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REVIEW ARTICLE

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Whose anxiety are we treating, anyway?

Nicole Nehrig[1,2] | Tracy A. Prout[3] | Katie Aafjes-van Doorn[3]

[1]VA New York Harbor Healthcare System, Manhattan Campus, New York, New York

[2]Department of Psychiatry, New York University, New York, New York

[3]Ferkauf Graduate School of Psychology, Yeshiva University, New York, New York

Correspondence
Nicole Nehrig, VA New York Harbor Healthcare System, Manhattan Campus, Department of Psychiatry, NYU, 423 East 23rd Street, New York, NY 10010.
Email: njnehrig@gmail.com

Abstract

Objectives: This paper explores the ways empirically supported treatments (ESTs) help patients, therapists, and institutional administrators contain anxiety regarding complex human problems.

Method: The authors synthesized relevant literature with their experience as clinicians and psychotherapy researchers.

Results: ESTs may manage patient anxieties by framing their symptoms in clearly stated mechanisms and relying on a therapist who is an "expert" capable of healing them quickly. ESTs allow therapists to streamline treatment decisions and minimize intersubjective aspects of treatment which reduces the complexity of therapy. ESTs assist institutional administrators in the top–down dissemination of treatments and limit concerns about malpractice and insurance reimbursement by providing assurance that interventions have been vetted.

Conclusions: While recognizing the benefits of ESTs, relying on ESTs to manage anxieties may diminish the importance of patient factors and clinical judgment, the other critical aspects of evidence-based practice, and thus limit the potential of clinical practice to reduce human distress.

KEYWORDS
anxiety, empirically supported treatments, evidence-based practice, psychotherapy, training

There has been a clear and consistent move towards evidence-based practice (EBP) in psychotherapy over the past four decades, with an emphasis on the study, implementation, and dissemination of empirically supported treatments (ESTs). EBP refers to the general practice of seeking empirical evidence to support the use of specific treatments, in concert with clinical expertise and patient values and preferences, whereas EST refers to the specific treatments that have been supported by empirical evidence. Among the numerous papers detailing the strengths and limitations of ESTs, to our knowledge, none have examined the role of patient, therapist, and institutional

anxiety and how they may inform this trend towards ESTs. This paper aims to explore the ways in which ESTs help individuals and institutions contain anxiety, avoid ambiguity, and foster a sense of self-efficacy in the face of challenging, multifaceted, human problems. We argue that the appeal of ESTs rests partially in their ability to simplify complex, multiply determined psychological distress thereby allaying fear and anxiety about psychotherapy for patients, therapists, and institutional administrators. Though EST is a critical component of EBP, there is a risk that anxiety may motivate us to prioritize research findings in making treatment decisions while minimizing the importance of clinical expertise and patient values, characteristics, and preferences which together comprise EBP.

Within EBP, clinical judgment and patients' values and preferences were intended to contribute two-thirds of the ingredients of EBP. In reality, the primary emphasis has increasingly been on scientific evidence of ESTs whereas clinical judgment and the needs and values of patients have been relegated as secondary or even irrelevant aspects of EBP (Shedler, 2018). This is a distortion of the original intent of EBP given that the Practice Directorate of the American Psychological Association (APA, 2002) described EBP as addressing patients' individual needs and preferences and emphasized the use of clinician's professional knowledge as well as scientific evidence in the Ethics Code (APA, 2010).

ESTs represent the "best-available research evidence" component of EBP. Psychotherapy treatment can be established as evidence-based if its efficacy has been shown in at least two independent randomized control trials (RCTs) or similarly controlled and systematic research designs though there is a movement towards using more stringent criteria (Tolin, McKay, Forman, Klonsky, & Thombs, 2015). This study design allows one to determine "interventionist causality" because the participants in the experimental group and the control group are deemed similar, and the intervention is identical for every participant in the experimental group. If these controlled conditions are not met, the improvements in the experimental group could be due to arbitrary sample differences instead of the intervention itself (Woodward, 2015). To standardize the intervention such that causal statements on the efficacy of psychotherapy are possible, researchers typically use psychotherapy manuals. Consequently, ESTs are often synonymous with manualized treatments. The ESTs that result from these clinical trials are increasingly becoming the standard of care and some even argue that offering any other treatment is tantamount to malpractice (Gnaulati, 2018).

