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Evidence-Based Practice

On reading this chapter you will:

- Understand the scientist-practitioner model of training and practice
- Understand the three elements of the evidence-based practice (EBP) model
- Appreciate the complexity of identifying sources of 'best evidence' and understand the importance of adopting a critical stance when doing so
- Be able to reflect on your own clinical skills and identify areas of strengths and weaknesses
- Appreciate the importance of collaborating with the service user in identifying values
- Understand the concepts of efficacy versus effectiveness of therapeutic interventions
- Understand empirically supported treatments and the importance of fidelity

Introduction

With roots in evidence-based medicine, evidence-based practice evolved to encompass not only the use of current best evidence to make decisions about the care of patients in healthcare settings, but to acknowledge the skill level of the practitioner and the values of the service user so as to ensure the most appropriate intervention. It is an approach that must always guide the practitioner as opposed to being a stand-alone decision-making tool; the continuous assessment and formulation practice of the practitioner psychologist means that they are always checking in with their own skillset and in the appropriateness of the intervention based on service user characteristics and values. When choosing a particular therapeutic intervention or modality, there must be confidence in its safety and outcomes, and care in its application, consistent with the evidence base. This chapter will allow the reader to consider the challenges of working within the evidence-based practice model and to appreciate the strengths of the model in ensuring best practice.

Scientist-Practitioner Model

A chapter on evidence-based practice cannot proceed without placing it in the context of the training and the role of practitioner psychologists. Jones and Mehr (2007) outline the scientist-practitioner model (SPM) and offer an informative and accessible account of the foundations and practice of the SPM. In brief, they describe the SPM as a training model based on the ideology that practitioner psychologists should be trained in both research and clinical practice. According to Jones and Mehr, the SPM is based on the following assumptions:

- The SPM will facilitate effective psychological services.
- Continued research in the field adds to the development of scientific databases.
- By adopting a critical research approach in clinical practice, important social issues will come to the fore (making research in the field more relevant).

The term 'scientist-practitioner' was first introduced in 1949 at a conference on graduate training in psychology in Boulder, Colorado. Sometimes referred to as the 'Boulder model', the SPM has been adopted widely by practitioner psychology training programmes throughout Western countries. However, the model is not without its critics, with questions being raised as to whether practitioner psychologists, despite being trained in accordance with the SPM, combine the roles of researcher and practitioner when qualified, and whether this is actually necessary (Long & Hollin, 1997). According to Frank (1984, as cited in Long & Hollin, 1997), two dominant areas of contention are (1) that the skills and abilities needed in order to be a researcher are incompatible with those required of clinical practice, and therefore it is impossible to combine the two roles, and (2) that research training is unnecessary for practitioner psychologists. Frank asserts that in order to evidence the added value of the research training of practitioner psychologists, we must look at research output. Although such research (e.g. Norcross & Karpiak, 2012) suggests that the modal number of published articles authored by Clinical Psychologists is zero, Norcross and Karpiak also show that across 588 Clinical Psychologists surveyed in 2010, 47% were involved in research/writing activities. If this sample is representative of practitioner psychologists in general, it can be said that there are a number of practitioners involved in research activity. Not all research activity leads to publication, and relying on published research output may not be the best approach to measuring the impact and value of research training.

There are also other areas of clinical practice that benefit from research training (Jones & Mehr, 2007), namely:

- The recognition of the importance of using empirically supported treatments and the skills to evaluate those interventions.

- The consumption (understanding) of research can be incorporated into clinical practice.
- The ability to constantly evaluate service user progress in relation to intervention success.

Ultimately, the benefits of research skills and knowledge arguably enhance clinical practice. The avoidance of training in research and practice risks the abandonment of curiosity – the whys and hows of psychology practice. Discussion of the SPM leads the chapter nicely into the main focus, which is evidence-based practice. Evidence-based practice embodies the qualities of the SPM training approach by focusing on evidence, evaluation and practice.

