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# What do you believe in ?
# Clinical conviction and / or empirical evidence ?

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Participants and scenary

As they did many times before, two psychoanalysts meet on an international psychotherapeutic conference somewhere in Germany in the late nineties. They are named Kalle and Ziffel, just like the two protagonists in Bertold Brecht's Fluechtlingsgespraeche (Brecht, 1990). Kalle is an American emigrant of German origin who is living in the mid-west. Ziffel is working in an university town in the south of Germany. Like strangers in the night they are meeting, discussing and separating again until their next opportunity to meet, discuss ...

Both are laughing and shaking hands very familiarly.

Ziffel: Halloo, halloo!

Kalle: Guten Tag! It has been a while since we last met.

Ziffel: Yes indeed! - I am actually surprised to meet you. I thought you would not come.

Kalle: Well, I was not sure if I would be able to make it, but then ... You know, my parents were from a village in the eastern part of Germany. I felt like I should to see this place now that it has become possible.

Ziffel: Oh, I see - for sentimental reasons. Hm, why not!

Kalle: Yes for some. Quite a bit has changed over here. (laughing) In an older magazine I read about this year' s love parade at Berlin. It must have been a most impressive event and very controversial at the same time.

Ziffel: A Berlin love parade? No, I only know that Berlin has become a gigantic building site after the reunion. But I must admit I am not wild about love parades even if they are much better than the parades and celebrations in the old days.

Kalle: That's true.

Ziffel: (with a little smile on his face) As a psychoanalyst I prefer to think of Berlin as the city that hosted the first psychoanalytic institute with a formal organized training.

Kalle: I see. Well, the Germans always have had a special hand for any form of organization - it was only poor when they had to make a revolution and some other ... But probably we shouldn't get involved too much in big politics.

Ziffel: There is enough politics in our field at present.

Kalle: Anyway, you seem as if you would like to tell me more about this institute.

Ziffel: Oh you are really empathetic. As a psychotherapy researcher you are surely interested that they have, very early on, begun to do some - let's say evaluative research. But I am still pondering why these guys like Fenichel and the others in the Berlin Institute didn't influence the psychoanalytic movement more by their rather systematic report on the outcome of psychoanalytic treatment[0]

Kalle: Hey, wait a minute, wait. What are you talking about? I never heard about this report?

Ziffel: (a little provocative) I really do not expect you to read all the old stuff in our field.

Kalle: Ha, ha.

Ziffel: No matter how, it seems that you haven't even read the psychotherapy researchers bible, the Handbook of Psychotherapy and Behavior Change. I mean the evaluation of the clinical work of the Berlin Institute of Psychoanalysis from 1920 to 1930 which is referred to in the first edition of this handbook[1].

Kalle: That is a little unfair. At least I try to cover the recent issues of our "Psychotheray Research" journal.[2]

Ziffel: Okay, but sometimes it is worthwhile to remember that clinicians like Fenichel, Rado, and Mueller-Braunschweig have their own way of accounting for what they were doing. They felt it to be part and parcel of their clinical work to report in a systematic fashion about their work. And this, this seems to be lost in our times.

Kalle: Hm, but it is just accounting, just poor counting without much statistics!

Ziffel: Now you are unfair. We are talking about the twenties and thirties; non-parametric statistics had not yet been invented, by the way.

Kalle: Okay, I guess you really want me to admit that the Berlin institute and it's members played an impressive role in the scientific development of psychotherapy in Germany.

Ziffel: Exactly, in a way, they were important historical figures. And later after the war - I guess you also do not know that - Schultz-Hencke wanted to replace some of Freud's metatheoretical constructs[3]...

Kalle: (interrupting) Really I never heard of him.

Ziffel: Harald Schultz-Hencke was thrown out of the paradise of membership in the International Psychoanalytic Association for his then politically incorrect claims. The fact is that he convinced the local general insurance company to support an outpatient clinic. There, his collaborator, Annemarie Duehrssen, later conducted Germany's first controlled field study on the success of once or twice a week unlimited psychoanalytic oriented psychotherapy.

Kalle: At least I know of that study. As far as I can remember, she demonstrated an enormous effect on days of hospitalization and days off work. And that's why the German general insurance system started to include payment for the treatment of neurotic and psychosomatic disturbances.

Ziffel: Yeah, you are getting better. And that was ultimately leading to the decision of 1967. But it needed more than just one study to get a national wide psychotherapy coverage implemented.

Kalle: What do you mean by this suggestive remark?

