PSYC 8344
Interventions I
Week 2 – Introduction to Evidence-Based Practice

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NARRATOR: Evidence-based practice refers to psychotherapy that is based on empirical research. Listen as Dr. Norcross describes various components of evidence-based practice, and addresses current controversies related to its use.

JOHN NORCROSS, PhD: The overarching goal of evidence-based practice is effectiveness. We take the best available research, put in clinical expertise, in the context of patient characteristics, culture, and preferences, to enhance the efficacy, efficiency, and applicability of psychotherapy. As applied to individual clinicians, evidence-based practice makes us more effective, allows us to meet patients where they are really. For society as a whole, evidence-based practice promises better public health for the entire populace. That's why we do evidence-based practice.

I like to think of it-- as psychologists we're indeed all scholar practitioners, or scientist practitioners. It is our field; it is our training that makes us the experts in human behavior. We will automatically be trained to be guided, fueled, not shackled, driven by the best research. That informs our practice. That's what differentiates us from various fields.

That's the reason for some of these gruesome, if not traumatizing, courses in statistics and research we all take. There really is a purpose to those courses, so that we can understand research, so that we can access it, and use it for clinical good. That's evidence-based practice.

In evidence-based medicine, they refer to patient values as a catchall for the patient's voice and contribution. As we were applying evidence-based practice into psychology, we broadened this notion of the patient to encompass patient characteristics, culture, and preferences, because in psychotherapy, it's a more active role, a more proactive stance of the patient to psychotherapy.

So it includes the characteristics, the personality, the strength, the resilience of the client. It encompasses their culture, not defined narrowly just in terms of race and ethnicity, but the entire person of the client, which might be sexual orientation, age, personality, disability status, religion, and so on. And then, of course, there's preferences. We know different folks require different strokes for effective psychotherapy. So what does that patient want, desire, need from particular psychotherapy? Evidence-based practice ties all that into the singular situation and unique individual.

The first and foremost pillar of evidence-based practice is the best available research. And this is usually derived from science and health related areas. Historically it's referred to the best research pertaining to treatment methods, but it's far more inclusive than that. It's the best available research on the prevalence of disorders, yes, of course, the treatment method, the best available research on the therapy relationship, evidence-based assessment, consultation, education, referral. It's bringing the best of science from the research lab to apply to the consulting room.

Evidence-based practice integrates three pillars, so the best available research, patient characteristics, culture, and preferences, and then clinical expertise. Clinical expertise comprises all that the person of the therapist brings in, their training, their experience, their inherent personhood, that goes into making diagnostic judgments, establishing a robust therapeutic alliance, case formulations, monitoring patient or client outcomes, making referrals as necessary. Everything that's human about psychotherapy is encompassed within that term "clinical expertise."

So we envision this as a Venn diagram of three overlapping circles, each representing the constituent elements. At that intersection of those three elements lies evidence-based practice decision making, right there in the middle. And when these three sources all converge, or overlapping circles, then the evidence-based decision is relatively easy. The best research, the clinician, and the patient all agree this is a way of proceeding that would maximize the probability of an effective, efficient psychotherapy.

But when the three circles don't overlap much with each other, then it becomes somewhat flawed and contested. Should we be honoring the best research? Should we go with the clinician's judgment at that moment? Or, should the patient's voice and preferences reign supreme in such instances?

I am an enthusiastic advocate for evidence-based practice. But we should be mindful of the major controversies in the area. At first blush, every psychotherapist acknowledges the importance of evidence-based. It's like prizing publicly apple pie and mother. No one disagrees. And surely no one is arguing for the converse. No one says we should just ignore all available research.

But when you look a little closer, it's not so simple and consensual. There are a series of cascading controversies about how one determines evidence-based. What qualifies as evidence? What's the best type of research to proceed? If we're not careful, there could be reckless extrapolation from the research lab to the consulting room. And then there would be premature impositions of static lists of evidence-based practice on clinicians.

So we have to be careful as we approach each of the controversies, which typically begins with, what exactly qualifies as evidence when it comes to evidence-based practice? Everyone agrees the three pillars of best available research, clinical expertise,

and client characteristics are sources. But then we argue about the relative values and merits of each of those.

