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Evidence-Based Psychological Practices and Therapist Training: At the Crossroads

Gerald John Mozdzierz[1], Paul R. Peluso[2], and Joseph Lisiecki[3]

Abstract

Fundamentally, counseling and therapies of all species are intimate, humanistic encounters between sufferers and healers. A variety of societal impingements on practitioners (e.g., the need to contain burgeoning health care costs via "sustainable growth rates," limitations on the number of treatment sessions authorized by managed care companies, increasing government regulations, ethical standards, hundreds of "schools" of psychotherapy espousing efficacy) and a growing body of supportive research have resulted in an increased attention to and demand for the use of evidence-based psychological practices that can potentially undermine the fundamental underpinnings of counseling and psychotherapy. This article proposes that care and caution need to be exercised in the rush to evidence-based psychological practices as a "solution" to the concerns noted. In turn, what is advocated in helping others to become effective and compassionate practitioners is a need for an organizing principle, that is, specifically teaching/learning to think in nonlinear ways in conjunction with already well-established empirically determined common factor principles of effective treatment.

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Keywords

evidence-based psychological practices, therapist training, nonlinear thinking, common factors of effective therapy

Practitioners are under siege from a variety of sources: the need to contain burgeoning health care costs via "sustainable growth rates" (SGRs), limitations on the number of treatment sessions authorized by managed care companies, increasing government regulations, ethical standards, hundreds of "schools" of psychotherapy espousing efficacy, a national call for increased professional responsibility, a public demand for effective treatments, calls for increased use of evidence-based psychological practices (EBPPs), decreasing reimbursements, increasing demands for treatment, computerization of medical records, more competition for health care dollars, and so on, to name some. Each of these concerns has its advocates pressing a particular point of view, all of which converge and impinge on clinical practitioners who treat clients and in the process become the crucible for all these concerns. The net effect can be seen with university professors, supervisors, clinicians, and students being hard pressed to find their way through the maze of what to teach students to best prepare them for such a volatile professional environment, how to treat unique individual clients (i.e., what sort of treatment to apply in various treatment circumstances), how to supervise students in clinical settings, and how to justify clinical decisions. One thing for certain, students are being required to learn more and more, use EBPPs, and be accountable for their treatment efforts. But are students learning what they need to know in the fast-changing macro health care environment to satisfy the multiple masters listed above and the demands being placed on them?

The issues involved have been accelerated and exacerbated by policy developments not only on the national health care level (i.e., "health care reform") but also on the professional level. For example, according to James H. Bray, the American Psychological Association's (APA) "Presidential Summit on the Future of Psychological Practice" was convened because "psychology is at an important transition point and is in the process of evolution and change" (Martin, 2009, p. 18). Moreover, Margaret Heldring, Summit Co-chair, indicated that "practitioners are still being trained for the 'first curve'—traditional practice" (p. 21). The "first curve" thus represents methodologies, products, services, and so on applied in traditional ways. For practitioners of counseling and psychotherapy, that means learning about psychopathology, theories of counseling and psychotherapy, microskills, cognitive behavioral therapy, theories of personality, counseling/therapy "techniques," and so on.

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Ian Morrison (1996, 2002) uses the term *second curve* to describe *new* technologies, consumers, and markets that are needed not only to survive but also to thrive for any enterprise. The second curve represents the *future* of how the traditional must morph to fulfill the demands of the ever-changing environment, whether business, education, health care in general or counseling and psychotherapy in particular. Business has evolved taking into account an online market place. So has online nontraditional education. Health care is experimenting with "tele health" as a new iteration in providing services. Counseling and psychotherapy will need to adjust to what, where, and how behavioral health services are applied and how their effectiveness is measured.

Given these considerations, it seems prudent that our profession needs to proceed with thoughtful caution about how we prepare newcomers to be practitioners of the profession. Miller (2004) has been particularly passionate about examining our profession, its history, and desire to help others. His brief examination of the proclivities for the fashionable treatment of the day and the results is quite stark. He recounts the "getting in touch with your feelings" of the Carl Rogers movement in the 1960s, T-Groups, nude Marathon Groups, Gestalt therapy, Primal Scream, just to name a few. Then came Erhard Werner's EST, Bandler and Grinder's Neurolinguistic Programming to include a few trends that Miller does not mention. Miller (2004) concludes,

> Just as studies were beginning to show a high casualty rate among clients in some of these popular experiential treatments, the field's interest in "letting it all hang out" was reigned in and zipped up. From feelings, the field switched to behaviors and thoughts, then to dysfunctional families. Skinner, Beck, Minuchin, Palazolli, and Beatty among others, became icons; systematic desensitization, confrontation of dysfunctional thoughts, and self-help groups the best practice. The process only continues, morphing most recently from the "decade of the brain," into a "greatest hits of the field" version known as the "biopsychosocial" approach. The so-called energy therapies are all the rage; drugs plus evidence-based psychotherapies now considered the "brew that is true" (p. 49).

