1 An Explanation of Evidence-Based Practice

This book on evidence-based practice (EBP) is about the use of research and critical thinking in assisting practitioners to determine the most beneficial ways of helping clients with social and emotional problems. The current practice in psychotherapy, counseling, and in much of our work as helping professionals, too often relies on clinical wisdom with little evidence that what we do actually works. Clinical wisdom is often used as a justification for beliefs and values that bond us together as professionals but that often fail to serve clients. Many of those beliefs and values, although comforting, may also be inherently incorrect. O'Donnell (1997) likens this process to making the same mistakes, with growing confidence, over a number of years. Issacs (1999) calls practice wisdom "vehemence-based practice," where one substitutes volumes of clinical experience for evidence that is "an effective technique for brow beating your more timorous colleagues and for convincing relatives of your ability" (p. 1).

Flaherty (2001) believes that there is a "murky mythology" behind certain treatment approaches that causes them to persist and that "unfounded beliefs of uncertain provenance may be passed down as a kind of clinical lore from professors to students. Clinical shibboleths can remain unexamined for decades because they stem from respected authorities, such as time-honored text-books, renowned experts, or well-publicized but flawed studies in major journals" (p. 1). Flaherty goes on to note that, even when sound countervailing information becomes available, clinicians still hold on to myths. And more onerous, Flaherty points out that we may perpetuate myths "by indulging the mistaken beliefs of patients or by making stereotypical assumptions about patients based on age, ethnicity, or gender" (p. 1), concerns that still worry those in the mental health field.

In a review of the effectiveness of psychotherapy over a 40-year period, Bergin (1971) calls for an EBP approach when he writes,

> "It now seems apparent that psychotherapy has had an average effect that is modestly positive. It is clear, however, that the averaged group data on which this conclusion is based obscure the existence of a multiplicity of processes occurring in therapy, some of which are now known to be unproductive or actually harmful." (p. 263)

In a more recent evaluation of the effectiveness of psychotherapy, Kopta, Lueger, Saunders, and Howard (1999) report, "The traditional view that the different psychotherapies—similar to medication treatments—contain unique active ingredients resulting in specific effects, has not been validated [and] the aforementioned situations are evidence of a profession in turmoil" (p. 22). Kopta and colleagues go on to say that new research designs might help provide needed answers about the efficacy of one form of therapy over another with specific groups of clients; however, "The field is currently experiencing apparent turmoil in three areas: (a) theory development for psychotherapeutic effectiveness, (b) research designs, and (c) treatment techniques" (p. 1). Kopta and colleagues go on to indicate that "researchers have repeatedly failed to find convincing evidence that different psychotherapies are differentially effective" (p. 3), and, when differences are taken into consideration, the differences noted often have to do with "researcher allegiance [which is] influenced by the superiority of some treatment classes over others for depressed patients" (p. 3).

The clinical wisdom view of practice has frequently been based on what the American Medical Association (AMA) Evidence-Based Practice Working Group (1992) refers to as (a) unsystematic observations from clinical experience, (b) a belief in common sense, (c) a feeling that clinical training and experience are a way of maintaining a certain level of effective practice, and (d) an assumption that there are wiser and more experienced clinicians to whom we can go when we need help with clients. All of these assumptions are grounded in a paradigm that tends to be subjective and is often clinician rather than client focused. Aware of the subjective nature of social work practice, Rosen (1994) calls upon the social work profession to use a more systematic way of providing practice and writes, "Numerous studies indicate that guidelines [for clinical practice] can increase empirically based practice and improve clients' outcomes" (as cited in Howard and Jensen, 1999, p. 283). Howard and Jensen continue by suggesting that guidelines for social work practice would also produce better clinical training, more cooperative client decision making, improved clinical training in schools of social work, more cost-effective practice, and a compilation of knowledge about difficult-to-treat conditions, because "few of the practice decisions social workers make are empirically rationalized" (p. 283).

