

## On Evidence

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EVIDENCE IS ALL AROUND US. But not the evidence of our senses, you understand. The new evidence is the evidence of "evidence based practice" and "evidence based medicine". Of course, before the days of evidence-based this and that, psychologists and psychiatrists didn't bother with anything as substantial as training or reading books and articles on which to base their practice. Oh no, charlatans to the core, we put a brass plaque on the front door and started randomly messing with people's minds and bodies, without even a cursory glance toward Descartes to determine whether body and mind are distinguishable. Or at least so the champions of the new evidence would have us believe.

There is some truth in what the evidence lobby suggests. After all, there must be some practitioners who have studied little but other people's navels since qualifying. There remain unsupervised and poorly tutored professionals in psychiatry and clinical psychology, just as in other fields. The idea that practitioners of psychiatry, psychology and psychotherapy pay no attention to scientific journals is, however, patently absurd. Sadly, clinical psychologists spend valuable time ploughing through the worst kind of pseudo-scientific writings. Many psychiatrists read official psychiatric texts and counsellors avidly read and write about the latest evidence for the effectiveness of their art.

What has been shown again and again, however, is that these journals consistently give a mechanistic view of therapy and humanity that seems to have no place for the complexity of relationships or the overwhelming absurdity of attempting to systematize these relationships. Worse, many psychiatric journals are little more than drug company propaganda and very few attempt to grapple with the ethics and ideology of their scientism. For those who do read the latest research there are major questions about the ways in which it is funded and results disseminated. Reported research is only a fraction of that carried out, and it is invariably only the results that suit the vested interests of researchers or sponsors which appear. A recent government publication, *Effective Health Care*, in reviewing the newest so-called anti-psychotic medication concluded, "Most relevant trials are undertaken by those with clear pecuniary interest in the results" (December, 1999). Further, the research is of a particular, very narrow type (so-called Randomized Controlled Trials), light years from what actually happens in everyday clinical practice.

There is more to life (and therapy) than the categorization of people into diagnostic entities or personality types and the application of theoretical models

of change derived from the laboratories of psychologists and pharmaceutical companies. This paper examines the evidence base for clinical psychology. In so doing it urges an acceptance of a far broader range of evidence than is the case at present with a particular emphasis on what might be described, or even decried as, non-scientific evidence; the evidence of literature, our senses and personal experience.

**The nature of psychological evidence.** Some years ago, I came across an article on the desirability of moving clinical psychologist expertise into the world of the cancer sufferer. The article was brief and well referenced. These references included the *Journal of Psychosomatic Research*, the *Journal of Psychosocial Oncology*, the *British Journal of Cancer*, *Cancer Surveys*, *Social Science and Medicine*, the *Journal of the Association of the Society of Clinical Oncology*, *Psychological Medicine* and *The British Medical Journal*, all, no doubt, prestigious examples of the scientific approach. My partner, Jacqui Leal, had recently received a secondary diagnosis of lung cancer. Neither she nor I sought solace or information in these journals. I didn't need to. I had already read, some twenty years before, Solzhenitsyn's *Cancer Ward* (1968). I knew that visits to hospital would be marked by waiting alongside grey-faced, anxious people and their forlorn lovers and relatives. I knew that the wards would be terrible places where emaciated people would barely glance up as we came in and side-rooms would be reserved for the middle-classes and the dying. I had already known, like Solzhenitsyn's Aysa, the moment when a breast would be offered up for kissing one last time as, "Today it was a marvel. Tomorrow it would be in the bin." (p.425) And I knew all this at fifteen. I can't even remember the authors of the article on clinical psychology and cancer but *Cancer Ward* stays with me still. As does Douglas Dunn's *Second Opinion* (1985) in which the narrator notices, with understated envy, the wedding ring of the junior doctor tasked with breaking the news of his loved one's spreading cancer. Somehow, this no longer counts as evidence; lived experience, literature, poetry, the realm of our senses.

So where might we find information that appealed to people's sense of what it is to be human rather than the psychology and psychiatry of diagnosis, drug-company sponsored clinical trials and experimentation? One challenge for the pseudo-scientific community of psychology would be to embrace the commonplace wisdom of philosophy, literature and poetry. Psychiatry and psychology treat the mind/body divide as if it is unproblematic, but how many mental health professionals have read Descartes or Ryle? There are good textbooks on the human condition (Judith Shklar's *Ordinary Vices* or Dorothy Rowe's *Wanting Everything* spring to mind) but if clinical psychology is to take its subject matter seriously then Dickens and Zola (*Hard Times* and *Germinal*, respectively, cover class oppression pretty exhaustively) should be compulsory reading. The angst, desperation and anxieties of the middle classes are described throughout Balzac's *Comedie Humaine*. The power of faith is to be found in Greene's *The Power and the Glory* while murderous hate is no better explained than in Mailer's *The Executioner's Song* and *The Collector* by John Fowles. *Drunkenness* and

domestic violence inhabit *The Woman Who Walked Into Doors* by Roddy Doyle and Lorna Sage's *Bad Blood*. Grief weeps from the final pages of Byatt's *Still Life* and madness permeates *Titus Alone* by Mervyn Peake.