Miller (2004) is not the only voice calling for an examination of what the profession has wrought. In an equally passionate and articulate fashion, Schneider (2008) identifies four bold, generalized, and transformative developments changing the shape of psychotherapy (i.e., cognitive psychology, biopsychology, transpersonal psychotherapy/post modernist philosophy, and social constructivism). He also incisively identifies that there has been a

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"price for these reformative developments" composed of: First, a proliferation of specializations and the ensuing "chaos of competing practices" that results from such proliferation; and second, the development of threats to the practice of psychotherapy imposed by "the limitations inherent in the respective points of view" (Schneider, 2008, p. 15). Schneider's antidote for these problematic circumstances calls for

> . . . a therapeutic foundation that will do justice to our diversity and our particularity, our freedom and our limits. Such a foundation would view human beings in their fullness while carefully acknowledging their tragedy and incompleteness. It would honor our biological and mechanical propensities, but not at the cost of compromising our capacity to create and transcend ordinary consciousness. (p. 15)

This article proposes that (a) classical methods of teaching and learning about counseling/psychotherapy, namely, microskills (e.g., communication skills, cognitive-behavioral techniques, emotion-focused methods), theories of personality, theories of therapy (e.g., Corey, 2005) and so on are all "first curve" in nature. However, although valuable in their own right, they may very well represent "silos" of learning (i.e., independent provinces of skills and knowledge that are not very well integrated with each other). As "silos," they may be inadequate to the task of preparing practitioners for the demands of the future, the "second curve," that need to incorporate classical humanistic understandings as well as current empirical realities about what generates positive treatment outcomes. Current and classical understandings about successful treatment outcomes and the realities of the *zeitgeist* specifically must address evidence-based psychological practices (EBPPs[1]); (b) it may be necessary to approach the training of clinicians from a new more integrative overarching perspective in the "second curve." Such a broader perspective would focus on *essential domains that are unavoidable in any therapy*. Of necessity, a broader perspective, "second curve," would *integrate* "silo learning" and teach apprentices *how to think* like a clinician in light of clinical experience and what has been empirically learned about effective counseling and psychotherapy.

The Evolution of Practitioner Training: Evidence-Based Practices

The APA (2006) defined EBPPs as "the integration of the best available research with clinical expertise in the context of patient characteristics,

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culture, and preferences" (p. 273). In turn, the counseling/psychotherapy literature has demonstrated considerable interest in the issue of evidence-based practices and rightly so. According to Norcross, Hogan, and Koocher (2008a) and others (e.g., National Guideline Clearinghouse, n.d.), such practice guidelines urge clinicians to "use the best available knowledge to compile statements of 'what works' or 'best practices'" (Norcross et al., 2008a, p. 12). In turn, compilation of "what works" sets the clinical structure for the development of "manualization," that is, a "manual" of what procedures (i.e., treatments) to follow in providing patients with a particular diagnosis or "problem." Such "practice guidelines" are seen as having great potential in attempting to facilitate medical cost containment, efficacy, and patient satisfactions.

Although oversimplified and somewhat reductionistic, the debate about the use of EBPPs appears to be framed around two major "moral" themes, namely, tensions arising from competing values and their corresponding arguments.

For practical purposes, the first argument maintains that counselors/psychotherapists should base their interventions on EBPPs. That is, clinicians need to be trained in the administration of EBPPs; such training is now routinely emphasized in most graduate training programs and supervised clinical internships. The clinical therapeutic procedures that practitioners use need to follow from treatments that have been *supported* by "evidence" of effectiveness for particular diagnostic conditions (anxiety, depression, school phobias, etc.). Unique client characteristics, clinical circumstances, and clinician expertise serve as moderating variables in the application of such treatments. Psychological assessments and interventions based on "psychological concepts and current scientific knowledge, principles and theories" are specifically mandated by the APA Commission on Accreditation (2007, p. 14) as part of a doctoral internship experience. According to Norcross et al. (2008a), this clearly follows a "medical model" with medicine following best practices and treatment guidelines. In turn, exactly what constitutes "evidence" has been greatly debated in the literature.

What qualifies as research for effective practice? The easy answer is that we should employ different research methodologies to address different clinical questions: for example, epidemiological research to ascertain prevalence rates, process–outcome research to demonstrate specific clinician behaviors that produce favorable outcome, effectiveness research to address whether a treatment works in naturalistic, real-world settings, and randomized clinical trials (RCTs), as in medicine to determine "what works." A spirited debate centers on the privileged status accorded to RCTs and their placement at the

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zenith on the hierarchy of evidence. Should case studies, qualitative designs, controlled single-participant, and effectiveness studies also have a role in determining effective practice? (Norcross et al., 2008a, p. 12).