An Introduction to Evidence-Based Practice

Evidence-based practice (EBP) informs the process of clinical decision making in health care. The earliest definition by Sackett, Rosenberg, Gray, Haynes and Richardson (1996: 3) states that EBP is ‘the conscientious, explicit, judicious use of current best evidence in making decisions about the care of individual patients’ (see also Sackett, 1997). This early definition adopted in medicine has since been adapted to suit other healthcare professions, such as nursing (Craig & Smyth, 2002) and social work (Gibbs, 2002). The American Psychological Association (APA) defined the EBP model for psychology as follows:

Evidence-based practice in psychology is the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences. (APA Presidential Task Force on Evidence-Based Practice, 2006: 273)

While the APA proposed the model of EBP in psychology, they did not clearly lay out the skills required for EBP. Spring (2007) proposed ‘the three-legged stool’ as a metaphor for EBP, encompassing the three basic elements of EBP: best evidence, clinical expertise and service user values. This tangible addition to the literature on EBP in psychology offers a firm foundation on which to identify the core skills and competencies required when engaging in EBP. Figure 1.1 illustrates the basic elements of the model.

Misconceptions about EBP

Before describing the three legs of the EBP stool in greater depth, it is necessary to dispel any assumption or confusion about what EBP is and, in particular, what it is not. When exploring the research literature on the topic, the term ‘evidence-based practice’ can be interchanged with ‘empirically supported treatments’, i.e. therapeutic approaches that have been shown to be effective/efficacious. EBP can also be used to mean the use of clinical guidelines. This



Figure 1.1 A model of evidence-based practice

may be as a result of the earlier medical definition proposed for EBP. In this chapter, EBP is used in Figure 1.1 to describe the elements mentioned by Spring (2007).

Best Evidence

Although seemingly straightforward, the decision as to what constitutes ‘best evidence’ is challenging, particularly for the busy practitioner psychologist. If we need to justify our approach to treatment, then it is prudent to adopt a method or intervention that has been shown in research trials to work for the majority of people. The ‘hierarchy of evidence’ stems from the medical literature and lists sources of research evidence in order of quality (see Guyatt et al., 1995). Additionally, the ‘hierarchy of evidence’ stipulates that the ‘best evidence’ comes from research methods such as the randomised controlled trial (RCT), which is least subject to bias or error, or systematic reviews/meta-analyses, which are based on RCTs. Within the ‘hierarchy of evidence’ there is a distinction between (1) research that demonstrates efficacy, where the therapeutic approaches are shown to be effective in tightly controlled experimental settings, and (2) research that demonstrates effectiveness, where therapeutic approaches are shown to be effective within the uncontrolled clinical setting (see Seligman, 1995). Regardless of debates surrounding what is and what is not a valuable scientific approach in psychology, the fact remains that psychologists are resistant to relying on scientific literature due to its focus

on objectivity, which is far removed from the subjective nature of therapeutic intervention (Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2013). This gap of ideals hinders any progress in EBP, which at its core lies in a need to do the best for our service users through delivering effective therapies.

What is considered ‘best evidence’?

As previously noted, ‘best evidence’ is typically illustrated by the ‘hierarchy of evidence’. The RCT is considered the ‘gold standard’ in assessing treatment efficacy but is not the only methodological approach that can assess the effectiveness of therapeutic interventions. Meta-analysis is considered the optimal summary of evidence as it brings together RCTs in a quantitative review. The hierarchy of evidence, as defined by Guyatt et al. (1995) and listed in order of ‘best evidence’, is (1) systematic reviews and meta-analysis, (2) RCTs with definitive results, (3) RCTs with non-definitive results, (4) cohort studies, (5) case control studies, (6) cross-sectional studies, and (7) case reports. The noted absence in this list is qualitative research, where the focus is on interpreting experience and on understanding the individual’s perspective. This is because, from a medical standpoint, interventions are aimed at finding a cure through objective data-driven approaches rather than focusing on an individual’s experience of a condition (although arguably this is changing). Despite the move to adopt EBP within psychology, much of the literature remains rooted in medicine. This impacts on how research in psychology is conducted, with funding and dissemination guided by the traditional view of ‘best evidence’.

