Sperry's "Achieving Evidence-Based Status for Adlerian Therapy: Why It Is Needed and How to Accomplish It": A Response

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The Journal of Individual Psychology, Volume 74, Number 3, Fall 2018, pp. 287-295 (Article)

Published by University of Texas Press
DOI: *https://doi.org/10.1353/jip.2018.0022*

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Abstract

This article is a response to Len Sperry's paper in which he lays out a compelling case and rationale—as well as the steps in a process—for helping Adlerian therapy to achieve the status of evidence-based practice. The pragmatic importance of Sperry's proposal cannot be ignored if the model is to survive in a clinical world largely controlled by managed-care systems, insurance, and government regulation. Still, the actual value of evidence-based practice for clients can easily be challenged, and as in other helping professions, a model for practice-based evidence might serve individual clients or single client units (e.g., couples, families, groups) much better.

Keywords: Adlerian therapy, evidence-based practice, interventions, practice-based evidence, replacement therapy

Sperry (2018) notes correctly that the very survival of Adlerian psychology as a therapy model depends on the achievement of an officially recognized evidence-based practice (EBP) status. EBP is defined as "the integration of the best research evidence with clinical expertise and patient values" (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000, p. 2). On the face of it, this seems like both a worthy and a fitting goal for any of the health-care professions, and yet there are many in the field of psychotherapy who avoid embracing it altogether. It simply does not matter, however, whether one likes the concept and the treatment approaches associated with EBP; evidence-based practice has permeated all health-care systems and programs, and it is here to stay. Those paying for health-care services want treatment to be viable, effective, and efficient. To be clear, the emphasis in health care is on treatment and treatment interventions, not on the beauty or elegance of the theoretical model that supports it. This emphasis on treatment works in health-care models where identifiable causes and/or effects can be cured, managed, or controlled.

A person with type 2 diabetes, for example, will have a measureable elevated blood-sugar level: This is because the individual's insulin is no longer effectively processing the sugars and/or carbohydrates that he or she ingests. Diet, exercise, and specific medications can be used to manage and control

The Journal of Individual Psychology, Vol. 74, No. 3, Fall 2018

Editorial office located in the College of Arts and Sciences at Lynn University.
Published for the North American Society of Adlerian Psychology.

blood sugar, and the treatment is, for the most part, effective with a wide range of people, regardless of gender, race, ethnicity, or age. I am not saying that family history, genetics, and other individual and cultural differences do not matter in the application of even medical treatment, but medical disorders are far more likely to be described and measured objectively than are psychological disorders (Taylor, 2007). In the medical and biological sciences, focusing on treatment outcomes guarantees that patients get the best possible intervention, as demonstrated in large clinical trials that include both comparison and control groups. When these trials involve medications, there is the federal Food and Drug Administration (FDA) to assess and verify the studies that are presented for approval.

In contrast to medical disorders, the language of psychological disorders is more subjective and often metaphorical. We do not know the precise etiology of even common psychological disorders, such as anxiety or depression, and the manifestations of these psychological disorders are often quite different from person to person. Even the medications used to treat psychological disorders vary greatly from individual to individual in dosage, effectiveness, and side effects. In contrast, a medication regimen for high cholesterol, elevated triglycerides, or the more complex problems involved in cardiology, for example, can be developed for the patient, and that person can often maintain the regimen with success for years, even decades. The effective dosage and use of psychotropic drugs, however, is far less precise and can vary in effectiveness, working sometimes for extended periods and sometimes not at all. Even when psychotropic drugs work to control one set of symptoms, the development of severe side effects, for example, akathisia—a severe shaking, like the person is coming out of her or his skin—can be so painful as to require the discontinuance of the treatment altogether. Unlike physical, biological, or medical disorders, effective treatments through therapy and/or medication are not so easily or universally defined.

Several studies have demonstrated that common factors across psychological therapy models account for more success than specific treatment interventions (Asay & Lambert, 1999; Blow, Sprenkle, & Davis, 2007; Sprenkle, Davis, & Lebow, 2009), with the therapeutic relationship having the most impact of those aspects of therapy that the counselor or therapist can control (Margison et al., 2000). Indeed, who the client is and the relationship the therapist forms with her or him accounts for most of the success in therapy (Duncan, Miller, Wampold, & Hubble, 2010). Specific treatment techniques account for only about 8% of success (Lambert, 2013). We know a lot about what constitutes a great therapeutic relationship: acceptance, compassion, empathy, kindness, presence, validation, and warmth are a good start—also confidence, clarity of purpose, and experience matter. And what about the client? It turns out that clients who are women, educated, financially stable,

and have strong social and family support do better in therapy than do those without those attributes and resources. These elements of success in therapy function across all models of therapy, regardless of the treatment interventions used. Although it is possible to define an effective counseling relationship in a manner that could be assessed and measured in clinical trials for EBP status, the result would not differentiate among the various models that include these variables. It would certainly not validate Adlerian therapy or any other as the model of choice.