Again, for practical purposes, the second argument seems to have two major components. The first component argues that clients in the "real world" do not come in the neatly packaged, perfectly controlled diagnostic categories and/or "problems" as do the carefully screened/selected somewhat pristine participants of various studies that use "controlled clinical trials" as the golden standard of research that are carefully and appropriately analyzed statistically. That is, participants are "recruited" for participation in research and carefully screened to circumscribe their particular problem. On the other hand, clients more often than not come for treatment wonderfully unsanitized and unscreened with a variety of comorbidities. As Mozdzierz, Peluso, and Lisiecki (2009) have suggested, clients can offer a panoply of complaints and problems that morph into other issues, represent exacerbations of chronic issues, become entrenchments for secondary gains, and so on. Clients can also come for treatment involuntarily or voluntarily to work (or not) on a particularly troubling "problem" but in widely varying *degrees of preparedness* to deal with that problem and make changes. They may come for treatment involuntarily because something in their life has become unmanageable and out of control or because they are under duress from life circumstances (e.g., the need to make a decision), others (e.g., spouse, other family members, significant others) or social institutions (e.g., employer, clergy, courts, attorney) to do something about their dysfunction. As briefly addressed by the APA (2006), clients and their treatment circumstances vary greatly and expert clinicians maintain optimum flexibility in dealing with such contingencies. Variable clinical circumstances do not necessarily yield nicely to the application of more "linear" treatment practices, that is, EBPPs, although efforts are being called for and made to develop research protocols that test the generalizability of EBPPs to "typical clinical practice," and how effective evidence-based treatments are in clinical settings (see Hunsley, 2007a, 2007b; Hunsley & Lee, 2006).

The second component arguing caution in the use of EBPPs is that equally careful research incorporating appropriate statistical methodologies (i.e., effects size, multiple regression, meta analyses, etc.) conducted over a period of several decades has demonstrated that (a) it is the therapeutic relationship/alliance that all "brands" of counseling and psychotherapy share as "common factors" (e.g., therapist warmth, empathy, encouragement) and (b) "extra therapeutic factors" (e.g., social support, fortuitous life changes) that account for the major proportion of change in clients. According to Lambert

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and Barley (2002), those two factors account for 70% of therapeutic change. "Therapy technique," theoretical orientation, and so on account for relatively little despite proprietary boasts by practitioners from a variety of "schools" of thought.

The controversy surrounding EBPPs in some sense bears a resemblance to the protracted and controversial debate that began several decades ago in medical practice regarding the end of life and the use of newly developed (at that time), highly effective treatment protocols involving cardiopulmonary resuscitative techniques: Because of the development of those highly effective techniques, the question became not *can we resuscitate someone* who experiences sudden cardiopulmonary arrest (e.g., a patient severely brain damaged with no hope of recovery of cognitive functioning, or the patient with multiorgan system failure) but *should we resuscitate him*. Analogously, the questions for mental health practitioners becomes not can we use EBPPs but under what circumstances should we use them and how should they be applied? Physicians need to be trained how to deal with important questions (i.e., how to do an ethical analysis of the issues at stake, the thinking involved in approaching such issues, how to identify the values at issue, how to help resolve the tensions arising from such issues, how to relate to and incorporate all stake holders feelings and evaluations about the issue at hand, etc.). Likewise, *how* mental health practitioners are trained bears relevance to who, when, why, where, and how EBPPs are or are not applied. This appears to be precisely one of the "key challenges" Hunsley (2007a) has suggested that needs to be addressed regarding the use of EBPPs:

> The provision of evidence-based psychological treatments requires that several relevant scientific literatures be consulted and that the research on the impact of evidence-based psychological treatments . . . be used in conjunction with evidence about the therapeutic impact of patient characteristics, and the treatment relationships . . . How does one find the information necessary to determine what, exactly, the best evidence is? Once located, how does one draw on this information in such a way as to develop a synthesis that can guide the provision of services that are clinically indicated and sensitive to both the patient's context and the clinician's skill set? Finding information is the easiest part . . . The research on clinical judgment suggests that psychologists, like people in general, have difficulty in appropriately modifying the results of decision rules on the basis of nomothetic evidence (Garb, 1998). Accordingly, when individually tailoring the intervention, it is particularly important that psychologists closely monitor the impact of

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treatment with sound assessment tools (Hunsley, Crabb, & Mash, 2004; Stickle, 2006). (pp. 114-115)

Other important matters also emerge as needing consideration in the ongoing professional dialogue about EBPPs continues in search of the best available methods of treating human suffering in the most economical way. For example, the APA (2006) has advocated a definition of EBPPs as, "The integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273). But what exactly does that mean? Which patient characteristics, what aspects of a patient's culture, and preferences about what aspects of the treatment process? Furthermore, how is "evidence" (however reliable it is deemed to be) to be used in "conjunction with evidence about the therapeutic impact of patient characteristics, clinician characteristics, and the treatment relationship," given the fact that "psychologists . . . have difficulty in appropriately modifying the results of decision rules on the basis of nomothetic evidence" (Hunsley, 2007a, p. 114). No one can deny that *clinical* expertise is important in determining therapeutic outcomes (see Jennings & Skovolt, 1999; Skovholt & Jennings, 2004; Wampold & Brown, 2005) and that more normative clinicians vary widely in the success that they have. What makes for such expertise? What distinguishes clinical experts from more normative practitioners?

