FRONTLINE—Evidence and Narrative in Contemporary Psychiatry

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In 1992, the Evidence-Based Medicine Working Group issued a clarion call to physicians to focus away from intuition, unsystematic clinical experience, and pathophysiological rationale as grounds for clinical decisions. They recommended, instead, that we base patient care on evidence from clinical research, that is, on our review of published literature (EBM Working Group, 1992). It ranked clinical evidence in a hierarchy based on the design of the study, from single case reports up through double blind randomized clinical trials (RCT), without regard to the quality of the research. An early training film showed a medicine resident telling a patient the results of some laboratory tests, then leaving the examining room to do a computer search, then returning to give the patient a prescription. In this scenario, the patient seems to make no contribution to the discussion, either as participant or as a person.

Criticism came rapidly from various sectors of medicine. Dynamic psychiatrists wondered whether this was a new paradigm or a new cognitive disorder. Others noted that this sort of medicine relies on imperfect methodology and a science base that is currently incomplete (Phelps, 1993); it addresses single aspects of a complex patient; it devalues clinical intelligence (Tanenbaum, 1993); and it views the patient as an inconvenient container of a biomedical process. It serves policies that aim to control costs for populations by sacrificing efficient care over the lifetime of the individual (Gray, 2000; Kassirer, 1993).
Responding to these criticisms, David Sackett (Sackett et al., 1996), the leading proponent of Evidence-Based Medicine (EBM), redefined it as the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. He noted that in best practice it represented a bottom-up integration of external clinically relevant evidence from systematic research with expertise of the clinician and with patient choice. He iterated that clinical evidence takes precedence over theoretical concepts and basic research; and encouraged appropriate clinical investigation. Physicians, and other health care professionals, were comfortable enough with this revised concept of EBM to increase their efforts to codify and test clinical intelligence (Gray, 2000).

Is EBM an appropriate paradigm for dynamic psychiatry? Freud certainly practiced EBM (Gray, 2008). He used the clinical research techniques of his era, case studies and clinicopathological correlation. He applied relevant scientific findings from a variety of disciplines. His explanatory models grew out of his clinical observations. He tested and verified or revised each one over and over again. He privileged clinical observation over theory or laboratory findings, for example neurohistology. This approach to patients reflected the French model of medicine, with its emphasis on clinical experience, that he had learned from Charcot in his fellowship years; and it is the one that Sackett and colleagues acknowledge as their progenitor (Sackett et al., 1996). It stood in contrast to the German model which privileged laboratory findings over clinical observation. In the United States, the patient-centered model is exemplified by the Harvard Medical School, which had been founded by physicians who trained in France, as did Freud; and it stands in contrast to that of the Johns Hopkins’ German model (Beecher & Altschul, 1977, passim.) in which the patient is often viewed as an inconvenient container of a biomedical process.

In some areas of mental health care, the patient-based model of EBM has been transformed, some might say perverted, into the valorization of empirically supported treatments. Some, such as the RCT of a specific dynamic psychotherapy for Borderline Personality Disorder are superb demonstrations of the validity of a conformed psychodynamic approach to a serious psychiatric disorder (Bateman & Fonagy, 1999). Others have been far less fortunate. Schottenbauer and colleagues (2008) reviewed 55 studies of the major empirically supported treatments of PTSD–cognitive-behavioral therapy and eye movement desensitization and reprocessing. These studies, RCTs of manual-directed treatments, report dropout rates that range widely, up to 50% in some cases, but dropouts and non-responders often were omitted from the re-
sults, leading to inflated success rates. Investigators used a wide range of study-specific methodologies, including idiosyncratic instruments for assessing outcome. The authors conclude that there is an urgent need for standardized assessment and reporting protocols if we are to engage in meaningful clinical research.