Randomised controlled trials in psychology

The RCT consists of two or more groups of participants who are randomly allocated (to avoid bias) into a treatment group or groups and a control group or groups so that treatment effects can be isolated. Optimally, the researcher and the participant are unaware of which group they are in (known as a double-blind study), or if this is not possible, it may require a single-blind process (where either the researcher or the participant is unaware of what group they are in) or no blinding at all. When looking at therapeutic methods and interventions, it is impossible to ‘blind’ the researcher as they will be trained in whichever treatment modality is under scrutiny and will therefore know what is being delivered. Equally, the participant may well realise which treatment they are receiving, having being informed of the study aims. RCTs are therefore, arguably, better suited to experiments involving pharmacological products or medical procedures. A placebo pill is easy enough to administer, whereas a ‘treatment as usual’ approach in therapeutic research is difficult to operationalise given the variation in typical clinical work.

Efficacy versus effectiveness

A frequent debate when considering the quality of the evidence base of a particular psychological treatment is whether the clinician should place priority on research that demonstrates *efficacy* or research that shows that a particular intervention is *effective*. It can be a challenge to remember the distinction between the two, but it is an essential consideration when attempting to translate success in research to good outcomes in clinical practice. In brief, *efficacy* refers to the internal validity of the study (that the results of the study are trustworthy) whereas *effectiveness* is about maximising the external validity (that the results of the study can be replicated in real-life settings) and balancing this with internal validity. Externally valid research is typically conducted in clinical settings that provide psychological services. Crucially, the balancing act between efficacy and effectiveness is a well-debated topic within the literature.

Evidence-based databases

Issues facing the busy practitioner when keeping up to date with the most relevant literature related to therapeutic methods and interventions comprise access and availability, time and cost. Practitioners can often resort to the use of tried-and-tested methods or a quick chat with colleagues on how to proceed with an individual service user. Practitioners can do an internet search of tools and resources applicable to whichever condition they are presented with (e.g. depression or anxiety) and therapeutic modality (e.g. cognitive behavioural therapy), but this does not constitute working within the boundaries of EBP. One approach might be to consult primary databases which house peer-reviewed primary research (studies that have collected data that has not been gathered before and that has been reviewed by experts in the field prior to publication).

When using primary databases, it is up to the practitioner to evaluate the scientific rigour and validity of the data and to incorporate the results into a clinically valid approach (over and above the peer review process). The most popular primary databases are PsychINFO, which, as its name suggests, comprises psychological and psychiatric journals, MEDLINE and CINAHL, which contain a vast array of research articles that can provide fruitful results when exploring a particular clinical question (Falzon, Davidson, & Bruns, 2010). However, a key issue facing practitioners is the ever-changing world of health-related research, and therefore keeping up to date with recent advances in the field can be challenging. When looking at the time it would take to read all the published material relevant to their practice, Alper et al. (2004) estimated 627.5 hours. This is therefore not the most time-efficient or even achievable approach to take.

Evidence-based databases are distinct from primary databases. Evidence-based databases summarise primary research through systematic reviews. Arguably the most popular evidence-based database is produced by *Cochrane* (previously known as the Cochrane Collaboration). Cochrane produce systematic reviews specifically related to health (including psychological health) and are designed to be used by health practitioners. Cochrane UK is funded by the National Institute of Health Research (NIHR), which supports the development of Cochrane systematic reviews through a learning and development programme. Cochrane systematic reviews are housed in the Cochrane database of systematic reviews (www.cochrane.org/). Most importantly, abstracts of the reviews are available free of charge. Cochrane reviews also inform the development of National Institute of Clinical Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN) guidelines. Importantly, the Cochrane evidence-based database removes the need for the busy practitioner to review primary research evidence. It should be noted, though, that the rigour applied to Cochrane systematic reviews may exclude some of the more niche topics or experiential approaches (e.g. qualitative research).

