of ESTs. The EST research was carried out on a selected group of clients who presented only one primary problem, but most clients have a number of overlapping problems. In addition, EST research failed to account for the effect of personality difference on clients' responses to treatment (for a summary of this response see Westen *et al.*, 2004).

The APA Presidential Task Force on Evidence-Based Practice

The debate between practitioners and research advocates of ESTs had become so heated, that in 2005, Ronald Levant, the then president of the American Psychological Association, convened a task force of eighteen leading researchers and practitioners to hammer out a report that would take into account the breadth of research findings about psychotherapy. Their report (Levant, 2005) on the Evidence-Based Practice of Psychology (EBPP) considerably enlarged the notion of research evidence from the exclusivity of the EST random clinical treatment designs and placed evidence of clinical opinion in an ascendant position (p. 8).

The report endorsed multiple types of evidence and recognized that different research designs are suited to address different kinds of questions. Thus, the evidence to be used by practitioners in deciding what to do should come from multiple sources. The types of evidence recognized as available to practitioners include: (a) clinical observations (including individual case studies) and basic psychological science, (b) qualitative research, (c) systematic case studies, (d) single case experimental designs, (e) public health and ethnographic studies, (f) process outcome studies, (g) effectiveness research, (h) randomized clinical trials, and (i) meta-analysis studies.

Practitioners were directed to the whole range of research efforts as well as their own clinical observations when determining their actions. It defined evidence-based practice in psychology (EBPP) as the "integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 5). Psychotherapy was not described as simply the application of treatment protocols (ESTs), but as in-situation clinical judgments drawing on the breadth of research generated knowledge.

The report recognized the complexity of psychotherapy practice and offered the following statement about EBPP.

> Evidence-based practice requires that psychologists recognize the strengths and limitations of evidence obtained from different types of research. Research as shown that the treatment method (Nathan & Goran, 1998), the individual psychologist (Wampold, 2001), the treatment relationship (Norcross, 2002),

> and the patient (Bohart & Tallman, 1999) are all vital contributors to the success of psychological practice Comprehensive evidence-based practice will consider all of these determinants and their optimal combinations. Psychological practice is a complex relational and technical enterprise that requires clinical and research attention to multiple, interacting sources of treatment effectiveness. There remain many disorders, problem constellations, and clinical situations for which empirical data are sparse. In such instances, clinicians use their best clinical judgment and knowledge of the best available research evidence to develop coherent treatment strategies. (p. 8)

The task force also noted that there are different levels at which research results could guide practice. EST researchers held that their research should guide (or determine) what practitioners do at the level of which specific actions they employ. The sequence of activities they found to have efficacy on their samples, were only verified or supported when they were carried out as prescribed in the manual. Also they were only verified to relieve symptoms on persons with a specified diagnosis.

Research findings should function at a less severe level than as prescriptions for what specific actions therapists carry out. Research findings can guide therapists at the level of supporting an intervention strategy for specific diagnosis. For example, giving support for the use of behavioral modification with persons with phobic reactions or use of the cognitive-behavioral approach with a person with depression. At this second level, research findings are used to decide on a treatment strategy, but not to determine the specific actions to be used by a therapist.

At a higher level of application research findings can be used to provide general operating principles of client change to guide therapists. Beutler (2000) culled the research literature and found a set of "reasonable and basic principles" of client change that appear across the literature. A few of the principles he noted were:

> "Therapeutic change is greatest when the therapist is skillful and provides trust, acceptance, acknowledgement, collaboration, and respect for the patient within an environment that both supports risk and provides maximal safety.
> "Therapeutic change is most likely when the therapeutic procedures do not evoke patient resistance.
>
> "The likelihood of therapeutic change is greatest when the patient's level of emotional stress is moderate, neither being excessively high nor excessively low." (Beutler, 2000, September 1)

As the levels of application of research findings move away from calling for specific therapist behaviors to those of general guidance, the judgments required to be made by the therapist increases. The actual performance of psychotherapy becomes less research-centered and more practitioner-centered. A practitioner-centered psychotherapy moves the responsibility for

successful therapeutic outcomes to the therapist. The implementation of such a therapy requires attention to the character and intellectual virtues needed by therapist to meet this responsibility.

