The Coalition

www.wacoalition.org

Advocates for Ethical Mental Health Care Summer 2005

Editor's Corner

Peter N. Moore, Psy.D.

The Queen is …. Well not exactly dead, in fact not even close! She's off gallivanting around the world. **Sue Wiedenfeld**, the Coalition's long time board chair and organizational glue has taken a sabbatical. She, her husband and son are sailing where their hearts lead them. You can read Sue's goodbye missive on page 5. In the meantime, long live the King, that is Ken King who is our new board chair. He is filling in ably in Sue's absence. Ken, a psychiatrist practicing on the East side recently gave up his post as chair of SIPSI. Hopefully he doesn't feel like he's hopping from the frying pan into the fire.

Just when you thought it was safe to enter the water….. For several years now managed care has been in retreat. While not dead, it is no longer its former force. GreenSprings is non-existence, Regence has dumped Value Options for its non-Boeing Selection plans and even Value Options is no longer hassling professionals about sessions. Now I fill out the requisite paperwork and receive the authorizations, questions no longer asked. But rearing an ugly head with a benevolent mask is **evidence based practice** (EBP). Under the guise of public protection, a movement within the mental health and insurance communities seeks to limit services to only those that can be empirically verified. While no patient wants quackery and no therapist wants to provide ineffective let alone harmful therapy, EBP appears to be a Trojan horse

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Who Ya Gonna Call !?!?!??!

Coalition Helpline: 206-444-4304

Who's My Legislator: 1-800-448-4881 (State and Federal)

Legislative Hotline: 1-100-562-6000

Evidence-Based Practice: A Wolf in Sheep's Clothing

Laura W. Groshong, WSCMHPC Lobbyist

During the 2005 Washington Legislative Session which ended April 25, there was a move to make "evidence-based practices" the standard for accepted mental health practices in Washington state in statute. WSCMHPC opposed this move as it would have had a chilling effect on many of the current ways clinicians work and prohibited treatment methods that are difficult to research but have proven benefit to patients. This article will summarize the difference between "evidence-based practice" and "relationship-based practice" and why the former is appealing when developing public policy.

The rise of "evidence-based practice" (EBP) based on the work of David Sackett and others in "evidence based medicine" (EBM), represents an attempt to apply mental health research to mental health practice on strategies for solving mental health problems. The basis for EBM was a stronger tie between research and practice, so that medical practices could be justified through the most rigorous research available. Medical procedures have been readily tested in randomized controlled trials (RCTs) and double blind research tests. Mental health treatment, however, does not lend itself as readily to these types of research models. Mental health "procedures" are not comparable to medical procedures. Both may have goals of symptom relief and curing of

underlying conditions, but the relationship itself is seldom the agent of cure in medical procedures. This article questions the validity of the EBP paradigm, which assumes that mental health patients improve because therapists use researched techniques and procedures, not because of the healing relationship between patient and therapist. While recognizing the importance of medications as a component of mental health treatment for many patients, the focus is on the interaction between the patient and therapist and whether emotional healing occurs through a "directive distance" or "mutually engaged" relationship between the patient and therapist.

The type of mental health treatment that is most useful to a given patient will depend on four factors. These include: 1) the degree of **emotional development** that has occurred prior to treatment, including the capacity for attachment, autonomy, and self-regulation; 2) the **physiology and neurology** of a given patient or "hard-wired" physical, including brain, functioning; 3) the patient's **subjective experience** of his or her own body and emotions, including the capacity for, and prevalence of, pain; and 4) the patient's **capacity to accept new emotional experiences with others** (Mauer, B. "The Four Quadrant Model and Evidence-Based Practices", Report to the National Council for Community Behavioral Healthcare, 2003.) Generally, the lower the level of emotional development (1) and the higher the level of "hard-wired" physical problems (2), the higher the chances of serious mental disturbance will be. However, the patient's disturbed view of self (3) and others (4) can also create serious emotional disorders, which may or may not interfere with a patient's ability to function successfully in the world.