Obviously, the personhood of the clinician and their interpersonal skills in connecting with and engaging a client and facilitating the therapeutic alliance are no small consideration (Miller, 2004; Mozdzierz et al., 2009). In this regard, several decades ago, Orlinsky and Howard (1977) astutely observed that "the inescapable fact of the matter, is that the therapist is a person, however much he may strive to make himself an instrument of his patient's environment" (p. 567). Although clinicians do play an important role in establishing and maintaining a therapeutic alliance, they are notoriously inept at judging a client's perceptions of treatment sessions (Garb, 1989, 1998). At the same time, more experienced clinicians (i.e., "experts") are more adept at knowing which of their judgments are likely to be correct and which are likely to be wrong than more inexperienced clinicians. Garb (1989, 1998) has suggested several ways for clinicians to learn from their experiences and improve their judgments: providing feedback on their performance, obtaining unbiased feedback, distinguishing biased from unbiased feedback, learning what feedback is accurate, entertaining alternative hypotheses, willingness to alter initial impressions, reduce reliance on memory, not feel that in "hindsight" they should be able to explain all of a patient's behaviors.

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Some researchers (Hunsley, 2007a, 2007b; Kazdin, 2008; Norcross et al., 2008a, 2008b) have attempted to "broker" the debate between advocates and cautionaries in the EBPP debate. Hunsley (2007a), for example, suggests that there is much evidence to support EBPPs but much scientific work needs to be done regarding their role in common but relatively mild psychological maladies for which clients seek practitioners' help. Kazdin (2008), another broker, has suggested that researchers and clinicians need to bridge the gap between them:

> More work . . . on the mechanisms of change—not correlates of change alone but . . . explanations of how therapy works . . . Let us attempt to understand more about the many change processes and how they can be triggered, activated, exploited, and *trained* [italics added]. This is different from disseminating treatment manuals and prescribing specific interventions as our primary focus. (p. 157)

Regarding clinical practice, Kazdin (2008), Miller, Mee-Lee, Plum, and Hubble (2005), Duncan, Miller, and Sparks (2004), and Lambert, Whipple, Hawkins, Vermeesch, and Smart (2003) are among a growing chorus recommending that practitioners *monitor treatment effectiveness on an ongoing basis*. They suggest that feedback from clients via systematic assessment of treatment effectiveness produces better outcomes. Clinicians also need be mindful that when using EBPPs, such treatments need to be integrated with experience, judgment, and contextual considerations. The reason? EBPPs in themselves do no not guarantee results.

Miller, Duncan, and Hubble (2004) have advocated that

> the empirically validated, integrative and evidence-based practice movements share in the belief that specific therapeutic ingredients, once isolated and delivered in reliable and consistent fashion, will work to improve outcome. *Yet research and clinical experience indicates otherwise* [italics added]. How best to proceed in the light of such findings . . . Significant improvements in client retention and outcome have been shown where therapists have feedback on the client's experience of the alliance and progress in treatment. (p. 2)

They conclude that "*rather than evidence-based practice, therapists tailor their work through practice-based evidence* [italics added]" (p. 2).

Elkins (2007) has been particularly direct and incisive in his "deconstruction of the myth" of evidence-based practices:

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> Research . . . show(s) that so-called empirically supported treatments (ESTs) are no more effective than are traditional psychotherapies . . . these findings deconstruct the whole notion of ESTs and make the current debate about them meaningless. (p. 474)

In no less an incisive manner, Elkins (2008) dissects short-term "linear" approaches to therapy, decrying them as less effective than longer-term traditional therapy based on contemporary research. He also concludes that psychologists with a proclivity for short-term treatment actually embed their treatment in a "more complex theoretical framework such as that which humanistic-existential psychology provides" (p. 474).

Finally, this debate is further complicated by several other formidable realities. For example, Barlow (2010), Dimidjian and Hollon (2010), and Castonguay, Boswell, Constantino, Goldfried, and Hill (2010) all have addressed the *potential negative effects* of therapy even though such occurrences may represent a relatively low percentage of outcomes. Castonguay et al. (2010) summarize the negative outcomes issue as follows:

> Despite evidence that psychotherapy works, some clients do not benefit; 5%-10% actually get worse. *Trainees in psychotherapy should learn not only about empirically supported therapies but also about potentially harmful treatments*. Relying on empirically based guidelines (and on more tentative clinical and theoretical implications), they also should learn to prevent and repair harmful impacts that are due to their own characteristics, those of their clients, the relationship, and the interventions they use. (p. 34)

Barlow (2010) is especially articulate in delineating the potential negative effects of evidence-based practices:

> However small or scattered these may be when practice guidelines are followed, they also require sustained attention to minimize harm. Unpacking elements of interventions, investigating occasional dramatic negative effects, applying single-case experimental designs, and utilizing databases that track progress during interventions are among the available, often idiographic, approaches possible. (p. 13)

Interestingly, although the current debate about EBPPs appears to exclude more traditional psychodynamic therapy as an evidence-based treatment,

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Shedler (2010) suggests that eight meta-analyses covering 160 studies contain data to the contrary:

> Empirical evidence supports the efficacy of psychodynamic therapy. Effect sizes for psychodynamic therapy are as large as those reported for other therapies . . . promoted as "empirically supported" and "evidence based" . . . patients who receive psychodynamic therapy maintain therapeutic gains and appear to continue to improve after treatment ends . . . nonpsychodynamic therapies may be effective in part because the more skilled practitioners utilize techniques that have long been central to psychodynamic therapy and practice. (p. 98)

Finally, McHugh and Barlow (2010) suggest that although EBPPs are gaining prominence because of increased demand for psychological services and government and private funding support, *how to disseminate training for practitioners* in order to promote access to evidence-based psychological treatments in such practices is lacking: "Dissemination and implementation efforts at the national, state, and individual treatment developer levels have quickly emerged, but they lack strong evidence for or consensus on, best practices for achieving success" (p. 73).

