

Evidence based practice in counselling and psychotherapy

by Peter Bower

Introduction

Clients, therapists and those who fund therapy services are all in agreement that clients deserve the best treatment for their presenting problems. However, deciding on the best treatment for a client is a complex task.

Counsellors and therapists have traditionally made decisions about treatment on the basis of their existing knowledge, prior experience and reference to the accumulated knowledge of their profession. The BACP *Ethical Framework for Good Practice in Counselling and Psychotherapy* (2009) (the *Ethical Framework*) captures this approach in its statement that therapists must act 'in the best interests of the client based on professional assessment. It directs attention to working strictly within one's limits of competence and providing services on the basis of adequate training or experience'. Professionals are expected to demonstrate 'reflective practice', involving critical reflection on their own practice and the development of consensus among professional colleagues (Harrison, 2002).

Recently there has been interest in changing the basis of decisions about treatment in the helping professions such as medicine, nursing and counselling and psychotherapy. This new approach goes by the name of 'evidence based practice'.

This information sheet defines evidence based practice, outlines the implications for counselling and psychotherapy, considers the advantages and disadvantages, and speculates how evidence based practice might develop in the future.

What is evidence based practice?

Evidence based practice was originally defined by its proponents in medicine as:

'the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients'
(Sackett et al., 1996)

There is much in this statement that is in line with the BACP *Ethical Framework*, which 'requires practitioners to keep up to date with the latest knowledge and respond to changing circumstances.' However, evidence based practice is controversial because the definition of 'current best evidence' and 'latest knowledge' is heavily weighted towards certain forms of information derived from certain types of research methods.

Counselling and psychotherapy can be studied using many different types of research, including quantitative research, individual therapy case studies and indepth analysis of therapeutic work. Many practitioners are interested in questions relating to *how* their treatments work. However, the focus of evidence based practice is on *whether* treatments work i.e. evidence based practice is concerned with treatment *effectiveness*. For a variety of reasons, determining whether a treatment is effective is best achieved through a particular type of study called a *randomised controlled trial*.

What is a randomised controlled trial?

The simplest way of evaluating a therapy is to measure client wellbeing before and after therapy. If therapy is effective, client wellbeing should improve after treatment. However, there are other reasons why clients might improve. They might have received support from friends and family, or their finances may have improved. It is possible that some problems improve simply through the passage of time. Because these other factors will impact

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on client wellbeing at the same time as they are receiving therapy, they make it difficult to tell whether the therapy is responsible for change. Technically, these other factors are known as *confounders* (Bower & King, 2000).

The randomised controlled trial is a research method that can overcome the problems of confounders and determine whether a treatment (such as therapy) is having a genuine effect.

In brief, a randomised controlled trial of therapy works as follows. First, one group of clients is given a therapy, while another (the 'control' group) is not. Where possible, both groups of clients are treated identically in every other way apart from the therapy itself.

Secondly, clients are allocated to the groups through *randomisation*. This means that they have an equal chance of being put in either group. The function of randomisation is simple, but powerful. When clients are randomised, the two groups will include clients who on average do not differ systematically on any characteristic. For example, each group will contain similar numbers of men and women, younger and older clients, those with severe problems and those with more minor ones. Not only will randomisation ensure similarity in characteristics that we know about (such as age, sex and initial severity of the problem), it also ensures that the groups are similar on characteristics that may not be measured or understood (such as client personality) but which are important in terms of their eventual outcome (Bower, 2003; Bower & King, 2000).

The randomised controlled trial allows researchers to test differences in outcomes (such as depression, well-being, or quality of life) between the two groups. The presence of the control group ensures that changes found in the clients receiving therapy cannot be explained by the mere passage of time, as this would influence both groups equally. Any differences found between the groups in outcomes after therapy cannot be due to any differences in their characteristics at the start of therapy, because randomisation ensures that their characteristics are very similar.

What is a systematic review?