However, the fact that manualized treatments are favored, does not necessarily mean that they are more effective. A recent systematic review (Truijens, Zühlke-van Hulzen & Vanheule, 2019) comparing manualized and nonmanualized treatments found little to no support for manual superiority. The authors concluded that manualized treatments are useful as research tools but should not be promoted as superior to nonmanualized psychotherapy in clinical practice. While ESTs have been shown to be effective, they are far from a panacea; at least one-third to half of the patients remain symptomatic following any given EST (Leichsenring et al., 2018). The battles over the relevance, ethics, and applicability of EBP and ESTs are numerous and well-documented and play an important role in refining the quality of patient care.

ESTs have been often been a point of contention between therapists and researchers. Our hope is that these views can be reconciled with close attention paid to the strengths and limitations of ESTs. Although we are actively involved in developing the evidence base for various psychotherapy interventions and disseminating ESTs, we think it is important to examine the underlying motivations for our reliance on these treatments. Our interest in this topic arises from the gap between the desire to rely on evidence and the inevitable fallibility of ESTs in addressing the complexity of human psychological distress. The reflections on ESTs that follow are intended to enhance our conceptualization and delivery of EBP, not undermine it.

1 | HOW DO ESTS MITIGATE PATIENT ANXIETIES?

With regard to the patient's desire for EST, the following questions arise: (a) Do patients want to decide what treatment is best for them? and (b) Do patients prefer ESTs and, if so, why?

1.1 | Do patients want to decide what treatment is best for them?

There is a multitude of reasons why patients may not be well-equipped to determine the course and type of treatment they receive. First, when patients arrive for therapy, they often encounter a foreign world while in a state of great discomfort, which makes it difficult to make decisions. As with anyone who feels overwhelmed and anxious, patients are not likely to thoroughly reflect on the pros and cons of different treatment options but might prefer to follow "expert" advice. Patients are often expected to take a more passive role as the therapist socializes them to the expectations of the therapeutic endeavor (Padesky & Greenberger, 2015). Relying on clinician expertise about a treatment that appears to be designed and researched by experts may appeal to a wish to be cared for in a parental way.

Patients may not want to be tasked with choosing the solution because they are not aware of different treatment options or have not been offered meaningful choices (Shedler, 2018). They may be informed about brief, manualized treatments and told they are the "gold standard." This is reassuring to patients who are uncertain about what they can do to feel better or are too overwhelmed to make an informed treatment choice. They may have few options available or be unaware of treatment options, therefore limiting their knowledge about seeking out a particular treatment.

In the therapy dyad, the therapist is often considered to be more expert than the patient; a situation that could be expected to potentiate the patient's deference to the therapist. While this type of deference may be preferable in psychotherapy approaches with a didactic component (such as homework), contemporary psychotherapy process researchers have described this acquiescence as a form of "withdrawal rupture" that can, in fact, impede the work of psychotherapy (Eubanks, Burckell, & Goldfried, 2018). Although homework is assigned across a range of psychotherapy interventions, it is more frequently used within manualized interventions (Nelson & Castonguay, 2017). Homework is also more likely to be completed by the patient when the therapist is seen as having greater social influence and directiveness (Branagan & Swanbrow Becker, 2018). Some clinicians argue that such deference is appropriate because they are the ones who digest research findings rather than the patients. Therefore, an expert who is attractive and trustworthy can "prescribe" a treatment course, thereby allaying initial anxieties in the patient by providing hope that their problems are manageable and treatment will be successful.

There is increasing evidence that patients do have preferences for psychotherapy or pharmacotherapy (McHugh, Whitton, Peckham, Welge, & Otto, 2013), cognitive behavioral or interpersonal psychotherapy, individual or group therapy, brief or long-term psychotherapy (Swift, Derthick, & Thompkins, 2018). As awareness of psychological treatments grows, prospective patients may want to compare different treatments before choosing a preferred psychotherapy approach. Thus, it might be important for psychotherapists to first assess what their patient knows about psychotherapy, and second, what they would prefer to happen in their psychotherapy. Engaging patients in treatment decisions can lead to a more appropriate and cost-effective use of health services and better health outcomes (Swift, Callahan, Cooper, & Parkin, 2018).

1.2 | Do patients prefer ESTs and, if so, why?

