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11

TEACHING CLINICAL DECISION MAKING

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When you look for it, it is everywhere—it permeates almost every aspect of professional practice. Whether one is setting up one's office, consulting on a referral, deciding what assessment instrument to use, meeting a client for the first time, reviewing and assessing the literature, or advocating for a particular treatment approach for a particular case, one is engaged in a form of it. The "it" can be termed *clinical decision making*, and it's not too much of a stretch to say that the fundamental goal of doctoral training in professional psychology or training in any advanced mental health discipline is to produce budding clinicians who have the knowledge, skills, and attitudes that enable them to make and carry out good clinical decisions.

Despite the centrality of this concept, professional psychologists are generally less likely than some other health professionals, such as nurses and physicians, to deliberately frame their work and teach their craft in terms of clinical decision making, although there are exceptions (e.g., O'Donohue &

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Henderson, 1999). The failure to explicitly frame our training in this manner may be a function of the old debate about clinical versus empirical judgment or the fact that "clinical" is still used to denote one of the three broad practice areas (with "counseling" and "school" being the other two) or the fact that conflict remains between the romantic and empirical visions of professional psychology. Whatever the reasons, it is my hope that this volume will change the current state of affairs. Emphasizing clinical decision making is apt because it encourages a deliberate, reflective, and intentional stance with regard to how to go about one's work as a professional psychologist.

Because *clinical decision making* is such a broad term, it has, not surprisingly, many facets and can be approached from many different angles. For example, Magnavita and Lilienfeld (Chapter 2, this volume) offer a powerful analysis that deconstructs the key elements of the clinical decision-making process from the vantage point of cognitive psychology (Kahneman, 2011). Part of that analysis includes a review of how people make decisions in general. Perhaps most central to understanding general decision making is that human's process information via two related but separable streams of mentation. The first stream is a fast, relatively automatic, perceptual, holistic, affective system of processing that sizes up a situation via "thin slicing" (Gladwell, 2005) and forms quick, intuitive judgments. The second system is a slower, more explicitly self-conscious and deliberate form of thought, mediated largely by processes of verbal justification. From an educator's perspective, this is a basic and central feature of the human mind of which students of professional psychology should be very aware. For example, a training exercise that I find useful when the class is viewing video is to stop the tape as soon as the patient (or client) appears on the screen and ask students for their report of their immediate perceptions, feelings, and intuitions about the client. Often trainees are initially reticent to say anything, generally because they don't want to appear as though they "judge a book by its cover." But once they are given permission, the associations flow, and we see that many impressions are formed almost instantaneously. They first notice the obvious demographics of the patient. Then they will notice how attractive they perceive the client to be and the manner of dress, hygiene, and body position, all which serve as indicators of socioeconomic status. Following that, a host of more imaginative wonderings will begin. These impressions are examples of thin slicing, an inevitable aspect of being human, and students need to be aware that they will then begin to form narratives and expectations on the basis of this very brief exposure.

Building on this basic formulation of the human mind, Magnavita and Lilienfeld (Chapter 2, this volume) further articulate how individuals develop *heuristics*, the general rules of thumb that are acquired over time that help consolidate the massive amounts of incoming information into relatively

reliable interpretations and guides. Although heuristics are necessary and central features of our cognitive system that enable us to get along in our everyday lives, it is also the case that they can be characterized as "lazy" and "miserly," meaning that in the service of efficiency they frequently result in inaccurate and misinformed judgments. Because the biases and traps are so easy to fall into, it is essential to teach clinical trainees about these cognitive mechanisms. Students should be shown explicit examples of how such biases and traps can lead practitioners astray and should be given training opportunities that allow them to build self-reflective awareness regarding their own heuristic processing tendencies that might result in them deviating from best practice.

Because the mechanics of clinical decision making are well examined elsewhere in this volume, I do not review them in detail here. From a training perspective such processes can be subsumed within a broader context—that is, within the identity and conceptual framework employed by the professional practitioner. The foundational elements that ground the more microlevel and situation-dependent cognitive processes can be considered, from the vantage point of decision making, as the "frame" of the practitioner. The *frame* of the practitioner refers to his or her worldview and practice orientation, and it is of tremendous importance in clinical decision making.

Magnavita and Lilienfeld (Chapter 2, this volume) offer the example that a psychoanalytic therapist will hear and respond to a patient's symptoms in a very different way than a psychopharmacologist. This gives rise to the question "What is the appropriate frame for a professional psychologist?" My position as an educator and scholar of the field is that practitioners should operate from the most coherent and comprehensive frame possible for understanding the key elements of a particular situation that requires clinical decision making. Unfortunately, this is difficult because the field of psychology is rife with competing, conflicting, overlapping, and somewhat redundant models and paradigms that attempt to offer practitioners a frame for understanding their patients or clients. This chapter introduces a framework that emphasizes key elements of the training of professional psychologists that enable them to make good clinical decisions. This framework is grounded in what is known as a *combined–integrated* approach to training professional psychologists (Shealy, 2004) and a more unified approach to the field of psychology as a whole (Henriques, 2011).

The first section of this chapter describes the general scientific humanistic philosophical approach and key values that we attempt to instill in our students, followed by a discussion regarding the implications for decision making. The second section provides a brief overview of the field and articulates why decision making needs to be grounded in a conceptual knowledge base. Following that an integrative approach to conceptualizing people is offered that directly informs budding clinicians in a wide variety of different

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contexts, including consulting and assessing patients. The fourth section addresses what is perhaps the most well-known and important frame of the clinical decision making of professional psychologists, the position of the American Psychological Association (APA) on evidence-based practice (EBP; APA Presidential Task Force, 2006). The history of EBP is reviewed, highlighting some of the major historical tensions that went into the emergence of EBP and how we train our students to approach the issue. Finally, an overview of a new unified approach to psychotherapy is offered that sets the stage for a heuristic that we train our students to use to frame their decision making in psychotherapy, called "TEST RePP."

CORE VALUES AND A SCIENTIFIC HUMANISTIC PHILOSOPHY

One of the most perplexing challenges for the field of professional psychology has been its struggle to navigate the tensions between the cold logic of science and the moral necessities of humanism. Indeed, in a seminal article, Kimble (1984) empirically documented the split between science and humanism in the broader field. It is the obligation of professional psychologists to understand the historical and epistemological issues that have contributed to this split and to be informed by both scientific and humanistic lenses when engaged in professional practice. First, by virtue of a core institutional identity, professional psychology is grounded in science, which means that it embraces the epistemic values and methods associated with science (Henriques & Sternberg, 2004). As such, it is crucial that a scientific attitude is instilled in budding professional psychologists. Some of the key ingredients of this attitude are skepticism and critical thought, a worldview that frames cause and effect with certain assumptions based on scientific plausibility, and reliance on evidence acquired in a systematic way (see Lilienfeld & O'Donohue, 2012).

Although a scientific attitude is crucial, it is not all there is to being a professional psychologist. Indeed, the primary identity of professional psychology is as an applied health service profession, and this means that the primary charge of professional psychology is prescriptive (Henriques & Sternberg, 2004). Ultimately, the function of professional psychologists is to change an existing state. This can be conceived as having the goal to move individuals or systems toward more valued states of being, which requires having a broadly philosophical—some might say metaphysical (O'Donohue, 1989)—position regarding the values that are guiding one's actions. The ethical code offered by the APA prescribes some of the key values that all psychologists need to consider in their professional behavior but, although essential, leaves much ambiguity in the details of how to be an ethical, values-driven practitioner. Because an individual psychologist has the potential for great influence over

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others, and because much clinical work and professional practice can be inherently subjective, it is essential that students be willing and able to understand and critically explore who they are; what they believe and why; and what they must do—personally and professionally—to become highly knowledgeable, skilled, and competent scientific practitioners. Thus, it is incumbent on the practitioner to be self-reflective and aware of the assumptions and the broader worldview that guides their actions. And there must be a narrative associated with that view that ties together core moral values, such as promoting human dignity and well-being with integrity (Henriques, 2011). These ingredients are fundamentally humanistic in nature.