Biography and biographical fiction has often covered the experience of institutional care and psychiatric treatment (e.g., White, 1954; Frame, 1961; Plath, 1963; Laing and McQuarrie, 1989). A brilliant exposition of hallucinatory paranoia ennobles the film *The Fisher King*, directed by Terry Gilliam, while the drug-induced variety saturates Waugh's *The Ordeal of Gilbert Pinfold* and *Fear and Loathing in Las Vegas* by Thompson. Hypocrisy is laid bare in Miller's *The Crucible* and love is no better explored than in *Possession* by Antonia Byatt. The list goes on and on. None of this counts for much in psychiatry or psychology.

Nor is the criticism new. In the late nineteenth century the wholly subjective introspection of William James epitomized psychology. Jung broke from Freud, in part, because Freud saw his respect for spirituality, an essential human concern, as pandering to neurosis. Freud himself, however, had considerable respect for the power of mythology. The psychiatrist Alfred Meyer attempted to bring a philosophical approach back into the domain of an overwhelmingly biological psychiatry. A psychologist, Richard Forsyth (1988) has argued: "Psychologists do not study the mind, they do experiments. If psychologists were genuinely interested in the mind they would use every scrap of evidence they could lay their hands on; novels, poems, films, folklore, introspection, dreams". (p. 23)

More recently, Russell Davis (1992) has made a similarly powerful plea on the importance of theatre for the work of mental health workers. It is, however, as if the eternal truths explored by philosophers, novelists and other artists are of no concern to mental health professionals who continue to absorb a diet of pseudo-science and drug company propaganda. Indeed, Double (2001) has noted that many psychiatrists and junior medical staff actually receive their so-called training in psychopharmacology from drug company salespeople. Looking for guidance from government bodies such as the National Institute of Clinical Excellence (NICE) is unlikely to be of much help if NICE continues to change its opinion on the use of drugs or approve addictive psycho-stimulants for children having already admitted that the diagnosis of ADHD is "controversial". Strikingly, a review by Jorm (2000) remarks, "The public's view of psychotropic medication is almost uniformly negative, contrary to the views of clinicians and to evidence from RCTs." The reading lists of counselling and psychology courses contain very little on pharmacology, let alone the iniquities of research funding, and don't even pay lip service to the world of literature.

We need to respect the evidence from literature as of at least equal importance to the evidence presented in scientific journals and at scientific conferences. Novels have at least one considerable advantage over scientific writing; the former are presented, honestly, as fiction. The meanings and lessons derived from novelists are clearly the personal constructions of the reader from material

not masquerading as fact. Evidence presented in scientific journals, supported by statistical analyses of bewildering complexity, is meant to be the truth: if it makes no sense to the reader, then the reader is seen to be at fault. Psychology, applied or otherwise, is characterised by this type of evidence.

**Evidence from experience** If we take seriously the evidence of our senses then there are paradoxes to be found at every turn: the decent psychiatrist who sees little reason to stop using ECT, the general practitioners who wouldn't dream of taking drugs (any drugs) themselves but who willingly give out repeat prescriptions of major tranquillisers, the psychologists who claim, publicly, to work as evidence based scientist practitioners, but in private admit that they have little evidence for anything, the people who espouse the benefits of multi-disciplinary teams but protect their clients from team members they do not trust.

Contradictory and confusing experiences abound in clinical psychology. Clinical psychology trainees rapidly discover that some psychotherapeutic techniques work quite well. More confusingly, they also discover that some clients on mental health placements seem to feel a lot better after only one or two sessions of what the trainee had seen as a rather stumbling attempt at assessment. So much better, in fact, that the client no longer wants appointments. What are they to make of this? Analysts might be quick to suggest a "flight into health". The more diffident trainee might suspect that the client actually feels no better but doesn't have the heart to say so. The scientific literature has something to say about this in terms of the dose-response curve in suggesting that the greatest impact of therapy is to be found in the first two sessions. Common sense has a different slant: "A problem shared is a problem halved". Talk to someone twice and, presto! Your problem is reduced to a quarter and easily manageable.