NICE guidelines

Clinical guidelines are now prolific in providing the evidence base in an accessible form for the busy clinician within physical and psychological service provision (Parry, Cape, & Pilling, 2003). Clinical guidelines are based on a review of the research literature that is considered by a committee made up of practitioners, care providers, commissioners, service users and carers. One of the most well-known providers of clinical guidelines is the National Institute of Health and Social Care Excellence (NICE), which aims to improve health and social care by (1) producing evidence-based guidance and advice, (2) developing quality standards and performance metrics for providers and commissioners of services, and (3) providing information services for commissioners, practitioners and managers. NICE provides guidance for the National Health Service (NHS), local authorities, employers, voluntary groups and any other groups that deliver health and social care services. The website (www.nice.org.uk/) is accessible to the general public, illustrating the organisation's aims of openness and accessibility.

NICE was set up in 1999 to reduce variation in treatments and care provision across the NHS (it was initially named 'National Institute for Clinical Excellence'). Through a merger with the Health Development Agency in 2005, public health guidance was produced and the name was changed to 'National Institute for *Health* and Clinical Excellence'. In 2013 NICE became rooted in primary legislation and became a statutory body, as outlined in the Health and Social Care Act 2012. The name was changed again to 'National Institute

for Health and *Care Excellence*’ to accommodate these developments. Importantly, due to the way NICE was established in legislation, the guidance is only official in England. Products are available to Wales, Scotland and Northern Ireland through special agreements. Ultimately, guidelines developed by NICE are the ‘go to’ database for the busy practitioner.

Although the aims of guidelines, such as those produced by NICE, are to encourage practitioners to engage in practice that is supported by the evidence, making such evidence relevant and practice-focused, there are potential problems and limitations in how guidelines are produced. As noted by Woolf, Grol, Hutchinson, Eccles and Grimshaw (1999), it is foolhardy to assume that the recommendations made in guidelines are without error. Members of the guideline group are typically the very professionals who would use the guidelines in their practice, so it is ironic that those members are under the same time, resource and skills limitations as their colleagues, leading to unintentional oversights and errors in their analysis. Woolf and colleagues highlight three areas where such oversights or errors occur: (1) there is a lack of good quality, well-designed research evidence, (2) guideline development groups are limited by the opinions and experience of the members, who may hold misconceptions as to what works, and (3) the needs of the service user may be overridden by costs, societal needs or special interests (e.g. political agendas). If guidelines are adhered to blindly, interventions or approaches that are ineffective, and at the very worst harmful, can become the norm. In contrast, Court, Cooke and Scrivener (2017) highlight the barriers to implementing and adhering to such guidelines, and provide an interesting overview of the reasons why practitioner psychologists may not routinely use guidelines. It seems that evidence-based guidelines, despite their aims, are not without problems, and within the context of EBP they may not serve their intended purpose.

Clinical Expertise

Much of the training in most healthcare professions utilises a competency-based framework where practice experiences inform certain skill requirements, such as communication, alliance building, etc. For practitioner psychologists, assessment and formulation skills are a core requirement, in addition to being competent in evaluating and delivering empirically supported treatments. While easy to monitor and assess throughout training, once qualified, clinical expertise is assumed to grow throughout the career, with importance being placed on continuing professional development and recognition of competency gaps through reflection and clinical supervision. However, the measurement and explicit recognition of clinical expertise as a component of EBP is weak, and possibly absent in some cases (Spring, 2007; Lilienfeld et al., 2013).

Lilienfeld et al. (2013) state that clinical expertise is made up of both clinical judgement and clinical experience. Although experience is measurable in time

or qualifications, good judgement is not necessarily an outcome of lengthy experience. Bourne, Kole, Healy, Hambrick and Wai (2014) suggest that the term ‘expertise’ implies being the best at what you do – being an ‘expert’ whose performance is superior. Such a label is heavy with expectancy, in that the practitioner may expect that in order to engage in EBP they need this ‘expertise’, and be reluctant to be defined by this label, given the power and status connotations inherent in the term. There is even some suggestion inherent in the term that being seen by an expert brings with it a better service. Bourne and colleagues further suggest that expertise is built through practice and experience, on a foundation of innate ability and talent. There is no doubt that this seems a fair explanation of expertise in a general sense. To qualify as a practitioner psychologist requires a battle through a lengthy recruitment process, leading to the development of clinical skill across a range of practice placements, in addition to academic tasks and research. Rather than view expertise as an end goal, where you have reached the pinnacle of your career, expertise would be better viewed as a process of ‘being the best at what you can do’.