An argument is often made by helping professionals that what we do is intuitive, subjective, artful, and based upon our long years of experience. Psychotherapy, as this argument goes, is something one learns with practice. The responses made to clients and the approach used during

treatment may be so spontaneous and inherently empathic that research paradigms and knowledge-guided practice are not useful in the moment when a response is required. This argument is, of course, a sound one. The moment-to-moment work of the clinical practitioner *is* often guided by experience. As Gambrill (1999) points out, however, we often overstep our boundaries as professionals when we make claims about our professional abilities that we cannot prove. She points to the following statement made in a professional social work newsletter, and then responds to it:

> **Statement:** Professional social workers possess the specialized knowledge necessary for an effective social services delivery system. Social work education provides a unique combination of knowledge, values, skills, and professional ethics which cannot be obtained through other degree programs or by on-the-job training. Further, social work education adequately equips its individuals with skills to help clients solve problems that bring them to social services departments and human services agencies. ("Proposed Public Policies of NASW," p. 14)
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> **Response:** These claims all relate to knowledge. To my knowledge, there is no evidence for any of these claims. In fact, there is counterevidence. In Dawes' (1994) review of hundreds of studies, he concluded that there is no evidence that licenses, experience, and training are related to helping clients. If this applies to social work and, given the overlap in helping efforts among social workers, counselors, and psychologists, it is likely that it does, what are the implications? (Gambrill, 1999, p. 341)

The psychotherapy literature is replete with concepts and assumptions that seem unequivocally subjective and imprecise. Consider, for example, definitions of psychotherapy that suggest it is socially acceptable to receive help offered by a trained professional to alleviate emotional pain. One might use the same definition for faith healers, psychics, and others who all have social sanction and alleviate pain. Or consider this whimsical definition of psychotherapy: two people playing together. The vagueness of such definitions certainly cannot convey to clients what we do and makes it more than a little difficult for clinical researchers to evaluate the effectiveness of treatment.

As a response to subjective and sometimes incorrect approaches to practice, EBP advocates consulting the research and involving clients in decisions about the best therapeutic approaches to be used, the issues in clients lives that need to be resolved, and the need to form a positive alliance with clients to facilitate change. This requires a cooperative and equal relationship with clients. EBP also suggests that we act in a facilitative way to help clients gather information and rationally and critically process it. This differs from authoritarian approaches, which assume the worker knows more about the client than the client does, and that the worker is the sole judge of what is to be done in the helping process.

Definitions of Evidence-Based Practice

Sackett, Richardson, Rosenberg, and Haynes (1997) define EBP as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individuals" (p. 2). Gambrill (2000) defines EBP as a process involving self-directed learning that requires professionals to access information that permits us to (a) use our collected knowledge to provide questions we can answer; (b) find the best evidence with which to answer questions; (c) analyze the best evidence for its research validity as well as its applicability to the practice questions we have asked; (d) determine if the best evidence we've found can be used with a particular client; (e) consider the client's social and emotional background; (f) make the client a participant in decision making; and (g) evaluate the quality of practice with that specific client (p. 1).

Gambrill (1999) says that EBP "requires an atmosphere in which critical appraisal of practice-related claims flourishes, and clients are involved as informed participants" (p. 345). In describing the importance of EBP, the AMA EBP Working Group (1992) writes,

> A new paradigm for medical practice is emerging. Evidence-based medicine de-emphasizes intuition, unsystematic clinical experience, and pathophysiologic rationale as sufficient grounds for clinical decision-making, and stresses the examination of evidence from clinical research. Evidence-based medicine requires new skills of the physician, including efficient literature-searching, and the application of formal rules of evidence in evaluating the clinical literature. (p. 2420)

Timmermans and Angell (2001) indicate that evidence-based clinical judgment has five important features:

1. It is composed of both research evidence and clinical experience.
2. There is skill involved in reading the literature that requires an ability to synthesize the information and make judgments about the quality of the evidence available.
3. The way in which information is used is a function of the practitioner's level of authority in an organization and his or her level of confidence in the effectiveness of the applied information.
4. Part of the use of EBP is the ability to independently evaluate the information used and to test its validity in the context of one's own practice.
5. Evidence-based clinical judgments are grounded in Western notions of professional conduct and professional roles, and are ultimately guided by a common value system.