Ziffel: I think we have to talk about the role of the clinical experts in this process of societal recognition. One study does not make a summer, it needed many formal and informal encounters between therapists and the funding agencies to develop what today would be called standards of treatment. These guidelines for conducting analytic psychotherapies were based less on formal research evidence, but on the consensus achieved by psychoanalytic leaders, like Cremerius, Duehrssen, Ehebald, Faber, Goerres, Haarstrick, Thomae. These leaders composed a formal statement that in post-war Germany the re-instalment of psychoanalysis would need the support of the German

Research Council[4]. And by jove, they got support for post-docs´training analyses for quite a number of years.

Kalle: Are you joking? Just like President Yelzin in 1996 officially declared the re-instalment of psychoanalysis in Russia[5].

Ziffel: Njet, I am not. It is really true that today we are in a position to experience exactly the same phenomena, for probably different reasons, in Russia that occurred in Germany after the second World War. Clinicians making politics, not waiting for research findings, but convincing, arguing with politicians and other representatives of the public.

Kalle: So, in a way, this historical agreement answered the question of who pays how much for what treatment. In this sense we are talking about a more general topic how consensus should achieved on the distribution of the resources of a society.

Ziffel: Ahm! What happened in West-Germany was that a group of highly influential clinicians were able to establish a financially well bolstered psychotherapy delivery system. I like to call it the "6 to 300 toll-free system".

Kalle: As a fairly healthy person I never had a chance to experience that. But it sounds interesting. Could you explain this to me, please?

Ziffel: Well, all you need to do is catch yourself a "psychogenic disorder" and visit a doctor. After some frustrating efforts on his side to find a somatic reason for your complaints he will refer you to a licensed psychotherapist - either a medical specialist for psychotherapeutic medicine or a specialist psychologist. He may offer you a quick emergency shot of six - to twenty-five sessions or he may talk you into a peer-review based and monitored long-term therapy between fifty to three hundred or even more sessions.

Kalle: Good Lord, I hope I never shall need it. You mean these groups have successfully developed this insurance based delivery system for psychotherapy without the companies clamoring for much further formal research on outcome?

Ziffel: Now you have got it. Except for the good start with the Duehrssen study, which is scarcely mentioned in the 1971 Handbook review, there was very little research on efficacy or on effectiveness, or on process . In these old days the public obviously regarded clinicians as experts who did not need much formal research. There was no so called evidence-based

practice as today Grawe[6] and others are clamoring for again and again .

Kalle: As far as I see it, at the time of Duehrssen there was not much formal research anyhow. So today, the salient question is: are we any better off with all our research and do we know enough to implement evidence-based psychotherapy today?

Ziffel: You are much too fast. Evidence-based practice is not easy to achieve and ...

Kalle: (interrupting) I know. And it is surely more than just using techniques with demonstrated efficacy in experimental settings. Evidence-based practice has something to do with the interdependencies of the state of research and its consequences for practice; it has to teach yoiu soberness about what we know and what we don´t know. So improvements in the therapy delivery system will not automatically result from just following experimentally-based treatments. Do you agree?

Ziffel: There is no doubt about that. Let's turn to the German psychotherapeutic history again. The events just mentioned were true milestones for the field and these stones were carried by a psychoanalytic professional community at a time when behavior therapy was just in its very beginnings at some of the clinical psychology departments in Germany. At that time, the demand for scientific credibility naturally included clinical expertise and wisdom.

Kalle: I heard about the most well known wizard was Alexander Mitscherlich[7]; he was more than an army fighting for recognition of psychoanalytic thinking, not only in psychosomatic medicine, but in many walks of life of the German post war "fatherly-less society".

(Both are silent for a short while. Suddenly Kalle starts laughing)

Kalle: Ha, I just had a nice idea: You could place Annemarie and Alexander on one of these cleared pedestals in East Germany where Marx and Lenin had to step down. A nice idea. But let's be serious again. Do you want to say that we have excluded clinical expertise from our scientific discourse.

Ziffel: Perhaps I want to say that? If you, for example, look closely to the 4th edition of our Handbook[8] you will find 'clinical experience' as a very relevant therapist variable. But the psychotherapy researchers bible does not know 'clinical

experience' as an esteemed research tool. Hm? You will not find a special chapter on this theoretically striking topic. At least Robert Holt[9] made it quite clear in the late fifties that clinical prediction cannot be replaced by statistical prediction without considerable losses .

Kalle: Do you suggest that formal psychotherapy research has narrowed our perspective?