Psychologists, psychotherapists and counsellors in training can be warned against consciously using personal experience in case it makes us less objective or emerges as counter-transference. Of course experience of any kind, be it childbirth or monitoring biorhythms during behavioural experiments can only be subjective. We need to recognise and utilise our subjectivity. We are parents, lovers, partners, children, men and women as well as psychologists. We will have loved, lost, betrayed, envied, suffered and survived. We have all used the health service. We are gendered and politicised. We will have used, or love people, who use services like the ones we offer. We may have been diagnosed. We are all oppressed. We can hurt others deeply and wish our children ill. We may have been criminals, miserable or hopelessly out of touch with what others call reality. We may be single parents or children of single parents. Our parents may be happy, divorced, adoptive or dead. Our sexuality, consumption of alcohol or use of drugs may be regarded as deviant or excessive. We may be able to cook, sew, or make flowers grow (Dylan, 1975). We may have a grandparent with learning disabilities and be regarded as the font of all wisdom. We may have a cousin with celiac disease. We may be considered mean or may think ourselves shy. We may hear voices or believe in the risen god; may struggle in

relationships or live contentedly alone. We may be moved by the doctors Dre, Faustus or Doolittle; by Prokoviev, Picasso or the Pixies and prefer Lucien to Sigmund in the Freud family. We may have been born on farms, live on council estates or in deepest suburbia. We may have learned that dishonesty and the willingness to run away are important to survival.

Any of these experiences should be invaluable in our work and will contribute to the sought after therapeutic alliance. They are all evidence from which we make judgements in our everyday lives. Why not in our clinical practice and our research? There is also evidence that psychology departments have local data available that may never see the academic light of day but is of some use in looking at outcome of therapy. In a recent survey of West Midlands clinical psychology departments (Stewart and Newnes, 2000) seven of ten respondents said that they regularly audited therapeutic outcome. They used a generally agreed set of standard assessments (e.g., SCL-90 and CORE) but none had published these results. This represents a huge store of unused data.

There is a great deal more. Clinical notes are full of material, never cross-referenced, about common factors in human misery. We notice, again and again, that people taking so-called anti-depressants are still depressed or people taking major tranquillisers are stoned most of the time. We notice the smell on wards and feel frightened when visiting institutions for the first time. We feel confused at ward rounds and can't follow the logic of organic theorizing. Conversations with colleagues about the terrible circumstances of people's lives, the frequent remarks about so-and-so's parents in the waiting room, the way a supervisor respects colleagues or upsets supervisees: this is all evidence. It all counts. It all influences the way we work. We are, quite literally, surrounded by evidence.

**What should we do?** It is not at all clear how wide an evidence base clinical psychologists use in practise. It is quite possible that the evidence from experience, literature and so on is already driving clinical work. We are, however, positioned as scientist practitioners and subscribe to appropriate journals. Some departmental bookshelves heave with books on cognitive behaviour therapy, research methodology and similar signs of scientific activity. My experience of many colleagues over the years, however, has been that the journals remain unopened and the textbooks are left to moulder. Departments may have a 1975 tome on neuro-psychological assessment or another on mental health promotion in children, but neither book will have been replaced by a newer edition. A dusty collection of volumes of similar vintage is likely to look untouched, as are many of the books on supervisors' shelves. Our department doesn't subscribe to any academic journals; they are not much missed. In other departments that can afford institutional subscriptions to journals few people want them for more than the very occasional article. The self help books, novels and poetry books in our own library are borrowed at least as often as textbooks and members of the department frequently let others in on the latest novel worth reading.

Perhaps clinical psychologists are already paying attention to the world of literature, the arts and their own experiences but feel constrained by the rhetoric of our profession from saying as much. Two Clinical Psychology Forum papers (Cliffe, 1994; Gurnani, 1993) have, for example, used Shakespeare as a reference point for insights into distress and therapy. This may have been tongue-in-cheek but the authors knew their stuff. A few others have name-checked popular culture in their titles (e.g., Sayal-Bennett, 1996) and two poets risked publication (Hussain, 1998; Gaussen, 1999). Two papers discuss the benefits of creative writing in therapy (Mills, 1991; Gilbert, 1995). One brave soul (Bailes, 1998) used A.A. Milne to good effect. There has been only one teaching tale (Marshall, 1993) and one paper explicitly calling for an approach to the mind that honours our artistic side (Chadwick, 1996), a call repeated in book form (Chadwick, 2001).

