The Trend Toward Evidence-Based Practice and the Future of Psychotherapy

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Abstract

This paper describes how the trend toward emphasizing evidence-based practice and empirically supported treatments is likely to affect the practice of counseling and psychotherapy in the future. Several specific predictions are described and discussed, particularly those of Nicholas Cummings. Predictions include that evidence-based practice and general psychotherapy will diverge; eventually only evidence-based practice will be reimbursed and covered by liability insurance; and psychotherapy will become briefer and more integrated into the healthcare system.
Introduction

The field of professional psychology has been split due to the controversy over the promotion of evidence-based practice (EBP) and empirically supported treatments (ESTs) (DeAngelis, 2005). On the one hand, practitioners tend to be open to considering new ideas and methods for helping their clients, regardless of their empirical support. Therapists naturally want to offer suffering clients help, even in the absence of firm scientific support for all therapeutic approaches. On the other hand, scientifically inclined psychologists decry the proliferation of new techniques that have little if any evidence for their safety or efficacy (Lilienfeld, 2007). “There is probably no professional issue more important to clinicians than the evolution of EBP in mental health” (Prochaska & Norcross, 2007, p. 545).

The Controversy Over Evidence-Based Practice

Speaking of psychologists, Raymond D. Fowler, past president of the American Psychological Association, said “Our scientific base is what sets us apart from the social workers, the counselors, and the Gypsies” (quoted in Dawes, 1994, p. 21). Setting aside Fowler’s slighting of counselors and others, his point that clinical psychology has a tradition of valuing the scientific method is well taken. The emphasis on establishing empirical support for psychotherapy over the past decade has lead to the development of lists of psychotherapeutic approaches that have good evidence for their effectiveness (Chambliss & Ollendick, 2001; Fisher & O'Donohue, 2006; Society of Clinical Psychology, 2009). Psychotherapists who want to practice
evidence-based treatments can consult such lists, although there is no requirement that they do so.

Although similar, evidence-based practice (EBP) and empirically supported treatments (ESTs) are different. Empirically supported treatments start with the treatment and ask whether the treatment works for a certain disorder; EBP starts with the client and asks what research evidence will help the psychologist to get the best outcome. Evidence-based practice is the integration of research with clinical expertise in the context of the client’s characteristics, culture, and preferences. ESTs are treatments with at least two randomized controlled clinical trials that demonstrate their efficacy. This is a very rigorous standard, and the APA policy on evidence-based practice allows for less stringent evidence (APA Presidential Task Force on Evidence-Based Practice, 2006). Since EBP allows for various kinds of evidence besides randomized, controlled trials, it is usually considered less stringent and less controversial than ESTs.

The trend is toward requiring psychotherapists to account for their clinical and cost effectiveness. “The EBP movement in U. S. society is truly a juggernaut, racing to achieve accountability . . . . psychology needs to define EBP or it will be defined for us” (Levant & Hasan, 2008, p. 658). Professional organizations have been proponents of EBP and ESTs in psychology and counseling. The document Ethical Principles of Psychologists states that “Psychologist's work is based upon established scientific and professional knowledge of the discipline” (American Psychological Association, 2002, p. 6). The APA Standards for Accreditation (American Psychological Association, 2000) include the guideline that students receive training
in ESTs, and a Division 12 Task Force report (1995) recommended that training in
ESTs should be a requirement for the APA accreditation of training programs.
Similarly, the Code of Ethics of the American Counseling Association (2005)
mandates that “Counselors use techniques/procedures/modalities that are
grounded in theory and/or have an empirical or scientific foundation” (p. 11). Of
course there is a big difference between theory and empirical evidence, so this could
be read as half-hearted support for science. Nevertheless, it seems clear that the
trend is for professional organizations to support the development of evidence-
based treatment. “Evidence-based counseling practices are necessary to establish
the credibility and effectiveness of counseling interventions, and many external
funding agencies have begun to mandate an increased use of evidence-based
practices” (Murray, 2009, p. 108).

