

## EBBM: Making Progress with Eyes Wide Open

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For the past two years, the EBBM Committee has attempted to articulate and disseminate ideas about how to apply or adapt Evidence-Based Medicine (EBM) to Behavioral Medicine. This dissemination has taken many forms including *Outlook* articles such as this one, an *Annals of Behavioral Medicine* manuscript, a post-conference seminar at the SBM 2002 Meeting, and the establishment of an EBBM Special Interest Group (SIG). Although our efforts have been met with much enthusiasm, the evidence-based discussions have raised a number of issues (1-2), some of which result from the experience of medical disciplines that have generally endorsed an evidence-based approach to treatment. These issues include the challenge of applying evidence-based research standards in disciplines like pediatrics that have limited clinical research data (3), and the dearth of methods to adequately examine therapies in combination (4). Some propose that clinical judgment, rather than being relegated to the lowest level in a best-evidence hierarchy, should be construed as a different type of information that guides in the absence of empirical data (5) and complements empirically-derived evidence (6). Others note that evidence-based policies are not immune to the politics of special interests (7).

We feel strongly that: a) the concerns expressed about the EBBM movement are important to consider in open dialogue; b) that these issues can be addressed and resolved by the burgeoning EBBM movement; c) that the resulting, continuing dialogue is vital and useful and can improve the nascent discipline; and d) that EBBM will place our field in a stronger position in clinical practice and in research. The intent of this article is to continue the dialogue about unresolved issues in the foundation of the evidence-based movement. Thus, we offer a partial listing and discussion of issues that have been raised in various critiques (8-9) of the evidence-based movement. We invite you to share your thoughts and comments so that our movement can be informed and shaped by a free and full exchange of ideas. Here, in no particular order, are a few of the cautionary notes that we have encountered regarding the evidence-based movement.

### Is EBBM Applicable to Clinical Practice?

- Restrictive enrollment criteria, implemented to enhance internal validity in clinical efficacy trials, can have the unintended consequence of excluding more representative clinical cases (e.g., those with co-morbidities).
- Overworked, under-supported practitioners may work in settings that actively discourage EBBM by not reimbursing behavioral intervention at all or not reimbursing the number of sessions needed to deliver many evidence-based treatments.
- Many non-behavioral interventions are reimbursed with only limited or no evidence base. The criteria for reimbursement of behavioral interventions should not differ from those for non-behavioral interventions.
- Treatment manuals are difficult to obtain; they can also be insufficiently developed to address clinician training needs, or too inflexible to respond to diversities in client characteristics and courses of recovery (10).
- Evidence-based behavioral medicine may be misapplied by policy-makers, payors and/or practitioners who misunderstand the approach and misinterpret it as prescribing a narrowly formulaic (“cookbook”) approach to healthcare.

### Neglected Issues in Research on Evidence-Based Treatment

- The focus on randomized controlled trials (RCTs) to the exclusion of other designs in developing an evidence-base is detrimental because: a) many patients are unwilling to be randomized to treatments, particularly when one assignment option involves inert or ineffective treatment; and b) the RCT’s evaluation of a single sustained treatment fails to reflect usual practice, in which shifts in treatment occur until a desired outcome is achieved and maintained.
- Research documentation and reporting of critical phenomena, such as treatment delivery (fidelity), therapy process measures, and population reach are infrequent.
- Relevant outcomes including functional status, quality of life, durability of change, potential negative or iatrogenic outcomes, cost of treatment, and client satisfaction have been neglected by researchers.
- New developments in basic science research are needed to spur the development of novel treatment approaches (11). If basic research dwindles, new treatments may not receive the research attention necessary to become evidence-based and the field may stagnate.

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# Outlook

## EBBM (continued from page 7)

- A major challenge concerns the need to develop and nurture systems that support the translation of evidence-based, proven interventions into practice. Experience to date with EBM has been eye-opening and contradicts the premise that, "If you tell providers, they will change." This specific issue is sufficiently large, complex, and important that we will address it alone in our next *Outlook* article.

### Possible Long-Range Adverse Implications for Science, Training and Practice Revenues

- Overemphasis on treating or fixing presumably homogeneous "disorders" may detract from a potentially more valuable effort to understand what caused the problem originally, what contingencies now maintain it (12), how treatment influences biopsychosocial processes to produce desirable behavior change, and what changes are needed to address more complex, comorbid problems (13).
- Efforts to standardize treatments potentially support progression toward a "dumbing down" of treatment that will enable therapy to be delivered by paraprofessionals or by computers.

### How might the EBBM movement address these concerns?

We propose that the best answer is for those skeptical of the EBBM movement, from practitioners to scientists, to join researchers in the EBBM movement. Understandably, practitioners often chafe at the perceived arrogance with which researchers deliver pronouncements about how to perform scientifically sanctified therapy. The felt lack of reciprocity in such exchanges is a major source of provocation, and a sorry one that ultimately disadvantages all constituencies. As initiators of clinical trials, investigators stand to benefit from involving expert, experienced clinicians in the intervention design and implementation phases of clinical research (14). Also valuable are the insights of those scientists whose skepticism may provide insight into alternative change mechanisms or types of research that must be conducted to improve the evidence base.

The work of research scientists is enhanced by greater understanding of the complexity of decision-making processes that practitioners use when deciding how to work with typical cases. The work of practitioners benefits from having a systematic base of research evidence that validates the use of effective treatment methods, discourages the use of ineffective ones, helps third party payers tell the difference be-

tween the effective and ineffective methods, and allows policy makers to make informed decisions about reimbursement issues. A collaboration forged between these co-existing forces will benefit both science and client care.

In short, we progress with eyes wide open into the development of EBBM, and also with great excitement about the prospects for diverse constituencies to benefit and learn from each other. The EBBM Committee has made valuable progress during the first two years of its tenure, and our work continues. For example, the committee is carrying out several projects that are intended to address the issues listed above. These projects include: a) creating a registry of intervention research studies, including information on how to access treatment manuals; b) expanding the focus from internal validity and RCTs to other methodologies and external validity issues with the help of new EBBM Committee member, Russell Glasgow, Ph.D., and the RE-AIM framework he and his colleagues have developed ([www.RE-AIM.org](http://www.RE-AIM.org)); and c) by introducing EBBM concepts, their strengths and their limitations, to a number of peer-reviewed behavioral medicine journals.

We continue to welcome the participation of *Outlook* readers in the EBBM process. Comments about this article and/or the activities of the EBBM Committee can be sent at any time to Karina Davidson, Ph.D., EBBM Committee Chair, at [karina.davidson@msnyuhealth.org](mailto:karina.davidson@msnyuhealth.org). We look forward to working with the behavioral medicine community on these issues.

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