

Evidence-Based Treatment

Colin Murdoch MacKenzie

This polemic argues that evidence-based treatment is only one important consideration when deciding a therapeutic program. The exclusive use of evidence-based therapy would be detrimental to the development of better psychotherapy. Evidence-based therapy has an important part to play in the future of psychotherapy. It employs scientific and statistical procedures rigorously. This article is not intended to argue against its use, only to point to the dangers of an evidence-based dictatorship in which financial and insurance imperatives will force us into using such therapies exclusively. This situation would stifle creativity and the individuality of both the therapist and the client.

According to some postmodern critiques, modern western life is preoccupied with reducing otherness to sameness, individuality to conformity, singularity to uniformity. Even the recognition of difference, as expressed in multiculturalism and the liberal concepts of autonomy and freedom are said, by these critics, not to be signs of real difference. Rather these reductions are evidence of turning the unfathomable strangeness of the other into a comfortable, graspable, understandable similarity — we are all the same underneath the cultural adornment of superficial individual identity.

Evidence-based treatment can be considered as a bureaucratic exercise designed to define us all as alike. It is the tyranny of the statistical majority that dissolves away our uniqueness. In the stead of understanding the uniqueness of the individual or group that the therapist meets, is placed the requirement to classify, to diagnose or type so that the appropriate evidence based treatment regime can be instituted. The unique individual or family, their unique history, experience and environment are lost in these efforts to homogenise and discover or create sameness.

The therapist too, is unique. No two are alike, even if they follow the same psychological and therapeutic model. Evidence-based treatment fails to recognise that each of us have different talents, abilities and limitations all of which enter into the therapeutic encounter. There are many roads to Rome, as the saying goes. Some are well trodden and others are more circuitous and less well known but with the right guide they will get you there. Research suggests that the personal qualities of the therapist are more important in deciding the outcome of a therapeutic encounter than

any technique that is employed. Are the evidence-based techniques usurping the place of the therapist's person? Will we become technicians rather than therapists? It is indeed ironic that while on the one hand, researchers are showing us the genetic uniqueness of each individual and that the interplay of this with the individual's unique (non-shared) environment is a major factor in defining who we are, we are giving away this precious individuality when we endorse the statistical 'realities' of evidence-based treatment. I am not against research that seeks the most efficient treatment regimes but I am firmly against any compulsion to use the results of this research in the therapeutic planning of individual cases. 'For many health care conditions, a gap exists between what medical science has shown to be effective practice and what is actually done' says Boluyt et al. (2005, p. 1378).

In paediatrics, where medical science is to the fore, this gap is probably important and evidence-based guidelines will probably lead to improvements in the quality of care, but in the much more diffuse field of therapy it is less clear that medical, psychological or sociological science can assist. For example, commenting on some theories that sex therapies use, Goodwach says: 'The fundamental flaw in these models (biomedical and behavioural) is the notion that life experience is reducible to objective physiology. The underlying assumption is that sex can be separated from the rest of life ...' (Goodwach, 2005, p. 158).

Most problems that people present when they come to therapy can be separated from the context and treated as issues to be dealt with in isolation from rest of the life of the client. But, is this the kind of care we want to provide? Treating depression with medication without addressing context when problems are social (i.e. detention in a migrant centre, unemployment or abuse) seem to me to be examples of social control rather than treatment. Yet the evidence suggests that antidepressant medication is effective in many cases.



Colin Murdoch MacKenzie, Launceston, Tasmania.

Evidence-based treatment favours the majority over the individual, the quantifiable over quality, routines and regimes over spontaneity, and simplicity over complexity. It espouses the world view of regimentation and bureaucracy rather than creativity, alienation rather than identity, efficiency rather than uniqueness, technology rather than art. It is based on diagnosis instead of treatment, thus favouring the medicalisation of what are often social, relational or cultural problems. Recall that not many years ago homosexuality was a medical diagnosis in DSM, that ADHD, anxiety states and depression are psychiatric diagnoses. Be aware of the power of the pharmaceutical industry to promote such medicalisation.

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Evidence-based treatment is the result of scientific, empirical research. That is, research that purports to be guided by experience understood using scientific rationality. Scientific rationality is more than just common sense or logic, it assumes that the world can be accessed, understood and found within the natural order rather than within the magical or religious domains. It believes in a real objective world that we can perceive. It is from these ‘objective facts’ that we perceive, that we classify, make cause and effect connections and predict future results. But, even if one accepts this world view, objective facts in the mental health field are notoriously difficult to acquire.

