Not Your Mother's EBT: A Look at the Past and Towards the Future

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"Evidence-Based." This term can elicit a range of reactions from practitioners. In the Sept/Oct issue of *The Oregon Psychologist,* OPA President Shoshana Kerewsky offered a definition and clarification of the term *"evidence-based therapy"* (EBT). We thought her column created a great opportunity to further delve into some of the changes that have been happening in evidence-based practice over the last decade or so; in particular, there have been important advances in making EBTs more flexible and more widely available to clinicians. This trend includes a deliberate movement away from treatment packages and toward understanding processes of change and developing testable theories.

One barrier to this discussion is the veritable alphabet soup of various *E-abbreviated terms:* EBT, EVT, EST, EBP, and EBPP! Even professionals become confused by the shifting nomenclature. We begin with the historical context of the evidence-based movement and clarification of the key lingo.

Some Historical Background

In the 60 years since Eysenck (1952) concluded that the psychotherapy treatments of his day were ineffective, there have been enormous advances in our understanding of effective interventions. These efforts took off in 1995 when the APA Division 12 Task Force published their criteria for what they eventually called *empirically supported treatments* (EST; Task Force, 1995). By definition, ESTs are specific manualized treatments restricted to a specific DSM-defined disorder. For example, there are manualized protocols for exposure and response prevention treatment for OCD.

From a research perspective, ESTs serve a useful function; however, the emphasis on highly controlled and manualized treatments tested in randomized controlled trials inadvertently created a divide between researchers and clinicians. Respected researchers criticized this approach as too narrow (e.g., Westen, Novtony, & Thompson-Brenner, 2004) and eventually Division 12 shifted from the narrower term "empirically-supported" to the broader term *evidenced-based treatment* (EBT). EBT refers to particular techniques or interventions shown to be effective in randomized controlled trials. Although the scope was expanded somewhat, the emphasis on randomized controlled trials remained the same.

APA's understanding of "evidence-based" was broadened further in 2005 when APA President Ronald Levant appointed a task force to define what came to be known as *evidence-based practice* (EBP; APA Presidential Task Force, 2006). EBP is closest in definition to what Dr. Kerewsky described in her column. According to the APA taskforce, EBP begins with the individual client, from whom the clinician draws on relevant research to guide decisions about the best treatment for this individual. EBP takes into account the unique characteristics of the client, including but not limited to character, culture, and preference. Throughout the remainder of this article, we'll use **EBT** when we refer to specific treatments and **EBP** to connote the flexible application of EBTs in practice.

EBT and EBP: An Example

Here's an example of the distinction between EBT and EBP. Edna Foa's Prolonged Exposure (PE) therapy for PTSD is an EBT. The manualized version of PE consists of 9-12 sessions that are 90-120 minutes long and is based on an emotional processing theory for anxiety disorders. PE rests upon a semi-flexible protocol of in vivo and imaginal exposure exercises that are developed collaboratively with the client in order to confront trauma-related stimuli.

A therapist engaged in evidence-based practice might incorporate procedures from prolonged exposure (e.g., imaginal and/or in vivo exposure exercises) in a way that is consistent with emotional processing theory and the EBT (i.e., PE) without strictly following the

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manual. Practicing in this manner might be evidence-based *practice,* but the therapist would not be, technically speaking, implementing an evidence-based *therapy*. Please note the mention of the use of *theory* in EBP. In our view, an understanding of theories and mechanisms of change in the treatments we use are important in EBP; otherwise, there is a risk of mechanically and improperly using techniques that are rendered inert when decontextualized from the original treatment.

EBP and Culture

Unfortunately, therapists sometimes misinterpret the flexibility of evidence-based practice to mean that EBTs should be completely abandoned in the face of cultural differences and comorbidities.

In response to concerns about whether EBTs are generalizable to clinical practice, a range of studies have shown that manualized treatments can be successfully transported from randomized controlled trials to community and private practice settings. These "benchmarking" studies compare the effect sizes for EBTs delivered in less controlled settings (e.g., samples with high comorbidity) with effect sizes found in randomized controlled trials of the same treatment. These studies have shown comparable effect sizes for EBTs for OCD treatment (Houghton, Saxon, Bradburn, Ricketts, & Hardy, 2010), mixed-diagnosis group treatment for anxiety and depression (McEvoy & Nathan, 2007), and group treatment for social phobia (Gaston, Abbott, Rapee, & Neary, 2006). Thus, although there may be a tension between the need for experimental control in research and the variability found in clinical practice, these studies show that EBTs can be implemented in typical outpatient settings with good results.

