Psychoanalytic Dialogues, 11(4):571–582, 2001
Symposium on Implications of the *Empirically Supported Treatment* Controversy for Psychoanalysis

Introduction

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This introduction to the symposium explores the key features of the American Psychological Association *empirically supported treatment* (EST) guidelines, the forces leading to their development, and some of the potential implications of these guidelines for the future of psychoanalysis. The EST guidelines consist of (a) a set of criteria for identifying psychotherapeutic treatments that can be considered effective on the basis of research evidence and (b) a list of treatments that meet these criteria. These guidelines are an outgrowth of a more general trend in the health care system—the shift toward an evidence-based practice model. Although the EST movement clearly has important professional implications for psychoanalysis, categorizing and possibly dismissing the relevant concerns as exclusively political or territorial would be a mistake. At issue are fundamentally important epistemological and ethical concerns.

In recent years, a cultural, sociological, political, and professional storm has been brewing that has important implications for the future of psychoanalysis. It involves the increasing shift toward an evidence-based practice model in the health care system. This symposium focuses on an important outgrowth of this general trend—the American Psychological Association (APA) initiative to develop psychotherapy practice guidelines. Although this initiative is likely to have an important impact on the development of

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We express our gratitude to Neil Altman for his helpful comments on an earlier version of this article.

psychoanalysis, many analysts are only vaguely aware of it, if at all. This symposium explores the controversy surrounding this initiative and addresses the question of what types of responses are warranted by the psychoanalytic community at scholarly, scientific, and political levels.

In the early 1990s, the APA Division of Clinical Psychology (Division 12) appointed a task force to create a list of empirically supported psychotherapeutic treatments (ESTs) together with a set of criteria and a procedure for identifying such treatments.[1] Following an extended process of internal deliberation and of seeking feedback on a draft of the report from various groups within APA (e.g., Committee on Accreditation; Council of University Directors of Clinical Psychology; APA Boards of Educational Affairs, Professional Affairs, and Scientific Affairs; APA Continuing Education Committee; APA Division of Clinical Psychology), the task force published a report in 1995 (APA Task Force on Psychological Intervention Guidelines, 1995).

In accordance with the mission of the task force, the report spelled out criteria for determining whether a particular form of psychotherapy could be considered empirically supported: (a) The treatment must be more effective than a pill or placebo or as effective as an established treatment in at least two good group-design studies; (b) the relevant studies must be conducted using *a* treatment manual (a criterion we elaborate on later); (c) the characteristics of the patient samples must be clearly specified; and (d) the effects must be demonstrated by at least two different investigators.

The report provides a list of 22 "well-established" ESTs and 7 "probably efficacious" ESTs. As it turns out, the majority of treatments falling into these two categories are behavioral or cognitive-behavioral. Only one of the "well-established" therapies is remotely related to psychoanalytic treatment (Klerman and Weisman's interpersonal therapy). Brief psychodynamic therapy is listed as a "probably efficacious" EST. Long-term psychoanalytic treatment does not appear on the list (long-term treatments of any form are absent).

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[1] The task force originally used the term *empirically validated* rather than *empirically supported*. However, in response to criticism that the term *validated* implies a more definitive status to existing research findings than warranted, the weaker term *supported* was subsequently adopted.

This report and a subsequent update to it (Chambless et al., 1996) have been the focus of intense controversy (some of which we summarize here) within the field of clinical psychology, but little or no attention has been paid to this controversy within the psychoanalytic community. On one hand, psychoanalysts' lack of attention to this matter is not surprising, given the traditional lack of interest in, if not downright antipathy toward, empirical research by psychoanalysts. Most analysts do not read the journals in which the controversy is being played out, and no special attempts have been made by the participants in this controversy to reach a psychoanalytic audience. On the other hand, given the tremendously important implications of the EST controversy for the future of psychoanalytic training and practice, as well as clinical practice in general, this lack of interest is puzzling and cause for concern.

Practice guidelines for psychotherapy? Empirically supported psychotherapeutic treatments? Evidence-based practice? Treatment manuals? These words and ideas are generally unfamiliar to and seem foreign and perhaps even threatening to most psychoanalysts. They may be particularly grating to those of us who are immersed in the specific subculture known as relational psychoanalysis—those of us who feel at home here in the pages of *Psychoanalytic Dialogues*. Relational and intersubjective approaches to psychoanalysis have particularly emphasized the personal and interpersonal, uniquely individual, spontaneous, improvisational nature of the psychoanalytic endeavor. Relational analysts have been particularly critical of "technical rationality" in approaches to psychoanalytic methodology (Hoffman, 1998), and they have questioned the more traditional psychoanalytic idea that there could be any single correct "standard psychoanalytic technique" or "basic treatment mode" (Aron, 1999), emphasizing instead the uniqueness of each analytic dyad and the necessity to rediscover psychoanalysis within each treatment.