Conclusions Regarding EBPPs

We derive three conclusions regarding evidence-based practices: First, *care* and *caution* need to be exercised in proselytizing EBPPs as *the* panacea for delivering effective treatment in the "second wave" and relieving some of the multiple societal and professional pressures and concerns sketched at the beginning of this article. An overemphasis on EBPPs can be misleading regarding their efficacy; as noted above there are still numerous questions to be addressed (e.g., transferability to common clinic settings, clients with multiple problems, training practitioners to be competent in implementing EBPPs) regarding their use. As in other eras, even *the* most highly touted treatment efforts have proven to ultimately fall on fashionable but limited and often infertile ground. Groopman and Hartzband (2009) have articulated the care in medicine that perhaps also needs to be exercised in the enthusiasm regarding EBPPs for psychological ills:

> Medicine is an imperfect science, and its study is also imperfect. Information evolves and changes. Rather than rigidity, *flexibility* is

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> appropriate in applying evidence from clinical trials. To that end, *a good doctor exercises sound clinical judgment by consulting expert guidelines and assessing ongoing research, but then decides what quality care is for the individual patient. And what is best sometimes deviates from the norms* [italics added]. (p. A13)

Needless to say, counseling and psychotherapy remain "imperfect" mixtures of science and art as does their study. Further complicating matters is the unveiling of the "blueprint" of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM V*), which is to be published in 2013. Shorter (2010) and Satel (2010) are both critical and cautionary regarding the direction that *DSM V* is heading. For example, Satel summed up her evaluation of an over reliance on the medical model of formal diagnosis in guiding treatment:

> With some important exceptions, drug treatment is often guided more by symptoms than by diagnosis . . . good psychiatrists do not rely too heavily on the DSM when they care for patients. *There is simply no substitute for observing the patient, listening to his story, and fine-tuning his treatments—psychological and pharmacological—as needed* [italics added]. (p. W13)

Elkins (2009) also challenges the "medical model" as being inappropriate for the practice of psychotherapy. He describes four reasons for his conclusion regarding the failure of the medical model to hold under scrutiny: (a) it does not accurately describe the nature of psychotherapeutic transactions, (b) it is a dominant force not because of acumen but because of dubious ties to guild interests (i.e., science, research, and insurance), (c) psychotherapy is an "interpersonal process" and not a "medical procedure," and (d) "the model fails to account for the fact that the vast majority of clients use psychotherapy for support, guidance, and personal growth instead of treatment for mental illness" (p. 66).

Our second conclusion: A hallmark characteristic of EBPP implementation must be flexibility and the use of clinical judgment as suggested by Groopman and Hartzband (2009). Accordingly, implementation of EBPPs must be subsumed under other well-established principles of treatment understood to affect outcomes, such as the empathic establishment of a therapeutic relationship and maintenance of the therapeutic alliance; a client's "stage of change" (see Prochaska & DiClemente, 1984, 2005) that examines preparedness for addressing changes; belief of the therapist in a proposed treatment

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(i.e., "therapist allegiance," see Luborsky et al., 1999; McCleod, 2009); appropriate introduction, explanation, and rationale of a proposed EBPP and adequate opportunity for question and discussion; the power of reactance (i.e., the tendency of human nature to resist threats to free behaviors) as discussed by Beutler, Moleiro, and Talebi (2002), J. W. Brehm (1966), and S. S. Brehm and Brehm (1981); client feedback about the treatment meeting their goals (see Miller et al., 2005); and resistance. If these empirically established "principles" of psychotherapy are not observed in the implementation of EBPPs, practitioners are vulnerable to becoming technicians who somewhat mechanically attempt to apply "techniques," which deserves a strong cautionary note (see Mozdzierz & Greenblatt, 1994; O'Connell, 1966/1975; Satel, 2010; Shorter, 2010) or "what the manual says." EBPPs can also be subject to degradation: curricula are developed according to what students will need to know to pass licensure (the ultimate criteria for practitioner aspirants) and get a good paying job but not what will necessarily make them more effective in the consultation room; the use of EBPPs for specific diagnoses can potentially be used for reimbursement purposes or to fulfill mandates (e.g., state-mandated Hawaii Evidence-Based Services Committee as reported by Schiffman, Becker, & Daleiden, 2006).

Our third conclusion: Regardless of EBPPs or other more traditional treatments, there is a need for ongoing assessment of and feedback from the client regarding perceived improvement, progress toward goals, and the efficacy of treatment. The empirical evidence for such ongoing assessment in treatment is compelling and growing (see Duncan, Miller, Wampold, & Hubble, 2010; Miller, 2004; Miller et al., 2005).

