Evidence-Based Psychotherapy and Counselling in the UK: Critique and Alternatives

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Developments in empirically supported therapy or evidence-based practice in the UK are outlined and critically examined. Perceived advantages and disadvantages are set out, with a commentary. It is asserted that the evidence-based ethos is seriously flawed and that psychotherapy is essentially a faith-based craft, not a thoroughly researchable scientific enterprise. Some alternatives to evidence-based practice are briefly outlined, before turning to an exploration of the wider context of ‘anthropathology’ in which therapy takes place and against which it must acknowledge its limitations. Broad-brush conclusions are drawn.

KEY WORDS: empirically supported therapy; evidence-based practice; anthropathology.

In the UK, the term “evidence-based practice” (EBP) is the most commonly used term—not only in the field of psychotherapy but in medicine generally—and I shall therefore use it for consistency. It is for the most part identical with empirically supported practice. The debate in the UK is less well developed than in North America, and this is due both to the typical transatlantic time-lag in intellectual, professional and commercial fashions, and to the different nature of health provision. EBP has been referred to ironically as an “international epidemic” (Klein, 1995). Behind such remarks is an implicit criticism of the globalisation of American products and services. This perception, and other British cultural factors, may account for some of the differing and sometimes hostile perspectives on this topic. It is also necessary to note that in the UK most of what is known as counselling (so spelled in the UK, Canada and Australasia) is psychotherapeutic in nature and this can lead to confusion, even within British healthcare culture; so here I shall mainly refer simply to psychotherapy or therapy.

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WHAT IS EVIDENCE-BASED PRACTICE?

Historically psychotherapy was largely unconcerned about “proving” itself and its effectiveness beyond the consulting room and the therapist’s circle of professional allies. If the therapist was faithfully following his or her training strictures and seeing moment-by-moment results (including expectable regressive and relapse phenomena), and the client kept returning for more, with perhaps some signs of occasional improvement, then that was considered proof enough. When this arrangement was purely between therapist in private practice and apparently satisfied client, few would demand any “evidence” that it “worked.” Dramatic case presentations often held sway. Most psychotherapy until the 1950s or 1960s in the UK was psychoanalytic psychotherapy. But even the rise of humanistic and psychodynamic counselling in the 1960s and 1970s held strongly to a faith in the therapeutic process rather than seeking any corroborative evidence (Halmos, 1965).

Challenges to in-house self-satisfaction appeared under various guises: Hans Eysenck’s lead in the construction of British (National Health Service, or NHS) clinical psychology and search for evidence; Carl Rogers’ use of tape-recordings to study therapeutic processes; the growth of humanistic and cognitive-behavioural therapies; and the expansion of counselling and therapy into employee assistance programs, doctors’ surgeries and educational settings. The British Association for Counselling and Psychotherapy has since the 1990s begun to develop explicit means of encouraging research. The NHS has focused much more on evidence, with the result that protocols have increased and therapists are increasingly conscious of links between employment security and readiness to address EBP protocols. To some extent EBP is practitioner-led, but these practitioners are likely to be clinical psychologists and cognitive-behaviour therapists rather than psychoanalytic and humanistic practitioners.

The evidence in EBP that is generally accepted is drawn from a range of studies, the so-called gold standard being the randomized controlled trial. And evidence-based practice is therapy that seriously takes account of such evidence. According to Sackett, Rosenberg, Gray, Haynes & Richardson (1996), it is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individuals. North American definitions are similar, Chambless and Hollon (1998, p. 7) stating that empirically supported therapies are “clearly specified psychological treatments shown to be efficacious in controlled research with a delineated population.” What follows for clinical practice is a scheme suggesting that certain approaches are more effective for specified clinical conditions (e.g. exposure therapy for obsessive-compulsive disorder or cognitive therapy for depression). The UK now has clinical guidelines, a milder version of the North American quasi-insistence on approved, empirically-supported therapies. Systematic reviews, centres for the collection and dissemination of healthcare evidence, and the generation of practice guidelines are now becoming well established in the UK.