Chapter X

Intervention, evidence-based research and everyday life

Ole Dreier
University of Copenhagen, Denmark & Lillehammer University College, Norway

SUMMARY

Intervention is a key concept in the technology of psychology and it plays a decisive role in evidence-based research. But analyses of this concept are remarkably sparse. Based on a critical analysis of the conception of intervention in the American Psychological Association’s guidelines for evidence-based research and practice, I argue that, while psychological interventions are primarily meant to work in people’s everyday lives, how interventions do so is barely addressed and poorly captured. Evidence-based research, as currently conceived, is an obstacle to overcoming this shortcoming. Studies of practices of intervening in relation to people’s ongoing everyday lives are needed to improve our empirical basis for reconceptualizing intervention. On the background of studies of how psychotherapeutic practices intervene in the everyday lives of clients, I show how interventions work in clients’ everyday lives and point out consequences for reconceptualizing psychological intervention.

INTERVENTION AND EVIDENCE-BASED RESEARCH

Intervention is a core concept in applied psychology. But it has barely been subjected to conceptual analysis. Evidence-based research (EBR) has reinvigorated the interest in intervention and led to a special understanding of intervention as we see in the report by the American Psychological Association (APA) Presidential Task Force on Evidence-Based Practice (2006), its proponents in the debates surrounding it (e.g., Norcross, Beutler & Levant, 2005) and in the research following up on it (e.g., Spring, 2007).

The view on intervention represented in these sources can be boiled down to essentially seeing intervention as the cause of the treatment under consideration, as an isolated and therefore simple causal relation between two separate entities, and as a specific cause.

On this background the APA presidential task force sets up a hierarchy of research methods and it claims that only “randomized clinical trials and their logical equivalents … are the standard for drawing causal inferences about effects of interventions” (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 274). This method alone can verify or refute that interventions work so that “empirically supported treatments … for particular disorders … (have) been tested in randomized, controlled trials with a specific population and implemented using a treatment manual” (ibid., p. 272).

According to this view on therapeutic practice intervention refers to particular aspects of what the therapist does. It stands for his causal powers over his client in the service of her cure. The term also separates the causal powers of the therapist from other influences on the treatment which are merely seen as moderating and mediating the effects of his intervention. We see this in the obvious answer to the question: who intervenes and in what?
The movement of EBR arose from the distrust of researchers and administrators in the expertise of practitioners which they see as being based too much on mere opinions. Instead, it advocates an evidence-based practice based on “clinical expertise informed by scientific expertise, allowing the psychologist to understand and integrate scientific literature as well as to frame and test hypotheses and interventions in practice as a ‘local clinical scientist’” (ibid., p. 276). The aim is that EBR comes to govern practice.

EVIDENCE-BASED RESEARCH AND PRACTITIONER EXPERTISE

The presidential task force lists eight “components” of clinical expertise in order to describe how therapists should behave. In this description it uses the following verbs to characterize therapist behavior (ibid., p. 276-278): Therapists should assess, judge, understand, seek evidence, identify, decide, set goals, plan, implement, deliver, consider, revise, adapt, monitor, alter, address, form a relationship, create expectations, respond, challenge, foster, attend, recognize, self-reflect, construct, and so forth. But it is not made clear how doing all this derives exclusively from evidence-based research, applies the specific causal mechanisms found in evidence-based research and, thus, guarantees an evidence-based practice in psychology.

In order to promote evidence-based practice (EBP) Spring (2007a) and others carried out training courses for students in gathering and processing general research information and in creating their own databases. They see this student training as being in line with “the fundamental goal of the evidence-based practice movement …, to effect a cultural change within health care whereby practitioners will make ‘conscious, explicit, and judicious’ use of current best evidence in clinical practice with individual patients.” (Bauer, 2007, p. 685) Spring and others also hold that when therapists engage in clinical decision making, “they act as consumers of the research evidence” (Spring, 2007b, p. 622). This, to them, is the decisive link between science and expertise. However, in their study they only specify how practitioners should relate to research—and not how research relates to the conduct of therapeutic practice. They do not make clear how this general research information is to be appraised and applied in the service of a patient-centered practice with individual clients, and they barely address other aspects of the conduct of therapy.

