Chapter 6
Evidence Versus Ethics: What Comes First in Psychological Practice?

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Introduction and Context

Norwegian clinical psychologists are subject to the principle declaration of evidence-based clinical practice (Norsk Psykologforening, 2007, translated and adapted from APA's policy statement from 2006). This implies that all work done by a clinical psychologist in Norway should be evidence-based. The declaration states that the principle is three-partite, consisting of (1) best available research evidence, (2) clinical expertise and (3) patient characteristics and preferences (Norsk psykologforening, 2007). The act of evidence basing is meant to keep practices research informed, which is imperative to all professionals in knowledge-based occupations.

The principle of evidence-based psychological practices is also emphasised by the Norwegian health authorities (e.g. The Norwegian Health Directorate [Helsedirektoratet], 2015), and there is a pronounced expectation that psychologists should base their clinical work on 'evidence'. The Norwegian Health Directorate also specifies that psychologists should be mindful of the costs versus the benefits of their practice and that therapy processes should be ended if the expected outcome of the therapy process does not commensurate with the use of resources (Helsedirektoratet, 2008).

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Norwegian professor of psychology Tor-Johan Ekeland (2011, p. 9) describes a politisation of mental healthcare during the course of the twentieth century, where mental health was perceived a public concern. Consequently, mental health services to a larger degree became subject to cost/benefit considerations and public mental healthcare institutions are evaluated according to their ability to reach the quantified goals set for them (Helsedirektoratet, 2020).

Shortcomings of Evidence-Based Psychological Practices

Berg (2019a, 2020, pp. 149–150) criticises evidence-based psychological practices, as described in the principle declaration, for claiming to be three-partite. Berg argues that the principle declaration is conceptually inconsistent and self-contradictory, failing to distinguish between the (legitimate and important) research on general characteristics of clinical experts and patients and individual clinical experts and patients. Thus, evidence-based psychological practices end up consisting of only the first part of the three-partite definition (best available research evidence), since the two latter parts are entirely legitimised through the former (2019a, 2020, pp. 134–135). Furthermore, Berg (2019b) puts forward that evidence-based psychological practices are supposed to work as a regulator in clinical psychology are unsuitable as ethical regulation of clinical psychological practices. He argues that the utilitarian cost/benefit approach that evidence-based practices are structured into does not allow for the complex ethical reflections he deems essential for identifying the right course of action in therapy (2019b).

Norwegian philosopher Trond Skaftnesmo (2013, p. 186) argues that scientific evidence meant to inform professional practicioners paradoxically ends up as anti-science. He claims that the aim of evidence-based practices is not to deepen insights, but rather to create an authority, which professionals must accept. Furthermore, he claims that postulations about the methodological superiority of randomised controlled trials are epistemologically unfounded (Skaftnesmo, 2013, p. 32).

According to Ekeland (2011, p. 29), research on clinical psychology is mainly, and disproportionately, concerned with treatment methods. He states that clinical practice is too complex and ambiguous for instrumentalist approaches to adequately inform the practices. In his view, clinical psychology is a highly complex field challenging the psychologists' interpretative skills and judgement building on non-instrumentalist knowledge relating to ethics, communication and comprehension of context. He therefore calls for more research on actual psychological *practices*, including for instance psychologists' views on knowledge (their epistemology) (Ekeland, 2011, p. 29).

Clinical Psychology and Ethics

Several psychologists, philosophers and thinkers (e.g. Berg, 2020; Tjeltveit, 2004) have called attention to the entanglement of psychological practice and ethics as well as scientific knowledge. Both Berg and Tjeltveit argue that psychotherapists are ethicists, as the goal of psychological therapy is to live better lives – implying the ethical question of what constitutes a good life (Wyller, 1996, p. 8). According to Tjeltveit (2004), answers to morally charged questions such as what is good and bad, right and wrong, *will* emerge from the therapeutic relationship, implicitly or explicitly. These emerging questions and answers constitute the foundation for an ethical context of psychotherapy, where therapists can practice 'at the highest possible ethical level' (Tjeltveit, 2004, p. 164). On the other hand, if the psychologist does not reflect upon the ethical context of therapy and the therapeutic relationship, the ethical context can prove ineffective, or even worse destructive (Tjeltveit, 2004).

