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New Kids on the Block: A Column for Early Career Psychologists

Evidence-Based Practice and Practice-Based Evidence: Implications for Psychological Client-Care

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Summary

In this article, the author argues that evidence-based practice (EBP) and practice-based evidence (PBE) models/approaches should work together and move towards complementarity because they both have great value in research and practice. In the context of this article, *complementarity* is drawn from Ellis's (2015) work which refers to "ways in which two different approaches to conducting a research synthesis can in combination provide a more complete, unified explanation of a phenomenon than either single approach" (p. 285). In other words, a practice should inform research, and research should inform practice. Further, both models provide a unique lens through which to value psychological client-care and neither element is complete on its own. From the above perspectives, researchers and psychologists should work collaboratively toward the goal of best practices for all diverse clients. The objective of this article is to emphasize the need for psychologists to be intentional in their work as they strive to uphold ethical standards in EBP and PBE.

Introduction

Historically, much attention has been given to evidence-based practice (EBP) in the field of psychology that values science-based knowledge "to help people understand, explain and change their behaviour" (Canadian Psychological Association [CPA], 2016, para. 1). Despite the scientific viewpoint that grounds EBP, it presents constraints in helping the profession of psychology better serve the growing complex needs of communities, especially the population whose intersected identities are given limited attention in the counselling context. As such, understanding how the applicability of evidence might differ across diverse populations and cultural contexts relative to client care warrants a holistic approach that considers practice-based evidence (PBE) (Green & Allegrante, 2020, p. 946). Although EBP integrates scientific knowledge with clinical expertise, a great value should also be placed on practice-based experiences. In this paper, the author will first provide clear definitions for EBP and PBE, with attention given to their historical contexts. Second, critiques of both approaches will be addressed. Third, the effectiveness of PBE will be explored as relates to working with diverse populations for whom EBP might not be culturally appropriate. Lastly, research and practice implications for EBP and PBE will be provided to enhance the knowledge of psychologists interested to better support clients.

Definitions and Historical Contexts of EBP and PBE

Research has shown that the history of EBP has strong roots in the medical field, specifically in developing evidence-based medicine (EBM). A relatively new term, McMaster's University researchers started using it in the 1990s (Claridge & Fabian, 2005). Formalized in 1996, Sackett and colleagues defined *EBM* as the "proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice" (p. 71). Although the conceptualization of the evidence-based process was initially geared towards physicians, since then EBP (also referred to as *evidence-informed practice*)

has been widely accepted by many health professions including but not limited to psychology, social work, nursing, and public health. *EBP* has been defined as "integrating the best available research evidence with clinical expertise and the [client's] unique values and circumstances" (Straus et al., 2011, p. 1). This definition holds much weight in the clinical context where EBP focuses on the incorporation of empirical knowledge to establish best intervention strategies (Centre for Community Child Health, 2011). An example of EBP would be cognitive behaviour therapy because it is strongly supported by scientific research and considers clients' behaviour patterns, cognitive thinking and emotional states in counselling settings (Cook et al., 2017). Therefore, this approach is informed by rigorous research and offers psychologists the best clinical expertise in client-centered care.

Conversely, the advent of PBE was in many ways a response to the need for best practices to address the growing concerns about the cultural appropriateness of EBPs that did not always align with the cultural realities of many racialized communities (Lieberman et al., 2010). Drawing from Bartgis and Bigfoot's (2010) work around traditional Indian practices and health care within the United States, *PBE* describes "[a] range of treatment approaches and supports that are derived from, and supportive of, the positive culture of the local society and traditions" (para. 7). Within many Indigenous communities, PBEs are ingrained in the culture and strongly accepted by community members to support healing from a cultural framework that encompasses their norms and traditions (Isaacs et al., 2005). For example, a PBE approach to indigenous ways of knowing and being is *Healthy Drumming*, a holistic approach aimed to reduce stress and anxiety by stimulating and connecting physiological, psychological, and spiritual schemas (Lieberman et al., 2010). PBE is client-centred and accounts for individual uniqueness and shared factors, so it is a suitable approach when serving a diverse clientele. Arguably, PBE may serve as a best practice approach to reconciling EBP since it considers the multi-faceted service needs and cultural values of diverse communities.