Benchmarking studies look at whether EBTs can be adapted to outpatient settings—but what about different cultural groups? Ten years ago there was limited data on whether EBTs could be effectively adapted to members of non-dominant cultural groups. However, in the last decade, there have been a large number of studies examining the systematic cross-cultural adaptation of EBTs.

We know that cultural differences can matter: there's compelling evidence that the impact of treatments measurably improves when adapted for specific cultural groups or are conducted in a client's native language (Griner & Smith, 2006). And there is evidence that EBTs may be effectively adapted for specific cultures. Just a few years ago, the *Journal of Clinical Psychology: In Session* (see Morales & Norcross, 2010) dedicated a special issue to six studies of successful adaptations of evidence-based practice in multicultural settings, including trauma-focused CBT for American Indian and Alaskan Native children and culturally-adapted parent training for Chinese immigrants. The studies offered examples for how EBTs can be successfully adapted for underserved populations. The Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP) listed the populations that were included in studies examining the effectiveness or efficacy of a specific treatment (to see the list of treatments and populations tested you can go to their website: http://nrepp.samhsa.gov).

Some clinicians have expressed concern that EBTs can harm the treatment relationship. In the past decade or so since this concern became widely expressed, a variety of studies have been conducted to see whether this is the case. Research has concluded there is no difference in the therapeutic alliance between therapists who use a manualized treatment and those who do not (Langer, McLeod, & Weisz, 2011). Thus, there is no evidence that EBTs interfere with building positive therapeutic relationships.

But I Don't Have Time to Keep Up with This Stuff!

When the first lists of EBTs emerged, a big problem emerged: clinicians did not have easy access to these treatments. Although more doctoral programs are now training students in EBTs and EBP, not everyone has received this training. While there's still room for improvement, the accessibility of EBTs has increased enormously within the last decade.

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For example, leaders in the field have published a number of clinician guides such as the *Treatments That Work* series by Oxford University Press (tinyurl.com/txthatwork). These easy-to-use, relatively inexpensive therapist guides with corresponding client workbooks are a wonderful resource for clinicians who don't have easy access to workshops. The series editor, David Barlow, and some of his colleagues (2011) have even published a "transdiagnostic" protocol for a broad range of emotional problems, boldly eschewing the "one diagnosis, one treatment" EST model of 1995. People interested in Acceptance and Commitment Therapy can have access to treatment protocols and training videos on the main organizational website (contextualpsychology.org/treatment_protocols). There's even a website offering free online training in Cognitive Processing Therapy, one of the gold standard treatments for PTSD (cpt.musc.edu).

Some Concluding Remarks

Since the creation of the APA Division 12 Task Force in 1995, the emphasis has shifted from evidence-based treatment packages, to specific interventions and techniques, to the more recent trend of adapting theory-guided interventions and techniques according to the needs of the individual client. With the increasing availability of inexpensive treatment guides and the promise of technology (e.g., web-based training, Skype consultation) most clinicians now have affordable and easy access to these innovations.

Even as you read this, there is another growing trend: we'll call it *scientifically-oriented psychotherapy* after a recent David and Montgomery (2011) paper, but it's too soon to know if this name will stick. Frustrated that even evidence-based practice standards allow treatments to enter the EBT canon with weak theory and scientifically inadequate explanations, researchers are now advocating additional criteria for allowing a treatment to pass EBT muster. Randomized controlled trials are a very important part of science, but are only one level of evidence. Unfortunately, evaluations of scientific merit based only on randomized trial evidence can allow interventions that are based on scientifically unsound theory to gain scientific credibility, in spite of more dubious elements. Scientifically-oriented psychotherapy requires evidence beyond randomized controlled trials; it includes more basic scientific research testing the scientific soundness of the theory that underlies the treatment tested in the randomized trials. We believe you're going to hear more about this idea over the next couple decades.

For now, we hope we've provided a snapshot of the exciting changes in the world of evidence-based practice. We thank Dr. Kerewsky for drawing attention to this issue in her column.

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