The movement toward finding and listing empirically supported treatments
is controversial. Some feel that the emphasis on using ESTs is misguided because it
moves psychotherapy further into the medical model: “Psychology’s medicalization
has accelerated recently . . . . Psychotherapy is at risk for being medicalized out of
existence” (Hunsberger, 2007, p. 614). Others assert that because there is good
evidence that psychotherapy in general is helpful most of the time, “Psychologists do
not have to apologize for their treatments. Nor is there an actual need to prove their
effectiveness” (Fox, 2000). However, if third-party payers continue to require more
accountability, psychologists probably will have to prove the effectiveness of their
treatments if they expect reimbursement for their services.
It may be that the idea that psychological problems can be objectified and treated with packaged treatments is simply wrong: “Psychotherapy more closely resembles a jazz collaboration than a medical treatment” (Hunsberger, 2007, p. 614). Also using a musical analogy, Frank said “To try to determine by scientific analysis how much better or worse let us say, gestalt therapy is than transactional analysis is in many ways equivalent to attempting to determine by the same means the relative merits of Cole Porter and Richard Rogers. To ask the question is to reveal its absurdity” (quoted in Engel, 2008, p. 192). Frank and Frank (1993) suggested that psychotherapy is basically a special form of conversation, and as such has more in common with rhetoric than empirical science.

While several lists of empirically supported treatments exist, there is much debate regarding how and why certain treatments get on the lists. In addition, some of the most common forms of psychotherapy offered to the public today do not have enough empirical support to appear on the lists (APA Presidential Task Force, 2006). Nevertheless, the trend toward evidence-based practice is clear. “The promulgation of evidence-based treatments has been relatively recent and divisive. What we can say with certainty is that EBP in health care is here to stay . . . . In fact, the demands for evidence from various constituencies will escalate in the future . . . . What is designated as ‘evidence-based’ will determine in part what psychotherapy is conducted and what is reimbursed” (Prochaska & Norcross, 2007, p. 545).

While the arguments on both sides of the controversy have merit, the proponents of EBP and ESTs seem to be winning the debate. While psychotherapy may fundamentally be seen as therapeutic conversation, which is by its nature
difficult to subject to empirical analysis, financial interests are driving the helping professions to define specific treatments that are effective for treating specific disorders. Third-party payers are more likely to be willing to fund therapy for disabling disorders than they are to pay for talk therapy for vague existential concerns or problems of living. As evidence-based practice becomes more recognized, third-party payers are more likely to require psychotherapists to use such treatments in order to receive payment. The APA Presidential Initiative on Evidence-Based Practice said “We will have more leverage with insurers, courts and policy makers when APA has a clear statement asserting that we are a science-based profession” (Levant, 2005, p. 5).

Predictions

Several prominent psychologists have offered predictions about the future of psychotherapy, taking into consideration the increasing importance of EBT and ESTs. The most prolific writer on the future of psychotherapy practice is Nicholas Cummings, a past president of the American Psychological Association and recipient of the APA Award for Distinguished Professional Contributions and the APF Gold Medal Award for Life Achievement in the Practice of Psychology (Gold medal, 2003). Cummings has been called psychotherapy’s soothsayer and one of the prime architects of modern mental health practice (Simon, 2009). He predicted (and helped bring about) the integration of psychotherapy into managed health care, and his recent predictions deserve to be better known. Other psychologists have agreed with the trends he predicts, as noted in the following sections. Although making
predictions is, of course, hazardous, the following predictions are based on current trends and the extrapolations seem justified.

_Divergence of EBP and General Psychotherapy_

A common prediction is that the practice of psychotherapy will follow two paths: evidence-based treatments for specific disorders (which will be paid by third-party payers) and general counseling and psychotherapy for problems in living (which will not be paid by third-party payers). While this is already occurring to some degree, the divergence will probably become more dramatic, and serve to more clearly distinguish evidence-based clinical treatment from general psychotherapy and counseling.

David Barlow (2004) has predicted that psychologists will offer two types of services: 1) psychological treatments that are evidence-based, clearly health related, and reimbursable; and 2) psychotherapy, for which people would pay out-of-pocket. _Psychological treatments_ would be empirically supported treatments for specific disorders, and _psychotherapy_ would be talk therapy for more general issues or problems of living. A potential difficulty with this division is that problems of living are often inseparable from psychological disorders (Gabbard, 2005).

_Only Evidence-Based Practice Will Be Reimbursed_

According to Nicholas Cummings (2006), third party payers will eventually reimburse only for empirically supported treatments. “Now, under health reform, if you don’t do evidence-based therapy, you won’t get reimbursed” (Cummings quoted by Yalom, 2009, p. 22). After the use of EBP or ESTs is made mandatory, therapists who use other treatments will not be able to obtain reimbursement for therapy:
“Professional psychology should prepare for the era of EBP-only reimbursement” (Cummings, 2002a, p. 14). Cummings, founder of Biodyne, the first psychological health maintenance organization, has recently become a promoter of evidence-based treatments, which he views as defensible both legally and morally. Restricting payments to EBP would reduce what third-party payers consider run-away, questionable or needlessly long-term psychotherapy (Cummings, 2002b).