To place ‘expertise’ in context, we have to consider the reality of working as a practitioner psychologist engaging in psychotherapeutic work. Goodheart (2006) reminds us of the reality of what therapeutic work entails, and that ‘expertise’ is better understood as the ability to endure the messiness of human endeavour, rather than having years of experience and typically a wide range of academic texts on the shelf that are unused and unread.

Clinical expertise

Clinical expertise involves the following:

- The ability to ‘sit with’ the messiness of human experience.
- Strength of character, illustrated by persistence and acceptance of challenges.
- Acknowledging that ‘knowledge’ changes: expertise is the ability to negotiate the ever-changing face of psychology as a science and to accept that what we know today may not be that informative five years into the future.
- The ability to adopt an approach informed by multiple sources of information (rarely in human sciences is there an absolute answer for any one situation).

How does clinical expertise develop? A useful approach outlined by Petty (2015) is to learn from our experience by engaging in the following:

- Reflecting on and learning from our clinical experience.
- Adopting a questioning and critical approach to clinical experiences.

- Being open to change and adapting to new knowledge.
- Welcoming alternative views and perspectives.

Service User Values

Described as ‘patient values’ by Spring (2007), the term ‘service user’ is used here as a better representation of the psychological rather than medical approach. As its title suggests, and in line with the APA’s definition of EBP, service user values, preferences and culture should inform the practitioner’s use of the best available evidence, which will rely primarily on clinical expertise and the skills therein. Of course, the service user is unlikely to present with clearly laid out values and with the confidence to assert their right for partnership. Indeed, there may be an implicit expectation that the practitioner is the expert and there may be resistance in moving away from this paternalistic model. It is therefore the practitioner who should explicitly highlight the need for collaboration in choosing and engaging with the mode of therapy or intervention used. In doing so, the practitioner should ensure that the service user is aware of the risks and benefits of a range of therapeutic modalities, and includes recognition of the role of pharmacological approaches to treatment. One size does not fit all.

When deciding on the best treatment approach, regardless of the quality of evidence or the practitioner’s experience, it is the expectations and hopes of the service user that determine the chosen approach. A tension exists between doing what is believed to be in the service user’s best interest and what the client actually wants. It is arguably clinical expertise that overcomes this tension, but it is not without risks – specifically, the risk of disengagement and potentially the risk of harm. The potential for misuse of power in the therapeutic relationship influences these decisions, hence the ethical need for the consideration of service user values. It is not to be assumed, however, that values are equivalent to ethics (i.e. justice and best interests). Values incorporate what constitutes a life worth living for the service user, such as honesty, self-esteem, and a right to be heard.

The interpretative quality of values and their fluidity in changing over time leads to questions about having a consistent approach to incorporating values within EBP. There is no ‘right’ or ‘wrong’ in values (other than those rooted in the ethics of ‘no harm’). We cannot create a list of values that must be adhered to as this would be unending and would perpetuate the idea that there is such a thing as values that are ‘wrong’. Eliciting service user values is a subjective endeavour laden with bias. Therefore, some points to consider in engaging in this process (and an acceptance that eliciting service user values will never be a straightforward task) are outlined below. These were based on those developed by Woodbridge and Fulford (2004), whose workbook on values is a highly valuable resource for professionals working in health and social care.

Identifying service user values

Awareness: Identifying a service user's values is essential. However, it is not an easy task as asking the individual to identify their values may result in confusion (for the service user and practitioner!). A useful exercise in highlighting the difficulty in identifying values is to ask yourself what your values are. Much of the problem lies with the meaning underlying the word 'values'. It is necessary not only to explain what is meant by 'values' to the service user, but also to use our clinical skills to notice how the service user speaks about their life, their history, their friends and family, and so forth. A great deal of value-laden information can be elicited in this way. A further consideration is the values of the social system and the professional setting. Any mismatch in values within external systems can result in problems within the therapeutic setting. An approach of openness and partnership is therefore recommended. Asking someone about what is important to them without explaining why this information is important should be avoided. It should also be a continuous task – values are subjective and therefore change over time. Checking in with the service user and keeping an awareness of values throughout the therapeutic journey is essential.