Gambrill (1999) points out that one of the most important aspects of EBP is the sharing of information with clients and the cooperative relationship that ensues. She notes that, in EBP, clinicians search for relevant research to help in practice decisions and share that information with clients. If no evidence is found to justify a specific treatment regimen, the client is informed and a discussion then takes place about how best to approach treatment. This discussion includes the risks and benefits of any treatment approach used. Clients are involved in all treatment decisions and are encouraged to independently search the literature. As Sackett et al. (1997) note, new information is constantly being added to our knowledge base, and informed clinicians and clients may often find elegant treatment approaches that help provide direction where none may have existed before.

Gambrill (1999) believes that the use of EBP can help us to "avoid fooling ourselves that we have knowledge when we do not" (p. 342). She indicates that a complete search for effectiveness research will provide the following information (p. 343), which is relevant for work with all clients (first suggested by Enkin, Keirse, Renfrew, and Neilson, 1995):

1. Beneficial forms of care demonstrated by clear evidence from controlled trials.
2. Forms of care likely to be beneficial. (The evidence in favor of these forms of care is not as clear as for those in category one.)
3. Forms of care with a trade-off between beneficial and adverse effects. (Effects must be weighed according to individual circumstances and priorities.)
4. Forms of care of unknown effectiveness. (There are insufficient or inadequate quality data upon which to base a recommendation for practice.)
5. Forms of care unlikely to be beneficial. (The evidence against these forms of care is not as clear as for those in category six.)
6. Forms of care likely to be ineffective or harmful. (Ineffectiveness or harm demonstrated by clear evidence.) (Gambrill, 1999, p. 343)

Hines (2000) suggests that the following fundamental steps are required by EBP to obtain usable information in a literature search: (a) developing a well-formulated clinical question; (b) finding the best possible answer to the question; (c) determining the validity and reliability of the data found; and (d) testing the information with the client. Hines also says that a well-formulated clinical question must accurately describe the problem you wish to look for, limit the interventions you think are feasible and acceptable to the client, search for alternative approaches, and indicate the outcomes you wish to achieve with the client. The advantage of EBP, according to Hines, is that it allows the practitioner to (a) develop quality practice guidelines that

can be applied to the client, (b) identify appropriate literature that can be shared with the client, (c) communicate with other professionals from a knowledge-guided frame of reference, and (d) continue a process of self-learning that results in the best possible treatment for clients.

Haynes (1998) writes that the goal of EBP "is to provide the means by which current best evidence from research can be judiciously and conscientiously applied in the prevention, detection, and care of health disorders" (p. 273). Haynes believes that this goal is very ambitious, given "how resistant practitioners are to withdrawing established treatments from practice even once their utility has been disproved" (p. 273).

Denton, Walsh, and Daniel (2002) suggest that most of the therapies used to treat depression, among other conditions, have no empirical evidence to prove their effectiveness. The authors believe that before we select a treatment approach, we should consult empirically validated research studies that indicate the effectiveness of a particular therapeutic approach with a particular individual. The authors describe EBP as the use of treatments with some evidence of effectiveness. They note that EBP requires a complete literature search, the use of formal rules of proof in evaluating the relevant literature, and evidence that the selection of a practice approach is effective with a particular population.

In describing the ease with which EBP can be used, Bailes (2002) writes, "Evidence-based practice is not beyond your capability, even if you do not engage in research. You do not have to perform research; you can read the results of published studies [including] clinical research studies, meta-analyses, and systematic reviews" (p. 1). Bailes also indicates that the Internet permits access to various databases that allow searches to be done quickly and efficiently. Chapters 2, 3, and 4 in this book are devoted to ways of obtaining and analyzing information for use in making informed treatment decisions.