To understand how training in a broad scientific humanistic philosophy has implications for clinical decision making, consider the following case: A 19-year-old college freshman is referred by the office of disability of her university for an evaluation because she believes she might have attention-deficit/hyperactivity disorder (ADHD). The scientific methodological perspective should inform the clinician to approach this case in a number of different ways. Specifically, a clinician should be informed regarding the empirical research that discriminates this disorder from other possible presenting conditions and be aware of the most reliable and valid assessment measures. Thus, a scientifically informed clinician would know that impressions formed in the course of a brief interview are a poor way to diagnose ADHD. Instead, what is needed is a detailed history of prior behavior patterns such as impulsivity, inattention, hyperactivity, poor organization, and poor academic performance relative to intellectual potential, supplemented via perspectives of an informant such as a parent, coupled with records from past school performance. In addition, reliable symptom inventories, both self- and observer report, a cognitive and academic profile suggesting difficulties with attention and processing speed, clinical observations, and a detailed interview assessing the nature and trajectory of the symptoms are all essential to make a diagnosis that would be "scientifically" valid.

But a scientifically informed methodological approach to assessment, although crucial, is not enough. Indeed, from the vantage point of a larger metaphysical humanistic philosophical approach, a pristine application of the scientific method that results in reliable diagnoses and points to evidence-based interventions might be seriously problematic when viewed from a broader perspective. Why? Because diagnostic entities such as ADHD have huge sociological implications. It carries meaning for how individuals understand their very natures, and there are good reasons to be extremely concerned about the "medicalization" of human experience. Indeed, the rising epidemic of mental health concerns (i.e., depression, anxiety, ADHD, etc.) has been linked by some scholars to the rise of the "disease–pill" model of human experience (Whitaker, 2010). Because humans are meaning-making entities, a professional psychologist in this context would be obligated to understand the personal

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significance of this diagnosis and its meaning in the context of this individual's social system. It is also the obligation of the professional psychologist to consider his or her role in the context of a system that creates policies that have broad social implications. There are no simple decision-making algorithms that can be applied at this level of analysis. However, if we are teaching leaders in mental health who will attempt to guide the system toward wise policies, it is incumbent on us to instill in our students a broad awareness of the implications of our actions beyond the narrow application of the scientific method to develop reliable, evidence-based answers in specific situations.

IS SCIENTIFICALLY INFORMED DECISION MAKING GROUNDED IN A METHOD OR A CONCEPTUAL KNOWLEDGE BASE?

When asked how he defined *science*, Robyn Dawes, well known for his work on fostering empirically based decision making, answered,

> I would define it as testing hypotheses through the systematic collection and analysis of data whether via what are called "randomized trials," where we randomly assign people to be given a vaccine or not or to a placebo group, all the way to informed observation. These are really the two essences of science. (Gambrill & Dawes, 2003; cited in Lilienfeld & O'Donohue, 2012, p. 59)

Dawes captured the methodological view of science. This view is embraced by many psychologists, both researchers and practitioners alike. Indeed, some argue that grounding psychology in the scientific method is the defining and unifying feature of the discipline (see, e.g., Stam, 2004). However, from the vantage point of a broad scientific humanistic philosophy, the purely methodological view of science is inadequate. In isolation, the scientific method (i.e., generating hypotheses and conducting studies) yields data and information. However, the professional psychologist needs to operate first from knowledge and wisdom. The incompleteness of method is obvious on reflection. Consider the question of why we engage in the scientific method in the first place. It generally is not solely for the specific data it yields about the specific phenomena under investigation. Indeed, if the data gathered were not generalizable at all, they would be largely irrelevant because scientific findings from specific studies—in the absence of a nomological network of scientific understanding—are essentially meaningless. The data and information from scientific studies become meaningful only when they are linked with data from other investigations and then placed within a network of understanding. Thus, science must include attention to the conceptually grounded meaning-making schema that organizes scientific knowledge.

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A bit of probing of even the most committed methodologists reveals this necessity. Consider, for example, the spirited call for the "clinical scientist" model of training in professional psychology offered by Baker, McFall, and Shoham (2009). Like Dawes, these authors have strongly equated science with the scientific method. Yet they acknowledged that the information gathered from science must be assessed for its external validity and generalizability. How do we accomplish this? The authors proclaimed that the "scientific plausibility" of the information gleaned from the scientific method must be considered. Consider, for example, that on the basis of the authors' articulation of scientific plausibility, it seems highly likely that they would dismiss empirical data derived via the scientific method that pointed to the existence of parapsychological phenomena (see, e.g., Radin, 2011) or the utility of energy psychology methods in reducing psychological distress (Feinstein, 2008).

All of this, of course, raises the question "What is 'scientifically plausible'?" We must have a way of answering this question or else we will simply generate a mountain of data and information without genuine understanding. To be a mature science, psychology must have an answer to the following: Is there a scientifically grounded conception of the human condition that is rich enough to speak to the complexities of the human experience while also assimilating and integrating major lines of information gleaned from various empirical investigations? To the extent that the answer is no, the field of professional psychology is destined to be deeply divided. Those who are impressed with the advances in the natural sciences will lean more toward the epistemic values of accuracy, objectivity, and reliability of knowledge and will emphasize the scientific method. In contrast, those who question the extent to which the natural sciences have effectively elucidated the nature of the human condition and who value meaning, relationships, subjectivity, and the unique and idiographic nature of the human experience will view the empirical commitment as sacrificing too much and missing the essence of what it means to be human. This is the fundamental reason the field has been pulled into two cultures.

The argument here is that the field of professional psychology needs to evolve from a conception of "science" as consisting solely of the method of hypothesis testing and data collection as Dawes described it to thinking about science as a knowledge system that provides a map of the human condition and our place in the universe. To be a credible system, the map must make sense out of the field of scientific psychology and point to a way of thinking about human behavior that offers a sophisticated guide to the practitioner. The construction of just such a formulation has been the focus of my efforts over the past decade (Henriques, 2003, 2004, 2008, 2011, 2013a).

Consider that it is not uncommon for students, in the course of their professional training, to be exposed to approaches such as person-centered

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therapy, cognitive–behavioral and emotion-focused therapy, family systems, and psychodynamic frameworks. Each of these perspectives has "data" supporting its views, yet they all have quite different fundamental assumptions that can overwhelm a student (or even a seasoned practitioner!). In addition, the conceptual connection between the various therapeutic paradigms and the science of human psychology as articulated by major domains of scientific inquiry, such as evolutionary, personality, developmental, cognitive, social, and cultural psychology, can easily result in contradictory messages and confusion.

For example, many ideas in evolutionary psychology seem to conflict with a cultural psychological perspective (Henriques, 2011). Even domains that seem like they should be obviously connected frequently are not. Consider that as a graduate student I took a personality theories class that was followed by a personality assessment class, and I found that the two courses were largely independent from one another. This was so even though they were taught by the same instructor! The main personality assessment instrument covered was the Minnesota Multiphasic Personality Inventory—2, and that seemed to introduce a whole different set of concepts than those that were covered in the personality theories class, which itself consisted of a series of schools of thought that were different and often disconnected and contradictory (e.g., radical behavioral, psychodynamic, humanistic, social cognitive). And when I was taught psychotherapy, the perspectives I was introduced to there were only loosely related to concepts in personality or personality assessment.

Given the enormous diversity, pluralism, and conceptual fragmentation in the field of psychology, I became deeply concerned that psychology in general and psychotherapy in particular were producing vast amounts of information but little cumulative knowledge (Henriques, 2011). In the 1990s, I began work on a project that sought to remedy this problem with a framework that would ultimately become known as the *unified theory* (Henriques, 2003, 2008). Because the term *unified theory* might sound to some like an all-encompassing idea that explains everything and makes precise predictions about how humans behave, it can also be characterized as a *unified approach*, which refers to an integrative metatheoretical framework that can define the field of psychology; integrate key insights from the major paradigms; and resolve long-standing philosophical disputes, such as the debates between mentalists and behaviorists (Henriques, 2004).