The more disturbed the patient, the chances are that the patient will have more difficulty engaging as a participant in the therapeutic relationship. All therapists need to be directive if the safety of the patient is at risk, but a directive approach interferes with the development of an emotional attachment in the patient/therapist dyad where both patient and therapist are participants. There is a parallel between healing in nursing as described by Jean Watson and Carol Montgomery, and the mutually engaged healing in mental health treatment. A quote from Watson on "relational communication" illustrates this similarity: "Relational communication focuses on analysis of a relationship rather than of the individual during a given communication, i.e. the communication is the relationship. An understanding of the **report aspect** and the **command aspect** is necessary to the understanding of relational communication. The report aspect is the content of the message, the command aspect deals with the relationship between the parties communicating. For example, a clerk in a hospital might ask a patient for their insurance card. While the content of the message is clear, the clerk and patient will also begin a process of communication which will influence how the patient feels about the care institution." (Watson, J. (Ed.) (1994). Applying the art and science of human caring. NY: National League for Nursing)

EBP necessarily deals with the "report aspect" of the relationship between patient and therapist. Relationships are not what is being evaluated in most research, or the impact of the relationship on the patient's emotional disturbance. This problem was noted in the Journal of Consulting and Clinical Psychology in 2003 that "deciding which therapy to use for a client should entail more than just picking the therapy with the most documented research support." ("Comparing the effectiveness of process-experiential with cognitive-behavioral psychotherapy in the treatment of depression." By Watson, Jeanne C.; Gordon,

Please see EBP on p. 7

Threats to Our Humanity

Peter N. Moore, Psy.D.

Just when you thought it was safe to go back into the water a **new shark threatens** our profession. Managed care is arguably a shell of its former self. Many practitioners have either opted out of the system entirely or made their peace with it. And it is easier to make peace with it; forms are far less complicated and receiving authorization renewals is much more routine. No longer do I have to run the gauntlet of case managers to acquire additional sessions.

However, in the summer issue of *Psychotherapy* the journal of the American Psychological Association's (APA) Division of Psychotherapy, psychologist Nancy McWilliams presents a cogent description, analysis and prescription to deal with a growing cultural disorder that threatens our humanity as therapists.

McWilliams argues that psychotherapy, beginning with Freud has always been a subversive enterprise. Freud's psychosexual model of human development and articulation of the unconscious drives shook the sensibilities of the Victorian era. Traditional psychotherapy values have traditionally been at odds with the values and beliefs that "suffuse contemporary, technologically advanced, market driven Western cultures." But now we are in danger, she argues, of being **subsumed by those market morals**.

She presents a very nice synopsis of the **principles that guide psychchotherpy** across disciplines. These values are "self-understanding, authenticity, empathy and compassion, egalitarianism, adaptation to unchangeable realities, growth in agency and personal responsibility, acceptance of normal dependency, and respect for others as subject rather than object."

However, she argues that:

A threat to traditional therapeutic values is the pervasive message that psychotherapists should not be trying to understand and mend the broken heart, or heal the tortured soul, or promote the acceptance of painful realities. Instead we should be trying to medicate, manage, reeducate, control, and correct the irrational behavior of people whose suffering is inconvenient to the larger culture.

For **proof**, as if we needed it, that those insidious commercial standards are permeating popular culture, she points to how drug manufacturers are directly marketing to the public and so the public is "regularly told that (drugs) will cure most of the more uncomfortable symptoms of being human." She also encapsulates modern commercial messages into 18 pithy statements. My personal favorite is "freedom inheres in having more choices rather than in the capacity to decide what is a choice worth having." Others include "the cure for a bad relationship is separation," "all problems are solvable by practical ingenuity," and "if you are rich enough…famous enough… beautiful enough, you'll be happy."

McWilliams fears that psychotherapy is quickly losing its subversive power to challenge these corporate, materialistic principles. She laments that the "commercial culture…has devoured us, redefining the complex project of psychotherapy in terms of the most simple-minded notions of how one person influences another and subordinating the therapist's humanity to the interests of social control and short-term cost saving."

What forces seek to co-opt us? McWilliams offers **four culprits**: the revamping of the

DSM-IV to accommodate research interests, the belief in the "magic of privatization," the role of evidenced based medicine, and "the worsening estrangement" between researchers and clinicians.

The last three offenders are of particular relevance to Coalition members. Stating that "half of those seeking therapy have a personality disorder," McWilliams argues that **market driven mental health services** have "contributed to an attitude of denial about the complex etiologies of many conditions" and turned therapists into " 'providers' and even 'vendors', and vendors who served the 'consumers' of psychotherapy for longer than a few sessions were unceremoniously dropped from the lists of therapists whose services insurance companies would cover." McWilliams echoes the Coalition's years of warning: "quality mental health care (and we would argue ethical care as well) … is disappearing."

While arguably insurance and managed care companies have retreated somewhat in the face of an outcry of professional and client criticism, the specter of evidenced based practice (see Laura Groshong's article on p1) rears its head. She traces the growth EPB to researcher's attempts to demonstrate that psychotherapy is at least as effective as medication. Consequently, researchers have focused on brief therapies and "with remarkable swiftness their work was expropriated by insurers to argue that if one *must* have psychotherapy, there are empirically supported, short-term ways to bring about changes that experienced practitioners, not to mention several decades of outcome research, have determined to require both time and trust.