“A number of local, state, and federal funding agencies are beginning to restrict reimbursement to [empirically supported] treatments, as are some managed care and insurance companies” (Levant & Hasan, 2008, p. 658). According to Cummings and O’Donohue (2008),“Slowly, the push for evidence-based therapy is winning…. Payers are beginning one by one to announce that they will not pay for psychological treatment unless it is grounded in evidence” (p. 292); We should “ensure that psychological treatment in healthcare is evidence based and effective. Those wishing to practice other forms of psychotherapy could do so outside the health system and without healthcare third-party reimbursement” (p. 312).

Third-party payers are moving toward pay-for-performance reimbursement mechanisms, which will lead to the use of quality performance measures. This requirement to document effectiveness will revolutionize psychotherapy practice. Of course the move to requiring EBP will have drawbacks. One major limitation is that currently empirically supported treatments have not been identified for many psychological disorders. Another problem is that lists of ESTs imply that any therapy not on the list is not effective, although that is not a correct inference.

*Only Evidence-Based Practice Will Be Covered by Liability Insurance*
Inevitably the beleaguered malpractice insurance industry, whose costs continue to rise, will jump on the bandwagon and restrict coverage to ESTs. After third-party payers limit reimbursement to EBP and ESTs, psychologists who do not use them will be vulnerable to professional liability suits. “Third party payers will make mandatory the use of ESTs, thus more narrowly defining what is reimbursable as healthcare . . . treatments not qualifying will be more vulnerable to professional liability suits, and . . . the malpractice industry will join the demand for ESTs” (Cummings, 2002a, p. 14). The concern is that professional liability insurance companies could ask why a psychotherapist did not use an existing EST with a client. Requiring such a justification could have a chilling effect on the use of treatments or approaches that do not appear on the approved lists of treatments. “Non-EBT practice will dry up or will be limited to those providers willing to practice without either reimbursement or malpractice insurance . . . Just one lawsuit could place the provider in a position of having to work a lifetime to pay off a judgment” (Cummings, 2002b, p. 4). Given the difficulties in establishing empirical evidence for the effectiveness of psychological treatments, and the difficulty of showing the superiority of one treatment over another, an over-reliance on EBP and ESTs could have negative consequences. “The scientific foundation in mental health is neither robust nor always replicable . . . Practitioners need assurance that the protocol has scientific validity but that varying from it as needed will not come to haunt them in a malpractice suit because the legal system has interpreted the protocol to be immutable” (Cummings, 2006, p. 601). This will require a delicate balance. Perhaps future lists of ESTs should come with a cautionary statement like
the one in the DSM-IV-TR which states that the inclusion of certain diagnoses does not imply that the condition meets the legal criteria for a mental disorder (American Psychiatric Association, 2000, p. xxxvii). The statement could say that the inclusion of a certain treatment on the list of ESTs does not imply that other treatments do not work just as well.

_Psychotherapy Will Become Briefer and More Medicalized._

Third-party-payers will require that psychotherapy be as brief as possible, and not scheduled simply based on tradition or the convenience of the therapist. Health insurers only want to pay for treatments that are “medically necessary,” not therapy aimed at working on problems of living, improving self-esteem, pursuing self-actualization, or other vague and ambiguous goals. This emphasis on treating only specific and at least moderately severe disorders means that psychotherapy in the future will look more medical or clinical than it does today. Conforming more to the medical model will mean that the fifty-minute hour will be used infrequently. According to Cummings and O’Donohue (2008), psychotherapists should aspire to diagnose patients and begin treatment in 15 minutes, just like physicians. While this may be extreme, it is likely that psychotherapy sessions in the future will often be briefer than the traditional fifty-minute hour.

_Psychotherapy will become not just briefer but more standardized._ Sessions will be spaced out more, rather than weekly. Both reimbursable and non-reimbursable psychotherapy will become more dependent on technology. Virtual interventions will include “interactive electronic systems” telehealth, web sites, and “computer models of psychotherapy” (Cummings and O’Donohue, 2008, p. 67);
“computers . . . will facilitate standardization – one of the prime characteristics of industrialization” (p. 399).