The unified approach works via the introduction of several new broad ideas (the tree of knowledge system, behavioral investment theory, the influence matrix, and the justification hypothesis) that allow for the key ideas of the major domains of psychological inquiry (e.g., evolutionary, cognitive, personality, social, cultural, developmental) and the major therapy paradigms (e.g., psychodynamic and cognitive–behavioral therapy perspectives) to be

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effectively assimilated and integrated into a more coherent whole. In short, the unified theory allows for both the "vertical" integration of the biological, psychological, and sociocultural dimensions of human functioning and the "horizontal" integration of perspectives on the human mind and behavior at the level of the individual (Henriques, 2013b).

The specific details of the unified approach are beyond the scope of this chapter, and the reader is referred elsewhere for an overview of the ideas that make up the system (see, e.g., Henriques, 2011, 2013a). What it offers in terms of teaching good clinical decision making is the position that it is both possible and useful to pull together, in a conceptually sound way, the primary lenses that are offered from the major perspectives in psychotherapy (i.e., behavioral, cognitive, existential, humanistic, psychodynamic, and family systems). In addition, it allows a foothold for organizing the vast data that researchers have gathered about human nature under the broad heading of psychology and the more specific research on psychotherapy such that those data can be brought to bear on real-life clinical situations in a holistic, nuanced, and effective way (see also Melchert, 2014).

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AN INTEGRATIVE MODEL FOR CONCEPTUALIZING PEOPLE THAT INFORMS CLINICAL DECISION MAKING

In this approach, concepts and theories are the bridges that link data and information gleaned from the scientific method to wise practice. Consequently, a major goal I have as a trainer of budding clinicians is to provide them with a broad framework that effectively maps the discipline, clears up the current psychotherapy tower of Babel, and allows the key insights from myriad perspectives and traditions to be coherently integrated into a whole. Directly related to clinical decision making in a wide variety of contexts is the approach to conceptualizing people based on analyzing five systems of character adaptation and the biological, learning and developmental, and sociocultural contexts in which the individual is immersed (Henriques, 2011; see Figure 11.1). The systems of character adaptation refer to the hierarchical arrangement of mental systems that enable an individual to respond to the current situation. The character adaptation system theory (CAST) approach refers to the hierarchical arrangement of mental systems that enable an individual to respond to the current situation. From the most basic to the most advanced, the five systems are as follows: (a) the *habit system*, which refers to the basic procedural processes shaped by learning and stimulus control; (b) the *experiential system*, which refers to the core of experiential consciousness that is organized by the flow of perception, motivation, and emotional reactions; (c) the *relationship system*, which is an outgrowth of the experiential system

that tracks self–other exchanges in an intuitive way on the dimension of relational value and social influence; (d) the *defensive system*, which refers to the ways the individual manages psychic equilibrium in the form of experiential avoidance, dissonance reduction, and defense mechanisms; and (e) the *justification system*, which refers to the verbally mediated explicit beliefs, values, and attributions people use to make sense of themselves and others.

As articulated by Henriques and Stout (2012), the five systems of character adaptation provide a framework for assimilating and integrating the key insights from major traditions in psychotherapy, placed in a biopsychosocial context. For example, behaviorists have historically tended to think and focus on habits, whereas humanistic and experiential practitioners have focused on core emotions and experiences; psychodynamic practitioners have focused on underlying relationship patterns and psychological defenses, and cognitive and narrative therapists have emphasized semantic meaning making in various ways. The CAST approach provides a way to understand how these are all component systems of adaptation that can be effectively woven together in to a more coherent whole.

How does this system influence clinical decision making? As O'Donohue and Henderson (1999; cited in Lilienfeld & O'Donohue, 2012) pointed out, "choosing appropriate treatment methods involves knowing and instantiating causal relations" (p. 51). To do this, a clinician needs to be able to understand the key variables and their hypothesized causal relations, and the CAST approach guides students on how to accomplish this. To see this, let's continue with the example that was introduced earlier, that of a college student who receives a referral for assessing the presence of ADHD and possible accommodations. Let's add the following background to the formulation and then apply the CAST approach to fostering a conceptualization:

> Tina is a 19-year-old college freshman. She grew up in a small rural town in southwestern Virginia. She is a first-generation college student and entered college with hopes of being a physician. She did extremely well in high school and has always been very driven and conscientious. However, her first semester at college did not go very well. She experienced difficulty making friends, and she was uncomfortable with the drinking and party atmosphere. She focused a lot on her studies and studied several hours a day, but she struggled to get the As she expected (her first semester grade point average was 3.2). Now she is reporting problems taking tests and staying focused and is worried that she has ADHD. She is starting to have trouble sleeping; she can't fall asleep because she is constantly worrying about what she needs to do the next day. She is also having nightmares about failing out of school. She also is reporting frequent stomachaches, and she is now considering whether she should transfer to a different college because it is closer to home.

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As O'Donohue and Henderson (1999) pointed out, people consult psychologists because they possess a form of specialized expertise. Specifically, they are able to understand key psychological variables and causal processes that contribute to the situation, have knowledge about what might foster adaptive change, and have a skill set that enables them assist with this process. Yet, exactly what scientific and professional information is considered relevant, and how psychologists are to maintain a reasonable level of awareness so that they understand people's presenting problems and make epistemologically informed and ecologically valid clinical decisions, remain extremely difficult and contentious. The volume of information and the markedly disparate lines of thought within our field makes this issue particularly daunting, and the CAST approach offers a heuristic to delineate key psychological variables that will enable the effective conceptualization of psychological problems. Here is an example of a formulation that might emerge if one was to apply the CAST approach:

> Tina is at a key developmental time in her life and is experiencing significant distress and psychological dysfunction due to a host of interrelated variables. Perhaps most salient issue is that Tina seems to be struggling with her identity and her sense of competence (Justification System), which is generating significant levels of negative affect, especially anxiety (Experiential System). It seems that her confusion is tied to her difficulties in adjustment associated with the change in her social context, from a rural setting to a university setting (Social Context). In the former context, she likely shared many of the social values and was able to perform in a way that was both personally and relationally affirming (i.e., she achieved academically and had friends—Justification and Relationship Systems). However, at college, the social values are deviating from hers in a way that leaves her more likely to feel isolated and uncomfortable (Experiential and Relational Systems). In addition, she is finding academic success more challenging than she expected. Thus, compared with high school, she is having trouble in two key life domains, academic and social. It seems that in an attempt to cope with her difficulties and control what she could (Defensive System), she has tried to increase her academic performance and has isolated herself a bit from her social connections. Unfortunately, it seems likely that the intense pressure she has placed on herself to succeed (Defense and Justification Systems) likely created additional problems because her anxious arousal (Experiential System) probably had the function of impairing her ability to perform in high-stakes situations like taking tests, thus creating a vicious, anxiety-producing cycle. As her general stress level increases, it seems likely that her basic biological and habitual patterns (e.g., eating and sleeping) have become disrupted, which will likely contribute to a dysfunctional spiral. It will be crucial to assess Tina's family history (past Social and Learning and Developmental Contexts) and what her status as a first-generation

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college student and desire to be a physician means in that context (Justification System). It would also be important to assess for any history of illnesses (in Tina or her family), especially for anxiety or depressive disorders (Biological Context). From the vantage point of diagnosis, it does not appear Tina has problems indicative of ADHD, but depending on additional information, she might meet criteria for a generalized anxiety disorder or an adjustment disorder with anxious features.

The CAST approach is a useful heuristic that is justified by its utility, parsimony, and conceptual coherence and is based on the argument that clinicians need to be guided by rationally coherent systems, which brings us to the point of exploring existing systems of decision making. It is helpful to review the history of the concept of EBP and then offer a framework that extends it on the basis of a metatheoretical approach to the field grounded in a scientific humanistic philosophy.