Finally, in clarifying the type of data EBP looks for in its attempt to find best practices, Sackett, Rosenberg, Muir Gray, Haynes, and Richardson (1996) write, "Evidence based practice . . . involves tracking down the best external evidence with which to answer our clinical questions" (p. 72). The authors note that nonexperimental approaches should be avoided because they often result in positive conclusions about treatment efficacy that are false. If randomized trials have not been done, "we must follow the trail to the next best external evidence and work from there" (p. 72).

Concerns About Evidence-Based Practice From the Practice Community

There are a number of concerns about EBP. One major concern is that EBP is a paradigm that was originally developed in medicine. Psychotherapy is a good deal less precise than medicine and cannot be held to the same

scrutiny or the same standards as medicine since psychotherapy is often subjective in nature. Another concern is that EBP seems to ignore the importance of practice wisdom and the countless years of experience of effective and dedicated practitioners. Many clinicians believe that researchers have difficulty evaluating what we do in practice and that attempts to determine effectiveness usually result in inconclusive findings. According to Bergin (1971), psychotherapy effectiveness seems to relate to worker experience. Combining inexperienced workers with experienced workers in a research study often results in inconclusive and misleading findings. Witkin and Harrison (2001) provide another concern about EBP and the problems encountered in reviewing clinical research:

> Small alterations in the definitions of problems or "interventions" can lead to changes in what is considered best practice. A review of readily accessible online reports of EBP or evidence-based medicine studies (see, for example, Research Triangle Institute, 2000) shows that various types of 'psychosocial' treatments are sometimes aggregated across studies. (p. 293)

The authors suggest that finding the strongest evidence for a particular intervention may require a great deal of research sophistication at a level many clinicians do not posses and may never be interested in possessing. They are also concerned that "best evidence" may deny the fact that therapy is a joint effort and, although the therapist may have a certain treatment in mind that shows research promise, it may not be acceptable to the client, and ask, "But what if practice is viewed as a mutual activity in which what is best (not necessarily effective) is co-generated by clients and practitioners? What is the relative value of different sources and types of evidence in this scenario?" (Witkin and Harrison, 2000, p. 295).

In one of the more recent large-scale evaluations of the effectiveness of psychotherapy, Seligman (1995) found most clients generally well satisfied with the help they were receiving. Although Seligman found no difference in client satisfaction between short- and long-term treatment, one cannot deny that clients remain in treatment because of a need for ongoing support and encouragement. These two factors are not easy to reconcile with scientific notions of treatment effectiveness. Psychotherapy, unlike medicine, doesn't often result in a cure. Clients may have prolonged periods of relief followed by a return of symptoms and the need for additional treatment. Using that description of psychotherapy, however, few could deny that medical care often results in relief of symptoms followed by the need for additional treatment. Finally, clinicians are trained in a subjective form of help we incorrectly call treatment. It really isn't treatment, which implies a medical process, but a more didactic exercise in which two people focus on the client's hurts and try to provide relief. It is, necessarily, a softhearted and empathic approach to healing that exists outside of an objective framework. Findings in empirical studies of effectiveness are, therefore, likely to indicate vague and undramatic results.

Among the suggested benefits of EBP are practice guidelines that describe best practice with certain types of emotional problems. Commenting on the use of evidence-based guidelines for practice, Parry and Richardson (2000) believe that clinicians are often reluctant to use practice guidelines because they believe the research underlying many practice recommendations often incorrectly generalizes findings from a specific population of clients to all clients. The authors also believe that clinicians reject "the medical metaphor, that psychotherapies can be 'prescribed' in any 'dosage' in response to a 'diagnosis.' There is also a strong belief amongst psychotherapy practitioners, that clinical judgments cannot be reduced to algorithmic procedures" (p. 280).

