Chapter 2
A Brief History of Evidence-Based Practice

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While Dr. Archie Cochrane takes most of the credit for today's widespread implementation of Evidence-Based Practice (EBP) in medicine, our story of EBP in psychology dates back to a clash between psychodynamic and behavioral/learning theory in the 1950s. In the 1950s, there was very little evidence to support the use of adult and child psychotherapy. In fact, both Eysenck (1952) and Levitt (1957, 1963) had concluded that "the simple passage of time" could account for any positive effects of psychotherapy. Luckily for the sustainment of this field, these scathing reviews led to more trials, tests, and a general movement towards evidence and research to justify treatment.

In the early 1960s, a clinical child psychologist named Alan O. Ross was staunchly in favor of empirically-based practice. In 1959 he wrote *The Practice of Clinical Child Psychology*, a book that goes into detail about how research is one of the main areas of clinical child psychology. Ross went on to help found and lead the Clinical Child Psychology section (Section 1) of APA Division 12, Clinical Psychology in 1962, which became Division 53 of the American Psychological Association, the Society of Clinical Child & Adolescent Psychology (SCCAP). Today, Division 53 works to bring evidence-based treatment to parents and therapists and sponsors online education and training. Division 53 and the Association for Behavioral and Cognitive Therapies (ABCT), founded under the name Association for Advancement of Behavioral Therapies (AABT) shortly thereafter in 1966, currently help to widely disseminate evidence-based practice by keeping updated research publications listed and available (Erickson, 2011).

The Task Force on Promotion and Dissemination of Psychological Procedures (part of APA Division 12) made a bold move in 1995 by publishing a report that

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defined and adopted the term "empirically supported." This report identified four main categories of treatments; "well-established" treatments were those that had been proven effective according to at least one randomized control trial (RCT) following very strict experimental guidelines. In order to be well-established, a treatment must be statistically significantly superior to a placebo or another treatment, or equivalent to (if not better than) an already established treatment. "Probably efficacious" treatments should be proven to be more effective than a no-treatment control group, "possibly efficacious" treatments must have at least one study showing positive results, and "experimental" treatments have not yet been tested in randomized control trials. These terms were general guidelines to categorize the full range of psychotherapy in adults and children. And of the identified and categorized treatments in the report, only three treatments specifically for children were decidedly "well-established." Not one of these acknowledged treatments were specifically designed for maltreated children. By laying out the standards of "empirical support," the APA confirmed its support for evidence-based practice. Evidence-based practice is an approach to clinical practice that calls for research, specifically quantitative experimental designs, to determine the best clinical methods.

In full support of APA's mandate, the very next year, Urquiza and McNeil (1996) published an article pushing for increasing evidence-based practice for a very specific population: physically abused young children. In their thought-provoking article, they suggested that Parent–Child Interaction Therapy (PCIT) could be the go-to treatment for that population. It became clear in the field of child clinical psychology that more research and evidence was needed to prove that treatment was actually making a difference for these children. Around the same time, Cohen and Mannarino (1996) and Deblinger, Lippmann, and Steer (1996) both conducted a randomized controlled trial looking at the effects of very similar interventions, which supported the use of TF-CBT in reducing trauma symptoms in sexually abused children. Cohen and Mannarino found positive results for TF-CBT being more effective than a nondirective supportive therapy, while Deblinger and her colleagues (1996) documented the importance of including parents in treatment with the children. At the time, finding a reliable way to treat the debilitating effects of sexual abuse was an important move forward for supporters of the use of evidence-based practice in clinical psychology. These clinical research scientists were changing the definition of clinical outcomes, from one emphasizing the way people thought about themselves and stressful events to one that depended on measuring changes of symptom intensity (Kazdin, 2008). While evidence-based treatments (EBTs) were gaining research spotlight and advocates in the policy world, many concerns were raised about the quality of EBTs empirical findings.

Opponents of the EBP movement brought up three concerns (Ollendick, 1999). First is the reliance on randomized control trials to establish the empirical base, proving efficacy caused a problem, because not all theories of practice lent themselves well to these types of quantitative experiments. For example, more psychodynamic interventions emphasized clients' changing perceptions of themselves and their social environment, and was less concerned about reductions in symptom levels. But according to the definitions of well-established EBTs these treatments that

did not have evidence showing positive "outcomes" through RCTs could not be considered effective. The evidence-based treatment game was being played on a lopsided playing field. Behaviorally oriented interventions, or interventions that aimed to reduce the frequency of discrete behaviors, were easy to research in RCTs and so were "empirically supported." More idiosyncratic psychodynamic approaches that strive for less measurable outcomes were difficult to research and lacked empirical support.