A BRIEF HISTORY OF EVIDENCE-BASED PRACTICE

Professional psychology has long been torn between two visions, the practice of psychology as an art versus an empirically based science. The artistic vision promotes the image of the master clinician as a wise and insightful healer guided by a deep intuitive knowledge. A prototype of such a clinician was offered by Caldwell (2004; cited in Garb, 2005), who, on receiving an award for his work in personality assessment, gave the following example of successfully interpreting a Minnesota Multiphasic Personality Inventory:

> We got a severe 4-6-8 profile on a young woman. I looked at the tortured implications of the pattern and somehow said, "She will have something like cigarette burn scars on her hands, where her father prepared her to steel herself to the suffering of life." The round burn marks were on her hands and extended a little way up her arms. (Caldwell, 2004, p. 9)

In contrast to the vision of the master practitioner as a wise artisan, the empiricist vision cautions psychologists against such ideals (Garb, 2005) and emphasizes judgments and decision making based not on intuition and the like but on existing empirical evidence. The practitioner's skill is in knowing how to acquire, interpret, and apply good empirical data to the question at hand. Empirically trained practitioners tend to dismiss with skepticism anecdotes like the one in the previous paragraph and point out the incredible biases of the human mind in seeing spurious patterns in nature. As a consequence, proponents of the empirical tradition argue that there is a great need to ground assessments and treatments in those validated by the scientific method. As alluded to earlier, the empirical tradition is now explicitly represented in "clinical science" training programs (Baker et al., 2009) that

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define clinical psychology solely as a science and generally reject the notion that clinical practice is in any way an art form.

Historically, these two traditions have been framed as the competition between the empirical and romantic visions of professional practice (Garb, 2005), but I believe this is an unfortunate way to characterize the split. In philosophy, there are two broad positions on the mechanisms humans use to achieve knowledge. The empirical tradition, epitomized by individuals like John Locke and David Hume, posits that the most fundamental and reliable way to achieve knowledge comes from systematic observations and data collection. This accords very well with the methodological view of science articulated by Dawes. The rationalist tradition, epitomized by individuals like René Descartes and Immanuel Kant, argues that the best approach to knowledge is achieved by using reason to arrive at conclusions about the most justifiable claims. Whereas empiricists emphasize "show me the evidence," rationalists emphasize "show me the logic and rationale." Consistent with my emphasis on approaching human psychology and the profession from the vantage point of conceptual coherence (Henriques, 2013a), my view is that the rationalist position has not received enough attention in the identity of professional psychology. This chapter can be characterized as a call for how to teach clinical decision making grounded in a rationalist approach. Of course, empirical data and the honed, artistic skills of the practitioner are valued, but from this perspective, the central guiding key to wisdom that informs best practice is a comprehensive system of justification.

Returning to the history of EBP, the competition for the core identity of practitioners and for the conceptual groundwork for making clinical decisions in psychotherapy reached a fever pitch in the 1990s. Much of it centered on the debate about the role and place of empirically supported treatments (ESTs) in psychological practice. For a host of reasons—managed care being a primary one—pressure was mounting on the field in the 1980s to demonstrate the effectiveness of psychotherapy interventions. At the same time, there emerged interventions that offered models and manuals for treatment that could be tested empirically relatively easily. For example, A. T. Beck produced a model and treatment for depression, the effectiveness of which he and his colleagues were able to test using a randomized controlled design. Studies began to emerge that suggested that cognitive therapy (or cognitive–behavioral therapy) was more effective in reducing symptoms than either no treatment or control conditions like supportive therapy. From the empirical–methodological perspective such findings were exactly the kind of data needed to ground the field in science. Many academics began to promote the idea that students of psychotherapy must be taught empirical approaches and that such interventions ought to be the first line of treatment in practice.

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Given that virtually all agree that by virtue of its history and identity, professional psychology is tied in some way or another to science, one might think at first glance that the EST movement would not inspire much controversy. It seems to represent a straightforward scientific advance, and indeed, from a pure methodological view of science and practice, ESTs are a straightforward advance. However, from the vantage point of a rationalist informed by a broad scientific humanistic view of the field, the issues are enormously complicated. I offer a brief discussion of just a few of them and refer the reader to Marquis and Douthit (2006) and Wachtel (2010) for more detailed critiques. The overall point here is that from a broad scientific, humanistic, philosophically informed view, it is naive and a form of scientism (i.e., an overreliance on power of the procedures and methods of science) to believe that data and information derived from studies emphasizing sound scientific methodology should be the sole guide in clinical decision making.

We can start unpacking the debate surrounding ESTs by considering that virtually all ESTs are grounded in concepts from the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). Many have criticized the *DSM*, which was produced largely by the field of psychiatry, as offering an overly simplistic, medicalized descriptive categorization of psychopathology that ignores psychosocial etiology and, as such, does not lead to effective treatment plans because it is blind to the dimensions of functioning that are crucial to understand in psychotherapy. Psychodynamically oriented clinicians were so frustrated by what the *DSM* failed to capture that they developed their own *Psychodynamic Diagnostic Manual* to guide practitioners in assessment and case formulation (PDM Task Force, 2006). Humanistic, critical, and positive psychologists have all been critical of the *DSM* system in various ways. Even biologically oriented scientists who study mental disorders have started to abandon the *DSM* (including researchers at the National Institute of Mental Health; see, e.g., Insel, 2013). The fact that the major mental health research institution in the United States is abandoning the *DSM* must raise a host of questions about the foundational validity of so many EST research projects.

The conceptual structure of the EST movement does not implicitly endorse just the *DSM* but also the medical model of treatment. By that I mean that the EST model of psychotherapy assumes that psychological disorders exist within individuals, are of a specific identifiable type, and are amenable to specific interventions that result in helpful change. Conceptually, the medical model places the disorder as the "figure" to be analyzed, along with the impact of the specified and generalizable intervention. In the traditional medical model of researching disorder–intervention match, the personality of both the individual and the treating professional and the nature

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of their relationship become the "ground" and are generally treated as error or noise, both in the way the interventions are presented and the way data are analyzed in randomized controlled trials.

The potential problem with this framing is that many view psychotherapy as a psychosocial or human relational process. In this view, the personality of both individuals in the therapy room and the nature of their healing relationship are front and center. In his now classic work, *The Great Psychotherapy Debate*, Bruce Wampold (2001) argued that the scientific data were clear on the best way to conceptualize psychotherapy: It should be considered a human relational process rather than a depersonalized medical intervention. Why? According to Wampold, the scientific data strongly support the notion that it is the quality of the therapeutic alliance that is more closely associated with good outcomes than is the process of specifically matching particular techniques to *DSM*-type problems.

To understand the differences between the two perspectives, consider an individual diagnosed with clinical depression being treated with a behavioral activation intervention (e.g., Martell, Dimidjian, & Herman-Dunn, 2010). The EST approach focuses on the nature of depression as a state of behavioral shutdown, and the key ingredient of change is considered increases in mastery, pleasure, and rewarding activity. Randomized controlled trials focus on comparing whether those in a behavioral activation condition show more symptom relief than those in a different condition. The specific personalities of the individual and the therapist and their relationship might be examined as moderating influences but generally are not considered central. In contrast, the process approach emphasizes that the key ingredient is not the specific intervention but the extent to which the therapist and client form a positive, trusting relationship; agree on the formulation; and are able to set tasks that foster change. This angle on psychotherapy research points out that widely different approaches to thinking about conditions like depression (e.g., behavioral, cognitive–behavioral, emotion focused, interpersonal, modern psychodynamic) tend to get very similar results. The key ingredients, according to Wampold and other outcome-informed therapists (e.g., Duncan, 2013), are not the model of the disorder or intervention per se. Instead, these scholars have argued that as long as the model is credible, the key ingredients are whether the healing relationship is strong, the formulation of the problem is shared, and the work leads to change-oriented tasks in which both individuals are invested. Thus, in this case, the key ingredients are whether the individual is at a stage of change that makes him or her receptive to the conceptualization of depression offered by behavioral activation, whether the therapist is seen as trustworthy and knowledgeable, and whether the individual is motivated to comply with the tasks designed to change the current state of affairs. Wampold pointed out that if these ingredients are present, the

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data suggest the outcomes are the same for all the credible kinds of therapy, which raises serious questions about a host of issues.