Barker (2001) wonders if practitioners use best evidence in the form of manuals or standardized protocols, and says that the answer is, "Rarely, if ever. Rather, the successful therapist tailors therapy to suit the individual needs of the person, or the contextual factors" (p. 22). He defines tailoring therapy as meeting the needs of "often changing characteristics of clients" (p. 22), a description of therapy that makes effectiveness research improbable. Baker goes on to say,

> The practice of psychotherapy is increasingly compromised by the pressures of economic rationalism and the demands for evidence-based practice. The diversity, which has characterized psychotherapy practice to date, risks being compromised by the narrow bandwidth of therapies which are deemed to fulfill the 'gold standard' validation criteria of the randomized controlled trials. (p. 11)

Chambless and Ollendick (2001) confirm that attempts to use EBP in manuals and in other disseminated ways often meet with rejection by practitioners for some of the following reasons:

1. Concerns about effectiveness studies suggest that nonempirically based research may be rejected as unscientific, but,

> "No matter how large or consistent the body of evidence found for identified empirically supported treatments (EST's), findings will be dismissed as irrelevant by those with fundamentally different views, and such views characterize a number of practitioners and theorists in the psychotherapy area." (Chambless and Ollendick, 2001, p. 699)

2. Presenting evidence-based information about treatment effectiveness can be problematic because it is difficult to design a manual or report that meets the specific needs of all therapists. Therapists are often unlikely to use such reports or manuals even when provided.

3. ESTs are effective in clinical settings and with a diverse group of clients; however, the studies found to support evidence-based treatment were high in external validity but low in internal validity. Consequently,

although the authors found no compelling evidence why ESTs could not be used in agencies by trained clinicians, more research on their use was suggested.

4. Economic problems facing many social agencies suggest that manuals prescribing treatments for specific social and emotional problems will be more of an issue as the economy softens and services for social and emotional problems are curtailed. The authors write: "Whatever the reluctance of some to embrace ESTs, we expect that the economic and societal pressures on practitioners for accountability will encourage continued attention to these treatments" (Chambless and Ollendick, 2001, p. 700).

In discussing the effectiveness of psychotherapy, Kopta et al. (1999) raise the issue of whether research evidence even exists to support the use of EBP, and note that researchers have been unable to find evidence of the superiority of one type of therapy over another. They also worry that the belief system of the researcher, as Robinson, Berman, and Neimeyer (1990) discovered, might actually influence the outcomes of effectiveness studies.

Witkin and Harrison (2001) discuss social work and EBP and conclude that what social workers do may not be open to the same level or type of evaluation as that typically used in medicine. Social workers act as cultural bridges between systems, individualize the client and his or her problem in ways that may defy classification, and work with oppressed people; therefore, what social workers do may not fit neatly into organize theories of practice. In response to the use of EBP, the authors write:

> Sometimes this involves using the logic of EBP with clients when there is credible evidence of some relevant knowledge available. Other times, however, the most important work is in educating decision makers or those who have control of resources about how irrelevant the best scientific evidence is to the world of people whose experiences brought them into contact with the professionals. (p. 295)

Witkin and Harrison (2001) also raise the issue of whether the helping professions should be placed in the same precarious position as medicine when it relates to issues of managed care. The authors write, "Is it a coincidence that EBP is favored by managed care providers pushing practice toward an emphasis on specificity in problem identification and rapid responses to the identified conditions?" (p. 246). The AMA EBP Working Group (1992) reinforces this concern when it states,

> Economic constraints and counter-productive incentives may compete with the dictates of evidence as determinants of clinical decisions. The relevant literature may not be readily accessible. Time may be insufficient to carefully review the evidence (which may be voluminous) relevant to a pressing clinical problem (p. 2423).

Additional Criticisms of Evidence-Based Practice With Responses

In response to concerns that managed care may use EBP to lower costs, Sackett et al. (1996) write,

> Some fear that evidence based medicine will be hijacked by purchasers and managers to cut the costs of health care. Doctors practicing evidence based medicine will identify and apply the most efficacious interventions to maximize the quality and quantity of life for individual patients; this may raise rather than lower the cost of their care. (p. 71)

An editorial in *Mental Health Weekly* (2001) challenges the idea that EBP is being pushed by the health care crisis. The editorial argues that EBP is an expensive approach to implement, particularly during times when budgets are tight. And while the approach might be implemented, the ability to force practitioners to us best evidence is still unproven.

