# Challenges of Formulating and Implementing Evidence-Based Practice in Counselling and Psychotherapy

*by Ramesh Ramsahoye*


**Introduction**

In response to the call for a debate on the posited need for Evidence-Based Practice (EBP) within the field of counselling/psychotherapy (Ó Braonáin, 2015), this author would like to offer a few thoughts on some of the problems implicit in the adoption of a new counselling paradigm. This essay will set out an alternative, and to an extent opposing, perspective to Dr Cóilín Ó Braonáin's article, *The Research-Engaged Therapist: Why Counsellors Need to Embrace Systematic Investigation*. In the following discussion, some of the problems presented to the counselling profession in adopting EBP are considered, including challenges facing individual practitioners, as well as related ethical concerns, in light of what seems to be a radical, inevitable and imminent rethinking of how counselling operates in Ireland. Funding and resource issues are highlighted and some tentative proposals are advanced concerning how counselling might successfully collaborate with its sister professions.

**The problems of counsellor-led research**

Firstly, there would seem to be an inescapable paradox inherent in the proposed endeavour of counsellors making the case for the effectiveness of counselling via research that they themselves conduct (Ó Braonáin, 2015, p. 22). How can a profession that so often eschews the diagnostic criteria and concomitant labelling of modern psychiatry claim to be evidence-based? Is it not the case that many of its practitioners purposefully choose not to organize their working methods around an established body of knowledge and scientific orthodoxy pertaining to the same mental health problems? The DSM-5 (American Psychiatric Association, 2013), contains a plethora of new (some additions are concealed as subtypes), and in the view of many, (Glasser, 2003, Shakeh, 2012, Frances, 2013, Pearce, 2014, & Kirk, Gomory and Cohen, 2014), spurious 'mental health disorders', and is, supposedly, the result of decades of research. If there is indeed consensus amongst 'scientists' that the categories in the DSM and the World Health Organization's ICD-10 (1992) have been empirically validated, then these documents would necessarily have to form a key component of counsellor training and a starting point for future research efforts - particularly if the desired outcome is for counselling to be accepted by its associated professions. If counselling is to fit in with current medical opinion, extensive research would have to be conducted in order to establish it as an Evidence Supported Treatment (EST) for identified mental health disorders. In fact, matching particular client problems with different counselling models is described by Sexton as the "basis of an evidence-based model of counselling" (1999, p. 1). Such a project could easily eliminate counselling, or a particular approach, as appropriate treatment for a condition, having the effect in some cases of restricting a person's access to potentially beneficial psychotherapy (American

Psychological Association, 2006, p. 273). Is the profession ready to have some doors shut, in order that others may open? As the American Psychological Association (APA) Presidential Task Force on Evidence-Based Practice (2006) noted, the "use and misuse of evidence-based principles in the practice of health care has affected the dissemination of health care funds, but not always to the benefit of the patient" (p. 274).

**Sorting out our terminology**

Furthermore, if there is to be a constructive debate, current confusion around the signification of our terminology would need clarification in order for research to be conducted utilizing clear and unambiguous frames of reference. For example, when it is stated that there is a larger body of research pointing to the efficacy of Cognitive Behavioural Therapy (CBT) (as indicated on the BACP website), is it always genuinely the case that that this research is operationally differentiated between CBT and other therapeutic modalities? As CBT is normally delivered in the context of a relationship, is it even possible to do this? Can it ever really be postulated that it was the CBT as opposed to the relationship that helped, or vice versa? Equally, proponents of CBT cannot justifiably absorb into their territory the claimed ingredients of that approach when counsellors with a more person-centred orientation also work with 'cognition' and 'behaviour'. Rogers' account of the fully functioning person (1979, p. 118) describes a person capable of performing a complex process of cognition, assessing - in the moment - thought, sensing and feeling. Is it not the role of the humanistic counsellor to facilitate the development of such cognitive and sensing capacities, even though their methods might be less procedurally determined than in therapy that is more easily recognized as 'CBT'?