In addition to debates about how to think about psychotherapy in general (i.e., whether we approach it via a medical model or a psychosocial process), there are many theoretical approaches to psychological treatment, and when one takes a broad view of the field it must be noted that the EST debate has been deeply entangled with the competition between the schools of thought on the various ways to conceptualize people in general and psychopathology and psychotherapy in particular. Compared with psychodynamic and humanistic approaches, cognitive and behavioral approaches were more closely connected with empirical traditions in academic psychology and were structured in a way to be more readily examined via traditional research methods. Thus, historically, support for ESTs basically translated into support for behavioral or cognitive approaches over psychodynamic and humanistic ones. All these forces set the stage for a deep and complicated debate, which, as is evident from the growth of "clinical science" programs, has yet to be settled.

Largely in response to the conflict the EST debate sparked in the field, the APA developed a broad framework for clinical decision making with its position on EBP (APA Presidential Task Force, 2006). EBP is defined as approaching practice via "the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences" (p. 273). Sometimes conceptualized as a three-legged stool, EBP thus has three predominant elements that should go into considerations of best practice: (a) the available research evidence applicable to the current situation, (b) the professional expertise of the practitioner, and (c) the values of the client in the given cultural context. The EBP concept is broader than the focus of ESTs and was issued in part by APA to provide a form of conceptual rapprochement between the various factions in the debate over the relevance and power of ESTs to influence practice. For example, the acknowledgement of both available research and professional expertise in the unique context of the specific client and culture attempts to speak to both sides of the issue. The basic framing of EBP provides a generally useful heuristic to guide practitioners in the key elements that should go into the decisions surrounding assessments, interventions, and consultations. However, despite its usefulness as a general framework, I have found as an educator that EBP requires more clarification to serve as an effective guide.

Grounded in the same integrative metatheoretical approach that generated the CAST approach for conceptualizing individuals, we have developed TEST RePP to provide students in behavioral and mental health programs with a heuristic that informs them of how to make effective, holistic, clinical decisions in a wide variety of professional contexts. It is a framework that is

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embedded in a course on integrative psychotherapy for adults, although it could extend to other related domains of practice, such as consultation and assessment. To apply it, we must first articulate a how a broad and general view of psychotherapy can set the stage for resolving the great psychotherapy debate and allow practitioners a truly comprehensive framework for rationally integrating research, professional wisdom, and unique contextual elements and client values into effective practice.

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A GENERAL, UNIFIED VIEW OF PSYCHOTHERAPY

The argument laid out so far is that if students are going to be informed consumers of scientific research applied to professional practice, they must operate from a broad scientific humanistic philosophy of the field. Such a view will enable them to consolidate findings into meaningful information that guides their decision making. Without such a framework, the field and its practitioners are destined to endless debates because of foundational disputes about assumptions that are not resolvable at the level of scientific data gathering. Earlier I described how a broad scientific humanistic philosophy is necessary to reflect on and make decisions about diagnoses and develop holistic conceptualizations that elucidate key variables and their causal interrelations in a way that leads to informed clinical decision making. In this section of this chapter, the focus turns to therapy and how the unified system offers a new way to approach the field of psychotherapy, one that is quite different from other approaches.

The field of psychology in general and the practice of psychotherapy in particular have been "pre-paradigmatic," meaning that there was no available broad framework from which professional psychologists could operate. This is apparent when one considers that the emergence of the major schools of thought were generally through a master practitioner gaining insights based on useful techniques in the therapy room. Although they were all students of human nature, the founders of the great therapy endeavors like Freud, Rogers, and Beck largely started with observations about the therapeutic process and generalized from there about insights for the field of psychology. These gurus then generated a following of individuals who tried to apply their insights and argue for the best approach to psychotherapy on the basis of this process.

The unified approach advocated for here works in the opposite direction. It specifically concerns itself with the construction of an integrative metatheoretical framework that then can be used to assimilate and integrate key insights and findings from both the science of human psychology (e.g., personality, cognitive, affective, developmental, neuroscience, social,

abnormal) and psychotherapy from a multitude of perspectives (e.g., cognitive–behavioral therapy, psychodynamic). Thus, the unified approach enables the psychotherapist to move beyond specific paradigms and toward a general model of psychotherapy that is grounded in the science of human psychology (Henriques & Stout, 2012; Magnavita & Anchin, 2014; Melchert, 2014).

Because the unified framework enables us to take a broad view of the field, it is well positioned to advance the search for a more effective way to approach psychotherapy integration. First, it can offer a general conception of psychotherapy, one that other perspectives cannot do because they are not tied to a coherent conception of human psychology. Via the unified view, psychotherapy can be defined as a professional relationship between a patient (or client) and a professional psychologist who is trained in applying psychological knowledge toward improving human well-being. In addition, the integrative metatheoretical perspective can also serve as a way to unify the various approaches to psychotherapy integration. One such perspective that has been quite influential has been the *common factors* approach, which is based on the early work of Jerome Frank. This view, supported strongly by Wampold's (2001) analysis of the field, emphasizes the fact that generally speaking, the different bona fide treatments yield very similar outcomes (the so-called dodo bird effect) and thus the primary curative agents are likely in the "common factors" of the various treatment protocols. One of the most robust findings in the research on psychotherapy has been the association between a strong working or therapeutic alliance and good outcomes. Consistent with Bordin's (1979) early formulation and much subsequent research, the working alliance consists of three primary components: (a) the bond or quality of the therapeutic relationship; (b) the shared goals of the therapy, which emerge out of a shared conceptualization of the problems; and (c) the tasks, which are the changes and interventions that are hopefully going to take place to achieve the stated goals. In accordance with this view, students can be taught to think about general psychotherapy as consisting of the three elements that together make up the concept of the therapeutic alliance.

Although some tend to think about the therapeutic alliance only in terms of the process and quality of the relationship, it is, of course, much more than that. In addition to the human bond, it also involves developing an effective, shared narrative of the problem and useful tasks that foster reaching specified therapeutic goals. This is where the CAST approach to conceptualizing is placed in the system because it attempts to ensure that a comprehensive, holistic picture of the individual can be formed and in a way that is both systematic and that can be shared with clients (Henriques & Stout, 2012). If successful, the conceptualization results in the collaborative weaving together of the key forces and domains that tell a story of how the person got to where they are and what will influence their trajectory in an

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adaptive as opposed to maladaptive way. The CAST approach is integrative because, as mentioned earlier, the five systems of character adaptation align with the dominant perspectives in individual psychotherapy. The conceptual foundations that drive behavioral, experiential, modern, psychodynamic, cognitive, and narrative approaches can now be integrated into a holistic biopsychosocial formulation. Thus, students can now effectively transcend the competing insights from these grand traditions and coherently integrate them into a more cohesive framework.

If this is done well, the case formulation gives rise to the goals of the therapy, which can be framed as a description of what would influence the ultimate outcome to be desirable and adaptive (e.g., if an individual could be less negative in their self-talk, be more assertive in their relationships, become aware of ways they defend against certain feelings). In this light, the goals of therapy can be now framed as decreasing distress and dysfunction and increasing valued states of being. Finally, these goals can then be matched with the empirical literature in psychotherapy, and a series of therapeutic tasks can be developed that can be expected to have a positive impact on the stated goals. In short, for the first time there is now a model of psychotherapy that can be effectively corresponded with the science of human psychology, allowing for much more unity and synergy between these two branches of our field.

A FRAMEWORK FOR CLINICAL DECISION MAKING IN PSYCHOTHERAPY

The three broad domains of a general psychotherapy (relationship, case formulation, and intervention assessed via clear outcomes) grounded in the conceptual map provided by the unified theory enables students to disentangle the complicated process of psychotherapy into more discrete, but clearly related, parts. To foster a deliberate working conception of the kinds of thought processes that ought to be guiding them in their clinical decision making, students are introduced to the mnemonic TEST RePP, which stands for "Theoretically and Empirically Supported Treatment and Relationship Processes and Principles." It provides a heuristic that captures the key elements that evidence-based practitioners ought to be aware of and adhering to. It is specifically organized in a way that allows the field to transcend the current "midlevel" paradigms, build bridges between psychotherapy research and meaningful practice, and move toward resolving the great psychotherapy debate by holding both the "disorder–intervention" and "healing relational process" perspectives in complementary relation to one another.