It is too early to see what effect the EBPP task force's report will have on the practice-research relationship for psychotherapy. The report mainly disavowed the position of the advocates of ESTs that research should determine the specific actions of psychotherapists. In describing the difference between their position and that of the ESTs, the wrote: "ESTs start with a treatment and ask whether it works for a certain discorder or problem under specific circumstances. EBPP starts with the patient and asks what research evidence . . . will assist the psychologist to achieve the best outcome" (p. 6). The report chides the health care organizations "not intimately familiar with the scientific bases of practice to dictate specific forms of treatment and restrict patient access to care" (p. 1). The debate continues alive and well with the bulk of psychology researchers represented in the EBPP report on one side and on the other side the psychological researchers who advocate ESTs along with the health care organizations.

Practice

Psychotherapy practice is carried out by individuals. These individuals assume a responsibility for acting in the best interests of those they serve. They are answerable for the decisions they make throughout the course of psychotherapy work with each client. Psychologists who become psychotherapists bring a background of research training as part of their preparation as well as specific training as therapists.

Practitioners

The psychologists who practice psychotherapy have received extensive training in doing research and have produced research in completing the dissertation requirement for their Ph.D. degree. The instruction in research is primarily given by university faculty members who, as part of their employment, are expected to conduct research. Practicing psychologists also receive training in psychotherapy. However, most of this training is not given by university faculty members, but by those employed as clinicians. Part of their graduate training requires participation in practicum and field work. However, supervision in these settings often takes place outside the university and is carried out by practicing psychotherapists (Ramesh, 2005). Psychologists are also required to complete pre-doctoral and post-doctoral clinical training to become eligible for a state license to practice psychotherapy. Thus, their training is bifurcated with little integration between what they have been taught about research and what they have been taught about practice. Advocates of ESTs have suggested that training programs should limit instruction to those procedures that have been experimentally verified as successful. They recommend that instruction in theories of psychotherapy, such as dynamic therapy and interpersonal therapy, should be curtained because they have not been experimentally demonstrated to be effective. Nevertheless, programs continue to teach various theories of psychotherapy, including eclectic and integrated approaches to treatment (Ramesh, 2005).

While psychologists were students in the academy, research values and interests of their faculty members are prominent. However, as students leave the academy, they are inducted into a new community, their community of practice. It is here that their professional identities are formed through associations with other practitioners in the field and from their own experiences as practicing psychotherapists. Their community of practice has values that are different from those of the academy. Here, psychotherapy is understood to be an individuated practice requiring sensitivity to differences and a mastery that comes from situated learning.

In the practice community research literature is less valued as directly applicable to their work. They are initiated into a second knowledge base. This body of knowledge consists primarily of case histories passed on orally by colleagues and supervisors and ones that were published; for example, those collected by Wedding and Corsini (1995, 1979), and Freud's descriptions of his work with clients. This second knowledge base provides psychotherapists with descriptions of situated judgments that were made in practice with individual clients. It furnishes therapists with vicarious experiences that can be integrated into their backgrounds and drawn on in their own work. Training in psychotherapy is primarily accomplished through apprenticeships in clinical settings. Supervisors assist trainees by reflecting on the judgments the trainees make in working with clients. Therapists are taught to monitor their clients' responses and to improvise and make adjustments in their sessions. Development is not aimed at the mastery of a predetermined set of techniques; but as the accumulation of experiential learning.

As practitioners mature and gain experience, they rely less on rules and more on their own judgment in deciding what actions to use with clients. Skovholt and Rønnestad (1992) have conducted an interview study of the development of counseling psychologists over the course of their careers. Psychotherapists between 60 and 70 years of age who had practiced from 25 to 35 years reported that over time their awareness of the complexity of human existence had grown continuously. These therapists no longer adhered to simple rules of treatment but relied increasingly on their experience-based understandings and accumulated wisdom. Rogers' description of his work with clients captures the approach of experienced therapists.