Reasoning: Despite the fact that values are deemed to be subjective, are neither right nor wrong, and should be considered without judgement, values are subject to change and therefore they are open to discussion. To reason about values is to consider their meaning, their source and their impact. Not only do the service user's values require reasoning, but so do the practitioner's values. Through engaging in this practice, certain beliefs and attitudes may be identified which determine the success or lack of success of certain interventions and approaches. Ignoring service user values when adopting a particular intervention or approach can lead to negative consequences, such as non-engagement or non-compliance.

Knowledge: Inherent in EBP is the importance of knowledge. When considered in relation to values, it is about identifying gaps in knowledge about what is personally important (for both service user and practitioner) as well as ensuring that the service user is fully informed at every step. It is about providing the service user with the opportunity to assess information about how any particular intervention or approach may challenge or meet their particular needs.

Communication: The ability to communicate with a range of individuals is central to any profession that works with vulnerable populations. Over and above seeking shared knowledge of the objective facts of the situation, it is seeking a communication style that allows the sharing of values. This is where skills such as listening and empathy, adaptation of language to meet the skills of the service user, adaptation of environmental cues and an overt acceptance of multiple perspectives, leading to negotiation and conflict resolution, are essential.

Responding to values and treatment effectiveness

An important concern is treatment effectiveness and, in particular, how to adapt our therapeutic approach while responding to service user values. The clinician may be reluctant to administer a therapy or intervention that does not have the strongest evidence base (or adheres to strict guidelines such as those outlined by Cochrane). There are two important considerations here:

1. Even though an intervention may not have a robust evidence base, it may still be effective, particularly if it meets the service user's values. The clinician can explore alternatives through accessing evidence supported by research methodologies which may not meet the requirements of evidence-based databases and clinical guidelines (e.g. qualitative research).
2. When engaging in shared decision making about the best approach, it must be remembered that the service user will need unbiased information on what the alternative interventions are so that their decision is informed.

Evidence-Based Practice vs Empirically Supported Treatments

Empirically supported treatments (ESTs) are sometimes referred to as EBP when in fact they are different. However, ESTs can be used as part of an EBP approach. As the name suggests, ESTs are therapies and interventions that have an evidence base that supports their efficacy. A report on psychological interventions and a subsequent list of ESTs (initially termed 'empirically validated psychological treatments') were first published by the Task Force on Promotion and Dissemination of Psychological Procedures of Division 12 (Clinical Psychology) of the American Psychological Association (Task Force, 1995). Subsequent reports were added (Chambless et al., 1996; Chambless & Hollon, 1998) and these have been updated and debated in the literature ever since. According to Tolin, McKay, Forman, Klonsky, and Thombs (2015), despite the intent of such reports in ensuring evidenced treatments, the EST approach has been subject to a great deal of critique. This includes the absence of focus on negative findings, favouring statistical significance rather than clinical significance, inadequate focus on long-term outcomes, variable study quality, poor translation of empirical support into practice recommendations, consideration of the effectiveness in non-research settings, and an emphasis on specific diagnoses. Such criticisms can be overcome and their identification is a valuable first step. Tolin et al. propose that the criteria upon which to determine the

quality of ESTs should be revised to include updated recommendations that overcome these problems.

Practitioner psychology training includes ESTs as a basis for clinical practice teaching. ESTs such as cognitive behavioural therapy (CBT) are well established and form the foundations of many training programmes. Having highlighted the potential problems with ESTs, the following recommendations for practice are made:

- Practitioners need to acknowledge the limits of research methods and adopt a critical approach to evidenced outcomes, recognising any inherent limitations.
- Having a clear approach to fidelity (see below) and knowledge of the core characteristics of a treatment helps practitioners to adapt that treatment to a variety of settings and service users.
- Do not dismiss ESTs based on prior negative experiences. Making appropriate adaptations to a treatment can be a challenge. Use peer knowledge and supervision to critique the approach and to reflect on what hasn't been effective and what has.