Relational analysts have been at the forefront of questioning any standardization of treatment that emphasizes technique at the expense of the unique personal relationship (Bromberg, 1998). They have attempted to move "beyond technique," focusing on *phronesis* rather than *techne* (Orange, Atwood, and Stolorow, 1997). How compatible could this approach ever be with "standardized treatment manuals"? Critique of an instrumentalist emphasis on technique goes hand in hand with relational questioning of classical psychoanalytic metapsychology and its tendency to approach the psyche and human

relations reductively in mechanistic terms. Hence, the relational turn led Mitchell (1997) to question both what analysts can know as well as what patients need. These postmodern questions are related inasmuch as, once we are less certain about what the analyst can know and what the patient needs, we inevitably become less certain about any standard technique or positivist methodology. Where does this leave relational analysts who are urged or even required to justify their practice as empirically supported?

And yet, with all the attention given to relativistic epistemologies and the postmodern sensibility with its glorification of uncertainty and fallibility, relational analysts are still clinicians and practitioners who are reminded daily of the pragmatic, goal-oriented, purposive nature of psychoanalysis. Even in the midst of championing uncertainty and of not being too knowing, voices have been raised among us calling for a renewed focus on practical attention to results, symptoms, and the patient's subjective reports of improvement. Questions have been raised not just by outside critics, but by fellow travelers asking whether our relativity has been too radical. What, after all, do we know? What is the nature of our expertise? What kind of objectivity can we offer? With changing notions of analytic authority, how do we justify offering professional services for a fee? All sides of this ongoing debate have been articulated by members of our community.

Sorenson (1997), for example, in an article lamenting the traditional isolation of psychoanalysis from the university setting, maintained that:

> Psychology is moving toward a future that increasingly recognizes only those treatment modalities with empirically proven efficacy. If this proves so, and if current models prevail in institute training, the day may come when psychoanalytic approaches to clinical practice—irrespective of other considerations regarding third party reimbursement and managed care—will not be able to be a part of any graduate school doctoral program that seeks [APA] approval [p. 177].

At the same time, Sorenson (2000) argued that that it is a mistake to idealize science or to purge those aspects of psychoanalysis that are based on faith rather than on evidence. He cited contemporary philosophers of science who argue that the distinction between scientific and nonscientific enterprises are not as clear-cut as once

thought and that belief and social indoctrination play important roles in science, just as they do in religion.

Cushman and Gilford (2000) argued from a hermeneutic perspective that the growing emphasis on demonstrating therapeutic efficacy and on cost accountability is part of a larger cultural shift toward the values of instrumentality, efficiency, and conformity. From their perspective, acceptance of the assumption that "evidence is the answer" buys into these values instead of engaging in critical moral deliberation. We must fight, they argued, for values such as the acceptance of ambiguity, complexity, uncertainty, mystery, and imperfection.

On the other hand, Bader (1998) argued that the hermeneutic turn in psychoanalysis is part of a more general retreat from therapeutics. This, he argued, is associated with a tendency to be pessimistic about the therapeutic value of psychoanalysis. Furthermore, he argued, this parallels a general cultural pessimism and a retreat from social action.

Silverman (2000), in a critique of the epistemological dimensions of the relational turn, argued that we need to distinguish between the way we work clinically and our approach to developing a psychoanalytic body of knowledge. She argued that a hermeneutic-perspectival perspective provides a good working clinical stance but also that, when it comes to developing psychoanalytic knowledge, "we must turn to a systematic scientific approach with hypothesis testing, confirmation, or refutation" (p. 152). Mitchell (2000), in response, argued that psychoanalytic knowledge cannot be considered objective in any traditional sense of the word and that (following Bernstein, 1983) we need to think in terms of a category that lies between the categories of objectivism and relativism. He maintained that, though empirical studies may influence our thinking, it is a mistake to hand over ultimate authority to empirical research. According to Mitchell, "we have a perfect right to claim validity (the nonstatistical sort) for our ideas because they are grounded in rigorous thinking and continually cross-checked with clinical experience" (p. 159).

In the midst of our preoccupation with pluralism, multiplicity, unique individuality, spontaneity, authenticity, relativism, and postmodernism, the vast majority of us are not academic psychologists or ivory-tower philosophers but clinicians and practitioners working with real patients with very real problems in real life. Whether in private practice or in clinic and hospital settings, we practice within

the context of today's health care system, and, whether or not we personally accept direct payment from health insurance companies or participate in managed care plans, we are directly affected by the changing culture created by these profit-driven systems. Whether we are psychiatrists, psychologists, social workers, or psychiatric nurses, it is our very own professional organizations that are now calling for evidence-based practice, empirically supported techniques, and standardized treatment manuals.