Historically, particularly in evidence-based medicine, research reigns supreme. It is the number one source of information and guidance for the practicing psychotherapist. And indeed, evidence-based medicine emerged for exactly this concern that we shouldn't simply go with the clinician's expertise and bias. We should be letting research guide us.

Another controversy in evidence-based practice, as it's applied to psychotherapy, is, what qualifies as research? Historically, particularly in evidence-based medicine, the gold standard of research has been the randomized clinical trial. Now, the easy response to what kind of research qualifies as evidence is, we should embrace a multiplicity of research designs addressed to different questions.

For example, if one is to ask, what is the prevalence of this disorder? Then you would turn to the epidemiological or survey research. If you were to ask, what's the best treatment method? Then you would turn, indeed, to this gold standard of a randomized clinical trial on a particular treatment method. If you wanted to know, does that effective research treatment work well in naturalistic settings, like a private practice office? Then you would look at large effectiveness studies. If you were interested in saying, "What clinician behaviors specifically correlates with successful psychotherapy," then you would use a process-outcome study.

So we all embrace a multiplicity of research designs. We all do not worship at the alter of randomized clinical trials. And that's where the controversy occurs, because randomized clinical trials have the distinctive advantage of allowing us to make causal statements about what works. But that's not the only question that faces us in our daily work as psychotherapists.

A core challenge for evidence-based practice is whether those treatments, assessments, and relationships, that have been found effective in majority populations, can readily be transportable to minority and marginalized populations. Let's say, if panic control therapy works brilliantly, as it does, for symptom reduction in 75% to 80% of middle income Caucasians, can we reliable use that in another country? Can we use that with African-American or Asian Americans?

So people have been arguing this point, literally, for years. And there's at least three perspectives because we know minority populations have been systematically understudied in most randomized clinical trials. So first, some people argue, well if these treatments work on majority population, we should assume they'll work, fairly successfully, with minority populations. This is a variant of the “Physics still works in China;” there are universal laws.

A second position, which happens to be mine is, that we simply don't know. If a treatment has been validated and found to be effective in a lab with a certain population, we simply don't know if it works with another population; that other population being defined by ethnicity, or international status, or immigrant, or sexual orientation.

And the third position is to say it does not work. And we should not be so bold to generalize so quickly. Most people adapt the middle view that I take, that we just don't know, and what we really need is future research.

An ongoing battle within the research community concerns whether efficacious, laboratory validated treatments generalize well to the naturalistic world in which most psychotherapists work. It's all about generalization. Are the patients seen in randomized clinical trials representative of the patients we see? Are the therapists, frequently graduate students, trained in a single manualized treatment, representative of what we do, as therapists in every day practice? Are the conditions of a randomized clinical trial transportable to what we do?

Randomized clinical trials are tightly controlled studies, which possess great fidelity, but they're also brief, manualized, and largely targeted at a single disorder or complaint. It's very different from the patients who wander into most of our rooms. So there's a fairly fierce but friendly debate concerning the ability of research results to generalize easily into everyday practice.

What becomes privileged by the term "evidence-based practice" will increasingly determine what is taught, what is funded, and what is practiced in the next two decades. Freud once remarked that words were once magic. And as any psychotherapist will readily attest, words can diminish, or they can privilege. And that's certainly the case with evidence-based practice. Because if something's evidence-based, we'll say, "Well, we should be teaching that, we should be funding that, you should be conducting psychotherapy that's called evidence-based."

So while we're enthusiastic about evidence-based practice, we do have to be cautious about how it's applied. We do not have good research for every clinical situation and decision. There are literally dozens of micro-decisions in any session. At this moment, should I emphasize, interpret, clarify, reflect, give a homework assignment? Should I do some sort of skill based training at this moment? There's no research to say what we should be doing at any one moment.

So evidence-based practice largely concerned the larger macro-treatment decisions. And, if we're not careful, evidence-based practices can be misused and abused. So while we need to go forward, because this is what good professions do, they base the best practice on the best available research, we should also be aware that many situations are not covered. And be careful of the deep philosophical and huge practical

consequences of labeling some practices as evidence-based, and then pushing others off and saying, they're not evidence-based. There's a great middle to this area. To paraphrase Chief Justice Oliver Wendell Holmes, the absence of evidence does not mean the evidence of absence. Some things are just untested. So we have evidence-based, we have untested and unknown, and then we do have, probably a smaller set of discredited practices.