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TEST REPP APPLIED TO THE CASE OF TINA

Each element of TEST RePP is described in greater detail in the subsections that follow. To help see how its elements have implications for clinical decision making, it is applied to Tina, with the context being that she has come to see a staff psychologist at a college counseling center, seeking guidance on what she should do and greatly desiring to reduce her distress. Note that TEST RePP guides the clinician within the context of an appropriate, ethical, and professional therapeutic relationship, and the assumption is made here that the proper considerations have been taken in setting up the frame for the relationship.

Theoretically Supported Treatment

A basic principle stemming from the argument thus far is that, as philosophers often point out, "facts are theory laden." Professional psychologists must be aware that humans do not perceive the world directly as it truly is (whatever that might mean), but we have perceptual and conceptual categories that enable us to actively make meaning out of the patterns in the world. This is the first meaning of the word theory here. Because the background conceptual structure "frames" what the practitioner sees in making decisions, it is crucial that the practitioner be as fully aware of those structures as possible. This starts at the level of broad philosophy and worldview and includes the views the professional psychologist has for how the world works, his or her religious and political perspectives, beliefs about the nature of human nature, and beliefs about humanity's place in the universe at large. If these sound deeply philosophical, they are. This is central because we relate to our clients at the level of meaning and inevitably hear their stories through a particular lens defined by our worldview.

Applied to Tina, consider how a Christian psychological practitioner might hear and respond to her story differently than a secular skeptical practitioner. To do so, let's make the reasonable assumption, on the basis of Tina's story and the demographics of southern rural Virginia, that she was raised in a socially conservative, Christian home. If so, it follows that some of her current anxiety and confusion likely would stem from the potentially conflicting messages she has received in the context of her transition from a socially and religiously conservative environment where she felt comfortable to one that is more secular and has looser mores regarding drinking and sexual activity. If so, then it is highly likely that a socially conservative Christian psychological practitioner will hear Tina's story differently than a purely secular practitioner. This is the case even when both practitioners are engaged in "secular" psychotherapy and are appropriately ethical and sensitive about imposing

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their own personal beliefs on the therapy practice. The issue here regarding clinical decision making is one of awareness as opposed to explicit formulations regarding what one ought to do. Because these deep structures will have a profound impact on how we practice, a foundational pillar of good practice is to have strong self-reflective awareness of one's identity, deep-seated beliefs, and values and the capacity to clearly identify the ways in which those frames influence how one hears and responds to a client's presentation.

The second meaning of the term *theory* refers to the practitioner's knowledge of human psychology. This consists of the biological, developmental, and social understanding of personality, psychopathology, relational, and human change processes through which both the individual and the process of intervention will be understood. Professional psychologists should have basic knowledge of elements such as behavioral genetics and their influence on mental illnesses; personality traits (e.g., neuroticism and conscientiousness); emotions and motivations; social psychological processes of first impressions, stereotypes, attitudes, and attributions; and general knowledge of intelligence and academic aptitude, along with categories and classification of mental disorders (i.e., the *DSM*).

This second level of theory, knowledge of human psychology, is usually organized around and telescoped into the primary paradigm of practice that the professional operates from (e.g., third wave cognitive–behavioral therapy, eclectic therapy, emotion-focused therapy). A humanistic psychologist operating from a person-centered approach would likely emphasize the external pressures that Tina is experiencing that "force" her to feel compelled to fit into a specific socialized mode. The assumption that she has within her an organizing growth force will position the humanistic practitioner to make choices in the therapy room to focus on Tina's internal emotional experience and create a relational context of empathy, congruence, and positive regard in which she can begin to discover and give voice to her "true" self, which is seen as central to healthy development from the vantage point of the humanistic tradition. In contrast, from a traditional cognitive–behavioral perspective, a psychological practitioner will attend to the interpretations and beliefs that Tina has about herself, others, and her situation. These beliefs will be seen to be the key to understanding the negative emotions and maladaptive behaviors that follow. Here the therapist will listen for how Tina's story indicates the presence of beliefs that she is incompetent or that she must get all As in order to be successful. From the current perspective, it is the obligation of the practitioner to be able to identify the general paradigm from which he or she is operating in understanding Tina and explain how it is consistent with the body of human psychological knowledge in general. This is deemed to be a basic requirement of doing psychological therapy.

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One of the distinguishing features of the unified approach that fosters advances in this area is that because its starting point is a holistic view of human psychology, it sets the stage for a much greater correspondence between the body of psychological knowledge and the conceptual understanding of the current situation. For example, as articulated when describing how Tina might be conceptualized, lenses from a wide variety of different domains were combined in a holistic picture, including biology and behavioral genetics, learning and development, interpersonal and sociological, behavioral (habits), experiential and emotion focused, psychodynamic (i.e., defenses and relational schema), and cognitive–narrative perspectives.

In short, to effectively decide how to frame the therapy with Tina, the professional psychologist must be clear about his or her theoretical and conceptual frame. The reason for this is that it guides how the psychologist sees Tina, conceptualizes her problems, and inquires about and deciphers Tina's valued states of being. It also informs the psychologist of how to think about the current condition, the key causal variables that led up to it, and the proposed mechanisms of change. The argument here is that the more coherent, clear, and comprehensive one's approach is and the more it aligns with our knowledge of human psychology, the better the decision making that will ensue about a particular case. That said, I am not advocating for a "purely" rationalist approach to intervention. Coherent and comprehensive formulations must be buttressed and informed by the empirical literature that has been done on cases similar, and that brings us to the next piece of TEST RePP, the EST.

Empirically Supported Treatment

As valuable as theory is, it needs to connect to and correspond with empirical research. Indeed, research and theory are complementary ingredients to growing our scientific knowledge. In this context, we can be reminded of Eysenck's (1952) famous early challenge to the field of psychotherapy, which was an important motivator to examine whether psychotherapy is actually helpful. Decades of empirical research have since demonstrated that, generally speaking, psychotherapy is an effective health intervention (Lambert & Bergin, 1994). In addition, much has been learned about the elements that are effective and associated with positive outcomes, and practitioners have an obligation to be aware of the research on the validity of the assessment instruments and treatment interventions they use. In addition, psychologists should be aware of their personal biases and seek to check their beliefs against objective research, be cognizant of the way motives and needs influence one's beliefs and perceptions, and be aware of alternative perspectives. They should also be aware of the way the research they are interpreting

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was conducted, be able to critique issues of methodology that might raise questions of internal validity, and have a conceptual map that allows them to consider issues of generalizability.

More concretely, practitioners operating in well-researched domains, as when working with anxious adults like Tina, should be aware of empirical findings associated with different treatment interventions, such as cognitive–behavioral and psychodynamic approaches, as well as common medications. Intervention principles that have consistent connections with good outcomes, such as those involving exposure with response prevention, should be at least acknowledged and seriously considered in a case like Tina's. Indeed, if there is a clear desire by the patient to reduce his or her anxious symptoms and there is good reason to believe that the levels of anxiety are contributing to dysfunction in important areas (as in Tina's case), it is the obligation of the practitioner to provide guidance toward interventions that have been empirically shown to be effective at reducing anxiety and improving performance.

In the case of Tina, for example, it seems that the minimum a professional psychologist should be aware of in terms of the broad empirical literature on reducing anxiety is summed up well by the renowned cognitive–behavioral psychotherapy researcher David Barlow. Reviewing a large literature on ESTs, Barlow and his colleagues have suggested that practitioners be able to view depressive and anxiety disorders from the general perspective of negative affect (Barlow, Allen, & Choate, 2004). From this, he argued that research has demonstrated three broad principles that foster effective treatment: (a) reducing catastrophic or overly pessimistic expectations for future events, (b) reducing avoidance patterns and increasing the capacity to stay with aversive emotions, and (c) training individuals to develop antithetical emotional responses to their dominant response style (e.g., fostering general relaxation skills for anxious individuals). Thus, high on the decision-making list of the clinician working with Tina are the following questions: When should Tina's anxiety symptoms become the focus of the intervention, how should they be conceptualized with her, how should she be motivated to engage in interventions known to be effective, and how can the utility of these interventions be tracked?