A Broader Model of Learning to Become a Counselor/Therapist

Given the "realities" and conclusions regarding EBPPs noted above, what is the nuance needed in the education of neophyte therapist-practitioners that will afford them the opportunity to be better prepared for the changes that are to come in the clinical setting? As a beginning, it is clear that, of necessity, classical preparation has much to offer but may not be sufficient nor its unifying emphasis accurate to practice effectively in the evolving future of the "second wave."

Systems of any kind (e.g., corporate cultures, government, education, the professions, health care) are difficult to change. Once in place, they develop self-sustaining, self-preserving qualities. This is as true in the preparation of physicians, nurses, lawyers, and therapist-practitioners as it is anything else.

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It has taken almost 10 years for the profession that trains large numbers of counselors/therapists to convene itself and issue an alert that macro changes are afoot in health care, and the profession will need to adapt to those changes in how it prepares its future members—from Charles Kiesler's (2000) warning regarding the "next wave of change for psychology and mental health services" (e.g., working in medical practices) to the Presidential Summit of the Future of Psychology Practice (Bradshaw, 2009). Along the way, the APA (2006) issued important guidelines and cautionary concerns that psychologists need be mindful of regarding the use of EBPPs as a part of the sea change to occur. To be more specific, APA indicates that its position regarding EBPPs requires psychologists to develop *a way of thinking*:

> What this document reflects, however, is a reassertion of what psychologists have known for a century: *The scientific method is a way of thinking and observing systematically, and it is the best tool we have for learning about what works for whom* [italics added]. (p. 280)

APA (2006) is directly noting that the best way of approaching the issue of EBPPs is *a way of thinking* as indicated by the scientific method. Psychologists may have known this for a century. The more relevant question, however, would seem to be, has the profession been teaching clinical students *a way of thinking* about people, the infinite variety of problems people have in living, and how to help people cope with or resolve those problems to their satisfaction with, at minimum, a modicum of improvement in functionality? The APA statement implies a disdain for "if this, then that" way of thinking, which would essentially be *linear* in nature. Instead, what APA is advocating (i.e., *scientific thinking*) without calling it such, is a need for an awareness of the *nonlinear* nature of "what works for whom" (APA, 2006, p. 280) and the significant permutations and combinations that emerge from that maxim. When considering the cautions APA advocates in the exercise of EBPPs, they suggest numerous contrasts between what we would refer to as *linear* versus *nonlinear* thinking (see Table 1).

Psychological treatment (whether dubbed counseling or psychotherapy) is a profound exercise requiring clear, logical, linear thinking (e.g., assessment of a client's potential for violence, possible organic basis for disturbed behavior, need for referral, maintenance of appropriate boundaries). It also requires *nonlinear thinking* and all that such nonlinearity implies: multidimensional empathy; intricately varied ways that vast numbers of therapists begin "connecting with and engaging" (Mozdzierz et al., 2009, p. 9) innumerable

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Table 1. Contrasts Between Linear and Nonlinear Thinking in the Implementation of EBPPs Derived From APA (2006)

Linear Thinking	Nonlinear Thinking
Uniform clinician characteristics	Clinicians vary in level of training, experience, sensitivity, and expertise
What diagnosis a patient has	What kind of person has this diagnosis
Client's perception of the strength of therapy relationship as incidental to the application of the evidence basis for the treatment	Client's perception of the strength of therapy relationship as essential precursor to any "intervention"
Patient *DSM-V* diagnosis	Unique patient characteristics (i.e., acute vs. chronic condition, complexity, circumstances, readiness for change, ethnic/cultural considerations, etc.)
What treatment a patient's diagnosis warrants	What a patient needs/is looking for, realistically or unrealistically
Strength of research (e.g., reliability, effect sizes) pertaining to a patient's diagnosis	Research relevance to *this particular patient* and their individual characteristics and circumstances
Treatment options for this diagnosed problem	Patient's preparedness (i.e., stage of change) for making changes
EBPP applied and resources (i.e., "cost") devoted	Possible/probabilistic benefits accruing to patient weighed with cost–benefit analysis
Linear application of EBPP	EBPP applied as secondary to relationship with adjustment of protocol as needed/appropriate
Singular measure of "success" (i.e., symptom reduction and prevention)	Range of successful outcomes (i.e., quality of life, adaptive functioning, more satisfying decision making, etc.)

Note: EBPP = evidence-based psychological practice. *DSM-V* = *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition.

clients in treatment; acute, compassionate, intense listening/responding as well as a plan for treatment agreed on by the client. Viewing it as such has interesting and valuable promise for an orientation in the teaching of and learning to be therapist-practitioners. Elaborating on and advocating a consideration of the contrasts between *linear* and *nonlinear thinking* Mozdzierz et al. (2009) describe both as follows:

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> Linear thinking is the process of looking at a problem along one dimension, a familiar, habitual, and perhaps previously successful way of approaching a problem or even life itself . . .[it] represents the characteristic and traditional way in which a particular personality approaches life and problem solving . . . nonlinear thinking is "out-of-the-box" thinking. It requires therapists to see and understand the client's characteristic, old, "personally" linear pattern; envision a new, alternative way (or pattern) of seeing and behaving; and communicate that new way to the client. (p. 5)

