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Reestablishing Clinical Psychology's Subjective Core

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The APA Presidential Task Force on Evidence-Based Practice (May–June 2006) is to be commended for their report valuing evidence from "clinical expertise" on a par with "research data" (p. 272) in guiding psychological practices. We clinicians tend to operate very privately, and our perspectives are underrepresented in psychology's professional discourse. By virtue of daily personal interactions with clients, clinicians are arguably the true experts on the nature and accessing of psychological evidence. I argue that in losing touch with clinician perspectives, especially regarding the subjective essence of the clinical encounter, psychology risks becoming perilously disconnected from its evidentiary base.

At the 1949 Boulder Conference, clinical psychology embraced a medical model for diagnosis and treatment of psychological problems when it accepted the medically directed training of clinical psychologists in medical clinics and hospital settings (Albee, 2000). This medical or "disease" model, and the biomedical science methodology on which it is based, views the source of the problem as an atomistic, concrete pathogen (e.g., a bacterium or carcinoma) located within the "patient," which is diagnosed using objective, quantifiable evidence from the patient (e.g., vital signs and lab tests) and treated with replicable, manualizable interventions (e.g., an antibiotic or surgical procedure; Hunsberger, 2005). In our medicalized psychology, "diagnosis" is based on objectively measurable client behaviors, and "treatment" consists of applying replicable protocols to change target behaviors.

Psychology's medicalization has accelerated recently, as delivery of clinical psychology services has come under the control of medically directed health insurance companies. "Medical necessity" and numerical diagnosis codes from the medically owned and behaviorally based *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*; American Psychiatric Association, 2004) have become the universal standards for any insurance-reimbursable psychological services, and "behavioral health" has increasingly replaced psychotherapy as an insurance benefit. Today our universal use of the terms *mental health, mental illness,* and *mental patient* reveal our culture's unquestioned assumption that psychological problems are medical in nature. We forget that as recently as 100 years ago there was no such consensus, as mental problems were widely viewed as spiritual or religious issues, not health concerns (Horwitz, 2002).

The medicalized notion that psychological problems can be objectified into behaviors and resolved by packaged treatments focused directly on these behaviors is a simple and appealing one. Unfortunately, it doesn't work. Clinicians know that without an ongoing subjective collaboration, objective data are unreliable. Good assessment requires relational skills to draw out accurate and in-depth information from the client, as well as emotional sensitivity to assess motivation and veracity throughout the assessment. And effective psychotherapy requires the establishment and maintenance of a therapeutic relationship strong enough to provide the safety and trust needed for the client to stay engaged with painful emotional material. Like the proverbial tip of the iceberg, test scores or behavioral changes are only surface manifestations of a much larger entity, most of which is invisible from a distance. Successful clinical work and valid clinical data are based on an evolving interaction, requiring the clinician to be subjectively attuned and responsive to the client's ever-changing presentation. In psychotherapy this process much more closely resembles a jazz collaboration than a medical treatment (Wardenburg, 1988).

Medicalization endangers clinical psychology in many ways. Psychotherapy, in particular, is at risk for being medicalized out of existence. In practice, clinical wisdom has recently been borne out by empirical research demonstrating that relationship factors in psychotherapy are twice as powerful as treatment factors in fostering therapeutic change (Hubble, Duncan, & Miller, 1999). Yet, ignoring this evidence, the researchers, teachers, and administrators who are guiding our field continue to assume that treatment type (cognitive–behavioral, psychodynamic, etc.) or specific treatment interventions (reflection, confrontation, hypnosis, etc.)—elements that are visible to an observer—constitute the active ingredient in the therapy. This sidetracks new therapists from honing their relationship skills and confuses potential clients seeking the best therapy.

In research, efficacy studies comparing psychotherapy with psychotropic medication typically do not provide, or adequately control for, a strong therapeutic relationship in the psychotherapy test

group. This washes out psychotherapy's strongest active ingredient—the therapeutic relationship—thus typically showing psychotherapy to be much less effective than it truly is. Efficacy research results powerfully affect how our society allocates its "mental health" resources, and psychotherapy suffers as a consequence, especially in contrast to increasingly popular psychotropic medications, thus accelerating our society's medicalization of psychological problems.

Subjective knowledge and skills are at the core of psychology, whose subject matter—the human psyche, or mind—is by definition subjective, abstract, and unmeasurable. For clinicians, operating skillfully at the subjective level is crucial to the success of the clinical encounter and the validity of the data emerging from it. Yet we are trusting our fate to a medical model that possesses neither the language nor the tools to understand the thoughts, feelings, attitudes, and beliefs that constitute psychic life. This model is objectifying our field into a subspecialty of medicine, and we are willing participants.

To preserve clinical psychology's vital subjective essence, I suggest that the American Psychological Association (APA) not only should make a place at psychology's policymaking table for "clinical expertise" but should prioritize clinical and subjective sources of data—the essence of the psychological—and set policies to ensure that objective data, such as behaviors and *DSM* diagnoses, are considered in their subjective context. The APA should also encourage researchers to devise ways, such as through the use of qualitative research methods suggested by Schneider (1998), to preserve as much as possible the personal "feel" of the clinical encounter in their data analysis and published conclusions.

The APA also needs to assign priority to subjective emotional and relational skills on a par with academic and analytic skills in the selection and training of clinical psychology students. Reconnecting clinical psychology with its subjective evidentiary roots in ways such as these should help to bring us out from under the dominance of medicine, to the benefit of our profession and our clients.

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