The AMA EBP Working Group (1992) identifies three misinterpretations about EBP that create barriers to its use, and then responds to those misinterpretations as follows:

1. Evidence-based practice ignores clinical experience and clinical intuition.

> On the contrary, it is important to expose learners to exceptional clinicians who have a gift for intuitive diagnosis, a talent for precise observation, and excellent judgment in making difficult management decisions. Untested signs and symptoms should not be rejected out of hand. They may prove extremely useful, and ultimately be proved valid through rigorous testing. The more experienced clinicians can dissect the process they use in diagnosis, and clearly present it to learners, the greater the benefit. (p. 2423)

2. Understanding of basic investigation and pathology plays no part in evidence-based medicine.

> The dearth of adequate evidence demands that clinical problem-solving must rely on an understanding of underlying pathology. Moreover, a good understanding of pathology is necessary for interpreting clinical observations and for appropriate interpretation of evidence (especially in deciding on its generalizability). (p. 2423)

3. Evidence-based practice ignores standard aspects of clinical training such as history taking.

> A careful history and physical examination provides much, and often the best, evidence for diagnosis and directs treatment decisions. The clinical teacher of evidence-based medicine must give considerable attention to teaching the methods of history and diagnosis, with particular attention to which items have demonstrated validity and to strategies to enhance observer agreement. (p. 2423)

In a review of the most effective practices in psychotherapy, Chambless and Ollendick (2001) note that one argument used against EBP is that there is no difference in the effectiveness of various forms of psychotherapy and that identifying best practices is therefore unnecessary. However, Chambless and Ollendick found considerable evidence that, in the treatment of anxiety disorders and childhood depression, cognitive and behavioral methods were fairly clearly defined and that positive results often ensued from the treatment.

The British Medical Association raises other issues with EBP in an editorial appearing in the July 1998 *British Medical Journal.* The editorial calls into question the implied ease with which good evidence is available in medicine and, by implication, whether it is readily available to the helping professional. The editorial notes that most published research in medical journals is too poorly done or not relevant enough to be useful to physicians. In surveys, more than 95% of the published articles in medical journals did not achieve minimum standards of quality or relevance. Clinical practice guidelines are costly and slow to produce, difficult to update, and have poor quality ("Getting Evidence Into Practice," p. 6).

By way of response, Straus and Sackett (1998) report that EBP has been quite successful in general medical and psychiatric settings and that practitioners read the research accurately and make correct decisions. They write, "A general medicine service at a district general hospital affiliated with a university found that 53% of patients admitted to the service received primary treatments that had been validated in randomized controlled trials" (p. 341). The authors also go on to note that three quarters of the evidence used in the treatment of clients was immediately available through empirically evaluated topic summaries, and the remaining quarter was "identified and applied by asking answerable questions at the time of admission, rapidly finding good evidence, quickly determining its validity and usefulness, swiftly integrating it with clinical expertise and each patient's unique features, and offering it to the patients" (p. 341). Similar results, according to Straus and Sackett, have been found in studies of a psychiatric hospital (p. 341).

Is Evidence-Based Practice Applicable to the Helping Professions?

Reynolds and Richardson (2000) argue that, despite concerns among clinicians that EBP may impede their freedom, new opportunities in practice research suggest that clinician freedom will be enhanced because more options will be available as creative research methodologies suggest new forms of treatment. As new research opportunities develop, the profile of psychotherapy will rise. And although EBP has been called "cookbook practice" and a "new type of authority" that threatens the autonomy of professionals, the possibility exists that research in psychotherapy effectiveness will have the same positive effect that medical research has had on the practice of medicine. In discussing the benefits of practice guidelines, Parry and Richardson (2000) believe that well-done practice guidelines will help clinicians crystallize their thinking about treatment. Published guidelines will also give clients more information and consequently give them additional power to decide on their own treatment. High-quality guidelines help in training new professionals and influence the writing of textbooks that must increasingly contain evidence of best practices. Parry and Richardson (p. 279) provide the following examples of well-done guidelines for professional practice:

1. The American Psychiatric Association has published practice guidelines for eating disorders (APA, 1993a) and for major depressive disorder in adults (APA, 1993b).