Ethics in psychology has predominantly been subject to two guidelines: the first being the research ethics and the second the ethical guidelines that health professionals must follow (e.g. confidentiality). While these two guidelines are both correct and highly important for psychology as a field of research and as clinical practice, they only represent a limited part of ethics in psychology failing to include clinical practice as ethical in its nature.

Proximity Ethics

Gantt (2000) argues that medicalisation has rendered modern psychotherapy less able to 'genuinely understand the ethical significance of human suffering' (p. 12). Furthermore, he conceptualises Emmanuel Levinas' perspective of *the other* and holds that the critical moments—'the real work' (p. 20)—of psychotherapy happen when psychologists comply with their ethical obligation, i.e. suffering *with* the other person in the here-and-now (2000). Telleus et al. (2019) describe *proximity ethics* (*danish: nærhedsetik*) as the ethics that unfold in the psychological, existential encounter between two or more people. In this encounter, basic human phenomena such as compassion and trust are expressed, and we as humans are enabled to be empathetic and caring. Within the framework of *proximity ethics,* one can focus on conversation, vulnerabilities, belonging and closeness (danish: 'nærhed') (Telleus et al., 2019, pp. 101–102), which depends on empathy. The findings of Elliott et al. (2011) support the notion that empathy is an important concept in psychotherapy. Carl Rogers, credited for the proposition of empathy as a critical condition for change in psychotherapy, states the following: '*To sense the client's private world as if it were your own, but without ever losing the "as if" quality—this is empathy, and this seems essential to therapy*' (1957, p. 99).

Research Questions and Assumptions

Norwegian psychologists are expected to follow the principle of evidence-based psychological practices. While there is general agreement that high-quality research is crucial for the development of clinical psychology, one may argue that relying on research and evidence alone will not enable therapists to make good decisions when meeting individual patients. Based on the abovementioned assumptions that the principle of evidence-based psychological practices is insufficient as practice regulator, a need for alternative regulatory practices arises. The overarching goal of this study is thus to investigate psychologists' reflections on ethics-based psychological practices.

Methods

Design

Data collection was done through an anonymous internet-based questionnaire, using *Nettskjema*, a survey tool developed by the University of Oslo, which has a high degree of security and privacy. The questionnaire consisted of a single open-ended question, for clinical psychologists to answer about their thoughts in the beginning of a therapy process.

Data Collection

Survey

The survey was done online. It contained only one question: *What are your first thoughts when meeting a new patient, after they have presented their problem/ reason for coming to you?* The question is open-ended and there was no limit regarding the length of the answers. No personal information about the respondents was collected.

Sample

The respondents were recruited from a Facebook group for Norwegian clinical psychologists. The survey was posted in the group and psychologists could volunteer to participate online. Fifty-one clinical psychologists chose to answer the survey, and all of the 51 responses are included in the analyses.

Data Analysis

The answers received were in the form of full-written sentences and reasonings. Thematic analysis was chosen as a flexible method suitable for this study (Braun & Clarke, 2006). An adapted version of the criteria from Braun and Clarke (2006) were followed: Familiarisation with the data, by reading through the material repeatedly and note initial thoughts; coding the entire data material line-by-line; categorise themes based on the codes; in the final step themes were named and checked against the material.

Findings

The conduction of thematic analysis produced three main themes: 'the encounter', 'limitations' and 'knowledge base'. 'The encounter' is a theme covering the reflections on the psychologists' role and contributions. It also refers to the psychologists' desire to know more about the patient after the initial meeting or conversation, and a wish to get a deeper understanding of the patient's problems. Here we find empathy, which contains the numerous reflections on feeling close to and having compassion with the patient. The theme 'limitations' contains reflections about whether or not they would be able to help this particular patient given inevitable limitations (e.g. economic or therapeutic). The last theme 'knowledge base' refers to the therapists considering what kind of research or scientific knowledge that will apply in the respective cases.