> I let myself go into the immediacy of the relationship where it is my total organism which takes over and is sensitive to relationship, not simply my consciousness. I am not consciously responding in a planful or analytic way, but simply in an unreflective way to other individual, my reaction being based (but not consciously) on my total organismic sensitivity to this other person. (quoted in May, 1958, p. 82)

Virtue Epistemology and Practice

Psychotherapists, like researchers, are agents who produce knowledge. The knowledge produced by psychotherapists is situated knowledge (Stricker & Trierweiler, 1995). Their knowledge production occurs within the immediate interpersonal dialogue between therapist and client. This knowledge is directly applicable for making decisions about what to do next in the situation. It is arrived at through the interaction of the therapist's background

understandings and motivations with the flow of evidence that arises in the therapeutic encounter.

In recent decades, some scholars have supported an approach to knowledge development called virtue epistemology (see, among others, DePaul & Zagzebski, 2002; Fairweather and Zagzebski, 2000; Zagzebski, 1996; Steup, 2002). The virtue epistemologists hold that human beings are the agents that produce knowledge and certain intellectual virtues of agents are conducive to responsible knowledge products. Norris (2005), although not a supporter of virtue epistemology, provided an accurate list of the intellectual virtues. He wrote: "There are certain distinctive virtues—among them honesty, integrity, caution, openness to criticism, willingness to give up cherished beliefs in the face of conflicting evidence—that are knowledge-conducive in so far as they characterize competent, responsible, and well-disposed epistemic agents" (p. 129).

The intellectual virtues are not techniques to be applied, but are personal dispositions of openness to responsible learning. Because therapy involves constant openness to learn from the responses of clients and to change course in the light of this evidence, the intellectual virtues are essential, or at least conducive, to successful therapy. As virtues, they reside at the core of the therapist and function in the service to the client. They are cultivated through experience until they become a habitual way of addressing the world. They address not only atomistic pieces of knowledge related to a situation, but aim at an understanding of the connectedness of the whole situation.

The intellectual virtues are mental qualities that serve to guide their possessors to learn from their encounters with the world and others. They allow what is seen and heard to affect and change beliefs. They are distinguished from the intellectual vices of closed mindedness and commitment to hold prior beliefs in spite of contrary evidence.

Like moral virtues, the intellectual virtues are dispositions that reside in the character of a person. They are ways of being-in-the world and they come about through the cultivation and practice of responding openly to what is before one. They may begin by emulating others whose actions are expressions of them, but their possession involves their practice over time until they become the habitual way in which one approaches knowing. Those in possession of intellectual virtues do not need to decide consciously to use them when confronting a situation; rather, they are the way they are ordinarily come to know and understand.

Zagzebski (1996) distinguishes intellectual virtues from intellectual skills. Skills are the techniques one learns about creating knowledge (such as, random sampling and statistical inference). "Intellectual virtues, like moral virtues, are psychically prior to skills" (p. 116). Intellectual virtues also "include a motivational component, whereas, intellectual skills are more like techniques needed for effectiveness in the pursuit of knowledge" (p. 116). The motivational component leads a person to acquire the skills and background knowledge to be effective in action. Thus, a therapist with intellectual virtues would be motivated to develop the interpersonal skills and techniques necessary to carry out successful actions and to attend

to the research and other sources of knowledge helpful for understanding the situation in which their actions are carried out.

Virtue epistemologists emphasize that knowing is a personal action. “To act is to exert power and, at least typically to bring about a certain kind of effect through the exercise of that power” (Zagzebski, 2001, p. 142). Knowledge is not the product of a research algorithm or pre-established method, but is the construction of people’s actions. Responsibility for knowing cannot be passed off to a technique or a research article.

The principles of virtue epistemology can be applied to the knowledge therapists use in psychotherapy. In entering into a psychotherapy relationship, therapists assume (along with the client) a responsibility to move the interaction toward the goals set by the client. In this sense, psychotherapy is a moral enterprise and an extension of the character of the therapist. Psychotherapists have to develop knowledge about what to do within an ongoing course of therapy. They cannot step out of the situation into a laboratory or conduct a field experiment. They practice “research” within the situation, trying out an action and noting the response it brings. The intellectual virtues open them to learning anew what is to be done next by allowing the clients’ responses to serve as evidence that overcomes pre-conceived notions of what should be done.