Finally she blames what she sees is a growing rift between academics and clinicians as also fostering the move to use only evidence based therapies. Fewer researchers in clinical graduate programs, at least in psychology, see fewer patients. Academics she worries view clinical work with increasing contempt. They see us treating the "worried well" and "raking in the money" (Sometimes referred to as the Woody Allan syndrome.) Consequently, some, including a "powerful and vocal contingent" within APA for instance, argue that a psychologist could be violating the ethics code if they did not use an evidence based treatment for a condition to which it applied. This move has caught the attention of public media and even some in our legislature.

So what to do. McWilliams offers several "prescriptions" to treat this disorder. The Coalition is already offering two of her remedies and this issue of *the Coalition* and Laura Groshong's efforts with legislators begins a third front.

McWilliams argues for one of the major goals of the Coalition: psychotherapists across disciplines (*and we would add consumers of our services*) need to "**join forces**… to articulate a vision of mental health care that is more humane and less technocratic." Since its inception the Coalition has brought practitioners from all mental health disciplines to fight against "influences that diminish what any of us can do for our fellow human beings."

McWilliams also calls on therapists to be **"politically proactive."** The Coalition's increasing political focus over the years has unfortunately alienated some of our members. However, McWilliams believes as we do that we need to "take the concerns of ordinary people and enlist their enlightened self-interest on the side of investing in the survival of a humane, sophisticated psychotherapy." Laura Groshong's tireless efforts on behalf of the Coalition in Olympia have educated legislators on the benefits of mental health services and helped stem the tide of managed care.

Finally, McWilliams says that our professions need to challenge the assumption that longer term psychotherapy lacks evidence of effectiveness and that we need to advocate for outcome research that has not only good internal validity but that includes other sources of data such as naturalistic observation. Hewing to the gold standard of randomized double blind studies with manualized treatments winnows out the very folks that many of us see in our practices; people with multiple diagnoses and dysfunctional character traits. As McWilliams states, ironically, it is the academic researchers who wind up treating the "worried well" while the rest of us in the trenches wrestle with severe and chronic dysfunction while battling the mechanization of mental health.

McWilliams warns: **"When we dutifully and compliantly restrict our role to curbing symptoms that interfere with our clients' adaptation to their environment, rather than considering that their symptoms may signal some shortcomings of that environment, our work has been compromised both practically and morally. We have become unwittingly complicit in redefining suffering in a way that benefits vested economic interests over our patient's best care."**

Until We Meet Again

Sue Wiedenfeld, Ph.D. Coalition Board Chair

Happy summer to all! I am excited to say that this will be quite a different summer for me and my family as it is the beginning of a year sabbatical. We will be going to Alaska and back on a boat for the next three months. After that we will travel briefly in the U.S with the intention to go to New Zealand for the winter (their summer—maybe we can get by with no winter at all!). We haven't worked out the details for the rest of the trip but hope to include the Galapagos, Israel, parts of Asia and a bit of Europe as our son has just studied Greek and Roman history and architecture. Needless to say, we are quite excited in anticipation of this adventure. In the meantime, back on the home front,

Ken King will be spearheading Coalition efforts for the next year. I am sure we all will be interested to see how the first year of implementation of parity for mental health goes.

We have some exciting many year plans beginning to come together at the Coalition such as our email action network, a Coalition directory, and our newly refined website. Tune in to future newsletters for details. And I leave with best wishes that each of you may also have some grand adventures over the next year!

Eds. Note: You can keep up with Sue's sailing adventures from the cozy comfort of your computer. Log on to www.suealhad.blogspot.com

Editor's Note *cont'd from p.1*

that seeks to severely limit our services. On p. 1 Laura Groshong, Coalition lobbyist explains what this new potential threat means for us.

One of the perks of being the editor is that I have a lot of say about what's said in our Newsletter. Recently I came across a series of articles in the Summer 2005 issue of the journal *Psychotherapy: Theory, Research, Practice, Training* which is published by the Psychotherapy Division of the American Psychological Association. The articles by Norcoss speak to the **"threat to traditional therapeutic values."** EPB is just one of those threats. I was so energized by these articles that present a cogent diagnosis, etiology, and "treatment plan" for the malaise afflicting the mental health community, I summarized them for you. I hope you find their ideas as stimulating as did I.