The theory behind EBP is that (a) there will be high-quality research that can be reviewed, assessed, and integrated into therapeutic practice; (b) the therapist will be able to accurately assess the individual client, identifying the outcome goals and treatment strategies, collaboratively with the client, taking into account all the biological, psychological, social, and cultural components of the individual; (c) the therapist will then be able to access the literature and evidence of effectiveness on the basis of large clinical studies; and (d) the therapist will be able to translate the evidence based on large samples to the individual client being treated. Let's examine each of these.

In the more physiological (objective) health-care fields—from various fields of medicine to allied health care (e.g., speech–language pathology, nutrition, physical therapy, occupational therapy), PICO works; that is, it is possible to identify a problem population, specify a desired outcome, and compare treatment interventions in relation to that desired outcome (see Heneghan & Badenoch, 2002). Using this method, a clinical research question might be "Will Zoloft be more effective than Prozac in reducing depression in children under the age of 10 who have no other physical or clinical disorders and without intervening therapy?" The question identifies the problem population, the medical interventions to be compared, and the desired outcome. Because depressed children younger than age 10 will not have dramatically different physiologies, the answer, if one is obtained, can presumably be applied across the population with little or no variance.

When we consider psychotherapeutic interventions, however, there is the good news that counseling and therapy seem to be effective, but in the comparison, no particular form of treatment is any better than another. Again, the common factors involved in a therapeutic relationship account for more success in therapy than specific interventions. This is perhaps why, in psychotherapy, there is a paucity of high-quality research related to comparative models. Clinical trials testing one model against another are extremely expensive and hard to control. Most clinical trials, therefore, are done through federal grants, and long before such grants are issued, there must be multiple levels of earlier studies leading up to the clinical trials: Such studies include exploratory studies that examine a potential intervention (e.g., observational or feasibility studies); efficacy studies in which the usefulness of the intervention is tested under conditions allowing for greater

experimental control; and then, and only then, effectiveness studies in which an intervention's usefulness is examined under conditions of everyday practice (see Robey & Schultz, 1998).

In the private sector, pharmaceutical companies and other health-care businesses fund large-scale research on their potential products, but there are few clinical trials devoted just to psychotherapeutic practice. So what does being an EBP mean in relation to psychotherapy? It does not mean that therapy Model A is more effective than therapy Model B. Rather, it means that both Model A and Model B have been shown to be effective when working with a specific diagnosis.

Almost all research leading to EBP status in psychotherapy is conducted as pilot studies with smaller samples than would be used in actual clinical trials. One reason these trials tend to be smaller is that the identification of clients with a single diagnosis is increasingly less common. Indeed, dual diagnosis is the norm. Depression and anxiety, for example, often go hand in hand, as do bipolar I disorder and psychotic experiences. Drug and substance abuse is also a common co-occurrence in psychological disorders. Clarity of diagnosis is usually less reliable in psychopathology than the physical or medical sciences, because diagnosis in psychotherapy depends on subjective reports from and the cooperation of the client, which in turn depends on a positive relationship with the therapist, which is often not achieved in the first session of therapy. Too often, the same individual interviewed by two separate therapists will receive two different diagnoses. The subjective orientation of the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (DSM-5) (American Psychiatric Association, 2013) is literally designed to be clinician friendly and allow for flexibility in diagnosis.

Even while the American Psychological Association (APA), the American Speech–Language–Hearing Association (ASHA), and other allied health-care professions are publishing guidelines for evidence-based practice and embracing it, the American Counseling Association (ACA) has yet to do so—even more so for single therapeutic models, like Adlerian therapy. To move toward a focus and incorporation of EBP in our field will require a complete paradigm shift. In educational programs, that shift would make research for consumers one of the first courses in the curriculum, with an emphasis on how to ask focused questions; how to retrieve relevant literature; how to write integrative literature reviews; and how to read, assess, and compare outcome literature in psychotherapy. Courses throughout the curriculum—especially in clinical skills, case conceptualization, psychopathology, human development, trauma, substance abuse, crisis intervention, practicums, and internships—would all be based on reviewing literature in best practices and learning to take what has been tested and matching it to the skills of the therapist and the needs and goals of the client. Such a paradigm shift,

while desirable, is not likely any time soon in the counseling profession, but maybe it should be. And Adlerian therapy needs to be in the mix of EBP and participative in the development of this paradigm shift.

Is there an alternative to evidence-based practice? The answer is both yes and no. Let's get no out of the way as quickly as possible.

Pragmatically for probably the coming decade or two, designation as an EBP will determine which therapies get reimbursed and used in managed care and government-sponsored health care. It will be a really simple dichotomy: Your model is either EBP, or it is out. Given the current orientation of health care in the United States, for Adlerian therapy survival depends on being classified as an EBP. This is why NASAP in 2016 initiated the Adlerian Research Network under the direction and guidance of Bill Curlette. This is why NASAP members are also supporting a number of other efforts to design intervention studies.