Although little empirical research has been conducted to systematically assess patients' preferences with regard to EST or no EST, initial evidence from a study of patients with cancer and depression suggests that most prefer ESTs (Reece, Chan, Herbert, Gralow, & Fann, 2013). There are a number of reasons why patients might prefer well-known ESTs. First, we are hard-wired to feel comfortable with what is familiar, and thus patients are likely to choose treatments that they have heard of before. ESTs, particularly those with brand names, are appealing to patients. This is a well-known marketing principle that, when given the choice, consumers choose products from a familiar brand, just to be "on the safe side" (Truong, Klink, Simmons, Grinstein, & Palmer, 2017).

Advocates of ESTs have been very good at public relations. Marketing of any psychiatric treatment increases its credibility and adoption by mental health consumers (Friedberg & Bayar, 2017). This phenomenon is well-documented among psychopharmacological treatments, with an enormous upsurge in adoption and profitability for

psychiatric medications in the years following the US Food and Drug Administration's easing of restrictions on advertising pharmaceuticals (Becker & Midoun, 2016). ESTs have excelled in direct-to-consumer marketing, which has a direct impact on patient preferences and expectations of therapy (Becker, 2015). These efforts have expanded the reach and accessibility of psychological interventions while simultaneously narrowing the definition of EBP to be synonymous with ESTs (Wampold & Imel, 2015).

Moreover, the expectation that therapy will lead to improvement is likely to be higher in treatments that patients perceive to be evidence-based and credible (Constantino, Coyne, Boswell, Iles, & Vîslă, 2018). Besides outcome expectancy, expectations about what will transpire during the course of therapy also influence the patient's wish for ESTs. The structure of ESTs helps clarify the patient's expectations which can relieve anxiety. Given the emphasis on short-term ESTs in the social and popular media, patients are inclined to expect a quick fix through concrete guidance delivered in the span of 10–20 weekly meetings (Vîslă, Constantino, Newkirk, Ogrodniczuk, & Söchting, 2018). In addition to allaying anxiety about the process, the short-term nature of most ESTs may inspire hope that psychological problems are not insurmountable and can be addressed in a reasonable timeframe at minimal cost. Similarly, another attractive component of all ESTs is their focus on a narrow symptom category. This may be appealing to patients because it simplifies their distress into discrete categories that no longer threaten to overwhelm and emotionally paralyze them.

2 | HOW DO ESTS MITIGATE THERAPIST ANXIETIES?

Regarding therapists' interest in EST, the following questions arise: (a) What factors contribute to therapist anxiety? (b) How does anxiety impact therapists' preference for ESTs?, and (c) How do ESTs specifically address trainee anxieties?

2.1 | What factors contribute to therapist anxiety?

There are many reasons why therapists experience anxiety in their clinical role. Despite hundreds of RCTs, extensive neuroscience research, and thoughtful work towards defining disorders and their treatment, there is no singular path one can take with every patient that offers the certainty of a positive outcome. Therapists generally enter the profession hoping to help others (Bager-Charleson, 2018) but, in practice, may struggle to reduce patients' suffering. The consequences of failing to help patients may not only have negative consequences for the well-being of the patient and their family, but also for the therapist. The uncertainty of treatment outcomes might affect the viability of the therapist's clinical practice, referrals, performance evaluations, and possibly even licensure, as well as the therapist's sense of self-efficacy and usefulness in their work. With such high-stakes, it is not surprising that therapists may experience anxiety about "getting it right."

Moreover, this anxiety might show itself in different ways in therapists' personal and professional lives, including emotional exhaustion, depression, anxiety, and burnout (Simionato & Simpson, 2018). Therapists also experience physiological distress during sessions, such as before an exposure intervention (Schumacher et al., 2014). Similarly, depressed patients' helplessness and hopelessness can activate similar reactions in their therapists (Wolf, Goldfried, & Muran, 2013). Therapists can become ensnared by their own negative emotions, which can subsequently create doubts about professional suitability in beginning therapists, and cynicism and despair about effectiveness in the experienced professionals (Rihacek & Roubel, 2017).

2.2 | How does anxiety impact therapists' preference for ESTs?

Given the emotionally taxing nature of providing therapy, therapists may welcome any options to keep them from becoming overwhelmed. We know that in times of stress, people often select the simplest and most immediately

rewarding choice (Starcke & Brand, 2016). Heuristics are used by therapists to manage overwhelming information that comes their way, in the form of psychotherapy research and patient problems. ESTs serve to reassure therapists that they are doing the right thing, that they have the tools to be helpful, and that they are competent. Treatment manuals, in particular, provide structure, explication, and simplification of a complex process which may help the therapist feel less overwhelmed, think more clearly and set the stage for intervening in a conscious and deliberate manner. Though this may have the positive outcome of decreasing therapist anxiety, it has the danger of constricting therapists' ability to flexibly respond to their patient's needs, foreclosing on a range of theoretical approaches that could be helpful, and using their own anxiety or other uncomfortable emotions to inform their interventions (e.g., countertransference).