2. The Australian and New Zealand College of Psychiatrists ran a quality assurance project that has produced several treatment outlines for agoraphobia (Quality Assurance Project, 1982a), for depressive disorders (1982b), for borderline, narcissistic and histrionic personality disorders (1991b), and for antisocial personality disorders (1991a).

3. The U.S. Agency for Health Care Policy and Research has been influential. For example, their depression in primary care guideline (Agency for Health Care Policy and Research, 1993a, 1993b) was widely discussed (Munoz et al., 1994; Persons et al., 1996). More recently, Schulberg et al. (1998) reviewed research published between 1992 and 1998 to update this guideline. Other guidelines worth exploring include those on the treatment of bipolar disorder (Frances et al., 1996), choice of antidepressants in primary care (North of England Evidence-Based Guideline Development Project, 1997) and treatment of obsessive-compulsive disorder (March et al., 1997).

Whether we care to admit it or not, we are in the midst of a health care crisis in America. Although it's easy enough to blame managed care for the

part of the crisis that relates to the helping professions, we, the helping professionals, must share the responsibility. As Witkin and Harrison (2000) and others have repeatedly noted, the helping professions have not embraced the concept of best practice or the need to function from a knowledge-guided frame of reference. The result is a growing suspicion among health care analysts and providers that what we do is expendable. In a warning to mental health professionals to begin close cooperative relationships with self-help groups, Humphreys and Ribisl (1999) give a prophetic view of what the current thinking is regarding the health of the helping professions by asking, "Why should public health and medical professionals be interested in collaborating with a grassroots movement of untrained citizens?"(p. 326). The reasons the authors provide are that money for health care is contracting and is likely to continue doing so, and that self-help groups often provide "benefits that the best health care often does not: identification with other sufferers, long-term support and companionship, and a sense of competence and empowerment" (p. 326).

Professions have a body of knowledge that shouldn't be based on practice wisdom or practice experience, but on the evidence that we are collecting from empirical data that support our interventions. Without such a body of knowledge, we begin to lose our status as professionals and the future of psychotherapy in the United States seems clear: less therapy provided, irrespective of client need; therapy provided by the least highly trained worker with heavy reliance on self-help groups; psychoeducational materials in the form of reading for clients and in lieu of therapy; and the hope that clients will be resilient and wise enough to get better, essentially, by themselves.

SUMMARY

This chapter discusses the definitions of EBP and some of the criticisms to the approach found in the literature. Among the strongest criticisms of EBP is that we fail to have a well-defined literature at present, and what we do have is not only difficult to read and comprehend, but it's far too time-consuming for most practitioners. There is also a strong suspicion that clinicians do not use manuals that contain best evidence on practice effectiveness. On the positive side, it is recognized that there is a need to organize best practices and to ensure clients and third-party providers that what we do works. EBP is an approach that tries to organize a way of providing the best possible service to clients by using a knowledge-guided approach to the research literature and substantial involvement of clients in decision making to ensure that the client-worker relationship is cooperative.

Integrative Questions

1. Do you think it's possible to organize best practice in ways that capture the individual nature of the client? Isn't this the problem with EBP, that it cannot individualize what's actually best for specific clients and their unique needs?

2. Why do you think training manuals are so unpopular with clinicians?

3. There is evidence in this chapter that we lack conclusive data to suggest best evidence for effective work with most client problems. Doesn't this suggest that EBP cannot function adequately until we have considerably more practice research available?

4. EBP originated in medicine. Do you think that medicine and therapy are similar enough to utilize an approach initially developed for medical practice?

5. Because therapy requires a more highly involved participation by the client than does medicine, do you accept Gambrill's criticism that we make statements in the helping professions about what we do and its effectiveness that are unsupported by the data and that create false impressions?

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