In effect, *nonlinear thinking* as a therapist-practitioner requires a capacity for listening, assessing, and responding in both linear and nonlinear ways. De Bono (1994) has advocated such thinking for problem solving calling it "lateral thinking":

> Lateral thinking is both an attitude of mind and also a number of defined methods. The attitude of mind involves the willingness to try to look at thinking in different ways. It involves an appreciation that any way of looking at things is only one among many possible ways. It involves an understanding of how the mind uses patterns and the need to escape from an established pattern in order to switch into a better one. (pp. 59-60)

In many ways, *nonlinear thinking* is ironic, dialectical, and paradoxical in nature. As an example that specifically pertains to EBPPs, once again note Table 1. EBPPs are suggested methods of treatment, yet there are many qualifications, limitations, and judgments that *must* be applied before a direct EBPP can be used. In turn, Fraser and Solovey (2007) have suggested that *all* therapies may be paradoxical in nature whether a clinician is providing paradoxical interpretations to induce "second-order change"2 (Watzlawick, Weakland, & Fisch, 1974) or prescribing symptomatic behavior (e.g., "When a therapist indicates he will help a patient over a problem and within that framework he encourages the patient to have the problem, he is posing a formal paradox"; Haley, 1963, p. 66; Seltzer, 1986). Fraser and Solovey suggest that EBPPs also are paradoxical in nature as can be seen in systematic desensitization that requires exposing a patient to something that he is attempting to avoid via methodical means (i.e., an EBPP) is paradoxical.

Schneider and Krug (2010) articulate this same paradoxical essence in describing existential–humanistic therapy. They depict the goal of existential–humanistic psychotherapy as being, in essence, *to free clients from themselves*.

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That is, to free them from self-imposed limitations and thereby derive a different more profound self-knowledge and sense of personal goal directedness as opposed to direction in life being imposed by others or even by one's unreflective self. Their approach is increasingly integrative and applicable to a wide variety of settings and diagnostic populations. This is precisely what Fraser and Solovey (2007) imply.

With specific regard to learning to be a therapist-counselor, Mozdzierz et al. (2009) advocate that nonlinear thinking is an essential ingredient in relating to and understanding a client before intervening in their life in addition to linear thinking. They further suggest that the concept of *nonlinear thinking* is unavoidable in understanding human behavior and essential in learning to become a counselor or therapist. The recognition of "the unconscious" (or minimally unconscious processes in human activity) is considered a substantial example of the nonlinearity of human activity. As a further classical example of nonlinearity in human behavior, what someone says must be *interpreted* rather than only being taken literally. It has long been known that behaviors such as tone of voice, emotional congruence, consistency, and so on all significantly qualify what someone says versus what someone means (see Emerick, 1997; Mehrabian & Ferris, 1967). Other indications of nonlinearity are demonstrated in significant differences between what someone may state as a goal of change and what they are willing to do or forgo to accomplish such a goal. Human nature has been known to "want its cake and eat it too" and to withhold information and lie outright for a variety of reasons. This is reflected in ambivalence—a universal reaction to human nature being confronted with discrepancies such as the difference between what "I" want and what life demands, which may be two entirely different things. Doing what life demands may put "me" in jeopardy of failing to meet that demand. Ambivalence may also represent the discrepancy between what "I" want to "pay" for something (give up, sacrifice, forgo, etc.) and what is actually required to obtain what "I" want. All this suggests that a linear (e.g., think an EBPP as a major focus) approach to learning about counseling is at best shortsighted and at worst naïve. As a suggested alternative, teaching would-be therapist-practitioners a *nonlinear way of thinking* about people, human behavior, life, and so on appears to offer a unique and useful organizing principle.

In conjunction with approaching learning to be a counselor from a nonlinear perspective, Mozdzierz et al. (2009) suggest that there is a "convergence of understanding" about what master practitioners pay attention to, namely, seven major domains (i.e., connecting with and engaging a client, assessing a client both classically and phenomenologically, building a therapeutic

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relationship and establishing a therapeutic alliance, understanding a client's cognitions, understanding and helping a client deal with their emotions, resolving ambivalences, and paradoxically helping a client to understand their circumstances from a *different* perspective). The nonlinear perspective and major domains (although each is extraordinarily complex) overlap in significant ways with the emerging convergence of understanding about "what works" in therapy as espoused by Duncan et al. (2010). Orlinsky (2010) suggests that

> therapeutic efficacy inheres primarily in the patient's experience and in the use of a remoralizing, resource-enhancing, and motivating relationship with a therapist who is supportive and challenging (in proportions and at times that suit the patient's needs and abilities). The therapist's procedures are important but become effective largely by contributing to the formation and development of this relationship in the patient's experience. (p. xxi)

Indeed, Duncan et al. (2010) and Orlinsky (2010) espouse that it is the client and their unique relationship and fit with their counselor-therapist and not therapeutic "techniques" and or specific practices that are the gateway to unleashing all manner of client potential for change. Furthering the "convergence of understanding" suggested by Mozdzierz et al. (2090), Cain (2007) proposes a number of "things every therapist should know, be and do" (p. 3) in their therapeutic practice. His suggestions include

> emphasis on the therapeutic relationship . . . the importance of empathic responding are . . . the importance of working with client emotion, effective use of the self, relational involvement and depth, working within the client's frame of reference, focusing on the self-concept, being present . . . helping clients embrace choice and responsibility. (p. 3)

The reader will note that none of these "useful things" have to do with techniques or microskills but rather being authentic with another human being in the context of a professional relationship.