It is important to contextualize the EST movement as part of a larger movement toward evidence-based practice and cost containment within the health care system that is taking place in North America and Europe. In the United States, much of this growing emphasis on the importance of evidence-based practice has been galvanized by the increasing dominance of the health care system by the managed care industry. But similar pressures toward cost containment are being experienced in other countries with more extensive traditions of socialized medicine (e.g., Canada, England, Germany). In England, for example, the National Health Service commissioned a review of the research on psychotherapy to provide guidelines for evidence-based practice (Roth and Fonagy, 1996). And in Germany the government commissioned an "expert report" concerning scientifically based recommendations about psychotherapy (Meyer et al., 1991, cited in Strauss and Kaechele, 1998).

One of the more immediate effects the EST task force has had is that its recommendations have been incorporated into the guidelines for accrediting APA-approved doctoral training programs and internships in clinical psychology. Under current APA guidelines, a program must provide training in EST in order to be accredited. One of the initial goals of the EST task force seems to have been to offer the criteria for use by mental health insurers (both government and managed care). However, intense opposition within APA led the board of directors of Division 12 to renounce this as a formal goal (Chambless et al., 1996). This does not mean, however, that the findings of the task force will not influence the guidelines developed by various health insurers in the future.

Those who support development and dissemination of such guidelines argue that health insurers will inevitably develop guidelines for determining which forms of psychotherapy should be reimbursable and that it is preferable for those who have the expertise in interpreting the research to play a guiding role in this process than to leave it in

the hands of those who do not. Partially in response to similar concerns, the American Psychiatric Association has developed its own practice guidelines (American Psychiatric Association Steering Committee on Practice Guidelines, 1996), and these, as might be expected, tend to be weighted toward the biological forms of treatment.

Proponents of the EST movement argue that an extensive body of research demonstrating the efficacy of a range of different psychotherapeutic treatments of a variety of different disorders currently exists and that it is vital for those familiar with this research to bring it to the attention of policymakers. There is a danger that psychotherapy will be left out of the rapidly emerging practice guidelines in favor of pharmacological treatments which have an empirical base no better than that of psychotherapy.

The concerns of EST proponents, moreover, extend beyond the importance of influencing policymakers. They argue that it is incumbent on practicing psychotherapists, and on those responsible for training them, to be aware of the empirical evidence regarding the effectiveness of various approaches and to take it into consideration. Increased use of ESTs in the field should, they argue, lead to improvements in patient care.

One of the vehicles through which the EST movement should, it is argued, lead to improvements in therapist training and patient care is the fostering of the development and the dissemination of treatment manuals. As we indicated earlier, one of the criteria for inclusion in the list of "well-established" treatments is that the treatment in question has been empirically supported using a treatment manual. Treatment manuals, which specify in a clear-cut, operationalized fashion what a treatment consists of, are considered an important innovation in psychotherapy research. By specifying the characteristics of a treatment and then assessing therapist adherence, the researcher can be sure that the treatment being investigated really is what it is supposed to be rather than some other treatment. Thus, for example, in a study comparing supportive and insight-oriented treatments, it would be important for the investigator to be certain that the supportive therapists were using predominantly supportive interventions and that the insight-oriented therapists were using predominantly interpretive interventions. One of the positive by-products of this use of manuals is supposedly that the increased clarity and specificity associated with it facilitate the training of skilled therapists.

Critics argue that it is premature (or downright wrongheaded) to develop a list of ESTs. They argue that developing such a list conveys the impression that our current state of knowledge is more advanced than it is. Various concerns are raised about the validity and interpretation of existing psychotherapy research and about its generalizability to real-world settings. The obvious dominance of the list by behavioral and cognitive-behavioral approaches has led critics to argue that nonbehavioral treatments such as psychoanalysis are inherently more difficult to operationalize and thus more difficult to research. The constraints of the dominant research paradigm favor the application of easily specified treatments to well-defined, circumscribed clinical problems in the pursuit of well-defined, easily measurable clinical outcomes. This decreases the likelihood that nonbehavioral treatments will be included on the list. Critics also challenge the assertion that psychotherapy treatment manuals affect clinical training and practice in a positive fashion. They argue that skilled psychotherapy is difficult if not impossible to "manualize" and that treatment manuals constrain creativity and lead to deterioration in therapists' performance. Questions are also raised about the political motivations of the EST task force. Finally, concerns are raised that the EST movement is "playing into the hands" of the managed care environment and that there is a danger that insurers will treat the findings of the task force as definitive, even if psychotherapy researchers and more sophisticated consumers of that research recognize that they are not.