Although randomised controlled trials are very powerful research methods, sometimes a single trial is not enough to determine whether a treatment is effective. It may be necessary to conduct trials in different settings to check that a therapy works in a variety of places and with a wide range of therapists. Researchers also like to repeat their results to ensure that they are reliable. Recruiting clients to trials is sometimes difficult, and some trials are simply too small to give a definitive

answer. When more than one trial exists on a particular treatment, evidence based practice uses a technology called a *systematic review* to make sense of this literature.

Systematic reviews draw together a number of individual randomised controlled trials to provide an overview that is more comprehensive and accurate than the results of individual trials (Gilbody & Petticrew, 1999). Further details concerning systematic reviews can be found in Bower, 2010.

Where can I find information about randomised trials and systematic reviews?

Randomised controlled trials and systematic reviews are regularly published in academic journals, but details of trials and systematic reviews in health care can be found on the Cochrane Library. The Cochrane Library is advertised as 'the best single source of reliable evidence about the effects of health care', and is a source of information on many thousands of trials and systematic reviews of various treatments, including counselling and psychological therapy. The Cochrane Library is freely available through the National Library for Health (<http://www.library.nhs.uk>).

How are randomised controlled trials and systematic reviews used in evidence based practice?

As noted earlier, evidence based practice has been defined as 'the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.' Current best evidence thus complements 'reflective practice' and 'professional consensus' as another key guide to decision making. When adopting evidence based practice, professionals were expected to search out the best evidence from randomised controlled trials and systematic reviews (using sources such as the Cochrane Library), and use that evidence to make a judgement about what treatment to provide for an individual client.

Although that happens on occasion, it was quickly realised that professionals (including therapists) may not have the expertise to search for evidence routinely in their clinical practice and certainly would not have the time to do so. Therefore, in settings such as the NHS, searching for and interpreting the evidence is generally done centrally by organisations such as the National Institute for Health and Clinical Excellence (NICE), which uses teams of researchers (assisted by clinicians and patients) to summarise 'current best evidence' about the effectiveness of treatments. To assist clinicians, these recommendations are placed into *clinical guidelines*.

What are clinical guidelines?

Clinical guidelines are 'systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances (Field & Lohr, 1990). Guidelines are often based around particular diagnoses or problem areas, and summarise 'current best evidence' to assist professionals to decide what treatment is most likely to benefit a client. For example, the NICE clinical guidelines for depression describe the role of different psychotherapies for clients with different severity of depression. In the United States, counselling and psychological therapy treatments, that have been shown to be effective in randomized controlled trials and are recommended for use, are known as 'empirically supported treatments' (Chambless & Ollendick, 2001; Weston, Novotny, & Thompson-Brenner, 2004).

The relationship between clinical guidelines and individual clinical decision making is sometimes unclear. Generally, clinical guidelines are thought of as the default position for decision making. Exceptions to the recommendations in the guideline are possible, but they would require the professional to justify why the guideline has not been followed (Roth & Fonagy, 1996). The expected result of the use of guidelines is both an increase in the overall quality and effectiveness of the treatments, provided to clients, and a reduction in the variability among professionals, so that clients receive more consistent treatment.

Although most guidelines are concerned with identifying those treatments that lead to the best outcomes for clients, economic issues are increasingly informing guidelines. This means that the guideline may identify the most costeffective treatment. This is to ensure that the limited resources available to provide treatments such as psychological therapy are used to the best effect.

What is the hierarchy of evidence?

A term often used in evidence based practice is the *hierarchy of evidence*. When considering evidence of the effectiveness of treatments, evidence based practice imposes a hierarchy of trustworthiness, with those forms of evidence lower in the hierarchy only to be used when higher forms of evidence are unavailable. The hierarchy prioritises the ability of research to provide answers about the effectiveness of treatments unaffected by confounding variables. At the top of the hierarchy is the systematic review of randomised controlled trials, followed by individual randomised trials. Forms of data such as clinical case series are given much lower priority, and would generally only be used where other forms of evidence are unavailable. Some forms of research (such as qualitative research

and in depth analyses of the process of therapy) may not even appear on the hierarchy of evidence concerning the effectiveness of treatments.