Moreover, there are important aspects of the therapists' personality that are associated with the development of theoretical orientation and that contribute to therapists' preference for ESTs. Preference for psychodynamic therapy, for example, is associated with the Big Five personality factor of openness to experience, whereas the opposite is true for preference for cognitive behavioral therapy (CBT) and preference for CBT is associated with conscientiousness, with the converse being true for psychodynamic practitioners (Buckman & Barker, 2010). Psychodynamic therapists also score higher than CBT practitioners on intuition (Topolinski & Hertel, 2007) and tolerance of ambiguity (MacLennan, 2008). ESTs often appeal to the trainee's wish to *do* something and to have clear expectations about what should transpire in the room with a patient. Manualized ESTs hold a particularly salient appeal for practitioners who are more inclined to minimize risk and ambiguity (Safi et al., 2017).

Another appealing aspect of ESTs and their manuals is that they divert attention away from therapist characteristics that may impact outcomes in psychotherapy. There is ample evidence that therapist characteristics —such as interpersonal skills (Schöttke, Flückiger, Goldberg, Eversmann, & Lange, 2017) and performance across treatments (Goldberg, Hoyt, Nissen-Lie, Nielsen, & Wampold, 2018)—are important predictors of outcomes and appear to supersede other variables—such as phase of training or treatment modality. For the vast majority of ESTs, the focus is on the patient's thought patterns, behaviors, role disputes/transitions, attachment history, or inner conflicts. There is minimal emphasis on the therapist's contributions to the therapy beyond the prescription for therapeutic tasks and goals. Taking on the role of an expert also limits the consideration of negative countertransference reactions (Hayes, Gelso, Goldberg, & Kivlighan, 2018). Although the APA Presidential Task Force on Evidence-Based Practice (APA, 2006) emphasized self-reflection on cognitive and affective heuristics and biases as an important part of clinical expertise, only a handful of treatment manuals address these issues (Hoffman, Rice, & Prout, 2016; Midgley, Ensink, Lindqvist, Malberg, & Muller, 2017). As such, it appears that most ESTs in their current form, limit consideration of the therapist's anxiety about clinical work, countertransference (both positive and negative), and intersubjective aspects of the therapeutic relationship. This protects therapists from having to contend with the aspects of psychotherapy that are often most messy, personally challenging and create a sense of vulnerability. These more complex aspects of the therapeutic relationship can and do arise in the context of manualized treatments and if therapists are taught to rely on providing ESTs as written, they will likely have underdeveloped skills to manage these relational challenges (Hayes et al., 2018). At best, this will result in missed opportunities for growth on the part of the patient and therapist. At worst, it will result in ethical violations and boundary crossings which can endanger the patient, therapist, and institution (Hayes et al., 2018). Complaints filed with licensing and ethics boards are often tied to the clinician's difficulties around awareness of countertransference and there is ample evidence that awareness and effective management of counter-transference has a direct impact on the treatment process and outcome (Gordon et al., 2016).

In addition, because ESTs are not designed to help therapists understand how symbolic, implicit, and sociocultural factors impact distress, important aspects of the patient's communications and the therapeutic process may be overlooked in adherence to ESTs which can also have implications for ethical practice and treatment outcome. By implicitly or explicitly limiting the role of therapists' unique contributions to the therapeutic relationship, ESTs have the potential to diminish the importance of therapist's self-reflection as an important aspect of their work which may lead to more ethical and boundary violations in clinical practice. Such violations

would have the opposite effect intended by EBP by endangering patients and weakening the reputation of our field.

2.3 | How do ESTs specifically address trainee anxieties?

Psychotherapy trainees, in particular, feel anxiety, especially, in the early stages of their training. Novice therapists experience great uncertainty as they enter the treatment room for the first time with real patients. Reliance on ESTs may reassure beginning therapists that they are doing the "right thing." The strict adherence to treatment manuals may be particularly reassuring to trainees who have not yet developed trust in their clinical instincts because they offer clearly delineated approaches and conceptualizations of common problems that rely less on the therapist's own clinical judgment. In addition, training programs in ESTs often provide training certificates suggesting expertise in a particular treatment model. Together, these manuals and training certificates can help bolster trainee confidence that they have the tools to be helpful, thereby increasing a sense of competence and reducing anxiety (Dimeff et al., 2015).