Still, it is not the goal of the task force to prescribe in every detail what practitioners must do. The goal is to develop guidelines for evidence-based practice in psychology. Many practitioners take this as a comforting compromise made in the task force of a professional organization. They highlight that the task force recognizes that EBP rests on three strands of data “(a) the best available research evidence; (b) clinical expertise; and (c) patient values, preferences, characteristics, and circumstances” (Spring, 2007b, p. 613), and that it holds that EBP is the integration of these three strands of data (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273). But the report and all other proponent sources are very vague about how this integration is to be composed and accomplished. Collins, Leffingwell & Belar admit that it is “a process for which there exists no cookbook” (2007, p. 660). So far there is room for so much slack in this integration that the influence of EBR on practice may very likely remain limited.

Moreover, the advocates of EBR do not study how practice is conducted and how research evidence is a part in that conduct. Bauer admits that:
One key issue in advancing EBP within psychology will be to pay attention to the key stage of the process by which knowledge (best evidence) is transformed into action and application. This, in my view, is the state of the process that is least understood from a psychological viewpoint. (Bauer, 2007, p. 691)

Kazdin also admits that there is “not yet much evidence for EBP in the clinical context where judgments and decisions are made by individual clinicians informed by evidence, expertise, and patient considerations” (2007b, p. 147). It is, indeed, unclear how practice does become evidence-based. This is a major weakness of EBR given its aim of defining and promoting EBP in psychology. Besides, there is no agreement about the definition of expert skills and about how they are employed in the conduct of practice. This is understandable when “much less research is available on clinical expertise than on psychological interventions” (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 278). At present the research basis for EBP is, therefore, clearly insufficient and it is no wonder that clinical expertise is “the circle that has generated greatest controversy” (Spring, 2007b, p. 614). The poor understanding of the conduct of practice is the Achilles heel of the EBR movement.

In this situation the advocates of EBR pass on their demands for accomplishing an integration of EBP with EBR to the practitioners:

Research has shown that the treatment method (Nathan & Gorman, 2002), the individual psychologists (Wampold, 2001), the treatment relationship (Norcross, 2002), and the patient (Bohart & Tallman, 1999) are all vital contributors to the success of psychological practice. Comprehensive evidence-based practice will consider all of these determinants and their optimal combinations. Psychological practice is a complex relational and technical enterprise that requires clinical and research attention to multiple, interacting sources of treatment effectiveness. (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 275)

This very wide-ranging set of demands complicates the task of integrating them for the practitioner. He is to know, consider, and integrate all this and much else while living up to the standards of EBR and with very insufficient and inadequate evidence-based guidelines for doing so.

Being able to handle this complexity well must then be a key competence to foster. But EBR, with its strict insistence on separating and controlling isolated variables and on the basic, stable causal power of isolated mechanisms, is particularly at a loss in assisting practitioners to meet this challenge.

We should also note that the point of view of EBR is very professional-centered since it leaves everything up to the expertise of the practitioner. Even so, the force of the EBR movement remains a double-edged sword for practitioners. They may use it to defend their position in health care in competition with other professionals, but they will fall short of the normative challenges of EBP. They will be thrown back upon feeling that they do not quite suffice.

Indeed, EBR draws a picture of the conduct of therapeutic practice as if it were essentially like the practice of experimental research. EBR does not acknowledge the different composition of relations and concerns in the practices of psychotherapy and of research.
Clients are almost lost from view in the battle between researchers and practitioners over expertise and the conduct of practice. Although the definition of EBP by the task force mentions “patient characteristics, culture, and preferences” (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273), patient preferences are “The least developed of EBP’s three circles” (Spring, 2007b, p. 614). The agenda of EBR is to make practitioners consult research, but there is little research about clients to consult. In the latest edition of the *Handbook of Psychotherapy and Behavior Change* (Lambert, 2004) only one of eighteen chapters—and one of the shortest—is about clients (Clarkin & Levy, 2004).

The advocates of EBR seem particularly hesitant to study clients. Even when Kazdin (2007b) admits that clients’ lives and changes to their lives is “where everything comes together”, he does not address this in his article. In order to understand this paradox we must remember that, according to EBR, the intervention—that is, specific features of the therapist’s behavior—is the primary cause of treatment. Only secondarily, the effect of this specific causal mechanism may be modified by other mediator or moderator variables (e.g., Kazdin, 2007a). When clients are studied, they are granted the role of secondary, moderating and mediating variables in their own treatment. Clients are, at most, seen as able to mediate and moderate the effects of the therapist’s intervention. Indeed, the distribution of variables in the basic causal format of EBR presupposes that the intervention is the primary cause and thus settles the question of causes beforehand. Even if a great impact of a moderating client variable were found, the client response is to be analyzed as triggered by the intervention as its primary cause, and knowledge about the client variable is merely meant to be used to moderate therapist interventions.