Critiques of EBP and PBE

Addressing EBP

Despite the benefits of using EBP and PBE in clinical settings to foster psychological client-care, there are challenges to both models that can likely influence best outcomes in counselling. Addressing EBP, there are numerous key factors worth noting around its limitations. First, the research which creates the groundwork for EBP must occur in controlled settings to accurately determine the effect of the intervention. Thus, many "real world" factors are disregarded and potentially present with low external validity (Adams et al., 2009). Also, critics of this model indicate that data used to make clinical decisions in practice tends to only focus on reducing bias instead of incorporating various sources of research methods such as "conventional wisdom and common sense" as well as "case reports, scientific principles and expert opinion in the form of knowledge gained from qualitative studies" (Estabrooks, 1998; Tickle-Degnen & Bedell, 2003; Woodbury & Kuhnke, 2014, pp. 28-29). Furthermore, data from EBP research appear to have inadequate samples from diverse populations, which impacts the generalizability of the results (Abe et al., 2018). Likewise, while this approach allows for greater control of mitigating factors, critics of EBP note that the carefully controlled research setting does not always allow for the findings to accurately reflect what would be found in an average clinical setting (Barkham & Mellor-Clark, 2003).

Secondly, there has been emphasis on EBP's colonial roots (Koro-Ljungberg et al., 2009), especially on the notion of colonization in westernized research ideologies. Many practices that have been determined to be evidence-based exclude cultural variables in research samples, fail to examine the impact of culture(s) on outcomes, do not consider co-occurring disorders, and undervalue context and environment (Isaacs et al., 2005). Further, the research samples by which EBP is informed are often unrepresentative of vulnerable populations and/or do not consider the many factors (e.g.,

comorbidities) that could influence client outcomes (Cook et al., 2017). These limitations are especially noteworthy due to the changing demography of the Canadian society. Psychologists are now challenged to purposefully and intentionally enhance their skills in culturally relevant and responsive client-care services and interventions. Since EBP appears to be the gold standard for clinical practice, these critiques are crucial especially when considering diverse populations like Indigenous peoples who value the cultural relevance and responsiveness that PBE offers to address community needs.

Addressing PBE

Similar to EBP, PBE models are not absolved from critiques. A major concern with PBE is the challenge of establishing rigorous measures, and define intervention precisely and accurately to benefit client-care (Lieberman et al., 2010). This limitation can have ethical implications if certain clients are negatively impacted by treatment protocols used by psychologists that might infringe on their values and worldviews. Another area of contention about PBE is the inability to translate science to practice due to constructs requiring greater rigor and clarity around parameters. To mitigate this issue, researchers must do due diligence to conduct community-based participatory studies that encompass a wide range of treatment methods derived from, and supportive of, the positive culture of clients' local society and traditions (Swisher, 2010). Within the context of PBE, the real, messy, complicated world is not controlled (Swisher, 2010). Rather, real world practice is usually documented and measured in all its complexities, just as it occurs. Hence, the measurement and tracking process is important, and it does not control how practice is delivered.

In recent years, PBE research have been developed in collaboration with local communities to account for individual needs and be more culturally sensitive (Bartgis & Bigfoot, 2010). However, these forms of community-based investigations have not been granted the same funding and research opportunities as compared to randomized controlled research efforts (Cook et al., 2017). This notable research discrepancy calls for greater funding opportunities for certain racialized communities such as Indigenous groups whose cultural customs are often misunderstood. As such, members from these groups might refrain from conducting PBE research due to fear of being misrepresented, othered, and further marginalized. While some individuals of these communities might want to engage in research, clinical trial studies for PBE models are often not possible because of limited research infrastructure such as training, staff, and operational grants to ensure sustainable funding (Bartgis & Bigfoot, 2010). Although an advantage of PBE is the ability of the researcher to tune into the community's needs (Forzani, 2014), the replicability of research can be viewed as a challenge because two communities might not benefit from the same practice-based modifications. Additionally, because PBE is mainly feedback oriented, Holmqvist et al. (2015) assert that "public agencies and private companies may want to present more positive figures of treatment outcome than the data really warrant" (p. 26). This disadvantage reinforces the fact that human bias and the desire to publish a specific outcome, that is not ethically sound, can have significant counselling and research implications for psychologists who might inflict harm on their clients and the general public.