Moreover, ESTs increase the trainee's ability to take an authoritative stance in treatment as a member of the therapeutic dyad who offers healing and solutions to life's problems. In contrast to approaches informed by clinical experience and phenomenology, ESTs typically empowers the therapist to take a more active role. Reliance on ESTs allows the therapist to position her/himself as an expert scientist-practitioner in the room. This is a powerful antidote to subjective countertransference reactions of powerlessness and self-doubt.

ESTs typically draw from a single theoretical paradigm (Goldfried, 2018) which results in therapists trained in specific, siloed modalities, without much opportunity for integrating other theoretical perspectives and approaches to intervention (Aafjes-van Doorn & Barber, 2018). Integrative treatment is rarely taught in training programs and both training directors and students report a need and desire for more integrative training (Morrison & Goodwin, 2017). Notably, in our experience, it is only after years of training and exposure to multiple treatment modalities that therapists begin to develop a more integrated treatment approach. It may be that the confluence of time in training and practice with "pure" forms of EST allow for significant reductions in therapist anxiety; this development then allows therapists to broaden their interests beyond ESTs to consider more tailored and individualized interventions. They may be more comfortable relying on their experience treating a range of patient presentations and their maturing clinical intuition to flexibly modify ESTs and/or integrate theoretical approaches to meet each patient where they are. Notably, advanced clinicians are most likely to report using a range of theoretical models (Forbat, Black, & Dulgar, 2015). Regardless of many therapists experience psychotherapy integration as emotionally difficult and cognitively challenging (Rihacek & Danelova, 2015) and therefore some therapists may opt not to endure this anxiety-inducing process and rely solely on existing ESTs instead.

2.4 | How do ESTs mitigate institutional anxieties?

Regarding institutional interest in EST, the following questions arise: (a) Do institutions prefer ESTs and if so, why? and (b) How does anxiety impact institutional preference for ESTs?

2.4.1 | Do institutions prefer ESTs and if so, why?

The EST movement has been widely embraced in hospitals and university clinics. For example, large-scale healthcare networks such as the United Kingdom's (UK) National Health Service (NHS) and the United States' Veteran's Health Administration (VHA) have adopted ESTs as "standards of practice" to bridge the gap between research and practice and meet the demand for mental health services in a timely, practical and cost-effective way. Efforts to disseminate ESTs throughout the VHA were a response to the increase in Veterans returning from Iraq and Afghanistan and their need for mental health treatment, particularly for PTSD, and the wish to provide

Veterans with therapy that meets the highest scientific standards available (Karlin et al., 2010). In many of these institutions, there is an assumption that manualized treatments are superior to nonmanualized treatments. For example, in the UK, the National Institute for Health and Care Excellence (NICE, 2018) guidelines require that psychological and psychosocial interventions be based on the relevant treatment manual(s), which inform the structure and duration of the intervention.

There are several reasons institutions may prefer manualized, short-term treatments. ESTs reflect efficiency, productivity, rational thought, goal orientation, and an active, cost-effective approach that parallels Western values. Institutions might appreciate ESTs, because standardization of treatments for specific problems and disorders promises to reduce variability across treatment providers, aid in developing practice guidelines, and enhance accountability in clinical practice. Additionally, the institutional adoption of ESTs has a cumulative effect. Once some institutions adopt ESTs as "gold standard" treatments then institutions that fail to do so appear behind the times, offering outdated or subpar therapies. There is a "keeping up with the Joneses" effect that relieves administrative anxiety around being perceived as operating below the optimal standard of care as judged by accreditation agencies, the institution's board of directors, care providers, and patients. This also has implications for malpractice liability if it seems, as some have argued, there is an ethical imperative to provide ESTs (Blease, Lilienfeld, & Kelley, 2016). If many institutions adopt ESTs as the standard of care, then institutions that allow for greater clinical flexibility to provide tailored and integrative treatments may fear increased scrutiny in investigations of malpractice claims.