Fidelity in Delivering Empirically Supported Treatments

One of the persistent problems with delivering empirically supported treatments is whether they are delivered in the way that was intended, that is, the way that was shown to be effective when the research was conducted. Fidelity is therefore defined here as how closely the practitioner psychologist adheres to the intended delivery approach of the intervention they wish to use. The issue is that if the research supporting the intervention is based on a particular method of delivery, any change or adaptation of this method invalidates the evidence upon which it was based. Of course, if we consider the central elements of EBP, it is not only the evidence base that must be prioritised, but also the clinician's expertise and service user values. To deliver an intervention based solely on the evidence without any discretion not only contradicts the assumptions of the scientist-practitioner model (SPM), but also introduces the idea that if an intervention is manualised, why does it need to be delivered by a profession that demands years of costly training? What is the added value of a practitioner psychologist? The answer lies in the ability of the practitioner to adopt practices that support fidelity while flexibly adapting to external variables, which requires a great deal of skill.

It is generally accepted that practitioners make small changes to interventions that require some level of fidelity following training in that intervention.

Such changes can include adopting methods of delivery that are inconsistent with that suggested by the intervention protocol. According to Stirman et al. (2015), modifications to ESTs can be defined as follows:

- Fidelity-consistent modifications – these do not alter the primary elements of an intervention or treatment so that adherence to the protocol is maintained.
- Fidelity-inconsistent modifications – these do alter the primary elements of an intervention or treatment so that adherence to the protocol is compromised.

Stirman and colleagues highlighted the importance of practitioner characteristics and how these lead to fidelity-consistent practices and fidelity-inconsistent practices. The authors examined such characteristics in practitioners ($n = 27$) who had received workshop training in cognitive behavioural therapy (CBT) for either child or adult populations who experienced symptoms of depression and anxiety. Within these workshops, fidelity was emphasised and defined as keeping to the core elements of the treatments. Participants were also encouraged to self-assess their fidelity after training. The primary outcome of this study was based on the openness and willingness of participants in adopting ESTs. Participating practitioners who were *open* to using ESTs (i.e. they were keen to adhere to the treatment protocol but recognised that some adaptation was necessary to make these work in clinical settings) tended to make fidelity-consistent modifications. Participating practitioners who found the treatment less appealing (i.e. they were less *willing* to adopt it) were shown to see less value in maintaining fidelity and tended to adopt fidelity-inconsistent practices. How can we overcome such issues? As outlined by Stirman et al. (2015), a focus on fidelity practices and outcomes could inform in-training approaches that incorporate discussion on acceptable adaptations that retain the integrity of the evidence base. Fidelity is therefore dependent on the practitioner's ability to balance what has been evidenced as effective in research against its delivery in practice.

Summary

Evidence-based practice as a process of decision making in health care ensures that interventions are fit for purpose. The combined focus on best evidence, clinical expertise and service user values offers a comprehensive starting point, and encourages a critical stance in how we conduct our work. That said, when you consider the challenges in determining what constitutes 'best evidence', the reliance on efficacy rather than effectiveness, the problematic nature of RCTs and EBDs, it is clear to see why practitioner psychologists are somewhat reluctant to fully embrace EBP. Although there are inherent

problems with guidelines, such as those by NICE, they do serve as a valuable source of information and guidance. It is for the clinician to explore the foundations of such guidelines, to use their expertise in judging the usability of those guidelines and, at the very least, to become familiar with approaches that are recommended. Empirically supported treatments are supported by the evidence when delivered as intended. However, fidelity to such interventions has to be measured against the practicalities of the service user and the setting.

It is easy to become habituated to our working practices. We do what we know best. Expertise as a process requires deliberate action by the practitioner. Such action requires a concerted effort to make time to reflect in one-to-one supervision and peer-supervision. The latter is valuable as multiple perspectives and approaches can be shared. Although such time might be viewed as a luxury with ever-lengthening waiting lists and organisational demands, the practitioner psychologist is in a prime position to argue for such practices and to effect their inclusion in job plans. Ultimately, it is a professional requirement of governing bodies such as the Health and Care Professions Council (HCPC) that practitioner psychologists engage in continuing professional development, supervision and reflection so that they are competent in the service they provide to the service user, the team, the organisation and their own development.