*Is the profession truly prepared for the implications stemming from an accumulation of counsellor-specific data, stored on a central database? (Ó Braonáin, 2015, p. 21)*

**Focussing research in Ireland**

If a solid body of evidence already testifies to the effectiveness of counselling (Ó Braonáin, 2015, p. 19, citing Carr, 2007, BACP, 2013, & McLeod, 2007, citing Wampold, 2001) then when some GPs are stubbornly sceptical, as Ó Braonáin rightly highlights, they are not behaving like scientists or observing EBP. Surely the solution is not endless research aimed at their persuasion, but rather intervention from the Health Service Executive (HSE) instructing these doctors to facilitate for their patients a proven treatment. Do the professional bodies have a greater role to play in that much needed dialogue, as advocates for this profession? The notion that Ireland-based research will be more compelling to those remaining dubious, despite the evidence, perhaps underestimates the extent to which cultural attitudes need to shift, as opposed to scientific understandings. If a cancer drug is shown to be effective in US and UK trials, the Irish medical profession does not resist it because it has not been shown in studies to work in Ireland on Irish people. It is a nonsense to make this demand of counselling. Rather, do we not need nuanced research on what can be shown to work best in culturally-specific contexts, with particular client presenting problems, age-groups and minorities? If a new research effort is to be launched in Ireland, please let it be properly and appropriately focussed, rather than duplicating studies simply to pander to an establishment prejudice that should ideally be overcome through other means.

**What counts as evidence?**

As a profession, we also need to consider what we mean by 'evidence'. Do we mean statistical data primarily? Are research findings based upon subjective experience, gathered via qualitative research, or mixed methods, to be given equal status? Arguably, they should be, in a professional activity that concerns itself with the uniqueness of a person's experience - yet within modern psychiatry quantitative data reigns supreme when treatment effectiveness is evaluated (Williams and Garner, 2002, p. 9). The APA (2006) commendably embraces multiple research designs. And what is to be the standing of data originating in specific clinical settings? An innovative, though complex, model for integrating research evidence by giving equal recognition to a) the level of evidence, b) the context into which evidence is implemented, and c) the method of facilitating change, was advanced by Kitson, Harvey and McCormack (1998) – a method that counselling may wish to consider. Barkham and Mellor-Clarke (2003) presented a cogent argument for the co-existence and relevance of multiple research paradigms, urging against a fracturing of the research effort due to the perceived dichotomy between evidence-based research and practice-based evidence.

Another salient issue is that of how data acquired through research is to be utilized? Is the profession truly prepared for the implications stemming from an accumulation of counsellor-specific data, stored on a central database (Ó Braonáin, 2015, p. 21)? Should an accredited counsellor whose CORE-OM results indicate that their clients show no measurable improvement, or

even demonstrate greater levels of distress at the conclusion of treatment, automatically have their accreditation renewed? A doctor shown to be repeatedly botching operations or failing patients has their licence to practice revoked – why shouldn't the same happen to a counsellor? Would unseemly league tables inevitably result? How will training institutions justify their certification of a counsellor as qualified in circumstances where subsequently acquired data appears to identify that practitioner as ineffective, acting unethically or even causing harm to vulnerable people? Could that data itself be suspect and misleading if a therapist is working in a challenging area with 'at risk' clients? The more collaborative model of the Practice Research Network (PRN) recommended by Margison et al., (2000) may be more acceptable to many counsellors.

*Is it not the case that counselling considers science - but is not bound by it; that it evaluates evidence, whilst appreciating the spiritual dimension to life, that it embraces mystery – without needing to reduce the universe to atoms?*

Another key question that emerges is that of how counsellors' methods should be informed and guided by evidence? For example, some counsellors might, as part of their conceptualization of the therapeutic process, entertain rather vague and unproven notions such as 'energy' and 'chakras' or concepts from alternative systems such as Reiki healing like 'spiritually guided life force energy'. The author has heard counsellors make highly controversial claims, like being able to "smell trauma in the room" etc. Concepts like 'projection' or 'transference', based upon subjective experience and perception, are seemingly impossible to establish as 'real' phenomena that could be agreed to be actually occurring by all objective observers, yet the therapeutic process in a particular instance might hinge upon such an unverifiable supposition. Without scientifically validated evidence for these ideas, should they be excluded from an evidence-based approach? Despite these obstacles, the effectiveness of specific interventions or Verbal Response Modes (VRMs), defined by De Stefano et al. (2001) as "the actual technical operations or techniques of the therapist" (p. 261) can be studied and measured (Margison et al., 2000, pp. 124-125) and that data can be drawn upon in the delivery of counsellor skills-training.