As a consequence, reimbursement by third-party payers becomes another factor reinforcing institutional adoption of ESTs as they provide clear guidelines for best practices and treatment durations that inform reimbursement rates. ESTs are a convenient way for insurance companies to know what therapy "product" they are paying for. Trusting clinicians to tailor their treatment approach to meet specific patients' needs would result in greater variability of methods used to manage diagnoses. Without substantial clinical training, insurance companies may be unable to evaluate the merits of the various approaches to mental health care. The standardization of treatment duration, usually ranging from 12 to 20 sessions, reduces the risk of paying for long and costly treatments. Similarly, in a public health system, the need for standardization of practice allows for governmental agencies to regulate the care they are paying for. The possibility that third-party payers will restrict reimbursement to ESTs only (Lebow & Jenkins, 2018), creates an impetus to implement these treatments to mitigate the threat that the services provided within an institution will not be paid for.

2.4.2 | How does anxiety impact institutional preference for ESTs?

In addition to these practical, financial, and clinical indications for the adoption of ESTs in an institution, there may also be reasons related to managing administrators' anxiety that are often overlooked or obscured. First, their performance is partially measured by the institution's ability to maintain fiscal solvency, provide healthcare services consistent with best practices in the field, attract talented providers and paying customers, and minimize their liability for malpractice. Second, as senior administrators are rarely mental health clinicians themselves and are only marginally involved in clinical care due to the high demand of their administrative responsibilities, they may not be knowledgeable about the process of change in psychotherapy and the complexity of patient care (Clay-Williams, Ludlow, Testa, Li, & Braithwaite, 2017). It can be difficult to regulate the change process in psychotherapy, which remains mysterious, even to seasoned clinicians. The ability to draw upon an evidence base allows administrators to make top-down decisions regarding treatment dissemination within their institution based on factors that can be understood without clinical expertise (e.g., comparing treatments based on statistical analyses of symptom reduction). Because ESTs tend to be quite clear regarding treatment approach and delivery, it is possible to assess therapist adherence and competence in standardized ways that do not rely on knowledge of clinical processes. For instance, treatment outcomes can be measured with symptom measure scores and adherence to the treatment manual can be assessed based on which topics were covered in the session and whether the homework was

completed. Having such objective outcomes allows for a sense of competence and clarity, but, in our view, can also oversimplify a complex process in the service of alleviating anxiety and uncertainty.

3 | DISCUSSION

In this paper, we have proposed ways in which anxiety about the complexity and challenges of psychotherapy can cause patients, therapists, and institutional administrators to place a greater value on ESTs than on patient characteristics and preferences and clinical expertise, the other critical aspects of EBP. In short, ESTs provide patients an understanding of their symptoms and the treatment in terms of clearly stated mechanisms which may alleviate fears that their problems are insurmountable. The ability to rely on a therapist whom they view as an "expert" capable of healing them in a short period of time, using the best available treatment, can be comforting and provide hope that they are "in good hands." ESTs allow therapists to avoid some of the intersubjective aspects of therapy, including self-reflection regarding personal contributions to the treatment process and countertransference reactions, which can be psychologically challenging for the clinician. Treatment manuals help therapists (especially those in training) feel greater confidence and certainty so that vulnerability and anxiety can be kept at bay. Finally, ESTs provide administrators with some assurance that the interventions provided at their institution are considered to meet the highest standard of care, which allays concerns about malpractice, ensures insurance reimbursement for services, and assists in simplifying top-down decisions about dissemination of treatments within the organization.

While valuing ESTs, we should also maintain a healthy dose of skepticism and question the underlying motivations for our reliance on the EST paradigm. We argue that the appeal of ESTs rests partially in their ability to simplify complex, multiply determined psychological distress thereby allaying fear and anxiety about psychotherapy for patients, therapists, and institutional administrators. Although EST is a critical component of EBP, there is a risk that anxiety may motivate us to prioritize research findings in making treatment decisions while minimizing the importance of clinical expertise and patient values, characteristics, and preferences which together comprise EBP.

We believe the optimal benefit of EBP is derived when ESTs are used flexibly to ensure that we are providing tailored and collaborative patient care, maintaining openness to creatively address the particular needs of patients and integrating and expanding treatment approaches to understand what works best for whom.