Ziffel: It certainly has narrowed our visions. We no longer maintain that psychotherapy would be a good thing for most people.

Kalle: Aren't you also relieved that this burden has been taken from our shoulders? That we are no longer the rescuer of society as we all have of in the late sixties.

Ziffel: Hm? So far so good. I don't know? However there is a considerable gap between many clinicians' conviction that a sizeable proportion of people need longer psychotherapies while the dearth of systematic research threatens to extinguish long-term psychotherapy as a respectable object of investigation. Luckily, Ken Howard's consumer oriented research policy will help to demonstrate that some patients do need longer term therapies[10].

Kalle: Don't tell me: I have read Seligman's enthusiastic evaluation of the Consumer Reports findings. Recently, in an SSCPnet (Society for a Scientific Clinical Psychology) posting, Ken Howard pointed out that something must be wrong in our field that the professional psychotherapy researchers are highly self-critical and outsiders like Martin Seligman are pouring out praise on the wonders of psychotherapy.

Ziffel: This is very surprising as Seligman has published a book on What You Can Change and What You Can't[11]where he limited his wisdom to the findings of randomized controlled studies. And now, he has changed from Saulus to Paulus. In his discussion of the Report he states that for the validation of psychotherapy as practiced daily, efficacy studies are using the wrong method as they leave out too many crucial elements[12].

Kalle: It sounds as though we have new wizards. Am I right, are you attacking my most favorite design: the randomized controlled trial?

Ziffel: I am not really sure. At least there are different kinds of therapeutic gold. In any case, we are talking about subtle changes in society and in the psychotherapy research

community. I have been trained that an experienced clinician would have a say in the evaluation of research findings and estimate their relevance for practicable application. For example, take the findings of the NIMH study where even a planned dose of 16 sessions was seldom realized; no wonder that with 12 sessions a high relapse rate occurred.

Kalle: You are critizing the over-estimation of formal research findings?

Ziffel: Indeed. At present I feel that we might be in danger of reducing the process of knowledge creation only to laboratory research conditions. Only rarely do we discuss those serious problems concerning external validity. Perhaps we tend to forget what we all should know, I mean that experimental validity has it's own threats[13].

Kalle: Three cheers for meta-analysis! But, hm? I mean meta-analysis indeed has had remarkable impact on psychotherapy research. On the other hand, today, many psychotherapy researchers still tend to overestimate the expected objectivity of this research tool. Sociologists are not so keen on secondary studies. For them meta-analysis is just one instrument among others. We ought to be aware of it's limitations. I share the common points of critique especially concerning the selection of clinically relevant methodologically adequate and properly conducted studies[14].

Ziffel: Oh no, stop, let's not talk about effect sizes, average Z scores, interval scales, dependent data, average clients etc[15]. (laughing) You see, I also have learned my lessons!

Kalle: (ironically) Yeah, I do see this!. (now more seriously) No, don't be afraid my friend I didn' want to go any deeper into these methodological considerations. And I agree that we, in principle, know about the opportunities and also the deficiencies of this and also our other methodological and statistical tools.

Ziffel: And what is causing your concern?

Kalle: (lost in thought) Hm, perhaps …? (ironically again) Meta-analysis is good for this kind of horse-race research: 'Is an average patient with an average, let's say, anxiety disorder better of with type A or type B or type C treatment, or perhaps a simultaneous or in succession combination of B and C? To me it seems that we are still discussing more about

methodology and statistics and to little about psychotherapy and how it ought to be conceptualized that it works[16].

Ziffel: You mean we still know too little to really understand psychotherapy?

Kalle: Exactly! Our head is occupied by mostly very simple linear models like: less of this causes more of that. But we still do not have a theory that grasps the complexity of psychotherapeutic change processes. There are only few and very preliminary attemps to formulate something like a common theory of psychotherapeutic change[17]

Ziffel: Oh, I have got an idea! We could adapt the current results of neurobiological brain research that suggest much more a synergetic perspective? Under this perspective the internal representations of the generalized significant social interactions of our development, that - at least - partly cause our symptoms, could be changed if patient and psychotherapist are able to modify those control parameters that are responsible for new emotional, cognitive and behavioral qualities in a close interpersonal relationship[18].

Kalle: You are talking about chaos theory, bifurcation and that stuff, right?

Ziffel: Yeah. You must not agree on this special theory mentioned. I just wanted to give you an idea of a theory that might be useful to conceptualize the dynamic processes of psychotherapeutic change.