Many psychologists will design practices that look more like coaching than the traditional private practice of psychotherapy. The most successful therapists may be those who supplement face-to-face therapy sessions with e-mail, web sites, and telephone calls (Grodzki, 2009; Truffo, 2009). Much more treatment will be provided in time-limited groups focused on specific disorders, rather than individual psychotherapy. Much therapy will be done in disease-management groups. “Only 25% of the psychotherapy of the future will be individual. Another 25% will be group psychotherapy, while at least 50% will be psychoeducational programs” (Thomas & Cummings, 2000, p. 399).

Mental health and substance abuse treatment constitute only 5% of the health care budget in the United States; psychologists need to provide psychological services to the other 95% of contributors to the budget because “that’s where the money is” (Cummings & O’Donohue, 2008, p. 83). The trend will be toward making psychotherapy more of a healthcare profession: Cummings maintains that psychologists treat patients, not clients, and treat diseases such as schizophrenia, alcoholism, and somatizing disorders. Psychologists also help people who have diseases cope with the psychological aspects of their disease and comply with their medical regimens. It may become difficult for the practice of psychotherapy to survive as an independent profession, but it would be more likely to survive if it is fully integrated into healthcare.

*Psychologists Will Not Conduct Much Psychotherapy*
If current trends continue, in the future little psychotherapy will be done by psychologists. “The majority of psychotherapy conducted in the United States is by social workers, who have accommodated to managed care far better than have psychologists” (Cummings & O’Donohue, 2008, p. 14). Doctoral psychologists who choose to do psychotherapy will have to accept the same fees as master’s-level providers (Cummings, Cummings, & O'Donohue, 2009). It is a buyer’s market for those who pay the bills (government, insurers, managed care, HMOs). To the consumer, all therapists are equally qualified, and doctoral psychologists have not proven they have much more to offer as therapists than counselors and social workers. In the future, doctoral psychologists will have to develop expertise in niche areas to differentiate themselves from master’s level counselors and social workers. Promising specialty areas include neuropsychology, forensic psychology, and health psychology.

Although some psychologists will be able to survive with an out-of-pocket fee-for-service practice, most will not. Currently only 5% to 7% of patients with insurance benefits for psychotherapy choose to forgo their benefits and pay out-of-pocket (Cummings & O’Donohue, 2008). While the great majority of psychotherapy in the future will be ESTs, there will still be a small niche for therapists who see clients who pay out-of-pocket. There will always be some clients who, for privacy or other reasons, are willing to pay for their own psychotherapy rather than using insurance benefits. Therapists who see these clients will have more freedom to practice pretty much any approach they like. But the self-pay
market will always be very small, and few therapists will be able to make a living seeing only self-pay clients (Cummings, Cummings & O'Donohue, 2009).

Conclusion

Over the past couple of decades much effort has been put into conducting research on the effectiveness of psychotherapy, resulting in lists of evidence-based and empirically supported treatments. This can be seen as a great advance since the days when few approaches to psychotherapy could boast empirical support. While the trend toward developing lists of ESTs has been, and will likely continue to be controversial, few would deny that if the effectiveness of psychotherapy can be measured then it should be measured. If there are differences among various treatments in their effectiveness with clients who have specific disorders, then information on such differences should be available.

There is a legitimate concern about whether information about EBT and ESTs will be used by managed care and other health care organizations to limit payment to practitioners who use such treatments. The state of the science in measuring the effectiveness of the inherently subjective art of psychotherapy may not yet be at a point that allows a clear alignment of disorder with treatment. Psychotherapists should be familiar with the literature on EBT and ESTs and use it to inform their practice, but in addition to the science, psychotherapy will always have a large component of art. We are not yet, and may never be, at the point where a therapist can simply consult a cookbook of ESTs and apply the treatment with reliable results.

Some have criticized Cumming's predictions as presenting an exaggerated picture of psychotherapy's future (Shulman, 1988; Simon, 2001). Indeed, some of
Cummings’ and his colleagues’ predictions do seem somewhat catastrophic, and may never come to pass. But psychotherapists cannot afford to be complacent; given the economic challenges sure to face Americans in the coming years, current trends toward supporting and requiring EBT and ESTs could well be a taste of things to come. Forewarned is forearmed, and psychologists on both sides of the controversy should work to make their views known. Psychotherapists in independent practice might consider the potential benefits of affiliating more closely with physicians and healthcare organizations, and students in training should learn as much as possible about EBT and ESTs.
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*American Psychologist, 58, 548-550.*