4 | CLINICAL IMPLICATIONS

4.1 | Providing optimal, tailored patient care

Evidence-based practice owes its rapidly growing popularity to its image of providing the ideal integration of individual clinical expertise and external scientific evidence, offering clinicians the best-available evidence about the most adequate treatment for their patients. At first glance, that sounds rather patient-centered, and yet, the tendency to overvalue ESTs above other aspects of EBP is not. First, ESTs are disease-oriented, not patient-oriented. They are designed to target a particular disorder, a cluster of symptoms, not an individual patient. Randomized controlled trials (RCTs) are not patient-centered and exclude a wide range of patients commonly seen in clinical practice (Shedler, 2018) for whom a more individually tailored treatment is indicated Second, the evidence fills the therapist's agenda with knowledge that is tapped from scientific research on populations: groups of patients in the same clinical condition. It does not draw from the patient's unique knowledge and experience, or their individual needs or preferences. Thus, we now have the paradox that ESTs are extremely important, since they offer patients high-quality care and protect them from unhelpful and unnecessary interventions, while at the same time it could become a threat to patient-centered work when patients' own opinions and needs are bypassed or even frustrated. Yet, without patient-centeredness, psychotherapy can lose its humane face and leave the patient alone amidst the institutional guidelines, and statistical figures.

Despite the important role ESTs play in reducing patient distress about symptoms and the demanding work of psychotherapy, there is growing evidence that patients value and benefit from a range of other factors. Patient beliefs and expectations about treatment have a significant impact on the development of early treatment alliance and the ultimate outcome of therapy (Constantino, Coyne, Boswell, Iles, & Vîslă, 2018). We can better integrate research evidence into clinical practice if the wishes of the patient are taken into account (Swift et al., 2018). Careful therapeutic attending and responsiveness to patient preferences, expectations, and anxieties are essential for providing tailored mental health services that take into account all three areas of EBP (Coyne, Constantino, & Muir, 2019; Walter, Turner, Macaskill, McCaffery, & Irwin, 2017).

4.2 | EBP as a shared endeavor

Besides the obvious benefit of the gained knowledge of ESTs for therapists, patients, and institutions alike, arguably, the process of sharing treatment research findings might also be therapeutic to our patients (Aafjes-van Doorn, 2017). There is a growing awareness of the need for a better-informed public, demands for information from patients and their representatives, media exposures to good and bad practices, and an overall litigation conscious society. We argue that by discussing the wide variety of available ESTs with patients, new evidence is more likely to be considered, implemented, and immediately applied—there and then. Moreover, patients often come to therapy because they want to learn how to change their old ways. Patients have often developed their maladaptive coping mechanisms for a good reason and letting go of old patterns is hard. Therefore, clinicians with a "curious scientist" approach might model curiosity toward new information, openness to trying out new methods, and life-long personal development. We should not accept that research findings are the only source of evidence in clinical practice. When the research evidence is unclear or we feel uncertain, this is the perfect opportunity to model how to tolerate not-knowing exact answers, as this intolerance of uncertainty in life and relationships is exactly why patients come to us. During a therapy session, we may choose to discuss general psychotherapy research findings or refer to books, papers, or presentations, with the aim of giving our interventions increased face validity or helping our patient decide between different treatment options (Aafjes-van Doorn, 2017). Patients might ask for the evidence for specific treatments or clinicians might choose to initiate these topics at a particular time in treatment. While the therapist is generally required to select the most cost-effective option if patients' preferred options are not "evidence-based," not available due to a shortage of resources, or the least cost-effective options, then this may need to be explained to the patient. Integrating patient involvement and clinical expertise may reduce the simplicity of a "one-size-fits-all" model of psychotherapy, but it also results in a more collaborative, empowering treatment for both patient and therapist.

4.3 | Maintaining openness and flexibility; leaving room for the art of psychotherapy

ESTs are an important and valuable part of providing targeted, cost-effective relief to patients in distress. However, the possibility that patients, therapists, and institutions may choose to narrow their focus to solely ESTs to reduce their anxieties, is not just unfortunate, it may have important implications for ethical practice. The desire for certainty, sense of competence, and wish to avoid vulnerability may cause people to place great faith in ESTs, despite the clear and consistent evidence that they work for only a minority of patients and are often not validated with complex patients who meet exclusion criteria for the RCTs that our evidence base relies on (Shedler, 2018). Avoidance of uncertainty and vulnerability require defensive strategies that close us off from connecting with others and from seeing ourselves and others as they really are, a key to change in psychotherapy. If we are blind in our adherence to ESTs, we may lose the ability to trust clinical judgment, be vulnerable, perhaps create the possibility for lasting change which might require breaking away from a manual or engaging in a longer-term, relationally-based treatment. While it is important to study psychotherapy outcomes to provide effective

treatment, and ESTs can undoubtedly be useful treatments, we must also be able to tolerate how much we don't know so we remain open to other possible approaches to therapeutic work.