The Encounter

The Norwegian term 'møte' (meeting; encounter) may partly refer to the formal appointment and physically meeting the patient. More importantly, the concept has definite existential overtones, when referring to the psychological encounter that may or may not happen in a therapeutic relationship. One informant puts it this way: *'I am mostly concerned with having an encounter with the other person, that is, to be mindful of whether there was a moment where we "met", and what the quality of that moment was*' (#30). It is evident that #30 is referring to (sometimes brief or rare) moments of interpersonal connection or understanding that is encounter (møte) and not only the formal, physical meeting (also møte) that is obviously happening every time a patient and psychologist are in the same room. This theme contains the psychotherapists' reflections on the patient's impact or impression on them, thoughts of how the therapists themselves are behaving and expressing themselves, as well as considerations about their role and contributions to the encounter, including existential reflections upon the encounter between two human beings. The importance of

the first encounter was underlined by for example #46, who creates space for the coming therapy by giving room for the patient: '*I try to welcome and receive the client with an open body language, and to convey to them that I can contain whatever they relay to me–and I try to just be with [...]'*. The respondent points out the role of body language and how the therapist is working to establish trust in the relationship by opening a space, where both can linger and give possibilities for the patient to convey his/her story. The respondent emphasises the therapist's responsibility in creating a safe atmosphere.

Another respondent (#51) talks about focusing more on feelings than on thoughts, as he/she takes in the patients' story, needs and wishes in order to get an overview of his/her own experiences. The therapist needs time to understand and contain, which includes organisation of his/her own feelings and experiences. This might be an indication of raising consciousness towards his/her own reactions that might hinder or support the therapeutic process. Respondent #32 goes further in his/her reflections by calling attention to the patient's communication and relationship with feelings and the therapists' reactions to it as relevant for an understanding of the patient:

> I try to notice how this person's story and the way he/she tells it affects me, so that I can get an impression of how this particular patient relates to and communicates feelings. And I try to notice what is activated in the rapport between us that could be relevant to understand the patient's problem.

Again, attention to one's own reactions to the patient's presence and presentation seems crucial at the beginning of a therapy in the first encounter. The therapists seem serious about the necessity of not letting their own reactions confuse the therapy but acknowledge these reactions as valuable clues. In continuation of these basic introspection and patient observations, cognitive curiosity is built up. Many of the responses (~40%) indicate that the respondents' initial thoughts include a desire to learn more about the patient. They seem curious about the person's story and experiences, but also eager to understand what is not being told them directly:

> Immediately, I think about how I can understand what the other person presents as their problem, if there are any underlying aspects of the problem, and I try to understand the reason why the person seeks help, other than what is verbalised. (Respondent #35.)

The respondent's curiosity is both on what is known and unknown to the patient. She/he wants to go beyond what is presented directly in order to be able to help the patient. The outset is the particular individual and his/her presentation, and individualised cognitive knowledge. In addition to this cognitive understanding the respondents report a curiosity about how they must be feeling, which is a presupposition for empathy. About a quarter of the respondents mentioned a feeling of empathy as a primary reaction to their client's explanations or statements: *'Immediately, (I get) thoughts of how it must feel to be this person, and what I myself or other people I've met would need [in the same situation]'* (Respondent #2). It seems this psychologist actively searches within him/herself by identifying with the situation and focusing on their own needs in order to get a better understanding of the other person's needs.

Only three informants use the term 'empathy' explicitly, but when we include statements of wanting to understand and finding similar feelings within oneself, as well as mentioning compassion, a total of 31 responses can be counted as using this concept in the broad sense. The moral charging of this concept is quite clear; one is not concerned about oneself as therapist, but rather concentrates on seeing and understanding the patient. The concept 'empathy' in this broad sense is thus defined as the concept that is most unambiguously linked to ethics. This is also the most prevalent concept in the data material.

Limitations

Some respondents report thinking in utilitarian terms when they meet a patient, as money, time and therapeutic skills do not come in abundance. Some therapists have to assess the patient's need for psychological help and consider whether or not they are in the target group of the institution they work for. In specialised mental health services and hospitals, this bureaucratic approach is often necessary; part of the psychologist's role is to decide who will benefit the most from receiving psychological therapy and prioritise some over others. In this way, the psychotherapists' considerations might concern people other than those who are in the therapy room; other potential patients and their needs are also implicitly taken into account. For example, respondent #12 expresses these thoughts:

> I think about the expected value and outcome [of therapy for this particular person], and whether or not the person already has some kind of support service, for instance from the mental health department in the municipality.

