

Monitoring Psychological Interventions

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By public policy and law, the licensure of a psychologist is intended to document qualifications to avoid jeopardizing public health, safety, and welfare. Conversely, licensure seeks to assure that there will be benefits from psychological services. The purposes are much the same for professional ethics. A cornerstone for professional ethics is the principle of beneficence and nonmaleficence: “Psychologists strive to benefit those with whom they work and take care to do no harm” (American Psychological Association, 2002, p. 1062).

Certainly every psychologist is committed to helping, which means there will be safeguards against ineffectiveness or failures. Part of the process is evaluating the efficacy of an intervention. Lambert, Jasper, and White (2005) opine: “Psychotherapists have a scientific and ethical responsibility to learn whether they are providing helpful services to their clients” (p. 236). Stewart and Chambless (2008) assert: “Although clinicians value their clinical judgment as a guide to treatment, other research suggests that they may not be particularly adept at predicting which treatments will lead to success or failure for their clients” (p. 176).

Service users (also known, in this day and age, as clients or patients) can impede intervention success. They may be opposed to receiving treatment and are there reluctantly or against their will because of extenuating circumstances (e.g., a court order or pressure from a significant other). They may exhibit outright resistance to the expectations of an intervention (e.g., refuse to enter into open communication, engage in

insight oriented tasks, or practice behavioral assignments). And there are, of course, some service users who are just not appropriate for psychological services, at least at the present time—not everyone can be expected to benefit from an intervention.

Given the foregoing, the psychologist must, from the outset, carefully appraise the suitability of a potential service user for the psychological services for which the practitioner has competency. As one possibility, the theoretical framework maintained by the psychologist must have proven efficacy with the characteristics, problems, and objectives aligned with the given service user. There is no one theoretical approach that is appropriate for everyone. If there is a poor match, the psychologist is obligated to make a referral to a more suitable intervention source. Koocher and Keith-Spiegel (2008) emphasize that professional ethics indicate that: “a psychologist should seek to terminate a relationship with a client when it is evident that the client no longer needs services or has ceased to benefit”; and they note that an ethical action could include “transferring the client to another practitioner, who may be able to treat the client more effectively” (p. 94).

When initiating intervention services, having a treatment plan or contract is a threshold necessity. It can be argued that the “peeling the onion one layer at a time” notion is antiquated. For several decades, a plethora of authoritative sources have held that interventions should be based on an operational diagnosis (which requires appropriate assessment) and well-conceived treatment plans (Cummings, 1986; Hof & Treat, 1989). Jongsma (2005) states: “Over the past 30 years, formalized treatment planning has gradually become a vital aspect of the entire health care delivery system,

whether it is treatment related to physical health, mental health, child welfare, or substance abuse” (p. 232).

A critical ingredient for successful interventions is having a scientific basis for any professional service that is provided. It is both an ethical and a legal mandate.

The Preamble to the APA (2002) code of ethics says: “Psychologists are committed to increasing scientific and professional knowledge of behavior and people’s understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society” (p. 1062). Also, Standard 2.03 Maintaining Competence casts a definite directive to rely on science: “Psychologists’ work is based upon established scientific and professional knowledge of the discipline” (p. 1064). This mandate is certainly compatible with what is required of psychologists who wish to offer expert testimony: “expert testimony is not admissible unless it is first determined by the trial judge that the expert is qualified and that the opinions of the expert are scientifically reliable” (Keefe-Garner & Wichwire, 2009, p. 17).

For about six decades, the scientist-practitioner model has been embraced for training in and the practice of psychology (Shakow, Hilgard, Kelly, Luckey, Sanford, & Shaffer, 1947; Curtis, 1996). VandenBos (2007) provides a succinct definition of the scientist-practitioner model: “a concept for university training of doctoral clinical (or other applied) psychologists in the United States that is intended to prepare individuals both to provide services and to conduct research on mental health problems, essentially integrating these two functions in their professional work by making a laboratory of their applied settings and studying their phenomena and the results of their administrations scientifically” (p. 818).

The scientist-practitioner model supports the contemporary emphasis on evidence-based practice of psychology (Levant & Hasan, 2008): “Beginning in the late 190s, a zeitgeist focusing on the use of empirical data to validate psychotherapeutic approaches became increasingly prominent” (Koocher & Keith-Spiegel, 2008, p. 104). Not only must a particular intervention have proven efficacy, it must be matched to the goals and objectives for the given service user. Williams, Beutler, and Yanick (2005) recommend that there be a systematic assessment and treatment matching for five domains: “the patient’s (1) severity and functionality; (2) personal and problem complexity; (3) distress; (4) level of resistance (sometimes called “reactance”) and (5) coping style” (p. 220).

Astute informed decisions about the successes and failures in interventions are best achieved by data based measures. The psychologist cannot depend on subjective pondering: “reliance on clinical judgment is problematic” (Stewart & Chambless, 2008, p. 180). Among other things, feedback from the service user is useful, assuming that conditions are such that reliable feedback will be obtained. However, other objective measures, including psychometric instruments, are logical.

Despite the distinct and irrefutable ethical and legal mandates for scientifically derived interventions, some psychologists flag in their commitment. Regrettably, it may be that: “some clinicians may be slow to identify clients who are not improving” (Stewart & Chambless, 2008, p. 180).

Any attempt to deny the foregoing ethical and legal rationale for scientifically based services, treatment planning, and outcome assessment is seemingly dissonant with contemporary professionalism. If a practitioner lacks competency in these areas, efforts at

professional development (e.g., continuing education, self study, supervision) should be implemented.

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