Individuality: A Threatened Concern in the Era of "Evidence-Based" Practice?

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Despite robust clinical and empirical literatures suggesting the importance of therapists' attunement to clients' individuality, current trends in conceptualizing psychotherapy effectively minimize considerations of individual difference. The popularity of studies of specific techniques targeting discrete disorders has had the unintended side-effect of marginalizing consideration of factors such as temperament, attachment style, defence, developmental challenge, affect structure, relational pattern, implicit cognition, religious belief, cultural context, and sexual orientation that affect the health of the therapeutic alliance and the success of therapy. Current pressures may also militate against practitioners' attending carefully to their own individuality and its role in influencing therapeutic relationships. Practitioners and researchers are urged to give more consideration to this traditional area of concern.

As a therapist in practice over many years with a wide range of patients and problems, I closely follow trends in conceptualizing, researching, and funding psychotherapy. I appreciate Paul Solomon's invitation to submit a short opinion piece for this journal on the topic of the limitations and dangers of narrowing our consideration of psychotherapy to efforts to compare and contrast different technical procedures for different discrete disorders – an approach that some have termed the "horse-race" model of psychotherapy research. The opinions stated here are my own, but I think they reflect attitudes that are common among experienced practitioners, across theoretical preferences and across patient populations.

Unintended Negative Consequences of Current Conceptualizations of Psychotherapy

Therapists of all orientations ought to be worried about some possible ramifications of contemporary, well-intentioned efforts to ensure quality and accountability in psychotherapy. The current emphasis on "evidence-based" or "empirically supported" treatment, or on "best practices" and "standard of care" may bode ill for the appreciation of individual differences (in temperament, personality, learning style, culture, belief, sexual orientation, socioeconomic status, and other factors) that has traditionally, and for good reason, been a central preoccupation of the practitioner community.

As a core value and explanatory construct, individuality has historically played a starring role in our understanding of the therapy process, but it is startling how little attention to individuality characterizes most of the empirical work that medical researchers, some academic psychologists, and (perhaps most ominously) insurance and pharmaceutical companies currently consider "evidence." This is particularly disturbing in the presence of an extensive empirical literature on personality differences, attachment, emotion, development, brain function, and

other areas of individual variability to which clinicians regularly attend to craft their interventions. Despite the inclusive definition of evidence adopted by the recent American Psychological Association task force on evidence-based practice (American Psychological Association, 2005), there has been a tendency among many of our colleagues to restrict the definition of "evidence" to randomized controlled studies of therapy outcome, as defined by reduction of observable symptoms.

In the past few decades, largely as a result of the medically conceived, categorical (rather than dimensional and contextual), logical-positivist orientation of recent editions of the *Diagnostic and Statistical Manual* of the American Psychiatric Association, there has been a tendency among researchers to reify "disorder" categories and then investigate manualized treatments aimed at ameliorating those disorders. If one wants to study depression, for example, one selects research participants with DSM-specified depressive symptoms irrespective of whether their personalities are more hysterical or obsessional, whether they are more introverted or extroverted, gay or straight, Italian or Chinese, or even whether their subjective experience of depression is more introjective or anaclitic (Blatt, 2004).

If they suffer from depressed mood, endorse enough vegetative signs to meet the DSM criteria for Major Depression, and are relatively free of "comorbid" conditions, they may qualify as research participants, and the results of the study may influence what is considered the standard of care for depression. We have learned a lot from empirical work of this sort, and the technical innovations that such studies have inspired have added valuable components to our therapeutic repertoire. But I worry that if the assumptions that underlie such research become definitional of what matters in our field, we will lose a focus that is critical to therapy outcome, one that has every bit as much empirical standing as the so-called evidence-based therapies.

Because our predecessors in practice began learning at least a century ago that individuals with similar symptoms but different personalities cannot be given a "one-size-fits-all" treatment, there is a long tradition in psychotherapy of attention to individual differences in the people we try to help. Our clients experience our interventions idiosyncratically depending on, among other factors, their temperaments, their experiences with earlier caregivers, their particular attachment styles, and their individual defences, maturational issues, cognitive and emotional schemas, social and family contexts, identifications, cultural and religious sensibilities, and relational patterns. Despite psychology's vast empirical literature on individual differences, I worry that the current tendency to treat a given symptom pattern as a thing-in-itself, rather than as an expression of a client's complex and unique subjectivity, may produce a generation of therapists whose main response to suffering is "There's a manual for that."

The Redefinition of Therapy from Healing Art to Technical Procedure

With no disrespect for the many valuable therapy manuals that have been developed in recent years or for the expansion of models that have enriched our options to help our clients, I think that what philosophers call a "category mistake" (Ryle, 1949) has been made with respect to the field of clinical practice. I have no doubt that most practitioners believe that psychotherapy should be based on scientific research and not just on clinical anecdote. But therapy's being *based on* research is different from its being *like* research.