In this same vein, Fauth, Gates, Vinca, and Boles (2002) propose more specific suggestions as to what the focus of psychotherapy training needs to be, namely "big ideas." This term is meant to convey to students that they need to develop "meta-cognitive skills," which include pattern recognition (i.e., attending and responding to the most important events in a therapy session);

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mindfulness (i.e., moment to moment awareness and acceptance of one's experience); and attentiveness to culture (i.e., "the prevailing implicit and explicit visions, assumptions, rules, norms, and policies of the organization (or subgroup) in which training and psychotherapy take place" [p. 387]). "Big ideas" and teaching students how to think versus teaching them in silos of complexity and noninterconnectivity may be a gross oversimplification of the issue, but it does tend to convey where the field has been and where it needs to go. Furthermore, the "big ideas" that Fauth et al. espouse, also have nothing to do with technique or microskills. Farber (2010) elevates the dialogue one level further. In particular, he addresses the role of supervision and the supervisory process using the combined richness of both humanistic and existential frameworks to enlighten the development of psychotherapy "competencies" in neophytes. He argues that such competencies are essential in the development of the effective psychotherapist. If anything, Cain and Seeman (2001) highlight a similar theme of convergence from a broad array of humanistic contributors (i.e., client-centered, Gestalt, existential, and experiential). Several contributors offer increasingly growing empirical support for the importance of therapist empathy and the therapeutic relationship in positive outcomes.

All the above developments substantially support the notion that a convergence of understanding at the macro level is building in momentum and in need of still further support, development, and explication. Such support can be seen at not only the clinical level but also the policy level as well. For example, Levant (2006) adroitly advocates for inclusiveness when developing a consensus definition of what constitutes "evidence" (i.e., "a broader view of research," professional expertise, and the incorporation of individual differences in treatment decisions [p. 392]) about what works in psychotherapy. A convergence of understanding perhaps under the rubric of nonlinear thinking must incorporate the controversies about EBPPs noted earlier in this article. Levant argues for taking responsibility regarding the definition of evidence, otherwise other special interests will impose their own self-interested definition of it with the profession left to deal with the consequences both good and ill. It is simultaneously nonlinear, paradoxical, and encouraging that, in his advocacy of inclusiveness and taking responsibility for the issue of "what works in psychotherapy" (p. 391), Levant demonstrates a respect for core values of what is an existential–humanistic orientation.

Counseling and psychotherapy are fundamentally intimate humanistic encounters between troubled, dysfunctional sufferers of varying degrees and presumed healers. Such an assertion is based on the inexorable fact of life that we are social beings who experience stress and suffering in living life no

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matter whether it is diagnosable or not. When that stress and suffering occur beyond a certain inflection point, our cognitions are substantially subordinated to the seeming vagaries of our emotions, which results in the sense that our lives are in turmoil and unmanageable. In some sense, it makes little difference whether the sources of our discomfiture are elaborations of our social interactions (i.e., interpersonal conflicts, the demands of life vs. perceived failure in meeting those demands, dysfunctional human parenting, loss of important attachments, abuse, neglect, etc.) or neurobiological misalignments. Suffering others consult healer-counselors as compassionate, nonjudgmental fellow humans to calm, energize, soothe, and reassure. As Mozdzierz, Lisiecki, Bitter, and Williams (1986) have said, therapists perform "role-functions" for others. Before EBPPs can or should be implemented, to be effective we are bound to "connect with and engage" our clients as fellow pilgrims (see Mozdzierz et al., 2009; Norcross, 2002). Only after such connection and engagement can EBPPs be considered for implementation.

Our conclusion is simple enough: The evolution of EBPPs warrants teachers and students of counseling and psychotherapy to consider the value of human encounter and *nonlinear thinking* as valuable concepts in bridging the perceived gap between clinicians' practical concerns and what EBPPs imply.

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1. EBPPs have also been called evidenced-based practices (EBPs) or empirically based psychological treatments (EBPTs). For practical purposes, we will consider these various initialisms as synonymous.
2. Watzlawick et al. (1974) summarize the essence of what is involved in second-order change as

   a. Second-order change is applied to what in the first-order change perspective appears to be a solution, because in the second order change perspective this "solution" reveals itself as the keystone of the problem whose solution is attempted.

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b. While first-order change always appears to be based on common sense (for instance, the "more of the same" recipe), second-order change usually appears weird, unexpected, and uncommonsensical; there is a puzzling, paradoxical element in the process of change. Applying second-order change . . . to the "solution" means that the situation is dealt with in the here and now. These . . . deal with effects and not with their presumed causes, the crucial question is what? and not why?

c. The use of second-order change . . . lifts the situation out of the paradox-engendering trap created by the self-reflexiveness of the attempted solution and places it in a different frame. (pp. 82-83)

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