Within the mental health field, one of the most influential movements of the past decade is one referred to as evidence-based practice. This movement has sought to systematically identify and promote the implementation of scientifically established treatments. Although this movement emerged as part of the natural need to determine how to best respond to mental health conditions, we suggest that like many social, political, and scientific developments, it is not without its potential dangers, no matter how unintended.

In this short piece, we wish to explore three potentially initially unforeseen risks that we believe may have emerged with this movement. These are a loss of focus on (a) the context within which human suffering occurs; (b) what generates change; and (c) how change should be measured. Our intention is to stimulate discussion about possible issues that are arising as this movement progresses. We explicitly, however, do not wish to turn back the clock or support a nostalgic longing for an idealized past. Space constraints limit our ability to comment on the achievements of the evidence-based practice movement, although they are important and notable.

The first issue we would like to raise concerns a loss of the importance of appraising the context, meaning, and ultimately culture within which psychological suffering occurs. The evidence-based practice movement has its roots in cautious assessment of what should be addressed by treatment. For instance, careful attention is paid to detecting psychosocial deficits and symptoms and then testing which approaches lead to group differences, often in randomized trials. Symptoms of depression, for example, as measured by questionnaire or interview, have been found to decrease after certain manualized interventions. However, psychological suffering and dysfunction can arise in grossly different contexts and hence mean very different things from person to person. As an example, consider five individuals who have reported the identical symptoms of major depression: prolonged sadness, poor sleep, anhedonia, fatigue, feelings of helplessness, poor concentration, and thoughts of death. Now, consider further that these people are (a) a 25-year-old man who was the driver in a car accident that caused the death of a parent; (b) a 35-year-old woman who has obtained a dream job and found it to be hollow; (c) a 45-year-old woman whose aspirations all seem to be met and can find no root for her distress; (d) a 55-year-old man who has secretly married four different women who have just found out about each other; and (e) a 65-year-old woman struggling to adapt to retirement. In this example, the suffering of each individual, albeit fulfilling the same diagnostic criteria, likely has a significantly different meaning, and it is thus difficult to imagine treatment could proceed without an awareness of those different meanings. Certainly, the evidence-based practice movement does not instruct clinicians to ignore this. The concern we raise, however, is the potential that this essential facet of clinical work—namely consideration of the context and meaning of any specific
experience of suffering—could be neglected in the midst of well-intentioned efforts to use the most effective interventions.

The second concern we raise involves the potential of clinicians to lose sight of the importance and uncertainty about why treatments work. A typical trial, whether randomized or open, may suggest certain clinical activities are linked to certain outcomes. At best, changes in some variables might be linked to changes in others; however, we can only speculate why change has occurred. For instance, a cognitive-based treatment could lead to a reduction in delusions for different reasons for different individuals. Delusions could be reduced after individuals alter specific beliefs, attain a greater awareness of their reasoning style, improve their overall metacognitive capacity, or develop a greater tolerance for intersubjectivity. As in the example above, where it was important to be aware of the context of a symptom, it is hard to imagine that an effective treatment could proceed with a narrow emphasis on technique in the absence of ongoing curiosity as to why an intervention could be helpful.

The final concern we raise is that with an emphasis on precise measurement, clinicians may forget that psychological conditions need not be defined solely in terms of highly discrete problems or skill deficits. In a prototypical evidence-based manual, a specific problem such as unemployment is addressed with a specific intervention or set of interventions. The risk here is that we may lose sight that important aspects of recovery from many mental conditions may involve larger processes, which are not so easily discernible using standard measures. This may include a range of synthetic processes, which are not necessarily a sum of discrete skills or experiences. To move toward wellness may be to experience oneself more fully as an agent in the world. It may also mean developing more complex ideas about oneself and others that are not a matter of being more or less correct, but are instead to varying degrees adaptive, complex, and flexible. We assert this can be measured—although it may not be as easily or quickly assessed—and that larger issues, which can be a focus of treatment, may take time to detect and articulate.

In sum, this short piece has tried to draw attention to some broad concerns regarding the evolution of the evidence-based practice movement. If placed end to end, we worry about the potential that ways to deliver the most effective treatment with specified outcomes in mind may have unexpected consequences including neglecting to some degree the need to understand the person who is suffering, the processes underlying effective treatment, and the larger changes that might be observed to occur as individuals recover. This is not to deny the importance or necessity of the evidence-based practice movement, but instead to promote dialogue about issues that seem essential to continue to develop treatment approaches that avoid stagnation and keep in the forefront a human understanding of suffering and resilience.

Paul H. Lysaker, PhD
Clinical Psychologist
Roudebush VA Medical Center
Indiana University School of Medicine
Indianapolis, Indiana

David Roe, PhD
Chair
Department of Community Mental Health
Faculty of Social Welfare and Health Sciences
University of Haifa
Haifa, Israel

The authors have disclosed no potential conflicts of interest, financial or otherwise.

doi:10.3928/02793695-20130130-04