Fall is around the corner. Time to send the kids off the school and dig out the sweaters amongst the mothballs. It will also bring your annual renewal. Susan Cohen, our crack membership coordinator will soon be mailing your renewal notices. Please, please, please do not let them languish on your desks lest they become forgotten. Update your information, let us know what you do not want in a membership directory and thank you for your renewal check. Speaking of membership directory, Lee Holt is putting the finishing touches on one now. Soon you will be receiving the first ever Coalition Membership Directory. All the more reason to return those renewal notices.

In November the Coalition will have its **annual meeting**. We are most fortunate to have long time supporter and member Steve Feldman, Ph.D., D. be our keynote speaker addressing ethical issues facing practitioners. Dr Feldman is both a psychologist and a lawyer and so he is well qualified to speak about ethics. I have had the pleasure of being in two of his workshops. I can say from experience that Dr. Feldman gives an interesting and entertaining talk. He will make learning about ethical conundrums much less painful and much more interesting for you. But wait, there's more. YOU have the opportunity to shape his talk. *You are invited to send topics or situations that you would like discussed.* Send the questions and topics you would like him to address. You can call the Coalition at ( ) or send and email to **SECOHEN100@aol.com .**This is a great opportunity to make the meeting relevant to you!

MARK YOUR CALANDARS NOW !
COALITION ANNUAL MEETING- ETHICS PRESENTATION

When: November 5th. 9:00 – 11:00
Where: Good Shepherd Center in Wallingford

Steve Feldman, Ph.D. will be speaking on **ethical issues and dilemmas** facing practitioners. Dr. Feldman is a practicing psychologist and expert in legal matters facing the mental heath community. **Continuing Education** credit for all disciplines pending.

Coalition Members: **Send in your questions, concerns, and topics of interest** to make this presentation relevant to you. Call the Coalition Help Line at 206. 444.4304 or e-mail Susan Cohen at **SECOHEN100@aol.com** with Feldman in the subject line.

EBP continued from p. 2

Laurel B.; Stermac, Lana; Kalogerakos, Freda; Steckley, Patricia. Journal of Consulting & Clinical Psychology. August, 2003, Vol. 71(4) 773-781.)

Why have relational communications been discarded in considering public mental health policy? Mental health treatment is harder to fit into the public sector than physical medicine because the relationship models of treatment are less amenable to research which can delineate best practices than physical medicine. EBP has apparently given public policy a way to integrate mental health treatment and public policy by focusing on the "report aspect" of what is being communicated and codifying this communication. However, according to one author EBP "will falter on organizational and epistemological barriers.", i.e., the loss of the "command aspect" or what is being communicated emotionally by the patient and therapist ("Evidence-Based Practice in Mental Health: Practical Weaknesses meet Political Strengths." By Tanenbaum, Sandra. Journal of Evaluation in Clinical Practice, May, 2003, Vol. 9, Issue 2, p. 287.

The standards of accepted mental health practice as defined by the Substance Abuse and Mental Health Service Administration (SAMHSA, 2003) have three other ways of identifying methods of treatment. They are (including EBP) as follows:

"**Evidence-based practices**" means a program or practice that has had multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population.

"**Research-based practices**" means a program or practice that has some research

demonstrating effectiveness, but that does not yet meet the standard of evidence-based practices.

"**Consensus-based practices**" means a program or practice that has general support among treatment providers and experts, based on experience or professional literature, and may have anecdotal or case study support, or that is agreed but not possible to perform studies with random assignment and controlled groups.

"**Emerging best practices**" means a practice that presents, based on preliminary information, potential for becoming a research-based or consensus-based practice, particularly with regard to diverse populations."

The last three categories would support the use of relational-based practices and should be included in any assessment of 'what works' in mental health treatment.

To summarize, EBP as it is currently conceptualized, seems to limit recognition of how the patient feels about the relationship, and will therefore limit the effectiveness of the relationship and the treatment. Most clinicians realize the importance of including the relationship as a topic in mental health treatment, based on the assumption that the relationship is a primary factor in what is therapeutic. WSCMHPC hopes that the inherent limitations of EBP with regard to the therapeutic relationship will be considered, and that mental health research and practice can become a cohesive whole, without either being sacrificed.

The Coalition of Mental Health
Professionals and Consumers
PO Box 30087
Seattle, WA 98103

Join or Renew Your Commitment to Protect Mental Health Care

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_____

Phone: _____-_____-_____ Fax: _____-_____-_____

E-mail_____

Member: $65
Student: $15
Consumer: Free
Organization: $124

Willing to help with specific tasks: YES _____

OK to publish information in a directory ? YES _____
NO _____