Although the focus of service user values is primarily on the service user, other values should be considered as these feed into service user values. These include clinician and systemic values. Values change over time, and it is not a 'one time' check-in that is then noted in the service user's file, but is something that should form part of the therapeutic journey. Points to consider include awareness, reasoning, knowledge and communication. Identifying and responding to values can be a time-consuming endeavour, but is an essential component of EBP. It could be argued that 'evidence' encompasses not only the outcomes of research into treatment efficacy, but also how those outcomes measure up to the values and preferences of individual service users.

Working according to a particular practice model may sound straightforward but there are important considerations that need to be made. We must remind ourselves that working as a practitioner psychologist in health care is a process rather than a specific set of practices. That said, the EBP model represents key areas within the process of working with service users, and indeed working towards other key responsibilities, such as conducting research, teaching, service development and clinical supervision. Efficacy and effectiveness are key considerations as well as fidelity in delivery. With deliberate action and a critical stance, the practitioner can navigate the path of evidence-based practice with the understanding that we have to acknowledge that psychological interventions are rarely of a 'one size fits all' design.

Key Points

- The scientist-practitioner model asserts that practitioner psychologists should be trained in both research and practice.
- Evidence-based practice is the integration of 'best evidence', 'clinical expertise' and 'service user values'.
- Efficacy refers to the internal validity of a study whereas effectiveness relates to the external validity, i.e. research conducted in real-life settings.
- Evidence-based databases and clinical guidelines rely heavily on studies that demonstrate efficacy.
- Clinical expertise is a process of deliberate enquiry.
- Service user values can be identified with awareness, reasoning, knowledge and communication.

Practice Case Studies

Case Study 1

You are a Clinical Psychologist working in a child and adolescent mental health team. The team consists of a mix of professions and includes a psychiatrist, two other Clinical Psychologists and a cognitive behavioural therapist. You enjoy your work and this is your first job since qualifying. You have been with the team for 12 months.

You meet with your supervisor every two weeks. Your supervisor is a senior Clinical Psychologist based within your team. You feel supported but often worry that your supervisor tends to focus on managerial elements, such as your workload, weekly tasks and meetings and annual leave. You were hoping that you would be encouraged to seek further training in evidence-based approaches, such as dialectical behaviour therapy (DBT) or cognitive analytic therapy (CAT), both of which have been shown to be beneficial for adolescents who engage in self-harm and who have difficulties in developing healthy relationships.

As an early career Clinical Psychologist, you feel it is important to develop skills that will enhance your current work and to pursue opportunities for career progression. The lack of focus on training is an issue for the team as a whole and this frustrates you.

Suggested questions

1. Which aspects of this chapter can you use in your request for further training in DBT and CAT?
2. Who would you approach with this request?

Case Study 2

You have recently begun working with Katie (16 years old), who was referred into your team by her GP. The referral stated that Katie was low in mood, unmotivated and frequently absent from school. You have met with Katie twice. She comes to sessions alone, having been dropped off by a family member on both occasions. According to Katie, her goals for therapy are (1) to be more confident, and (2) to be able to make friends.

Katie is an only child and lives with her mum and dad. Both her parents work full time and Katie is often left alone. Her parents appear supportive and Katie does not report any difficulties at home. Katie is able to look after herself and presents as being mature for her age.

Katie is pleasant and attentive and appears to engage well. You have spent some time getting to know her and your initial formulation is that Katie is low in confidence and self-esteem, which impacts on her ability to make friends. You have shared this assessment with Katie and explained that you feel a cognitive behavioural therapy (CBT) approach would be best.

Katie, although polite, states in no uncertain terms that CBT is not for her. You gain the impression that if you were to pursue the issue, Katie would not attend your sessions. It transpires that Katie had heard her mum talk about 'CBT' to her aunt and the impression it gave Katie was that it involved a great deal of 'homework' and was 'less than useless'.

Suggested questions

1. Based on the information in this chapter, what would inform your next step?
2. Do you choose another therapy/intervention? Why?
3. How would you overcome the challenges that you might face should you continue with a CBT approach?

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