It is important to recognise that evidence based practice has a somewhat limited focus. It is designed to reduce bias in decisions about what treatments produce the best outcomes in clients. There are many questions about therapy beyond this limited focus, where the hierarchy has much less relevance. For example, randomised controlled trials are much less helpful in showing how a treatment works. There are many issues where data from randomised controlled trials are scarce or difficult to collect and some aspects of guidelines are still based on professional consensus as to what is 'good clinical practice'. Questions relating to the wider value placed on human well being and the role of therapy in achieving that cannot be answered using the 'hierarchy of evidence'.

What are the advantages of evidence based practice?

Psychological therapists and their clients stand to gain from the use of evidence based practice in a number of ways.

Evidence based practice is a way of achieving the 'scientist practitioner' model espoused by some segments of the psychological therapy community (Barlow, Hayes, & Nelson, 1984). Adopting evidence based practice can avoid dogmatic adherence to particular therapies and can be an impetus to further development of treatments (Weston, Novotny, & Thompson-Brenner, 2004).

As well as identifying treatments that are effective, randomised controlled trials may be able to indicate when therapies are actually doing more harm than good (Roth & Fonagy, 1996) and thus can help to protect clients. Evidence based practice can provide protection for professionals in terms of legal challenges to their practice (Persons & Silberschatz, 1998).

Evidence based practice can provide support for effective treatments that might otherwise be under threat (either in general, or from alternatives such as pharmacological treatments). The standards required of treatments to be considered 'evidence-based' can be made explicit and transparent and the guidelines can be made available to clients to help them decide on treatments.

What are the disadvantages of evidence based practice?

There are a number of criticisms of evidence based practice. Some are general criticisms of the approach,

whereas others are specific to counselling and psychotherapy.

Randomised controlled trials are particularly suited to the evaluation of certain types of treatments and clients. For example, trials are easier to run with short term treatments, where the treatment can be specified in a written manual and delivered to clients with discrete problems or diagnoses. There is concern that this creates a gap between the research evidence and the realities of clinical practice, where treatments are longer, unstandardised and clients present with more complex problems (Weston, Novotny, & Thompson-Brenner, 2004).

There are concerns that the emphasis on evidence based practice can distort decisions about how treatment is provided. For example, clinical guidelines may suggest that certain problems should be treated using certain 'brand name' therapies that have been tested in trials. However, a therapist who delivers such a 'brand name' therapy may be ineffective if they do not attend to other issues of relevance to the effectiveness of the treatment, such as the quality of the therapeutic alliance (Roth & Fonagy, 1996).

A reliance on randomised controlled trials may also downplay the contribution of other research methods. The sort of research which is prioritised by evidence based practice may often be seen as irrelevant to clinical professionals. For example, randomised controlled trials and clinical guidelines may provide no assistance with issues such as engaging with difficult clients, overcoming a therapeutic impasse or dealing with multiple problems (Persons & Silberschatz, 1998). There are a number of situations in which randomised controlled trials are inappropriate (Black, 1996). For example, trials are less helpful when events are very rare (e.g. client suicide).

Clinical innovations require an understanding of how therapies achieve change, which may require in depth analysis of individual cases of therapy (Persons & Silberschatz, 1998; Rice & Greenberg, 1984). Evidence based practice has traditionally paid little attention to the benefits of qualitative research (Pope & Mays, 1995) and has focused almost entirely on quantitative research designs. However, there is some evidence that this is beginning to change. For example, NICE now includes work on patient and client experience in its clinical guidelines, and there is increasing interest in the way in which quantitative and qualitative research can be combined (Dixon-Woods et al., 2005). However, the relative importance placed on each type of evidence is still the subject of controversy.

Randomised controlled trials that show a therapy can work may need to be complemented by other methodologies (such as audit and benchmarking) that

can ensure that their delivery in routine settings is still producing positive outcomes (Barkham & Mellor-Clark, 2000; Seligman, 1996).