On the whole, then, clients are considered as a set of variables affecting their treatment, but not as agents in bringing it about. Because the task force report insists that it is the intervention that works and that it is the therapist, who carries out the intervention, there can be no real recognition of client agency. The client is, at most, an assistant to her therapist in this practice where the therapist is meant to assist his client. Client factors are seen as something the therapist should consider and monitor, and the client’s work is seen as responses triggered and induced by the therapist’s intervention. Knowledge about client factors is to be used by the therapist as agent while the client remains a recipient of his therapist services. A few researchers have objected to this state of affairs in psychotherapy research. As Miller, Duncan, and Hubble remind us: “There are hundreds of books about great therapists but few, if any, books about great clients” although “Clients, the research makes abundantly clear, are the true masters of change in psychotherapy; they are always more powerful than their therapists” (1997, p. 25 & 26). In the discussion volume on EBP Bohart wrote the only chapter arguing for the role of clients. Here he presented a variety of studies about it and held that “therapies and their techniques are not really treatments that operate on clients to change them but rather tools used by clients in their self-healing and problem-solving efforts” (2005, p. 223). In the discussion he got this response from leading advocates of EBP:

Bohart’s contribution illustrates still a different tendency among authors, that of allowing personal experiences and beliefs to supersede empirical demonstration in determining what works in psychotherapy. Bohart believes that the patient is the
impetus of therapeutic change, raising a variety of largely unresearched and poorly measured patient variables to the highest position among contributors to change. (Beutler & Johannsen, 2005, p. 245)

These advocates of EBR use their hierarchization of research methods to dismiss going into dimensions of therapeutic practice which they themselves have neglected to study.

EVERYDAY LIFE AND INTERVENTION

Nonetheless, we must go even further than Bohart who highlights the active role of clients in sessions. After all, whatever happens in sessions is primarily meant to have an indirect effect in clients’ lives outside sessions. Psychotherapy must, therefore, work by means of a combination of direct and indirect influences. It is insufficient to assume that it works by means of direct, immediate causal relations in sessions between an intervention and the effect on a client of this therapist behavior. In order to work as intended, therapy must rely on client agency elsewhere. Let me briefly mention some main points about this which came out of my research on *Psychotherapy in Everyday Life* (Dreier, 2008):

First, therapy only works if clients link it to particular features of their everyday lives and include it in their ongoing everyday lives to deal with their problems (ibid., p. 93-99). This is so basic to how therapy must work that it should be in focus in research (see also Mackrill, 2008b, 2009a, 2009b). But psychotherapy research has not studied in depth what it involves for clients to accomplish this in their everyday lives. Obviously, this accomplishment cannot be a direct causal effect of a therapist’s intervention because it must be up to clients to find out how to do it.

Second, clients must pursue changes to their problems across places because therapy sessions occur in a secluded place outside their ordinary everyday lives and because their problems are part of their lives in several places (Dreier, 2008, p. 100-104). They must learn how to pursue a resolution to their problems into their sessions and out again into and across various other contexts of their lives.

Third, in therapy sessions much more is said, experienced, understood, and suggested than it is possible to pursue elsewhere and later. Clients’ uses of sessions elsewhere and later are necessarily selective (Dreier, 2008, p. 94). Any therapeutic intervention—also a manualized treatment—is a complex nexus from which clients must pick some features and leave the rest behind. Just like therapists do not do therapy by the book (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 276 & 278), clients do not apply their therapy by the book. What clients find reasons to use from sessions does not follow directly from the therapeutic procedure and rationale. Their selective uses of sessions are primarily grounded in what they believe may make a desired difference in their everyday lives elsewhere. What they use therefore depends on the contexts, relations, events, and opportunities of their ongoing everyday lives. So therapists cannot control clients’ uses of their therapy, and therapy cannot be a simple effect of the therapist’s intervention.