Generally speaking, the term *treatment* here evokes a "medical model" conception, in which the individual is thought of as having an identifiable problem that can be matched with a set of interventions that will alleviate the difficulty. This model is the dominant frame of thinking in cognitive–behavioral literatures, and from our broad scientific humanistic view of human psychology and psychotherapy, it is a useful framework. But it is limited in scope. It often fails to consider deeply other issues of personality, especially identity and relational functioning. And it frames psychotherapy in a particular way that can blind practitioners to equally important aspects

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of treatment. As mentioned earlier, referencing the great psychotherapy debate, the other major perspective is to consider the process of psychotherapy as a psychosocial or relational one, whereby two individuals enter into a meaningful professional relationship with the intent of relieving distress and improving functioning. Students should be taught and professionals should be able to think about the psychotherapeutic process both as matching a presentation to an intervention and as a unique human relationship process that unfolds between two individuals. This brings us to the "Re" in TEST RePP.

Relationship

Whereas the "EST" stands for thinking about systematic interventions that might reduce suffering and improve functioning, with "relationship" the focus shifts to the nature of the exchange between the practitioner and client and their personalities as well as the broader social variables at play. At a basic descriptive level, this would include attention to the gender, age, and socioeconomic and ethnic background of both parties. But it is much more than that. Every psychotherapy encounter consists of two unique individuals experiencing one another at a unique moment in time. The individual uniqueness of both the therapist and the client tend to be considered either error or noise in traditional treatment research. That is, for research purposes, the treatment is standardized, a set of inclusion and exclusion criteria are developed based on symptoms, and then the results are reported in aggregate form, averaging across groups.

Humanistic and psychodynamic thinkers have done the most developed systematic work on the therapeutic relationship and how it can be used to foster healing. As noted previously, a strong empirical claim can be made that the effectiveness of psychotherapy is related to and dependent on the quality of the therapeutic relationship. There are several crucial key relationship variables. First, it is important that the therapist be seen as competent, trustworthy, and someone who has the best interests of the client at heart. The client must experience positive regard from the therapist as well as empathy and warmth. Moreover, therapists are expected to have interpersonal grace and be able to understand how they feel about their clients and maintain a helpful, professional stance.

Second, the unique interpersonal relationship provides a wonderful opportunity for psychosocial learning. Thus, the therapist ought to be skilled in the art of interpersonal process, and should be dialoguing, when appropriate, about the way the exchange is unfolding and eliciting narrative from the client about how his or her experience of the therapist relates to past experiences. The opportunity for this kind of conversation should be present

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in all meaningful therapy, certainly not just analytic therapies that emphasize working with transference.

Third, the therapist should be effective at tracking the nature of the relationship and pacing it appropriately. Interpersonal process comments need to be timed appropriately relative to the nature and development of the relationship. For example, strong feelings toward the therapist are much less likely to be present very early in the process. In addition, recognizing potential ruptures and subtle changes in the patient's attitudes about either the therapy or therapist is crucial to maintaining an effective working alliance.

With regard to Tina, the relationship factors will likely be central in a successful intervention. They are also likely to be complicated. It is reasonable to surmise that Tina is both feeling extremely vulnerable and at the same time desperately seeking guidance. In addition, given the context of her emergence into the therapy system via a referral for ADHD, it is highly likely that Tina will already feel frustrated with the system. If she wanted a label, a pill, and accommodations to foster her academic performance and she gets referred for the reflective work of psychotherapy, then there already is a mismatch between what she anticipated and what she is receiving. And, given that her anxiety symptoms are likely a function of the fact that her core emotional self is feeling overwhelmed by deep existential conflicts, it seems highly likely that she will be defensive about exploring such issues, especially when she is feeling the pressure to make a life decision quickly (i.e., to transfer or not). Because of all of these factors, she likely will not have much tolerance for a slowly developing therapy (i.e., a therapy that does not help her feel grounded and better quickly). And yet there is the very real concern, which many therapeutic perspectives would emphasize, that a therapy that moves too quickly and a therapist who is too directive might short-circuit a key developmental task, that Tina needs to sort these issues out for herself, and that the job of therapy is to provide her with a context for doing so but not necessarily to be an advice-giving guide. The point here is that the decisions that will go into establishing a working relationship with Tina will have a number of potentially competing considerations that require thoughtful reflection. This point raises the question regarding the final elements of TEST RePP, which involve a description of the key processes and principles that ought to guide practitioners in their work.

Processes and Principles

The last two elements of TEST RePP remind practitioners of how to be guided by their knowledge systems. Historically, the emphasis on empiricism has been so strong in certain domains (i.e., academia) that the message seemed to be that rigid adherence to specific procedures enacted by a

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practitioner following a step-by-step treatment manual were the key to scientific treatments. Thankfully, it now appears that the majority in the field are moving away from the attempt to reduce the therapeutic process to a series of prespecified steps, like what one would do when baking a cake, and more toward a view that recognizes therapy as an organic process that should not be overly structured like some algorithmic recipe. The latter has long been the model of humanistic and psychodynamic practitioners and is now becoming the general way many cognitive–behavioral practitioners operate. For example, acceptance and commitment therapy, a new wave cognitive–behavioral treatment, emphasizes a set of guideposts for clinicians as they form a relationship and foster commitments toward valued goal states (Hayes & Spencer, 2005).

"Processes and principles" is an attempt to remind wise practitioners of the guideposts that are shaping their work and orient them toward the rest of the TEST RePP formulation. With regard to processes, I emphasize three broad domains of process that I encourage students to keep in mind as they make decisions about what to do in their psychological interventions: (a) awareness, (b) acceptance, and (c) active change. Central to all therapeutic encounters is assessment—problem formulation and fostering systematic awareness in relative parties regarding the nature of the problem and the variables that are contributing to it. Human behavior is enormously complex, and humans notoriously are unaware of how much they do not know or understand. Much of the work of a psychologist is the process of developing a shared formulation that fosters clarity about the current situation. As such, a key treatment process variable for the psychologist to keep in mind when making decisions is awareness, in terms of understanding what level of awareness the client has, how greater clarity might be achieved, and self-reflective awareness of the psychologist.

Although traditionally psychoanalytic practitioners deemed awareness (or insight) as fundamental to a successful intervention, it is now generally understood that treatment must be geared to more than fostering awareness. The other two process variables, acceptance and active change, are both quite complicated, but they can serve as guideposts to the process of therapy. For example, learning to accept the aspects of the world that cannot be controlled is now broadly recognized as a key ingredient to mental health. The rise of mindfulness as a key ingredient to many therapeutic perspectives is a testament to the centrality of enhancing capacities for acceptance. And for as long as people have being doing therapy, acceptance of past losses, unfinished business, failures, or traumas (usually via fostering a more compassionate attitude) and of warded-off feelings have been salient aspects of the therapeutic process.

Of course, sometimes people need to actively learn how to be different so that they are in a better place to flourish and avoid the vicious,

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maladaptive cycles associated with their distress and impairment. When this is the case, the focus of therapy is on fostering active change. Individuals often need to learn to do things differently, whether this involves altering a maladaptive habit, training themselves to think differently, or developing a new relational skill. Here, understanding the process of human change is crucial, including recognizing the client's stage of change, how gradual and dramatic change can happen, and how changes can be maintained. The twin processes of acceptance on the one hand and active change on the other can seem almost contradictory. However, it is worth noting that both psychodynamic (Wachtel, 2011) and cognitive–behaviorally oriented (Linehan, 1987) practitioners have helpfully pointed out that acceptance and change can be thought of as existing in dialectical relationship to one another. This dialectical emphasis offers a more useful holistic view of the two processes than when they are viewed separately or in conceptual contrast to one another.