**Evidence-based need not mean evidence-driven**

Notwithstanding these problematic questions, there is a strong case to be made for research-led interventions, as Lilienfield (2014) succinctly explains:

> By constraining clinical selections to interventions that at least have some modicum of research support, evidence-based practice increases the chances that clients will receive treatments that work, and decreases the chances that clients will be exposed to interventions that are ineffective or that can cause harm.

However, if psychologists and psychiatrists are purportedly already using research-led interventions, does that mean that counselling should automatically follow? Is it not one of the great strengths of counselling that it is already guided by research, but not *constrained* by it. Sackett et al. (1996) opined that evidence-based medicine entailed "integrating individual clinical expertise with the best available external clinical evidence" (p.71), according primacy to the practitioner's clinical judgment (the issue of the availability of research evidence to counsellors is addressed below). Although this could mean setting aside a statistically indicated approach, 'going against the data' is only EBP if the practitioner is *informed* about research. That does not mean practicing as one would please, in ignorance of research findings. But how often have Éisteach readers heard a client utter words to the effect: "I have seen psychiatrists and psychologists for years, but no one has been able to help me"? In such cases, wasn't it something novel, something creative, something arising from the understanding formed during a genuine relationship that, in the end, helped? Another issue is: how would a revised Code of Ethics that incorporated research findings actually look? Does it suddenly become unethical to utilize an approach to a mental health issue that differs from established 'best practice' and what has been shown to be most frequently effective *for other people*? Recording evidence in a rigorous and systematic way would also mean following uniform guidelines for note-taking. Current IACP guidelines are helpful, yet vague. Would a counsellor, in certain circumstances, be advised to justify in their notes why their interventions are, or are not, sourced in relevant research?

The role of intuition in the counselling process as a factor guiding effective therapeutic intervention also needs to be considered. Many counsellors rely upon their sense of what is 'appropriate' or 'feels right' without being able to directly relate their methods to research. If such spontaneity becomes de-emphasized, does the evidence-

based practitioner inevitably end up performing a role that is already occupied – in other words, could following data prompt the counsellor to work within the parameters of the psychologist? This begs the fundamental question of whether counselling is a science at all. Can it be? It is this author's contention that counselling is by its very nature an art. It is, amongst other things, the art of positive, nurturing, healthy, loving human relating. Is it not the case that counselling considers science - but is not bound by it; that it evaluates evidence, whilst appreciating the spiritual dimension to life, that it embraces mystery – without needing to reduce the universe to atoms? However, this author's admittedly romantic position is somewhat confounded by evidence that shows manualized therapies to be highly effective in specific contexts (Margison et al., 2002, p. 127, citing Crits-Cristoph, 1992).

Rather than the profession seeking to align itself with those who are bound by evidence in relation to categories that are themselves perilously mutable (as the reclassification of particular 'mental health disorders', and proliferation of new ones, in DSM-5 demonstrates), should we not realise that the uniqueness of counselling lies in its relative freedom from evidence-driven thinking, its capacity to tear up the rulebook and examine a problem with fresh eyes? Even in only a few years of professional experience, the author has witnessed terrible damage done to people by prescriptive 'evidence-based practice' within the medical profession - human beings needlessly medicated and wearing the uncomfortable, ill-fitting label of a condition they turned out not to have. And here we encounter the crux of the problem in integrating counselling with the mental health care system – would counsellors not find themselves often taking a totally different perspective from the psychiatrist directing a care plan? The potential for friction instead of harmony is immense and could be terribly destructive to the profession.

