PSYC SPOT PSYCHOLOGY CLINIC

Understand & Develop Your Inner-Workings

Why Empirically Validated Treatments Can be Invalid in Actuality…

NEWSLETTER #7

Once upon a time, psychotherapists allegedly practiced in wild and random ways. In an effort to improve the standard of care to patients, authoritative lists of empirically validated (i.e., scientifically proven) treatments were compiled to guide and regulate treatment selection.

The use of research evidence to guide psychotherapy sounds perfectly logical on paper, but is poorly executed in practice. Critical flaws lied in the type of research conducted and the sort of evidence accepted. Consequently, even exceedingly dubious treatments managed to receive the scientific seal of approval and rose in prominence.

Consider Eye-Movement Desensitization and Reprocessing (EMDR), a hugely popular treatment empirically validated for Post-Traumatic Stress Disorder (PTSD). In brief, EMDR proponents claim that trauma disturbs the brain in ways that can be corrected by manoeuvring one's eyes according their instructions during trauma reprocessing.

EMDR is regarded as an Evidence-Based Treatments for PSTD because it is shown in Randomized Controlled Trials (RCTs) to be more effective than placebo and similar to established treatments. The thing is, research also shows EMDR applied without eyeball manipulation (i.e., basic trauma processing) works just as well as EMDR done with its key component. Also note that EMDR's claims about guided eye-movements having therapeutic effects on the brain after trauma are so "innovative" that they make no sense to those well-trained in neurological and psychological science.

In scholarly texts, EMDR has been satirically compared to the hypothetical Purple Hat Therapy. Imagine if someone claims to have a purple hat that emits curative magnetic waves and test it by asking patients to wear the hat during (obscured) classic therapy. Patients improve, and the hat gets credited – even though Purple Hat Therapy suspiciously works just as well with or without the hat that defines this treatment…

Under the prevailing scientific paradigm, a brand of therapy can be wholly validated as "evidence-based" if ***something*** within its package of procedurally-defined interventions can ***somehow*** lead to symptom reductions in ***some*** participants (with decontextualized symptoms that may stem from disparate problems). The improvements just need to be methodically "evidenced" in RCTs. Thanks to these lax rules, many have created novel evidence-based treatments via packaging "innovative" components with tried & true ones, or use new procedures and rationalizations (often shrouded in neurological babble or other fashionable lingo) to deliver what is otherwise familiar to seasoned clinicians.

Why did psychiatry and clinical psychology embrace such a shoddy research paradigm, which led eminent researchers to question whether our "gold standard" methodologies are gold plated or fool's gold? Likewise, why did we subscribe to a shallow diagnostic system that (according to its creators) is not designed to meaningfully distinguish between problems to guide treatments (see Newsletter #4)?

While nothing resembling the full answer will fit into this short read, I hope it helps to highlight that decision-making in scientific disciplines (just like those in politics) are not always based on what is most logical or beneficial to society. In reality, they are also a product of unwanted compromises, selfish interests, power plays, trends and dogmas etc.

I wish Evidence-Based Practice is as straightforward as what many make it out to be (e.g., just use validated treatments), but it is not. The issues outlined here are just the tip of the iceberg, so it is important to find practitioners who can and will make judicious use of research findings and evidence.

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