Kalle: It is true, chaos theory has been usefully applied in many other areas. May be it is of help in our field too. At present it is just at the very beginning. But, in my opinion, we should not fall into a black and white pattern, not between theory and methodology orientation and also not between different research strategies.

Ziffel: Uhm, I might have been misunderstood. To make it clear, I do not see a black or white pattern either. For me there is no reason for a flight from systematic clinical research into laboratory statistical pragmatism which usually does not pay much attention to complicating factors like comorbidity and so on. There is no reason beacause yet there are issues that can only be clarified by empirical research based on methodologically well designed and elaborated statistical approaches - where the empirical research based on clinical experience is doomed to fail.

Kalle: I accept that many issues are only accessible in natural settings.

Ziffel: Are you able to give me an example?

Kalle: Sure!. The psychoanalytic concept of free association has been tested in quite a number of experimental studies[19]. However, none of these studies could clarify the role of free association as a clinical tool as they were analogue studies with limited validity for the clinical situation. From your own experimental study, I know how difficult it is to catch the therapeutic dialogue with elements of free running thought in such a study[20]. We need much more of the kind of research that tries to study the clinical everyday reality as well as possible. And we need different kinds of research for different purposes.

Ziffel: So we agree on this decisive issue. Couldn't it be that we might need clinical expertise to cover those domains of knowledge that are hard to come by experimental procedures?

Kalle: After all, a lot of medicine is not evidence-based[21]. For example, most of the surgical techniques are based on the expertise of rather skilful surgeons. According to the personal skills of many other surgeons they have been modified and so, step by step, in the everyday practise they have been proofed to be effective. In medicine there is a long tradition of action and experience based decisions.

Ziffel: But is this desirable? I hate going under the knife based on only one guy’s opinion!

Kalle: Desirable or not, it is simply a fact. And therefore, and this is another fact, most patients see a second or even a third surgeon before they make up their minds.

Ziffel: That is very wise as it seems! By the way, I remember a young patient I met at the hospital. He was suffering from an acute myeloproliferative leukemia. A few years after a bone-marrow transplantation at one of the most famous and successful transplantation centers his blood cells started proliferating again. As he had and he further developed quite e few complicating factors his docters denied his wish for a second transplantation although a donor was given. He went to another statistically less successful hematological unit which was known for very high clinical standards and successful transplantations even in very severe cases. There things went well and he got his second chance. It's always wise to seek for

a second oppinion. While the first doctor might not treat you in the light of some perhaps questionable group-statistics the other might overlook your personal situation more complete and treats you with the risk of a failure. No easy decisions!

Kalle: (ironically) That's it for today's topic: empirical evidence versus clinical expertise.

Ziffel: Ha, ha! I' ll try to return to our field: Do you think it is possible to apply the randomized controlled trial model to long-term treatments with hundreds of sessions?

Kalle: Isn't one point that we do not know enough about the natural course of a disorder? Well, I would not wait a long time if I was elected as a waiting group patient in a research trial. Rolf Sandell reported on a perplexing finding. In his study on long-term treatments, waiting-list patients received more informal treatment while waiting than the patients in his experimental group[22]. Long-term follow-up sometimes demonstrates striking findings, not only on the service delivery system.

Ziffel: You mean the patients' impatience does in fact spoil our wonderful randomized controlled trial design? So what would you suggest ? What do you think of single-case studies that most psychoanalysts retreat to ?

Kalle: I am afraid that single case studies don't have much impact on the agencies of society and on our scientific adversaries - they are a treat for our hearts, they are a high noon of inner psychoanalytic scientific achievements [23]

Ziffel: Perhaps it is not as critical as it looks. Systematic observational studies on a large natural sample are a good answer. The Stuttgart Centre for Psychotherapy Research has collected systematic prospective evaluative data on the psychodynamic treatment of 1200 patients with eating disorders[24].

Kalle: Wooh! Who gave you the money?

Ziffel: A German Ministry for Research and Technology's program was wise enough to consider treatment not only as crisis intervention, but to regard long-term relapse prevention to be the major aim of psychotherapy. Thus, the ultimate question would be how much treatment would be sufficient to provide long-term protection against symptomatic relapse.

Kalle: So we are happily back to Freud! I mean this was one of his core ideas. Freud was aware that we have no means to totally eradicate the propensities for psychic disturbances; life always can confront us with situations where our capacities for successful coping are not enough.