*And here we encounter the crux of the problem in integrating counselling with the mental health care system – would counsellors not find themselves often taking a totally different perspective from the psychiatrist directing a care plan?*

However, in order to secure funding, counselling needs to acquire a more esteemed status in western medicine than alternative therapies like acupuncture. Many GPs are happy to recommend that treatment, without concerning themselves with its premises. The HSE website states that there is "evidence that acupuncture works for a small number of conditions" but warns that "there is little or no scientific evidence that acupuncture works for many of the conditions for which it is often used." Despite this official stance, this author's GP recently recommended this treatment for his back pain. The Treatment, he would have to fund himself. At this point in the analysis, money enters the equation. In order to obtain resources and advance the profession, counselling services have to show that their activities really do help people. Nevertheless, it is clear that rigid forms of Evidence-Based Practice may not be in the best interest of clients. It is this author's belief that the future for counselling is best secured by promoting strategically targeted research whilst maintaining some independence from western psychiatry and its sometimes inflexible procedures, questionable diagnoses, uncertain conclusions and undisclosed financial relationships with pharmaceutical companies (Cosgrove and Krimsky, 2012 & Whitaker and Cosgrove, 2015).

**Valuing client-based evidence**

At this juncture, a question we must address is what alternative suggestions might ensure quality in the profession? Perhaps Cooper and McLeod's (2007) concept of a pluralistic approach to counselling offers one possible way forward. It is "based on a philosophical and ethical commitment to valuing multiple perspectives, and therefore holds that the client's view on what is helpful and not helpful in therapy is as valid as the therapists [sic]" (p. 11). A model of EBP could be devised that is entirely compatible with a pluralistic approach that respects the autonomy and dignity of the client. (IACP Code of Ethics 1.0 & 1.1.14). When defining clinical expertise and effective decision–making, the APA (2006) lists interpersonal expertise and responsiveness to patient feedback as essential elements (p. 276). Similarly, Sackett at al. (1996, p. 72) advise that any external guideline should be integrated with clinical expertise in deciding "whether and how it matches the patient's clinical state, predicament, and preferences, and thus whether it should be applied" (p. 72). More recently, Norcross and Lambert (2011) argued that client feedback constitutes a form of evidence that should be esteemed, warning against "therapist centricity" and asserting that the client's contribution to psychotherapy outcomes is greater than is often recognized. The diverse components of a pluralistic EBP are nicely expressed by Cormack (2002) in relation to Sports Therapy, thoughts that transfer well to psychotherapy practice:

> Incorporation of EBP into practice does not mean adopting cookbook practice. Each patient problem

> is a distinct entity. Patients respond to intervention differently based upon the pathology, the course of the problem, the socio-cultural-economic background of the patient, the goals of the patient, and the skill level of the therapist. All of these patient-specific considerations must be combined with research evidence and expertise for the therapist to formulate a decision, in conjunction with the patient, on best care.
>
> (p. 484)

This view is echoed in the APA's recommendation that "clinical decisions should be made in collaboration with the patient on the basis of the best clinically relevant evidence" (2006, p. 280). Building more systematic feedback into client work may help in this regard. However, this model of ethical treatment planning would place a heavy demand on the counsellor, whose responsibility it becomes to be informed about available evidence in any given case. Making research methods and a dissertation component compulsory on training programmes may help to ensure that counsellors have some of the necessary *skills*. However, to mitigate again personal interest bias in the type of research that a particular counsellor will be familiar with, there would need to be some form of annually updated guidebook, containing the systematic reviews of research cautiously advocated by Shlonsky and Mildon (2014). A whole new industry would be needed to complete such a colossal project. The resourcing of this enterprise will only be forthcoming when the already compelling evidence for counselling is propagated through effective lobbying.

## Practicalities

When writing the article, this author was unable to make his arguments as evidence-based as he would like. His access to academic journals was restricted by his financial means. Thus, this writer takes issue with the statement by Ó Braonáin (2015, citing McLeod, 2013) that "the publication of research is a reliable and accessible way to share knowledge, and gain new insights, all of which informs practice and can increase the effectiveness of treatment" (p.18). Much research is neither accessible by being affordable, nor by virtue of the manner in which it is written. Should the IACP subscription include library and journal access? How could counsellors be reasonably expected to adopt a truly evidence-based approach in a sphere in which their income is so often limited, not by client demand for counselling, as is often suggested, but by current HSE restrictions privileging a narrow field of counsellors meeting the criteria of "Health and Social Care Professionals" (HSE Counsellor/Therapist (National Services) Grade Code 3028). A fairer system would arguably empower the *patient/client* to choose their own therapist, irrespective of whether or not they hold a first degree in Social Care or a related field. In addition, profit-making corporations currently soak up available resources for the provision of counselling services. In relation to these corporate structures it is significant that in relation to EBP the APA "recognized the risk that guidelines might be used inappropriately by commercial health care organizations not intimately familiar with the scientific basis of practice to dictate specific forms of treatment and restrict patient access to care" (2006, p. 271).