Evidence-based practice has a long past, but a short history. The long past goes into the introduction, really, of the fields. In psychology, as it separated from philosophy, it prided itself on its scientific roots; it's experimental applications. We were a science of behavior. Similarly in psychiatry, they wanted to split away and demonstrate that they were a science of mind. So in virtually all of mental health and psychotherapy, we've always prided ourselves on our research base, on our scientific underpinnings.

Well, the short history of evidence-based practice really goes just only to the 1990s. It began in Great Britain, largely in medicine, evidence-based medicine. Then it moved over to Canada, into the United States, where it then moved into mental health, just not evidence-based practice. In fact, psychotherapy is coming at this a little later than our medical colleagues.

And no longer is it just health care. Evidence-based practice, or best practice, is truly an international juggernaut. It's now infiltrating virtually every country, and virtually every applied science, be that education, architecture, public policy. Everyone's asking, what's the best practice? What does research tell us is the best way of proceeding? So it has a long past, but as a specific area, a relatively brief history, just back into the 1990s.

Evidence-based practice in psychotherapy is most developed for brief, manualized treatments, largely cognitive behavioral therapy, for specific disorders, with the goal of symptom reduction. Research has shown that 70% to 80% of treatment methods that are branded "evidence-based" are cognitive behavioral treatments. So while they're not certainly the only ones, they're the primary areas right now.

The least developed areas of evidence-based practice are just the converse: lengthy psychotherapy, we don't know much about those, and they usually don't make these lists, privileged as evidence-based; non-manualized treatments, people doing more eclectic, integrated, innovative therapies, that have not yet been manualized; insight oriented, and humanistic therapies do not lend themselves as easily to the usual strictures of evidence-based practice criteria, that is, that they be manualized, that their primary goal is symptom reduction. And when someone presents with multiple psychological disorders, co-morbid disorders, or a psychological disorder and an addictive disorder, we do not have much in the way of best available research now, to call those evidence-based.

And one other area that most of us are very concerned about is, what happens if the primary goal of psychotherapy is not symptom reduction? That is, let's say someone comes in and says, "I'm functioning fine, but what I would like is greater insight into myself, into my family of origin. I would like to enhance the joy that I'm having. I'm not clinically depressed."

Right now, well over 95% of the outcome measures we use in psychotherapy research studies are symptom focused, and while that's important, necessary in many cases, in other cases, our goals maybe slightly different. For example, in classical psychoanalysis, Freud's stated goal was to make the unconscious conscious. That is certainly not going to be well captured by changes on a client's Beck Depression Inventory.

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Asking the right specific clinical question is the first sequential skill in evidence-based practice. You ask yourself, what do I need to know, from the research literature, from myself, and from my patient or client, in order to practice evidence-based practice? And, indeed, it is the first of six core evidence-based practice skills.

We call this Triple A Tie, that AAATIE. The first step is, ask a specific clinical question. What's the prevalence? What's the best treatment? What's the most valid assessment measure? For this family, how do I align or join them best? For this group, what kind of therapeutic relationship do I want to create? And how specifically do I do that? Given that this couple presents with two or three different disorders, how do I proceed? That's asking a specific clinical question for that patient, or the patient population you're working with.

After that, the next “A” is to “Access” the best available research. This is increasingly done online. The third “A” is then to critically “Appraise” that research, is it valid? Is it representative? Would it generalize? Does this seem to apply? So they're the three “A’s”.

After that it's the “T”, for to “Translate” the research you found into this particular circumstance. Then the “I” is to bring in, “Integrate” the clinical expertise and the patient's voice, that is the patient's characteristics, culture, and preferences. And finally the T, I, “E” is to “Evaluate.” Evaluate the effectiveness of the entire enterprise.

So evidence-based practice is not a static list posted somewhere. It is a dynamic process for each new clinical encounter, in which you go through these six steps. You ask the question. You access the best research literature. You then appraise that research. You translate that into the immediacy of the clinical situation. You integrate the patient, the clinician with the best available research. Then, boom, you evaluate how the whole thing has worked.