Ablon, Katzenstein, and Levy (2006) compared treatment as usual (TAU), a naturalistic psychodynamic therapy that is best known as a control (active placebo) for trials of manual-based therapy, with formal CBT. Participants were assessed pre- and posttreatment. Psychotherapy Q-Sort analysis (c.f. Ablon & Jones, 1998) revealed that the successful psychotherapies were not pure; they integrated cognitive and psychodynamic techniques.

Why do even motivated clinicians deviate from their manuals? Why are dynamic psychiatrists generally leery of manuals? Joseph Weiss (1993) after extensive empirical study of dynamic psychotherapy, concluded that this form of treatment does not support manual-directed approaches because each patient has his or her specific manual encoded in as a set of unconscious ego functions (Weiss, 1971). The aim of therapeutic interventions is to help individuals implement their unique manuals. What data does the Weiss model generate? Stories! Does theory matter? Yes, theory matters. It informs how psychiatrists will interpret the story. Do they see a neurological deficit influencing several aspects of the patient’s life? Do they see the impact of poor parenting? Do they see the adverse effects of overdeveloped capitalism, as psychoanalysts in the Soviet Union viewed aggressive behavior? Or, as Weiss postulated on theoretical grounds (Weiss, 1971), do they see the patient’s effort to master trauma?

Narrative-Based Medicine is a way of organizing patients’ stories. It counterbalances the influence of research—albeit clinical research—on large populations by studying the stories patients tell their physicians about themselves and their illness, as well as the stories physicians tell about their clinical encounters (Greenhalgh, 1999). It focuses on the patient and on the doctor-patient dyad in which the history of the illness unfolds, and it delineates a place for intuition and creativity in the clinical encounter (Greenhalgh, 2002). It takes as its starting point the notion that physicians base their clinical interventions not only on epidemiology and clinical trials reported in the literature, but also on the clinical intelligence accumulated in an oral tradition (Tanenbaum, 1993) in which medicine is best remembered as stories about patients, especially stories about the physician’s encounter with a particular patient.

Psychoanalysis is, perhaps, the most narrative based discipline within medicine. Its data are the stories patients tell the analyst, and the new
stories patient and analyst co-construct in their sessions (Aron, 1996, *passim*). Early in his career, Freud (1985) wrote

> It still strikes me as strange that the case histories I write should read like short stories . . . I must console myself with the reflection that the nature of the subject is evidently responsible for this, rather than any preference of my own. (p. 160)

The science of psychoanalysis is, from a certain perspective, the study of the content of these stories (history), how they are told (words, action, etc.), how the analyst explains them (interpretation), and what happens after the treatment (outcome). As we move into EBM, though, our literature on what happens in the consulting room between a particular psychoanalyst—or other dynamic psychotherapist—and the patient has diminished. In an occasional series in this Journal, we hope to revive the psychoanalytic narrative tradition of closely examining a single case, to illustrate how one makes the transition from personal experience in the session through theory to intervention, or finds a new way to address a vexing clinical problem.

Kim and Gray (2009) demonstrate Aron’s (1996) relational formulation that technical errors, openly acknowledged by the therapist and understood by the therapeutic dyad, stimulate therapeutic change. In a recent Frontline piece, we saw how an experienced psychotherapist was able to fashion psychoanalytic theory into a broad splint that supported him as he worked with countertransference feelings in the work with a severely distressed individual (Brockman, 2008). In his article, Orlandini (2009) shows us a self-contained segment of a long treatment. He describes his thought processes as he and the patient cooperated in an intervention that led to the resolution of her long-standing inability to mourn significant loss. In each instance, the first response of a reader might be shock at the avowal of intense sexual feelings about a patient, at the unquestioned acceptance of dual agency, at the support of an enactment; but sympathetic readers will find the psychoanalytic core in each treatment. They will see that the essence of good psychoanalytic technique is honest acceptance of whatever is expressed or experienced in a session, and the transformation of this material by the analyst into a clinical intervention that supports the patient’s continued emotional growth. These reports are new contributions to our oldest and also newest approach to the care of psychiatric patients.
REFERENCES


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