This psychologist finds these considerations important as they will be decisive for whether the patient will be admitted or not, which is important to know for the patient as soon as possible. The utilitarian approach thus also encompasses an element of care for this particular patient, but also other people who might be in need of help.

The concept 'helping' is one of most frequently occurring concepts, however, used meaning different things. One aspect is the strong wish that psychologists have to help their patients: 'I think about how I can help the person' (#16). This might be interpreted as representing a deep existential need and moral obligation to be helpful to other people or being associated with more technical solutions as tools and instruments. Furthermore, 'helping' as a concept has yet another significance in the data material, where 'help' is referring to institutional help, and not the existential-oriented personal help: *'I'm first and foremost [thinking] about assessing their rights; is this a person who has the right to healthcare in the specialist health care services?'* (#12). The concept itself is thus ambiguous. On the one hand, it may reflect a genuine wish from a specific therapist to help a specific patient. On the other hand, it can represent the institutional and technical duty that the public healthcare services have to help those who have a right by law to receive help (i.e. services) (duty ethics).

Knowledge Base

In line with the therapists' reflections on whether and how to help, we find some respondents explicitly mention that they think about scientific as well as experience-based knowledge when they meet a new patient. *'My thoughts search in my conserved scientific or experience-based knowledge, to find something that is relevant to what this person is telling me'* (Respondent #31). Seemingly, they simultaneously take in what the patient is telling them and try to link it to relevant research or previous experience. Four respondents explicitly mention that they consider scientific knowledge this early on in the therapy process as parts of their total reflection on how they best can help their clients. In contrast, three other respondents explicitly distance themselves from research results. Earlier experience seems to play an important when the therapists try to figure out how to help:

> I am sometimes intrigued by their story and details in it, because it touches me and/ or gives associations to former patients, and to psychological hypotheses I have–I connect things to theory that I apply in my clinical practice (#15).

This statement focuses on the therapist's feelings and associations to both former patients and his/her own theories as basis for the encounter. Triggered by feelings and associations, the therapist connects the patient's story to knowledge that might be scientifically, or experience based. Respondent #15 also talks about his/her hypotheses, which essentially are a generalisation from one or more specific experiences. Hypotheses are created as abstractions from certain contexts, but can as well be used as a synonym for 'guesses'. It looks like both these interpretations are included in the data material. While #2 seems to use hypotheses as guesses: *'Often, I quickly make hypotheses about circumstances in the patient's life, that I want to further explore'*, #45 seems to refer to a more abstract and scientific generalisation: *'I often think about what research says when I am to position the person in a landscape of general risk factors or when I assess the degree of marginalisation'*. The therapist, apparently, utilises different approaches according to their reflections. Expertise, knowledge and competency are widely recognised as the most important foundation to get official authorisation to work as a clinical psychologist in Norway. Interestingly, there seems to be some uncertainty regarding their competency among the therapists as they look at it as a process of adaptation on their part; the psychologist needs to use their acquired psychological knowledge and rework it so that it fits the specific patient they are working with. Competency (or competence) is thus regarded as something one is constantly acquiring and which consequently does not have a static content.

Discussion

During analyses, we found three overarching themes that together account for the psychologists' reported initial thoughts when meeting a new patient. In the theme 'encounter', we found the reflections on the psychologists' role and contributions. It