## Conclusion

A dubious presumption prevails in this debate, which is that western science is itself stringently evidence-based. Why is evidence that contradicts accepted scientific thinking so often summarily dismissed? Why are anomalous archaeological artefacts simply shelved and hidden away in the darkest corridors of museums (Cremo and Thompson, 1993). Why did Professor Richard Dawkins, celebrated exponent of modern Darwinism, while filming 'The Selfish Gene' in 2007, refuse to even consider Cambridge Professor Rupert Sheldrake's research on psychic phenomenon with the dismissive refrain "extraordinary claims require extraordinary evidence"? A lot can be learned from Sheldrake's response:

> "This depends on what you regard as extraordinary", Sheldrake replied. "Most people say they have experienced telepathy, especially in connection with telephone calls. In that sense, telepathy is ordinary. The claim that most people are deluded about their own experience is extraordinary. Where is the extraordinary evidence for that?"
>
> (Sheldrake, 2016)

In a professional activity that so often invites people to trust in their own experience, evidence from the client's and the therapist's experience must surely be honoured and incorporated into any model of EBP that is to have a reasonable chance of gaining traction. Successful implementation of EBP needs to overcome barriers and include incentives and we still lack the knowledge about how best to proceed (Grol and Wensing, 2004). So, an unavoidable conundrum emerges from the above discussion: either we adopt a *methodologically sound* evidence-based approach and confront all of the issues outlined above, and others not here discussed, or we do not. If we do not, we remain free to cherry-pick according to what we sense is in our client's best interest, harnessing our intellect, our personal knowledge of research, our intuition, our sensory impressions and our clinical experience, at liberty to share

"all expressions and manifestations of that which is alive" in us (Fromm, 1957/1985 p. 19). That can be a fabulous freedom to have – it allows for the full expression of the individual personality of the therapist, but it is one that may, in some instances, let a client down. Clarity and transparency with clients about what we are offering as individuals in relation to EBP is surely an ethical requirement, as the profession finds its way.

## References


American Psychological Association (2006). Evidence-based practice in psychology. American Psychologist, Vol. 61, No. 4, pp. 271–285. DOI: 10.1037/0003-066X.61.4.271.

American Psychiatric Association (2013). Diagnostic and statistical manual for mental disorders. (Fifth Edition). Washington DC/London: American Psychiatric Publishing.

British Association Counselling Psychotherapy (2013). Evidence for counselling and psychotherapy. Lutterworth: BACP. Retrieved from: http://www.bacp.co.uk/admin/structure/files/pdf/12228_research%20evidence%20summary.pdf

Barkham, B. & Mellor-Clarke, J. (2003). Bridging evidence-based practice and practice-based evidence: developing a rigorous and relevant knowledge for the psychological therapies. Clinical Psychology and Psychotherapy, 10, pp. 319–327.

Cormack, J. C. (2002). Evidence-based practice: What is it and how do I do it? BMJ, Vol. 324, pp. 484-487.

Cooper, M. & McLeod, J. (2007). A pluralistic framework for counselling and psychotherapy: implications for research. Counselling and Psychotherapy Research, 7 (3), pp. 135-143.

Cosgrove, L. & Krimsky, S. (2012). A Comparison of DSM-IV and DSM-5 panel members' financial associations with industry: A pernicious problem persists. PLOS Medicine, Vol. 9, 3, pp. 1-4.

Cremo, M. C. & Thompson, L. (1993). Forbidden archaeology: The hidden history of the human race. San Diego: Govardhan Hill Publishers.

De Stefano, J., Bernadelli, A., Stalikas, A. & Iwakabe, S. (2001). The relationship of therapist verbal response mode and client good moments in short term dynamic psychotherapy. Canadian Journal of Counselling, Vol. 35, 4, pp. 260-276.