ESTs may mitigate therapist anxiety by excluding some of the more emotionally taxing elements of psychotherapy such as managing alliance ruptures, enactments and other complex aspects of intersubjectivity that are bound to arise. Not surprisingly these therapeutic experiences are much harder to manualize since the way they arise in treatment is unique to the patient-therapist dyad. This raises concern for the future of psychotherapy training if it moves towards training clinicians to deliver manualized treatments as therapists will be confronted with complex issues that they have not been specifically trained to manage. To uphold EBP as defined by APA, it is critical to continue to develop and encourage clinicians' judgment and self-awareness throughout the career development lifespan to best serve our patients and help therapists manage the natural anxieties that arise in treatment.

Therapy is part science and part art. The EST movement is critical for finding and developing the most effective treatments but cannot be assumed to replace the art in therapy altogether. It is unlikely that science will find exactly the right therapeutic treatment for each individual. Therapists need the freedom to use their intuition and take risks. There is a danger that the EST movement can curtail that freedom by creating more anxiety for therapists and institutions and making it seem that it is unethical to deviate from EST. Excessive adherence to ESTs can shut out essential information from the patient about their needs, values, and preferences (Elmore, 2016) ultimately creating a disservice to patients and discrediting the profession. If we inhibit creativity for alternative ways of working, we have nowhere to go beyond the manual. At worst, this can cause therapists and institutions to blame patients who do not respond to the ESTs we offer and can result in patients viewing mental health treatment and providers as unattuned and unhelpful. It is important to remember that that which makes therapy messy also requires that it be flexible enough to respond to the complexity of human experience.

4.4 | Future directions of EBP: integrating approaches and determining what works for whom

The outcome data from studies of ESTs clearly demonstrate that no one model is a panacea, even for a particular diagnosis. Therefore, no psychotherapy approach can claim to be the gold standard (Leichsenring et al., 2018). Rather many can claim to be beneficial, and none without limitations. Different approaches may be suitable for different patients and therapists. When faced with the unique and complex distress of each individual patient, ESTs may be insufficient. Ethical best practice requires the implementation of ESTs while also maintaining clinical flexibility, managing uncertainty, and preserving our humanity as therapists. We must act on what we know at any given time while also being aware that there is much we still do not know. Progress in research results from openness to new ideas and learning from diverse perspectives. Thus, different evidence-based psychotherapies are required. Instead of a uniform "one-size-fits-all" approach, there is a need for a plurality of ideas and approaches in science in general, and in the field of psychotherapy in particular (Leichsenring et al., 2018).

Alongside the EBP movement, or perhaps in response to it, a small contingent of psychotherapy researchers and clinicians have proposed that instead of studying specific treatments, research should focus on broader principles of therapeutic change (Elmore, 2016). Transtheoretical concepts (e.g., common factors such as alliance and empathy, and deliberate practice to develop psychotherapy skills) aim to more fully meet the tasks of EBP by integrating research evidence with the other essential aspects of patient-centered care. These approaches have the potential to enhance the delivery of ESTs while also directly addressing the underlying anxieties we have outlined in this paper.

It is important to remain open to theoretical models that might offer patients something different from the "gold standard" treatment when it is not effective or unacceptable to some patients. If the mental health profession becomes siloed in one particular way of working (e.g., following manualized treatments, learning only one theoretical perspective) therapists are at a disadvantage when that way of working fails. There is a risk of therapists

losing confidence and feeling ineffective which may increase anxiety, and potentially reliance on ESTs, and/or labeling patients as "difficult" or as saboteurs of treatment as a means of managing therapist/institutional anxiety.

In therapy, we expect patients to reflect on their experience and tolerate the anxiety of the unknown therapeutic process and outcome. Therapists and administrators of mental health services should take even greater responsibility for examining and tolerating their own anxieties around the complexities of the psychotherapeutic process. It is important to remember that ESTs are only one aspect of EBP; patient involvement and clinical expertise are also critical aspects of EBP. Fully integrating all three aspects into the psychotherapeutic work may introduce greater anxiety in all parties involved, but the benefits of doing so are worth the cost.

ORCID

Nicole Nehrig http://orcid.org/0000-0002-9495-8126

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