also referred to the psychologists' curiosity about the patient after the initial meeting or conversation, and their wish to get a deeper understanding of the patient's problems. Empathy, which contains the numerous reflections on feeling close to and compassion with the patient, was the most prominent feature. The theme 'limitations' contained reflections about their ability to help given inevitable limitations as structural, institutional and personal shortcomings. The last theme 'knowledge base' referred to the basis on which the therapists formed their hypotheses regarding a specific patient. In total, the emphasis on empathy as well as connectedness and helpfulness, outweighed and preceded thoughts about research and cost-benefit. Consequently, the principle of evidence-based practice is not followed blindly. We might ask which role does 'evidence' actually have in psychological treatment? According to Berg (2019b), evidence-based psychological practices are used to separate legitimate from illegitimate practices and basing psychological practices on the results from randomised controlled trials creates an illusion of ethical neutrality. Evidence-based practices are structured to favour utilitarianism as its normative ethics. The tendency in our data material is that evidence or research results are by no means predominant initially in therapy. A vast majority of the psychologists simply do not mention thinking about research at all when meeting a patient for the first time. Despite being subject to the principle of evidence-based practice, the explicit use of scientific knowledge is not the apparent *starting point* for this sample of 51 Norwegian psychologists.

Vaskinn et al. (2010) reported that up to 90% of Norwegian psychologists use psychometric tests, instruments and inventories (for example intelligence tests such as the Wechsler scales, inventories such Beck's depression inventory or structured diagnostic interviews such as M.I.N.I) to some degree in their practice. While the statistics reported by Vaskinn et al. (2010) do not contain any information of the frequency of use, one might expect that several of the respondents in our sample more or less frequently use tests or inventories when working with their patients. However, it seems that our respondents are more concerned with meeting their patients on an existential level and one can imagine that filling out forms can disturb the possibility of having a valuable psychological encounter or disrupt the unfolding of empathy in the therapy room. Requirements from the institutions they work for (e.g. the public specialist healthcare services) might compel them to spend time on psychometric tests rather than establishing a meaningful interpersonal connection. This may create a discrepancy between the psychologists' intentions and what they end up doing. Limited resources at various healthcare institutions may lead to a utilitarian, cost/benefit approach, that the psychologists must submit to. For example they might be required to diagnose their patient after only a few meetings and this may lead to a high pressure on the density of information that should be retrieved from the patient, thus leading to an increased use of inventories. For some types of psychological problems, the use of inventories is strictly required (Helsedirektoratet, 2020). However, our material indicates that the psychologists initially have other ideals, concerns or wishes, that are more morally charged, when entering a new therapy process. Prominent concepts in the data material, such as encounter and empathy, are value-based concepts. When prioritising these, the informants also expose their values. While Berg (2019b) is concerned that

evidence-based psychological practices limit the ways ethical perspectives can be applied to evaluate psychological practice, our respondents seem capable of appraising the initial therapy process outside an explicit evidence-based perspective. By means of curiosity, understanding, empathy and their own feelings, they report to interpret the information that is unfolded in the therapy room.

Looking beyond the concepts and themes derived from the data material, we can discern a tendency that goes across concepts, themes and priorities: the intention to help the other person. While helping others in need is an essential pillar for moral thought in general, the Hippocratic legacy makes helpfulness particularly imperative for healthcare personnel, including psychologists. When the psychologists have to decide which patients they are most likely to be able to help with the available resources, the moral duty to help a person in need might be set aside with bureaucratic justifications. Trying to be helpful is an ethically founded choice (submitting to moral duty), and the question of *how* to be helpful is also, at least partly, an ethical one. The alleged tripartite evidence-based psychological practices tries to address this point (how to be helpful); best available evidence, clinical expertise and the patient's individual needs are supposed to inform each other so that the 'best' course of action (i.e. the best way to help) can be determined. Berg's (2019a, 2020, pp. 134–135) point is that this model fails to regulate practices the way it is supposed to. Given this shortcoming, there should be an opening for ethical considerations to have precedence in the question on how to be helpful. It is natural to think that the clinical expert, while being informed by best available evidence, has reflections concerning 'what is right and good to do now' and that these reflections should constitute the basis of the help the patient receives. Non-judgmentalism is essentially a virtue for psychotherapists; a few of our respondents do mention this as important when they meet patients. Tjeltveit (1986), however, claims that a certain *value conversion* often happens—from the therapist, onto the patient. The query of *whose* moral is unfolded in therapy may then be deemed in favour of the therapist, which may lead us to touch a sore point: whom do the morals really benefit? Our respondents, while favouring morally charged concepts when describing their thoughts, do not explicitly reflect on the power relations intertwined with morals. Considering the apparent preponderance of morally charged concepts, recognising the implications of these seems important. That is, when ethical considerations are prevalent in therapy, it is necessary that the psychologists acknowledge that their thoughts are indeed value based.