In response, proponents have emphasized that any list of ESTs is provisional—to be revised in an ongoing fashion in response to accumulating research evidence (e.g., Chambless, 1996). In addition, they argue that, although it is true that dominance of ESTs by behavioral and cognitive-behavioral treatments may reflect the relative lack or research by nonbehavioral clinicians, there is no reason for this imbalance to persist. The EST movement could ultimately have a positive impact on the field by spurring psychoanalytic and humanistic clinicians to conduct more research activity.

The EST controversy is a matter of serious concern for psychoanalysts. In the past two or three decades, psychoanalysis and psychoanalytically derived treatments have moved from a privileged position within the health care system to one of increasing marginalization. For example, the percentage of clinical psychologists who identified themselves as psychoanalytic or psychodynamic in

orientation had fallen from 35% in 1960 to 18% in 1995. At the same time, cognitive therapy, which was relatively nonexistent in 1960, had become the primary orientation of 24% of clinical psychologists by 1995 (Norcross, Karg, and Prochaska, 1997).

In addition to the ongoing push toward cost containment within the health care system, a number of factors have contributed toward the embattled status of psychoanalysis. One such factor has been the increasing "biologilization" or "remedicalization" of psychiatry. Another is the ascendance of the cognitive-behavioral tradition. A third is the ongoing assault on psychoanalysis within the popular "culture wars." Although psychoanalysis continues to have an important role within the humanities and social sciences and within serious intellectual discourse, a common public perception is that it is an approach that is at best arcane and ineffective and at worst pseudoscientific, authoritarian, antihumanistic, reductionistic, and mysogynistic.

Some may be tempted to categorize the concerns raised by the EST controversy as exclusively political or primarily territorial and therefore not of central interest to those who are more concerned with clinical theory and practice than politics. It is important to remember, however, that at issue here are fundamental epistemological and ethical concerns. Beginning with Freud, psychoanalysts have always had an ambivalent relationship to the question of whether psychoanalysis can be seen as natural science. In our current postmodern era, it has become fashionable to reject any claims in favor of the discipline's standing as a scientific enterprise. But if psychoanalysis is not a science, what truth claims can it make, and on what basis can we argue that it has value for our patients? In the face of the EST controversy, one possible stance would be simply to reject the relevance to psycho-analysis of any of empirical research conducted within a positivist paradigm. But if we do so, what alternative form of validation can be substituted?

Some critics dismiss the EST movement as politically motivated—as an attempt to establish a hegemony of the cognitive-behavioral approaches (e.g., Henry, 1998). But it is important to recognize that, though this type of political motivation may play a role, there is also a belief among EST proponents that they are "fighting the good fight"—that there are ethical grounds for insisting that therapeutic practice be evidence based. Many years ago, Hudson (1972) spoke about the fundamental divide between two different cultures in psychology: the culture of the researcher or experimentalist and the culture of the nonexperimentalist. Experimentalists (the "tough-minded"), he

suggested, tend to think of nonexperimentalists (the "soft-minded") as sloppy, and even morally remiss, in their unwillingness to treat hard data seriously. Nonexperimentalists, on their part, tend to view experimentalists as mechanistic, dehumanizing, and simple-minded.

This type of difference in worldview has created a deep chasm between psychotherapy researchers and practitioners, with a resulting impoverishment of both cultures (Safran and Muran, 1994; Goldfried and Wolfe, 1996). The splitting, lack of communication, and even hostility between clinicians and researchers span all psychotherapeutic schools and modalities of treatment. The situation is particularly problematic, however, for the modality of psychoanalysis. Contributing to the problem is the fact that, historically, psychoanalysts have been skeptical about any contributions arising outside the clinical (and specifically the psychoanalytic) situation and deriving from the use of anything other than psychoanalytic methodology. Perhaps more important, psychoanalysis, more than most other well-established treatment modalities, has throughout its history remained isolated and independent of the university setting. With psychoanalytic training taking place almost exclusively outside academic departments and independent of a culture of empirical research, the divide between clinicians and researchers is amplified. In recent years, numerous psychoanalysts and psychoanalytic organizations have begun to call for psychoanalytic research, to fund such research, and to begin to train a new generation of psychoanalysts to become researchers. However, relationally oriented clinicians working on an everyday basis within the context of their offices may well feel caught between contemporary theorists who question what they can ever know and what they should be providing for their patients and researchers who raise concerns about the lack of empirical support for what they are doing and who encourage them to practice from treatment manuals or to use empirically validated techniques.

Our hope is that the dialogue in this symposium will help bridge the chasm between these two cultures and help heal the split between clinicians and researchers. The symposium begins with lead articles by Lester Luborksy and Hans H. Strupp, perhaps the two most distinguished and influential psychoanalytically oriented investigators in the field of psychotherapy research. Their articles are followed by commentaries by Robert S. Wallerstein, Sidney J. Blatt, and Peter Fonagy. In the final article, Safran synthesizes and elaborates on the major themes that emerge in the dialogue.

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