Fourth, clients use sessions in situated ways in diverse contexts, situations and events of their everyday lives. Interventions must be usable in diverse situations. They must be fitted into the varying possibilities and abilities of clients and their varying co-participants in various contexts. It therefore varies how a feature of sessions may be
used and what it takes to use it. Using it adequately mostly involves learning, and it must often be modified or transformed in order to become usable.

Fifth, as changes get on the way and as their everyday lives change, clients learn to use their therapy in other ways.

Sixth, psychotherapy research must recognize that therapy never works alone (Dreier, 2008, p. 94). It always works alongside and in interaction with other environmental influences and client responses hereto. How it works, depends on many other circumstances and events, client activities and experiences, as well as on responses and initiatives by others in their ongoing everyday lives. Its effects cannot merely be caused by particular features of the therapist’s behavior in sessions.

Seventh, clients’ everyday lives may be changing for many other reasons, which then affect the dynamics and course of their ongoing therapy (see also Mackrill, 2008a). We therefore need to know how therapeutic and other influences interact and are combined by clients in their everyday lives.

These points call for a radically different view on intervention than the one adopted in EBR. Ironically, this other view is in accordance with the literal meaning of the word to intervene as:

(1) to come, be, or lie between, (2) to take place between two events, points of time, etc., (3) to come or be in between as something unnecessary or irrelevant, (4) to come between as an influence, as in order to modify, settle, or hinder some action, argument, etc. (Webster’s New World College Dictionary, 1997, p. 707)

To intervene means to get involved by getting in between things which already are going on. This is a crucial difference between the experimental arrangement of separation in EBR and the practice of intervening where nexuses cannot be separated and interventions become a particular part of them. To understand the practice of intervening we need knowledge about how things hang together and work together and about ways of getting in between them. To intervene involves getting in between a multitude of forces and relations in particular times and places. Indeed, in the conduct of intervening practices influences cannot be controlled and separated. This complexity of conducting practice is lost in EBR which–by its very choice of research methods–is blind to the complex and dynamic ways in which things interact and hang together in bringing about outcomes.

What is more, a client’s everyday life does not consist of a string of isolated situations and events into which therapy intervenes. Its situations, events and contexts hang together and interact as parts of the client’s everyday life. Just like any other person, a client must conduct his everyday life in order that it does not fall apart and in order to get done what he needs and wants to do in relation to various parts of his everyday life (Dreier, 2008; 2009; Holzkamp, 1998). He must juggle, balance off and prioritize the various dimensions and parts of his life to make certain that he pursues and realizes that which matters most. How he can do this, depends on the arrangements of the societal practice in which he lives and he must arrange his everyday life in a particular way in relation hereto. The social arrangements afford and guide his personal arrangements and make them more or less robust and changeable.

In shaping his conduct of everyday life a person must also coordinate it with various others in various places. He must negotiate the ordering of his everyday activities with
various others, and the arrangements they make establish a particular ordinariness in their everyday lives. Besides the ordinariness of everyday arrangements everyday lives also hold variations and breaches which afford other ways of participating and other experiences. Indeed, persons prefer different kinds and degrees of order and variation in their everyday lives. They prefer different degrees and kinds of regularity and plannedness versus openness and variations in the arrangements of their everyday lives and they must negotiate scopes for these differences with each other.

From these arrangements emerge everyday lives of persons with “commitments to specific others in rich, concrete social relationships, to specific places and senses of place, to specific activities and organizations of rhythms of life” as Smith (1987) puts it. The way persons understand themselves is therefore marked by the order, direction, and ways of handling possibilities and conflicts in their conduct of everyday life. Archer makes a similar point by quoting Frankfurt: “It is these acts of ordering and rejection—integration and separation—that create a self out of the raw materials of inner life” (1988, p. 170). She adds:

… in dedicating oneself to a cluster of concerns, one takes responsibility for them and makes them one’s own. The subject constitutes her identity as the being-with-this-constellation-of-concerns (and) thus … the subject reflexively attains a strict personal identity by virtue of her unique pattern of commitments. (Archer, 2007, p. 87-8)

Persons also care for themselves through the way they conduct their everyday lives in relation to social arrangements.

I shall finish this paper by linking what I said about intervention with what I said about conduct of everyday life. It is widely recognized that the success of medical interventions depends on a person’s life style. Some, e.g., Ogden and Hills (2008), also hold that the success of psychological interventions directed at sustained behavior change of, e.g., weight loss depends on habits in a person’s life style. But to conduct an everyday life is more than a matter of style and habits. It is a matter of commitments and accomplishments, of making it hang together and of coordination—on the basis of personal arrangements in relation to social arrangements. My research on psychotherapy in everyday life has led to the following general insights about the relations between interventions and a client’s conduct of everyday life.