Closeness and the Encounter

The respondents are generally attentive to the psychological encounters that may emerge between them and their patients. According to Telleus et al. (2019), this attentiveness would be a manifestation of proximity ethics (*nærhedsetik*), that is, an ethics of closeness or intimacy. Practicing *nærhedsetik* is an ethical action. It fulfils the moral duty to help fellow human beings without concern for the costs versus benefits of the time spent with the other person. This is in stark contrast to utilitarian

approaches where the financial considerations, as well as generalisations from research results, may determine whether or not a person will receive help (healthcare). With *nærhetsetik*, considerations of the specific human being are superior to economic considerations. Facilitating important psychological encounters is important for the unfolding of empathy in therapy. Our respondents use their empathetic skills as a means of getting information from and understanding and connecting with their patients. One can assume that empathy is rendered more potent if it is allowed to unfold in a meaningful encounter. Carl Rogers' quote '*To sense the client's private world as if it was your own, but without ever losing the "as if" quality–this is empathy, and this seems essential to therapy*' (1957, p. 99) beautifully illustrates empathy and professes its importance, and there is reason to assume that 'sensing the client's private world' is best done in moments of psychological connectedness. An ethics-based psychological practice requires psychologists who are highly aware and knowledgeable of how ethically based reasonings and attitudes unfold in therapy. In later years, we have seen that the institutions educating psychologists in Norway have moved away from focusing on self-development (as is common for psychoanalysts) towards training students to reflect critically about for example research findings. The latter is of course important for future professionals who will have to inform themselves on the newest scientific knowledge throughout their careers. If ethics-based psychological practice is to be successful, students need to be trained in ethical reasoning as well. As mentioned initially, the associations with ethics in psychology are often limited to (1) research ethics and (2) ethical guidelines for health professionals. An increased consciousness of the extent of ethics' presence and possible significance in therapy could enhance any therapy process, but will be crucial to an ethics-based approach. This is in line with Alan Tjeltveit's (2004) view that while questions of what is right and wrong, good or bad are bound to emerge in therapy, it is up to the therapist to use this to the advantage of the therapy and the patient—regardless of therapists being able to practice 'at the highest possible ethical level' (Tjeltveit, 2004, p. 164). According to psychologist Tor Johan Ekeland (2014), it is a mistake to think that a patient can be an object comparable to a research object, when the patient always is an acting subject; therefore, the relationship between patient and therapist is the only possible basis for psychological treatment. It is hard to imagine a psychological practice where ethical considerations are not the foundation for therapeutic choices. Although informed by scientific knowledge, it is necessarily the ethical considerations of the therapist that is momentous for the course of a therapy process. Science cannot make choices for us.

Conclusions and Implications

Berg (2019a) suggests that evidence-based psychological practices fall short as a regulatory principle. The principle is insufficient to fully cover the distinct qualities of each therapy process, each encounter. Until now, the term 'evidence-based' has been used as a demarcation between legitimate and illegitimate practices. Evidence

is often self-proclaimed *neutral*, but it is not; at least the application of scientific knowledge can never be completely morally neutral. Psychological practices are fundamentally ethical, but this is often obscured by an overemphasised ideal of objectivity and neutrality. Ethics-based practices will need other justifications than what randomised controlled experiments can offer. Our study indicates that 51 psychologists tend to prioritise morally charged concepts, indicating that psychological practices are already partly implicitly based on ethics. Our respondents seem oriented towards the existential dimension of therapy and to a large degree base their work with specific patients on experiences from important psychological encounters with that person as well as earlier experiences. As this aspect seems important, one must consider the implications for the more and more common use of internet-based therapy, therapy via chat, telephone or video. When this chapter is penned, autumn of 2020, a pandemic is raging, and non-physical meetings have had a spike, therapeutic meetings included. While non-physical meetings can undoubtedly be meaningful, maintaining 'closeness' requires a special sensitivity for the morally charged content that occurs in therapy. Psychologists need to acknowledge their role as ethicists, when approaching the intricate question how to obtain 'a good life' for their patients.

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