Measurement is the basis of any evidence. Some things are not easy or even possible to measure. There is no doubt that CBT has gained favourable reports because it is easier to measure behavioural changes. Attempts to measure subjective states, like feelings or even thoughts, can be critiqued for their semantic difficulties such as differences in understanding, in definition of words and phrases. Kagan has identified four problems with the use of questionnaires especially those in which the client’s emotional state are targeted:

- 1 Respondents do not always extract the same meaning from a question.
- 2 People try to give consistent answers — a motive which can lead to distortion.
- 3 Language is not rich enough to describe all experience so researchers designing questionnaires have to choose among many possibilities, while questionnaires designed to measure variation in emotional experience cannot describe in sufficient detail the combination of action and context in relation to the emotion elicited.

- 4 ‘Biological features of emotional arousal are not consciously available to the respondent so the quality and intensity of moods and feelings that are influenced by biological factors are not reportable’ (Kagan, 2004, p. 62)

Reports of the frequency and intensity of past emotions are always influenced by a comparison of the present with the past, but recall of past feelings and actions are inaccurate and suspect. Even attempts to quantify the intensity of emotion run into difficulties. Furthermore, the context in which thoughts and feelings occur and are verbalised can affect the reports given.

To take the example of depression: What does one assess? Do we use behavioural criteria (i.e. amount and frequency of sleep, number of social interactions, eating habits) that can, to a large degree, be observed by other people and thus measured? Or, do we try to assess thought processes and content, perhaps by using psychological or neuropsychological tests, some of which may have some statistical validity when comparing the depressed person’s results with those of the general population. Alternatively, we could seek to elicit the subjective state of the individual by enquiring about their mood, and so on. Usually a mixture of all of these approaches is used, but since we are trying to be objective and scientific those features that can be more easily measured may be privileged over the more subjective emotions. This skewing may or may not be appropriate but what is achieved is not an evidence-based treatment for depression, it is an evidenced-based treatment for some specific signs of changes in behaviour and/or in psychological test results. Thus in every case of evidence-based results we have to ask what is it that the suggested treatment is evidence of?

Furthermore, the world view that there is an objective world that we humans have access to is disputed. The separation of the real world out there from the internal world inside is a fundamental Western concept that predates Descartes, though it was given clear expression by him. Evidence-based, that is, scientific and empirically based, results are founded on this separation. Family and systems therapists are aware of the importance of relations between aspects of the system. They recognise interconnections, interdependence and attempt to consider the system as a whole. They attempt to reduce the separation between individuals though rarely that between the internal and external world. Most of us still think in terms of there being some objectivity in what we observe.

The difficulty is, how do we find a way to bridge the gap created between the internal and external, between the mind and the body, between the real and the imaginary? Philosophers have considered the various ways used to deal with this split. Attempted solutions to these problems take three forms. One form asserts the primacy of the inside and is called *idealism, subjectivism, solipsism, or rationalism*. Another form asserts the primacy of the outside world and is called *realism, objectivism, representationalism, or empiri-*

cism. The third form tries to balance primacy between *both sides* and is called *interactionism* or *mutualism*.

None of these approaches is completely satisfactory. In the first two, the gap remains, it is just ignored; in the last form the split is still recognised and the gap is bridged by inferring that interactions occur between them. A more elegant approach is to dissolve the differences by recognising that the inside, outside and the relation between them all merge together. They are co-dependent and have no separate existence. The uncritical acceptance of evidence-based treatment perpetuates separation. It thereby prevents exploration of alternative forms of work that are based on ideas of emergence and subverts the possibility of 'the new' resulting from the interplay of systems — client(s)' worlds and therapists' worlds merging and emerging. Evidence-based research takes no account of these philosophical concerns. It places to one side whole areas of our understandings.

As far as I am aware, most advances in psychotherapy have occurred as creative, imaginative ideas tentatively

put into practice and, if some successes are noted, further developed. This creative development can take years to become sufficiently well established to be subject to scientific, empirical research. My major anxiety with evidence-based treatment is that it will become so authoritative that only 'evidenced' treatments will be possible if therapists want to be insured and get payment from a government or private agency. In such a situation, creation and development will be curtailed to the detriment of all.

References

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'When students realize that unhurried emotional encounters may generate creative solutions and take less time than an exclusive focus on problem solving, they tend to relax without using more time for therapy than people who hurry to be brief.'

(Rosemarie Welter-Enderlin (315), 'The State of the Art of Training in Systemic Family Therapy in Switzerland', *Family Process*, 44, 3: 303–320).

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