With regard to Tina, issues of awareness, acceptance, and change are all very salient. Sooner rather than later she needs to develop a better way of understanding her character and her situation and the origins and nature of her anxious symptoms. It seems likely that she lacks awareness about many of the features that are contributing to her distress, and if so, this needs to be addressed. At the same time, she needs ways of coping with her immediate problems that will help improve her functioning. My approach would be to take an active stance, helping Tina in a fairly direct way to come as quickly as possible to the understanding of her situation that is spelled out in the formulation described earlier. That is, I would likely use the approach of a "therapeutic assessment" (Finn & Tonsager, 2002) to attempt to generate such an understanding. From there, a shared plan could be developed that teaches her evidence-based strategies to (a) reduce her test anxiety; (b) enable her to increase her social support; and (c) adopt a longer term, hopeful perspective about what she might learn about herself in the context of this difficulty with adjustment. If this stage was initially successful and her symptoms were stabilized, then a focus on her core identity, purpose in life, and relational style and needs could be employed to build a deeper, more aware and resilient character structure that would enable her to make more adaptive interpretations and decisions, both in the short and long term.

The final "P" in TEST RePP stands for principles. It serves two related functions. First, the goal is to remind budding practitioners that they are guided by principles—values, goals, and knowledge bases—and that effective clinical decision making involves a frame that keeps these ideas salient and keeps the practitioner reflective and aware of his or her actions. The second function of "principles" is to help elucidate the more specific guiding frames that inform practitioners regarding their practice. It encourages

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them to consult both the literature and existing practice guidelines in their work. A sample of key treatment principles is offered in Appendix 11.1.

SUMMARY

If we are to produce ethical, self-reflective, and effective professional psychologists, we must be able to teach them the capacity to deeply answer the questions "If this is the case, what should you do and why?" and "In that situation, why did you do what you did?" These basic questions provide the frame for thinking about clinical decision making, and it is crucial that practitioners of psychotherapy have solid justification systems that guide them.

The field of professional psychology has historically not attended systematically to the process of clinical decision making as much as other health care professions, such as nursing and medicine. In addition, the field has often been characterized as being split between empirical and romantic visions of practice, with the former emphasizing decisions grounded in data derived from the scientific method and the latter emphasizing the deep, intuitive skills of the seasoned practitioner. It is time that we transcend this old dichotomy and move toward a different conception of science and a more rationalist approach to intervention. It has always been the case that the only effective bridges between the worlds of research and practical knowledge are found in concepts and theories. Thankfully, for the first time, there are comprehensive, scientifically grounded visions for human psychology that effectively bridge to the world of practice. Thus, we are set for a new era of unification and synergistic growth between the fields of professional practice and human psychology.

This chapter has outlined some of those emerging perspectives and articulated how a unified view of practice and human psychology can give rise to a scientific humanistic perspective on decision making that speaks both to methodological issues of precision, reliability, and validity and to broader philosophical questions. There is also now a model for conceptualizing the human condition that transcends the traditional midlevel paradigms and affords practitioners a systematic approach to conceptualizing that is grounded in scientific rationality.

APA attempted to bridge the disputes between clinical researchers and practitioners with its guidelines for EBP, which emphasizes the three domains of best available research, clinical experience, and patient values in the particular cultural and policy context as being the primary sources that practitioners ought to be relying on when developing their interventions. However, more specificity is needed in helping students approach their clinical decision making about psychotherapy interventions. The reason for this is that

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the vast field of psychotherapy is conceptually fragmented at a multitude of levels. To address the conceptual fragmentation, a heuristic frame going by the acronym TEST RePP, which stands for "Theoretically and Empirically Supported Treatment and Relationship Processes and Principles," was developed that attempts to delineate the key conceptual elements that ought to guide decision making in developing and enacting such psychotherapeutic interventions. This perspective allows future practitioners to address the competing paradigms in the field, provides them with an integrative metaperspective, and allows them to appreciate and consider major debates in the field of psychotherapy research (e.g., medical model vs. psychosocial process). We hope practitioners informed by this model will make more effective clinical decisions.

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APPENDIX 11.1

The following list offers some of the key principles that guide effective psychotherapy. This attempts to breakdown the elements of TEST RePP in a way that is congruent with the empirical literatures in psychology and psychotherapy.

1. *Set an appropriate, ethical frame.* Psychotherapy is a relationship that is grounded in professional obligations and constraints, and it is crucial that all stakeholders involved understand the purpose and function of the relationship; issues of confidentiality; financial reimbursement; general focus of the work; and, where appropriate, expected time frame.
2. *Begin to foster a strong therapeutic relationship.* It is crucial that the psychologist exhibit a level of competence and respect toward the client such that the client feels valued and heard and believes the therapist can help where appropriate.
3. *Identify cultural context variables.* Consideration of the social construction of identities is crucial for both the therapist and the client. When the client and psychologist do not share the same broader cultural background, particular attention should be paid to how the influence of cultural context might lead to differences in communication patterns, expectations of roles, core values, and so forth.
4. *Identify client values and hopes.* The central goal of psychotherapy is to enhance adaptive ways of living, a central element of which is the client's value states of being.
5. *Identify risk of harm.* A fundamental tenet of practice is to minimize the risk of harm. A practitioner must be reflective about the possible ways an intervention might have unintended side effects. If there is anticipated possible harm, all parties should be informed, and that must be carefully weighed against probable benefits.
6. *Begin to formulate an ongoing case conceptualization.* A comprehensive assessment includes a general categorization of the major symptoms, character, key developmental factors, relevant biological and sociocultural variables, current relational context, and major stressors and affordances in the environment. In addition, a systematic approach to assessing relational style, identity, and presenting problem (i.e., diagnosis) should be included.
7. *Begin to identify realistic, adaptive treatment outcomes.* The therapist should work with the client to identify therapy goals in

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the context of the client's values and stage of change within a holistic, biopsychosocial, developmental conceptualization. In cases of excessive maladaptive symptoms, these goals are often straightforward (e.g., reducing levels of depressive symptoms). Sometimes, however, goals need to be more focused on awareness (i.e., increasing values or clarifying identity issues) or acceptance of past losses or current injury.

8. *Tailor treatment to level of client functioning.* More than anything else, treatment outcomes are determined by the client's history, level of impairment, and attitude about therapy. It is crucial that the goals of therapy consider this fact. It is also recommended that therapists increase their levels of direction and guidance when impairment is high.
9. *Consider therapy as a nonlinear process of fostering awareness, acceptance, and compassion and of engaging in active efforts to change.* Although therapists should have a clear road map of their work, it is also the case that therapy is rarely a simple, linear, stepwise process. Instead, many times individuals have symptoms that are the consequence of tangled and confused psychological processes that require an unfolding of awareness, acceptance, and active change, in varied sequences.
10. *Reducing maladaptive levels of negative affect.* When the major treatment goals include reducing the levels of negative affect, the treatment plan should consider the following: (a) altering maladaptive antecedent cognitive appraisals, (b) identifying layers of emotional–experiential processing and preventing problematic avoidance (i.e., foster exposure and acceptance), and (c) facilitating action tendencies antithetical to the dysregulated emotion (teaching clients to relax when they are anxious or becoming active and to focus on mastery or pleasure when they are depressed).
11. *Altering problematic aspects of relationships and identity.* When the major treatment goals include altering aspects of identity and maladaptive relationship patterns, the practitioner should consider (a) patterns between old relationships and current relationships, looking especially for vicious relationship cycles; (b) role functions and conflicts relative to core relational needs; (c) developing awareness of purpose in life, existential narratives, and problematic core beliefs and considering ways to renarrate self or life in a healthier way; (d) fostering compassion for both self and other and flexibility in human relating; (e) making conscious defense mechanisms

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and working toward restructuring maladaptive defenses; and (f) ways to increase agency, coherence in identity, or coping self-efficacy.

12. *Monitor changes in desired goals*. Once problem areas and treatment goals are identified, therapists should monitor changes in symptoms and problem areas (e.g., with appropriate test instruments).
13. *Monitor client satisfaction and attitudes about the therapist*. In addition to monitoring symptom outcomes, it is crucial that regular feedback is solicited about the satisfaction the client has with the therapist and the treatment. Ideally, there should be intermittent opportunities designed to solicit authentic opinions about the treatment.
14. *When there are ruptures or failure to make adequate progress, process this and be open to making changes*.
15. *Plan for termination, monitor changes, and taper therapy if necessary*. Therapy, especially when financed by an outside source, should be conducted in a time-sensitive way. It is the obligation of the health care professional to foster treatment advances as efficiently as possible and not to extend treatment beyond what is necessary.

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