Ziffel: The Freudian enterprise always was standing for more than just rapid symptom relief with short-lived follow-up results. And at present, indeed, there seems to be a little "crisis" in our high estimate of the impact of short term therapy. Some protagonists - I think of George Silberschatz - are really shocked by the limited life span of their once impressive outcomes[25].

Kalle: I must admit that there is a smile even on the clinical side of my face.

Ziffel: As long as it is not a mocking smile it is okay. Mocking at clinicians' conviction usually was the business of psychotherapy researchers, wasn't it? Lawrence Kubie once said someting like: Love and cherish the therapist, but for heaven's sake do not trust him[26]. Is this the way to bridge to the worlds?

Kalle: Isn't this only a little romantic wish of the peaceful meadows' ... Only lambs, no wolfs ?

Ziffel: In reality, in Germany, at least, the influential meta-analysis by Klaus Grawe and his co-workers had its impact because the pending legislation of psychologists to become part of the medical system was about to get over the hurdles. Klaus Grawe's claim that the chairs for psychotherapy were occupied by the wrong people as all of them happen to be psychoanalytically-trained was no longer a statement justified by the meagre meta-analytic differences - it was sheer politics[27].

Kalle: You mean a clever selection of studies. A purposeful interpretation and translation for the public, especially for politicians, is sometimes very creative and innovative?

Ziffel: Exactly!

Kalle. Are you still suffering from those conclusions?

Ziffel: Well... To me it was a new experience to be called a misplaced person.

Kalle: I am glad that you did not suffer so much from that attack. By the way, as you know yourself, the clinical significance of the differences in effect sizes between various treatments reported by various meta-analyses still await corroboration by Phase IV studies.

Ziffel: That makes me feel better! And what do you mean by clinical significance? Is it perhaps what clinicians think that is significant?

Kalle: Don't be silly. This kind of circularity may suffice for psychoanalysts following a famous definition that psychoanalysis is what psychoanalysts do. No, we are in a better position. After many years in medieval darkness of statistical significance testing a few of us have discovered that true significance resides in meaningful changes according to practical value, or importance of a treatment[28].

Ziffel: To me it seems we agree that we need a continuous discussion among us of clinical and research viewpoints[29]. Meta-analytic findings that run counter to my clinical experience will have a harder subjective screening before I am able to assimilate them. And if I do not find sufficient support ...

Kalle: You are aware that you are in danger of remaining in conservative, sometimes even ideological tracks?

Ziffel: Yes, at least in principle.

Kalle: Perhaps I should admit this too? Hm?

Ziffel: Clinical work is constantly teaching me new things and these clinical findings have a huge impact on me personally. Each of my patients has left a mark on me and formal research - and also consensus on so called professional standards - do have a hard times matching this.

Kalle: You know I also work as a clinician. Still it seems to me that formal research findings open my scope. In the clinical situation I too often find myself lost in a jungle of certainties which are not much more than singing in the night when it is dark. Therefore, to me formal research holds a strong promise of overcoming present limitations of daily routines. Too often I feel myself practicing at a sub-optimal level and would hope to be supported by well established evidence. The main dilemma in our present situation seems to me that the gulf between the laboratory charades - as Kubie termed a lot of

experimental work in 1952 - and the clinical situation is still too large.

Ziffel: Yes, we need more experience in bridging these domains, more training how to do this instead of a precarious use of laboratory findings for making professional politics. And we need ways of professional monitoring and auditing of service delivery[30]. Otherwise the majority of our collegues will remain as uninterested in research findings as they are at present.

Kalle: So, maybe, we have to develop a personal culture of multiple identity? It may seem risky, to try to work as a clinician, as a researcher and as an administrator. However this might lead to a professional identity diffusion ...

Ziffel: (interrupting and laughing) Ha, ha, beware of your axis two diagnosis!

Kalle: Don't worry! I mean we will have different options in the different roles and we will have to make different commitments.

Ziffel: At the very beginning even the decision to see a patient entails one hour less of research and to distribute money to research may mean less money for any immediate gain for patients; so our aim should be to raise more money for patients by creating good, clinically meaningful research and acting as responsible administrators.

Kalle: Quite a sizeable number of conflictual tasks.

Ziffel: Do you need a psychotherapy session from time to time?

Kalle: Yes, I am afraid I do.

Ziffel: We could make toll-free appointments, even for longer times. Let's first check your prerequisites like goals, motivation, willingness to take part in research projects etc.

Kalle: I'll see. I think we should join the conference routine again. See you again, next time, next place ....

Ziffel: ... next mood, next controversy. Good bye.

Kalle: Auf Wiedersehen!

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