To do a certain kind of outcome research with methodological integrity, one must have a homogeneous group of patients who meet diagnostic criteria for a particular condition and yet lack comorbid problems; one must take objective measures before and after a series of interventions; and one must manualize the treatment to be sure each therapist in the research project is proceeding similarly. To reason backwards to the conclusion that therapists, in working with complexly suffering people who are often filled with shame for seeking help, should treat disorders as separable from personality and context, should manualize their work, and should take objective measures before and after a delimited treatment conflates the demands of one field (empirical research) with the demands of another (applied clinical practice). Parenthetically, I should note that it is a prevalent observation among therapists that patients with a single, discrete, non-comorbid disorder exist only in the imagination of researchers and in the context of naively interpreted self-report.

This conflation of what is good for research with what is good for treatment has contributed to a subtle but, to my mind, sinister paradigm shift. Psychotherapy used to be generally understood as a healing relationship. Recently, it seems to have been reconceived as a set of techniques to be applied to certain specifiable, discrete types of suffering. Therapists have historically seen themselves as practitioners of an art, one that is based in psychological science, but they are being increasingly pressured to define themselves as technicians in the service of the narrowest possible definition of symptomatic improvement – the kind that nonclinical researchers might use as externally observable indications of positive change.

Clinicians have traditionally defined their role as including their calling into question, with individual clients, some of the psychologically stressful or damaging assumptions of the dominant culture - especially the commercially driven pressures that a mobile, mass society generates to consume products and compete for narcissistic supplies. Increasingly, therapists are being asked to be instruments of that society, to improve people's behavior only to the point where it is no longer inconvenient to the larger community. "Behavioral health" is replacing "mental health" as an organizing concept, as if the internal aspects of experience are only incidental to an emotionally satisfying life.

Our current focus on short-term treatments for delimited disorders is at least partially driven by the realities of current academic life (in which the prompt

amassing of a list of time-limited research projects is much more conducive to tenure and promotion than longer-term, more complex scholarship), the interests of pharmaceutical companies (who have a stake in defining mental and emotional difficulties as discrete symptoms that their drugs can relieve as easily as a psychological treatment can), and the interests of insurance companies (who learned, after marketing their policies as covering "comprehensive mental health services," to exclude Axis II diagnoses from those services, given that personalities do not change after a small, inexpensive number of therapy sessions).

The Therapist's Individuality

Despite our longstanding attention to the individuality of clients, we have paid much less attention to individual differences among therapists. In fact, research on divergent personality styles among clinicians is only in its infancy (e.g., Hyde, 2009). And yet the most consistent overall empirical finding in the outcome literature is that the best predictors of change and growth in therapy are personal factors such as the warmth and genuineness of the therapist and the quality of the relationship that develops between a specific healer and a specific sufferer (Norcross, 2002; Wampold, 2006). As therapists we know intuitively - and our clinical writing reflects this understanding - that if our technical knowledge is not integrated with our idiosyncratic personal style, we will feel deadened, inauthentic, and at risk of burnout, and our clients will feel they are being treated as objects of manipulation rather than as subjects in a mutual collaboration.

In an effort to represent the perspective of experienced mental health practitioners in current debates - in which large corporations, policy wonks, and academic researchers seem to have a much louder voice - I have written on individual differences from several perspectives (e.g., McWilliams, 1994, 1999), and although my orientation is psychoanalytic, my work has resonated with clinicians of many theoretical inclinations. We therapists often characterize our professional development in terms of our progressive integration of our technical knowledge with our most genuine personal qualities. We tune our instrument, our personality, more and more sensitively as the years go by, and we find more and more internal resonances to the diverse compositions that our individual patients play for us. In view of this prevalent attitude among seasoned therapists, and in light of recent research on the importance of the therapeutic alliance to outcome (e.g., Blatt & Zuroff, 2005), I have come to believe that for psychotherapy to be effective, the individualities of both therapist and client must be honored.

A Plea to Colleagues in Both Research and Practice

In summary, I want to inject into the current conversation about scientific evidence and psychotherapy the view that a critical kind of evidence that should influence our work is the evidence for individual uniqueness. As one of my cognitive-behavioral colleagues recently asserted, we treat *people*, not artificially isolated conditions. Much good empirical work has been done on individual differences, and yet much remains to be done on the relationship between individuality and

psychotherapy. Such work that would be more relevant to patients as they actually experience themselves and present themselves to therapists than are the "horse-race" models of randomized controlled trials. I urge my academic and practitioner colleagues to consider reviving this currently underemphasized area of study.

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