Sperry's article has much to offer in this regard, providing both a rationale for clinical research and the steps to get there. He is correct that Adlerians have spent too much time focused on the elegance of our theory or philosophy while declaring that we are technically eclectic. To be clear, Adlerian therapy does have unique intervention strategies, including lifestyle assessment, disclosure processes, and more specific strategies and interventions, such as acting "as if," reflective acting "as if," and the push-button technique, to name a few. Indeed, Mosak and Maniacci (1998) provide a detailed list of Adlerian "tactics," and many of these intervention strategies could be the focus of EBP studies. What I like most about the Sperry proposal, however, is not the identification of intervention strategies and techniques unique to our model, but the focus on Adlerian pattern-replacement therapy. The goal is not simply to reduce or eliminate those compelling emotions (Rasmussen, 2010) like anxiety, anger, or depression, but rather to replace maladaptive patterns of living with more effective ones.

To be sure, Adlerians, like all clinical practitioners, need to learn to address symptom reduction and management and to engage crisis situations with first-order change processes—and Adlerians know how to do just that (Sperry, Carlson, Sauerheber, & Sperry, 2014). But the heart of the Adlerian model is in the recognition of movement patterns in meeting life's challenges and problems. It is about helping the person to adopt a more responsible, productive, and functional way of life based on the implementation of a community feeling and social interest in the face of life tasks. It is about replacing a maladaptive pattern with an adaptive one. This is also at the heart of what Rasmussen (2010) calls adaptive reorientation therapy (ART). Validating a pattern-replacement model is an ambitious goal for evidence-based research, but it is exactly the foundation on which additional evidence-based research studies can build.

I would prefer, of course, to stand the entire model of evidence-based practice on its head, to engage in practice-based evidence (PBE; Margison et al., 2000). Most often, PBE is promoted as an adjunct to engagement in evidence-based practices. In a field where the clinical relationship accounts for more therapeutic success than techniques, the goal for clinicians should be rational, clinical decision making. Here, the primacy of theory—indeed, the fullness and elegance of theory—takes center stage once again. If there is no evidence that one approach or intervention is more effective than another, then a fully developed theory of the human condition and human development is the most important guide to clinical practice and rational decision making.

Kamhi (2011) notes that the true scientific practitioner is always seeking a balance between certainty and uncertainty, between the confidence that one has in his or her approach to therapy and the room one allows for new information, new possibilities, and even complete paradigm shifts to enter into consideration. This balance is especially important in adapting what we do and how we treat individual clients or client units (e.g., couples, families, groups). Not everything "we have always done" is going to work out well with any given client. Tailoring treatment to unique individuals coming from unique backgrounds and different experiences of gender, race, culture, affectional orientation, and so on, is central to case studies and case conceptualization.

Practice-based evidence and its more systemic model of community-based evidence (CBE) requires a dedication to qualitative inquiries in therapeutic practice. PBE and CBE are based on the notion that the scholar-practitioner can bring questions of effectiveness right into the therapeutic relationship. It is paying attention to what works with a given individual or couple or family, reflecting on the meaning of interventions from one's theoretical orientation, and investigating the guidelines and interventions supported within the client's multiple systems, including local communities, cultures, religious affiliations, gender orientations, and age groups. PBE emerges when therapists record and review their sessions, collaborate with clients in evaluating the therapeutic experience, and note and validate growth and transformation across multiple sessions.

When Adlerians record and review a set of early memories with the client at the beginning of therapy and then again much later nearing termination, these therapists are engaged in a PBE exercise with the client. They are looking at changes that can be traced back to specific interventions or processes that made a difference. Almost all the early models of therapy were developed precisely from this kind of qualitative investigation.

In the end, therapy is never simply the application of evidence derived from large, carefully constructed clinical trials. Clinicians work with single individuals or therapy units, and each clinical case is different. Tonelli

(2006), seeking to merge EBP with PBE, developed a case-based approach with five avenues for achieving rational clinical decisions and a balance between certainty and uncertainty. The five areas can be adapted to therapeutic practice and serve as entry points into deciding what will work best with an individual client. First is empirical evidence: The practice of clinical therapy requires ongoing study and an openness to what other models and approaches are doing and achieving, to what clinical evidence actually tells us. Second, experiential evidence: Clinicians learn a lot about clients just by being present with them and fully engaging in a therapeutic relationship—by conducting lifestyle assessments, for example; what does experience tell you and how can treatment be tailored to the needs and goals of the individual? Third, bio-psycho-social-cultural case conceptualization and rationale (see Sperry & Sperry, 2012): Having a fully developed clinical theory to guide the choice of interventions is often more important than knowing what works with which disorders. Fourth is client goals: Always the ultimate guide to successful therapy comes from the collaborative identification of therapy goals. Last is systemic features: This is the consideration of the conditions beyond the individual (economics, race, ethnicity, culture) and part of the individual (gender, age, ability, affectional orientation) that affect the individual on multiple levels.

None of these areas of knowing has any greater importance than any of the others; they are all entry points into knowing the individual and deciding how to help. Which of these areas gains primacy at a given moment in time depends completely on the case at hand and on the rational, informed judgment and decision making of the clinician—a therapist who occasionally asks "Is this working for my client?" and "How will I know if it is or it isn't?"

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