The meaning and impact of an intervention depends on the particular way in which a client conducts her everyday life. It also varies which linking points and triggers for therapy assisted changes will be most meaningful and profitable for various clients because different social contexts, possibilities, relations and concerns matter most in their conduct of everyday life. The effects of a given general intervention will vary accordingly.

The way a client conducts her everyday life affects the course and dynamics of her problem changes. Thus, the degree of order or openness to variations in a client’s conduct of everyday life affects which options for problem changes are available, such as how and which new arrangements can be made. A conduct of everyday life also involves particular ways of addressing and handling problems such as preferring to let things calm down before addressing problems, to put problems behind you whenever possible, to opt for a fresh start as a way out, to continue having a grudge against
somebody, to demonstrate willingness to renegotiate, or to need a timeout for pondering in order to be able to identify your way of addressing problems.

An intervention may interfere with an established conduct of everyday life. This intervention cannot really work unless the conduct of everyday life is changed in relevant respects.

On the other hand, interventions are often occasioned by major events, breaks, and troubles in clients’ everyday lives which call for reestablishing a pre-existing conduct of everyday life or for changing it.

Clients need time to reconsider and to make up their minds about which changes to their everyday lives they want to make in relation to problems. Until then, changes cannot be built into the regular arrangements of their everyday lives.

Some troubles make clients reconsider their lives and want to live differently in some respects because they revalue certain things, want to avoid certain troubles in the future, and so forth. They then reconsider and experiment with changing their conduct of everyday life, and they may draw on their therapy in doing so.

Clients may rearrange their conduct of everyday life in order to compensate for what they have now come to see as a prior neglect or mistake. Therapy interventions may become part of these rearrangements.

Clients must often create new room in their conduct of everyday life in order to make it possible to pursue a resolution to certain problems.

Clients often disagree with others about problem related changes to their joint conduct of life. They must negotiate such changes and find each other in accomplishing them.

Changing a problem involves doing something extra about it for some time in order to overcome it, and taking responsibility for these extra-ordinary pursuits. Family members, friends, and colleagues must also be willing to take part in this: go to talks, take over chores, deliver extra assistance, and adjust their relationships and everyday lives.

Just like troubles, interventions are something extraordinary that must be made part of the ordinary life in order to be sustained and not be forgotten again after some time.

As a reaction to troubles and interventions clients may merely make temporary changes, believing that they can get back to their old normal life again after some time when the troubles have vanished or are less prominent. If the improvements they hoped for do not surface in what they take to be due time, they may stop believing in them and engaging in them.

What is known as relapses often simply means that clients fall back into their old conduct of everyday life.

CONCLUSION

What follows from the arguments in this paper for future research on psychological intervention? We are taken back from the privileged, isolated situation of randomized controlled trials into a much broader world of psychotherapy research. We must cease granting a causal privilege to randomized controlled trials and acknowledge that EBR will have limited effects on the practice of therapy because of its lack of attention to practice broadly taken. We must give up the inadequate assumption that therapist behavior is the decisive cause of client change and instead consider the particular contributions of therapists to a much more complex and dynamic causal interplay in
change processes. EBR turns our attention away from important topics we need to focus on in order to understand the workings and conduct of expert and client practices. Other research methods and topics are called for which can be more productive in supporting the qualitative development of the practice of psychotherapy. The practical, clinical relevance and productivity of research methods and topics are emphasized. But research should not simply get closer into practice. It should address the practice of therapy in a much broader sense than it has traditionally done. First of all, it should pay more attention to the active role of clients in bringing about their treatment outcomes, and it should do so by looking beyond sessions into the ongoing everyday lives of clients and into the interplay between their sessions and their everyday lives— in sessions as well as in the contexts of their everyday lives. Such research is broader than EBR as well as than other traditions of therapy research. It rests on a broader conception of the practice of therapy which attends to the social arrangements of therapy sessions and of the ways in which therapy may fulfill its overall goal of affecting the everyday lives of clients. Doing this calls for a different take on intervention which is just as relevant in other fields of practice than therapy.

REFERENCES