Decisions about what to do in psychotherapy can be artificially separated into four components. The first is the background knowledge and motivation the therapists brings to the situation. The background knowledge contains all the knowledge a therapists has accumulated before making the decision of what to do at the present time with the present client. Background knowledge is a complex network of understandings, knowledge, and conceptual repertoire. It comes from multiple sources including what is passed on by one’s culture, what has been learned from training and instruction, what has been communicated by supervisors and colleagues, what was has read and heard about research findings, and what was learned through past personal experience in interacting with others, especially interactions with clients and previous interactions with the client one is treating. The background is constantly being added to and amended. The intellectual virtues open it up to continuous renewal and new understandings.

The second component is the actual process of deciding what to do now. The decision is based on an understanding of the present situation. This understanding is a consequence of the therapist’s background knowledge in interaction with the present situation. The richer and deeper the background the more sensitive is the understanding therapists can have of the situation in front of them. The background allows those aspects that are salient to the decision to be drawn out from the complexity of the situation. Deciding what to do involves anticipation in one’s imagination of the effect an action might have. Making the decision involves choosing among the possible actions, the one that will be undertaken. The decisions are spontaneous and are enacted directly in what is said (See the quote from Rogers above). Schön (1983, 1988) calls this kind of deciding reflection-in-action and is a process that does

not necessarily involve thinking in words. Most often this complex decision making process takes place out of awareness.

This kind of decision-making is an intellectual activity that cannot be reduced to following a decision procedure or set of rules laid out in advance of the situation in which the action takes place. “Some rules arise out of the motivation for knowledge and the motivational components of intellectual virtues, but the motivational elements of intellectual virtues lead their possessors to do much more than to follow rules” (Zagzebski, 1996, p. 220). One of the intellectual virtues is the willingness to sort through the salient features of a particular situation and to make a judgment among the various available possibilities that is responsive to a particular need at a particular time.

The third component is the actual enactment of the decision. It is the saying or doing something that has been decided on. The therapist’s action brings about a response from the client.

The forth component is noticing and evaluating the client’s response. The intellectual virtues attune the therapist to hearing and seeing the client’s response as a communication of the client’s experience of the action. The virtues prevent the therapist from only hearing what was expected or what they intended to occur by the action. The clients’ responses are new evidence to be incorporated into and to enrich the therapist’s background. It is new knowledge which now informs the next decision making process, leading to another action, and then to new learning from the response. Psychotherapy involves a continuous monitoring process of whether the clients’ responses are moving the therapy forward to its goal. Evidence that a decision was a good one can only be available after the effect of their decision is known (see Millgram, 1997). If the evidence from the clients’ responses gives knowledge that the therapists’ action was not successful, this knowledge is used in the next decision as information that a change in action is needed.

The psychotherapy process is temporal. It moves from past knowledge gleaned from many sources, to present action, to future client response to the action. These responses, in turn, add to the background new knowledge of the situation which is used in making the next decision. Therapists’ background knowledge needs to include multiple sources. Among those sources are the findings of researchers. These findings are about what happened to other clients in other situations and in past times. Research findings are valuable in providing the results from controlled conditions and need to be included as the therapist considers what to do.

As therapists themselves have experienced and as researchers have found (Levant, 2005), the therapy course includes the ongoing complex interaction of individual therapist, method of treatment, the relationship between therapist and client, and the particular client. The therapist takes on the responsibility for the success of the therapeutic interaction. The fund of knowledge developed by the researchers of psychotherapy and the fund of knowledge derived from the clinical literature and personal experience serve as background understanding for the therapist’s decisions about what to do. Both researchers and therapists are producers of

knowledge that informs therapist actions. Both are accountable that the knowledge they create is responsive to the evidence. For both, the openness to be taught by evidence requires they possess the intellectual virtues. However, it is the therapists who are responsible for the integration of the various sources of knowledge and who are responsible for the generation of the in-situation knowledge that informs their actions.

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