Frances, A. (2013). Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM-5, big pharma and the medicalization of ordinary life. Psychotherapy in Australia, Vol. 19, No. 3, pp. 14-18.

Fromm, E. (1957/1985). The art of loving. London: Harper Collins.

Glasser, W. (2003). Warning: Psychiatry can be hazardous to your mental health. New York: HarperCollins Publishers.

Grol, R. & Wensing, M. (2004). What drives change? Barriers to and incentives for achieving evidence-based practice. Medical Journal of Australia, Vol. 180, pp. 57-60.

Kirk, S. A., Gomory, T. & Cohen, T. (2013). Mad science: Psychiatry, coercion, diagnosis and drugs. London: Transaction Publishers.

Kitson, A., Harvey, G., & McCormack, B. (1998). Enabling the implementation of evidence based practice: a conceptual framework. Quality in Health Care, 7, pp.149–158.

Lillienfield, S. (2014). Evidence-based practice: The misunderstandings continue. Retrieved from: https://www.psychologytoday.com/blog/the-skeptical-psychologist/201401/evidence-based-practice-the-misunderstandings-continue

Margison, F. R., Barkham, M., Evans, C., McGrath, G., Clark, J. M., Audin, K. & Connell, J. (2000) Measurement and psychotherapy: Evidence-based practice and practice-based evidence. British Journal of Psychiatry, 177, pp. 123-130.

Norcross, C. J. & Lambert, M. J. (2011). Evidence based therapy relationships, in Norcoss, J. C., Psychotherapy relationships that work. New York: Oxford University Press.

Ó Braonáin, C. (2015). The research-engaged therapist: Why counsellors need to embrace systematic investigation. Éisteach, Vol. 15, Issue 3, pp. 18-22.

Pearce, S. (2014). DSM-5 and the rise of the diagnostic checklist. Journal of Medical Ethics, 40, pp. 515-516.

Rogers, C. (1979). On becoming a person: A therapist's view of psychotherapy. London: Constable.

Sackett, D., L., Rosenberg, W. M. C., Gray, J. A. M., Haynes, B. R. & Richardson, W. S. (1996). Evidence based medicine: what it is and what it isn't. BMJ, Vol. 312, pp. 71-72.

Sexton, T. L. (1999). Evidence-based counseling: Implications for counseling practice, preparation, and professionalism. ERIC Digest, EDO-CG-99-9.

Shakeh, M. (2012). Interface: Considerations of difference: Is 'complicated grief' a viable new diagnosis in DSM-5? Psychotherapy in Australia, Vol. 18, No. 4, pp. 53-54.

'Sheldrake, R. (2016). Richard Dawkins comes to call, Retrieve from http://www.sheldrake.org/reactions/richard-dawkins-comes-to-call.'

Shlonsky, A. & Mildon, R. (2014). Methodological pluralism in the age of evidence-informed practice and policy. Scandinavian Journal of Public Health, 42 (Suppl 13), pp. 18–27.

Whitaker, R. & Cosgrove, L. (2015). Psychiatry under the influence: Institutional corruption, social injury, and prescriptions for reform. New York: Palgrave Macmillan.

Williams, D. D. R. & Garner, J. (2002). The case against 'the evidence': A different perspective on evidence-based medicine. British Journal of Psychiatry, 180, pp. 8-12.

World Health Organisation, (1992). International statistical classification of diseases and related health problems. 10th Revision (ICD-10). Geneva: WHO.



## Ramesh Ramsahoye

Prior to commencing his counselling career, Ramesh worked as a tutor and Director of Studies in leading London sixth form colleges for 15 years. He holds a BA (Hons) degree in Art History and Theory, a Masters in History of Art from the Courtauld Institute of Art and a PGCE in Art and Design. Working with young people as a Personal Tutor, a pastoral care role, inspired Ramesh to go into counselling. He obtained his diploma in 2012 and went on to complete a BA (Hons) degree in Integrative Counselling and Psychotherapy at the IICP, Dublin in 2014. He works in a local family resource centre and is currently a Pre-Accredited member of the IACP. Ramesh's research interests include crying in the therapeutic relationship, personal development and the role and power of client and therapist 'presence'.

**Contact:** rameshramsahoye@hotmail.com (may be shared)