Research and Practice Implications for PBE and EBP

There is a reciprocal interaction between practice and research in the psychological domain relative to client-care. EBP and PBE models challenge psychologists to critically analyse the research they consume objectively and subjectively (Cook et al., 2017). Knowing that research findings have practice implications for the everyday lives and treatment of clients, psychologists need to ensure that the information they are integrating into their work has sound scientific and cultural groundings. However, while scientific evidence in evaluating and selecting an intervention strategy is vital, restricting practice to best research evidence affirms an undeniable Eurocentric worldview in psychology. Undoubtedly,

this westernized mindset is non-reflective of the current diverse and multicultural Canadian demographics. This means that research should be drawn from culturally appropriate sources such as aggregate data collected from clients' histories within community contexts (Lieberman et al., 2010). By so doing, both researchers and psychologists should avoid inadvertently ignoring (or being unaware of) other culturally relevant interventions grounded in PBE models that could generate successful results for ongoing client-care. Further, with respect to EBP, researchers need to ensure that the data and conclusions behind any given approach or intervention are sound, justified, and enhance our collective knowledge. Along the same view, PBE research can fill a gap in the profession of psychology by utilizing culturally adapted interventions supported by the literature (e.g., Healthy Drumming); these tools are deemed effective for Indigenous cultures and responsive to the varying needs of diverse communities (Abe et al., 2018). While EBP allows for accountability to consumers, their families, and the communities in which they live, PBE permits space for the cultural context and characteristics that represent consumers, families, and communities (Bartgis & Bigfoot, 2010).

In terms of practice, psychologists have an ethical responsibility to support treatment and interventions rooted in evidence to protect clients from harm. Since no one approach will be successful with all clients, psychologists must consider diversity and integrate *cultural safety* and *cultural humility* into all aspects of practice (Gushue et al., 2022; Hatchett, 2021). The former term emphasizes the delivery of quality mental health care through changes in thinking about power relationships and client's agency and rights (Papps & Ramsden, 1996). It acknowledges the barriers and challenges to clinical effectiveness emerging from the inherent power imbalance between psychologists and clients (Laverty et al., 2017). The latter concept encompasses an openness to learning about clients and the ability to have a deeper appreciation of clients' unique cultural experiences, beliefs, values and worldviews (Sommers-Flanagan & Sommers-Flanagan, 2012). With the understanding that research informs practice and vice versa, a PBE approach that embodies community-based participatory research can "help bridge the gap between science and practice through community engagement and attention to existing relationships, needs, and assets in a community" (Ammerman et al., 2014, p. 52). This form of bridging requires psychologists to share expertise and work collaboratively to develop culturally appropriate interventions that are adaptable and replicable in clinical practices.

Conclusion

Even though EPB and PBE approaches represent differing orientations, they offer unique strategies to navigate client-care and improve the lives of those served in psychology. By valuing the benefits that both models have to offer, psychologists will be better positioned not only to advance their competencies to inform their practice but also provide equitable services to vulnerable communities. As psychologists find strategic and ethical ways to infuse both models into practice, they are gently encouraged to engage in self-reflection and reflexivity to assess the potential impact of their own cultural worldviews on vulnerable populations (Dixon & Chiang, 2020). In sum, there is a greater need for high-quality evidence from practice-based and evidence-based data to support the implementation of relevant, generalizable and effective work with diverse clients within the field of psychology.

Author Information

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