Randomised controlled trials are expensive and time consuming. Clinical innovation tends to occur at a faster pace than research and trials which are published after long delays may provide evidence which does not reflect current clinical practice. Therapies may not be evaluated if there is insufficient impetus to fund studies. Users of evidence based practice are cautioned that 'no evidence of effectiveness' does not mean 'evidence of no effectiveness' (Persons & Silberschatz, 1998). However, in practice, lack of evidence often means that a therapy will receive little support from those who purchase or provide therapy and there will be a focus on those therapies that have received the bulk of attention from researchers.

Professionals often complain that evidence based practice leads to an excessive reliance on the results of research and downplays clinical judgement (Tanenbaum, 1993). This can lead to a 'cookbook' approach to therapy, where clients with complex problems are reduced to a few broad categories written into a clinical guideline. Randomised controlled trials are based on the average responses of groups of clients, whereas clinicians are faced with individual clients and have to make decisions which are sensitive to the client's needs, preferences and the context in which they live and work (Greenhalgh & Worrall, 1997).

Therapists are not alone among the professions in resenting the effect of evidence based practice in restricting their professional freedom. However, this tension may be heightened in counselling and psychological therapy. When evidence based practice is applied to a profession such as medicine, the results of trials of particular treatment do not challenge the legitimacy of medical professionals per se. The situation is different in counselling and psychological therapy because most practitioners are more firmly wedded to particular theoretical orientations. A doctor can easily replace one medication with another, but it is difficult for counsellors and therapists to be so flexible. Providing a different 'evidence-based therapy' may have significant implications for retraining, and may require changes in fundamental values as well as new technical skills (Bower & Barkham, 2006).

What is practice based evidence?

Evidence based practice involves the translation of research evidence into clinical practice. Some believe that clinical practice should feed more actively into research. The model of 'practice based evidence' involves taking data from routine practice (such as outcome measures routinely completed by clients)

and using that to inform research, policy and practice (Barkham & Mellor-Clark, 2000).

How will evidence based practice change in the future?

Although clients are likely to be as interested in effective treatments as professionals, evidence based practice is fundamentally a professional issue. Although evidence of effectiveness is an important determinant of choice about treatments, there are other factors that need to be taken into account. Health services often try to be 'client-centred', where services are designed to be delivered in line with the needs, wishes and preferences of clients (Laine & Davidoff, 1996). Policy makers are also very interested in issues of client choice. Guidelines such as those developed by NICE often explicitly discuss the importance of choice. Practicing in a way that is both 'evidence based' and 'client-centred' remains a key challenge for professionals (Bensing, 2000).

Conclusion

Evidence based practice has had a major impact on many of the helping professions, including counselling and psychotherapy. Although there are many aspects of counselling and psychotherapy that make the application of the principles of evidence practice more difficult, it is likely that the evidence based practice approach will continue to be an important driver of clinical practice in the future. It is important to understand the strengths and limitations of the approach to ensure that research has an appropriate impact on clinical practice in the future.

About the author

Peter Bower is a psychologist and health services researcher working at the University of Manchester. He conducts research work into the effectiveness of psychological therapy and other mental health interventions in primary care, and has a special interest in the use of randomised controlled trials and systematic reviews in this area. He works as a consultant on systematic review work conducted by the British Association for Counselling and Psychotherapy and is a member of the BACP Research Committee.

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Further information

Information about the Cochrane Collaboration can be found at <http://www.cochrane.org/>

The Cochrane Library is freely available at <http://www.library.nhs.uk>

Clinical guidelines for many disorders can be found at <http://www.nice.org.uk/>

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It should be noted that this Information Sheet offers broad guidance, which sets out professional good practice, but it should not be substituted for legal and other professional advice, including supervision, applicable to your particular circumstances.

BACP is aware that law and practice are always in a process of development and change. If you have evidence that this Information Sheet is now inaccurate or out of date feel free to contact us. If you know of any impending changes that affect its content we would also be pleased to hear from you.