A special issue of *Changes* (Newnes and Marzillier, 1993) included papers from clinical psychologists on *Troilus and Cressida*, *Vonnegut*, *Wuthering Heights* and Marie Cardinal's *The Words to Say It*. John Marzillier has written on narcissism and *Dorian Gray* (1990). Forum has included personal accounts of cancer (Crawford-Wright, 1993), AIDS (Passariello, 1988), obsessionality (McCourt, 1999), visual impairment (Pimm, 1993), procrastination (Graham White, 1994), motherhood (Wallace, 1993), retirement and resignation (Cattrall, 1988; Scott, 1993; Kirkland-Handley, 1998) and getting older (Graham White, 2000). There has been at least one appeal for clinical psychologists to look inward rather than out (Seager, 1993) and five papers on the importance of religion and spirituality (Golding, 1993; Mills, 1997; Myers and Baker, 1998; Cunningham and Simpson 2000; Clarke, 2001). Two articles examine the experience of cross-cultural therapy (Aitken, 1998; Patel, 1998). One paper speaks of the experience of management (Newnes, 2000) and another on the felt fraudulence of being a clinical psychologist (Mollon, 1989). An honest account of being gay clinicians almost brought the house down (Taylor, Solts, Roberts and Maddicks, 1998; Roberts, 1999). Meanwhile, a coming out piece passed without public comment (Daiches, 1998). Curiously, only one paper deals directly with why the author chose to be a psychologist in the first place (Rowe, 1992), surely something which should be publicly available from all clinicians. Lars Sjodahl (1997), Peter Chadwick (1997) and Rufus May (2000) have written of their own experience of madness, recovery and receiving psychiatric services. Rachel Perkins writes in similar vein in a regular column for *Openmind*. The experience of service users has also been usefully converted into material for use with other clients (White, 1993).

Overall, clinical psychology is not a desert when it comes to discussing personal experience and the usefulness of art and literature. These examples are, however, very much the exception; the Forum articles cited are taken from a total N exceeding 1500 and the majority were commissioned rather than spontaneously submitted. Thus, in Forum at least, less than three per cent of papers explicitly engage with the personal in our work and fewer still have

explored how it feels to sit with or attempt to help people in distress. The proportion diminishes dramatically if this kind of writing is considered in relation to the thousands of articles published in journals requiring statistical means to determine what is evident.

The way forward I should like to suggest the way forward in three areas: training, practice and research.

### **Training**

- Course set books should include a range of novels which trainees are encouraged to read as valid alternatives to textbooks. Many lecturers already illustrate themes of distress and therapy by means of film clips from popular cinema; courses should encourage all lecturers to use film (see, for example, Spellman, 1998).
- Courses should actively encourage the exploration of personal experience by trainees both in terms of sharing experiences of distress and in exploring common-sense ways of helping and being helped.
- Courses should employ service recipients as lecturers on a third of topics.
- Courses should teach rhetoric, its origins and contemporary applications.
- Supervisors should be supported in encouraging supervisees to explore evidence from personal experience and literature.
- Discussion groups on film, poetry and literature should be a regular part of training.

### **Practice**

- Departments of psychological therapy and clinical psychology should have easy access to a full range of literature. If they hold library resources and budgets then these should reflect as many attempts as possible to capture human dilemmas and difficulties, from film to poetry, from text books and scientific journals to novels, autobiography and philosophy texts.
- Many clinicians already recommend novels and poetry to clients and are offered literature by clients attempting to illustrate their difficulties. These exchanges should be encouraged.
- Reflections on literature and the arts and their importance to therapy and in the life of therapists should be a regular part of departmental seminars.

### **Research**

- Clinical and service research should be based on the lived experience of service users rather than utilising test instruments developed in academic psychology departments using paid undergraduates as research subjects. Lindow (2001) suggests that it is time that research was controlled and directed by service users and survivors themselves.
- When writing for publication, clinical psychologists should review their use of literature and consider literary sources of inspiration and information as equally valid to scientific references.

**Is all this too much to ask?** It is bad enough trying to sift through the tidal wave of scientific evidence. What I am suggesting may appear to be a huge undertaking, an attempt to incorporate the world of the arts and the lived experience of clinicians into our training and practice. I suspect, however, all of this happens all the time. Academic writers and researchers might like to believe that their work is somehow free of personal bias. Clinicians might position themselves as scientist-practitioners, but what really goes through our minds when confronted by a despairing parent or crazy-seeming client? What do we really use to find meaning in the midst of human suffering? Are we coolly formulating before intervening? And if we are, then what else is simultaneously going on? I suspect that we are as flawed, biased, fearful, hurt, enthusiastic, driven, confused, even spiritual as anybody else, despite the scientific sloganeering.

It is time to celebrate our subjectivity, admit to our humanity more often and embrace arts and literature.

That should provide more than enough evidence for anybody.

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### **Dedication**

This paper is dedicated to Professor Steve Baldwin.  
He would have hated it, but how we should have enjoyed arguing about it.