Second, there was a concern that the evidence base was rolling out from the settings that could fund it, and that these interventions would not translate to the "real world." Finally, therapists are concerned that their clinical training and judgment would not be valued if their practice came solely from manualized treatments. They argued that a manual could not contain an answer for every possible scenario that might pop up in a treatment session and that having to maintain fidelity to the treatment would interfere with meeting the needs of each client (Ollendick & King, 2004). Ollendick and King, addressing these concerns, came to the conclusion that there are major arguments for and against using EBTs, and in order to fully address them, clinicians and researchers must communicate about what works and how to streamline translation of empirical evidence to practice. Furthermore, they asserted that "Children and their families presenting at our clinics deserve our concerted attention to further the true synthesis of these approaches and to transform our laboratory findings into rich and clinically sensitive practices." (Ollendick & King, p. 21)

While the number of evidence-based treatments were increasing, national surveys such as those conducted by the U.S. Surgeon General in 1999 (U.S. Public Health Service, U.S. Department of Health and Human Services, & Office of the Surgeon General, 1999) made it clear that many people were not receiving these services. In 2002, President Bush convened the New Freedom Commission on Mental Health to address this problem. After careful study, the Commission issued a report in 2003 recommending the transformation of America's mental health care system. The recommendations suggested that the transformation should involve a push towards making evidence-based practice the foundation of all clinical practice. The report states that it currently takes far too long for research on effective treatments to translate into clinical practice. This transformation was meant to eliminate confusion, and increase effectiveness and efficiency within the overall mental health care system. It was stated that in order to achieve this transformation, more funding from clinical programs would need to go toward supporting evidence-based practice for children, specifically for PCIT, multi-systemic therapy, functional family therapy, and treatment of foster care children. The commission urged the Centers for Medicare and Medicaid Services (CMS) to aid programs in making these financial changes (President's New Freedom Commission on Mental Health, 2003, p. 17). This 2003 President's New Freedom Commission report is an example of how on a national level a light is being shone on evidence-based practice, increasing the pressure on community mental health agencies to provide these services.

With policy makers and government agencies advocating for and funding psychotherapeutic interventions that actually worked for the people they were designed for, treatment developers had strong incentives for conducting research to

confirm the efficacy of their interventions. As a result, the number of controlled investigations supporting treatments increased dramatically, although the evidence for some interventions was noted to consist of laboratory analogues, small groups, or using children whose symptoms were non-clinical (Ollendick & King, 1998). Research focused largely on proving efficacy rather than their effectiveness in clinical practice. In 1996, Barlow, sounding a rally cry, wrote an article underlining the concerns the mental health field would face if researchers didn't find more evidence to help create a more comprehensive list of effective psychotherapeutic interventions and establish evidence-based treatments as effective in practice settings. His concern was that government agencies such as the American Psychiatric Association placed too much emphasis and funding on pharmacological interventions over psychotherapy because there was so little evidence that their positive outcomes would generalize in the community (Barlow, 1996). Also responding to the need to establish effective treatments in clinical practice, Brown and colleagues discussed ways in which clinical researchers could begin to bridge the vast gap between research and practice in a 1997 article (Brown et al., 1997). Their article described how multisystemic therapy (MST) was structured in a way that insured communication among clinical researchers, clinical practitioners and stakeholders (e.g., Child Protective Services). While MST serves as a model for optimizing communication between research and practice, the "gap" between evidence-based treatments and the patients who need them in the clinic is a continuing problem in child clinical psychology (Shafran et al., 2009).

In spite of the increasing hope that EBTs would reduce the burden of mental health problems in young children, researchers' ability to demonstrate success in the laboratory continued to outpace their effective use in clinical practice (Weersing & Weisz, 2002). Findings from studies comparing the effectiveness of EBTs in community mental health settings with research settings suggested that their effects were more modest than expected (Weiss, Catron, Harris, & Phung, 1999), not much better than control groups fared in the university setting (Weersing & Weisz). The results of these studies presented a new burden for treatment developers and EBP advocates: to consider how the community practice setting might reduce the effectiveness of the intervention.

The history of evidence-based practice contains important research breakthroughs in the realm of clinical child psychology. It allowed us to move past the question of "if" psychotherapy works for children, and tackle the question of "which one" works best for which children. The push toward evidence-based practice has helped us to make sure that treatment will "have a sound theoretical basis, a good clinical-anecdotal literature, high acceptance among practitioners in the child abuse field, a low chance for causing harm, and empirical support for their utility with victims of abuse" (National Crime Victims Research and Treatment Center & Center for Sexual Assault and Traumatic Stress, 2004).

More recently, research on evidence-based treatment in psychology has shed light on the fact that there are not always tailored interventions for specific underserved populations (APA Task Force on EBP for Children and Adolescents, 2008), such as maltreated children. In 2000, Congress established the National Child

Traumatic Stress Network (NCTSN). Originally developed as part of the Children's Health Act, the NCTSN has helped to develop over 40 evidence-based treatments to date (National Child Traumatic Stress Network, 2012), suitable for treating traumatized children. They are also a large force in providing training resources for clinicians working with maltreated children.

On the journey towards improved mental health for children, the good news is that we have many excellent EBTs that are developed for maltreated children and have demonstrated value – both in university laboratories and in the community – for decreasing child mental health problems resulting from different types of sexual abuse, physical abuse, and neglect. Additionally, these interventions address nearly all of the common mental health problems presented to private practitioners, non-profit mental health agencies, and state and local mental health programs.

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