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EVIDENCE-BASED PRACTICE IN PSYCHOTHERAPY – THE PROS AND CONS

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Summary

The article addresses controversies raised by psychotherapeutic evidence-based practice in psychotherapy (EBP). In the first part of the paper, the key assumptions of EBP are presented, which concern clinical decision-making that is based on three integrated components: 1. clinical research data, 2. taking the patient's value system into account, and 3. the clinical skills and experience of the therapist. The second part of the article focuses on the merits and limitations of EBP. Proponents of the EBP approach believe that it facilitates choosing the best kind of assistance for a patient with specific problems. In addition, the therapist sidesteps the traps associated with appealing to their own intuition. Critics of EBP point out that EBP favours a certain type of research. Moreover, the results of these studies are difficult to put into practice. They also believe that EBP is underpinned by hidden values (despite the ideological neutrality of this approach declared by proponents of EBP). In the conclusion of the article, the author argues that scientific research on psychotherapy cannot determine all clinical decisions, due to various methodological limitations and a still insufficient number of studies. However, the rejection of research results by psychotherapists can easily lead to the implementation of ineffective or even harmful interventions. The EBP proposes, among other things, criteria to verify the effectiveness of new, promoted approaches to psychotherapy.

Evidence-based practice (EBP) is the subject of much controversy among psychotherapists. Its proponents believe that it not only allows for the objective choice of the best type of help for a patient with specific problems but also (or maybe above all) for the rejection of pseudo-scientific psychological support procedures [1]. A psychotherapist who uses EBP can steer clear of the pitfalls associated with referring to one's own intuition [2]. Opponents of EBP point to the many limitations brought by this approach as well as the hidden values underpinning it [3]. In this article, the views of both the advocates and the critics of evidence-based practice are discussed. It is worth knowing them in order to clarify one's own opinion about the ongoing discussion on EBP. This approach is influencing the development of psychotherapy and also shaping social policy concerning psychological support, especially in the scope of its funding.

Knowledge about evidence-based practice seems to be quite superficial among psychotherapists. Syllabi termed as "comprehensive" do not devote much attention to evidence-based psychotherapy courses. This has led to EBP being perceived in quite a trivial manner, as an approach where the results of scientific research are the only determinant of conducting psychotherapy. According to its adversaries, EBP consists

of making use of "prescriptions for psychotherapy" [2], where the role of the psychotherapist is to implement them as faithfully as possible. Therapists usually reject such an approach to therapy. Thus, the aim of this article is to illustrate to the Reader what the assumptions of evidence-based practice are and how it can be useful for a psychotherapist, regardless of the theory they identify with. I will begin the deliberations by presenting the roots of EBP, derived from medicine.

The roots of evidence-based practice

EBP has emerged from evidence-based medicine[1] (EBM), which began in the early 1990s. Gordon Guyatt, Professor of Medicine at the McMaster University in Canada, first coined the term EBM [2]. Evidence-based medicine was created firstly in opposition to academic medicine where the main emphasis is on basic research and, secondly, to casuistic and intuitive medicine where the physician's experience and intuition are key [4]. Psychotherapists also deal with the research of academic psychologists that often have little to no reference to practice. At the same time, many schools of psychotherapy refer to empirically unverified clinical concepts. In the diagnosis and conduct of therapy, the therapist's intuition and experience is a salient compass.

Making clinical decisions in line with evidence-based medicine requirements implies three integrated elements: 1) clinical research data, 2) the patient's value system and treatment preferences, and 3) the clinical skills and experience of the physician [2]. In literature, this way of approaching EBM is sometimes termed as the "three-circle model". According to Sackett and colleagues (1996), evidence-based medicine is "the conscientious, explicit, judicious, and reasonable use of modern, best evidence in making decisions about the care of individual patients. EBM integrates clinical experience and patient values with the best available research information" [quoted after: 4, pp. 9-10].

In medicine, the EBM approach has had such a substantial influence that there is talk of a paradigm shift in this field. However, the critics of EBM point out that this is an overstatement, as physicians, even before the EBM era, also referred to scientific evidence. According to the opponents of EBM, the basic assumptions in medicine have not changed [3]. However, physicians are now also expected to be able to assess the results of scientific research in terms of their correct execution, that is, the methodology. This is to help them in choosing the results that are reliable, thus, the ones that clinical decisions can, in effect, be based on. It was suggested that methodological standards applicable to research in medicine be unified [5].

A physician applying EBM principles is encouraged, in a sense, to act like a scientist, in other words, to first and foremost pose a research question (in this case, a question concerning the choice of treatment), then to search for the data needed to obtain the answer, assess the reliability of such data and, finally, to make a clinical decision. In making this decision, consideration is also given to whether the treatment whose

[1] There is no widely adopted, hence, uniform translation of the term "evidence-based medicine" in the Polish literature.

efficacy was confirmed by research can be implemented for the given patient. This scheme is difficult to replicate in psychological practice if only because most therapists do not have access to databases of articles on psychology. This would also be time-consuming, considering that good psychotherapeutic practice also requires supervision and participation in training.

EBM gradually started affecting such fields as nursing, welfare services, public health, library science, and finally psychology (particularly here, emphasis is placed on evidence-based assessment). This has led to the creation of an interdisciplinary evidence-based practice model as an extrapolation of the classic EBM approach [2]. According to this interdisciplinary model, when deciding on an intervention, the following should be taken into account: 1) the best available empirical evidence from research, 2) the characteristics of the client (or relevant population in relation to which the intervention is being undertaken), and 3) the availability of resources, including the practitioners' skills and expertise, as well as the accessible infrastructure (e.g., skilled personnel or funds needed for the intervention to be carried out). This model also factors in environmental and cultural aspects that constitute the context for the clinical decisions being taken.

It is worth highlighting that evidence-based practice (EBP) is not a new school of psychotherapy but a certain way of thinking about therapy and its practice. The assumption underpinning this way of thinking is that the results of scientific research should be a significant but not the exclusive factor driving the clinical decisions taken by psychotherapists. EBP is sometimes wrongly identified with the cognitive-behavioural therapy (CBT) approach. This is probably because much of the research on psychotherapy is carried out within this approach. EBP, however, is not limited to just one school of psychotherapy. It rather endeavours to fulfil an integrating function, bringing together many approaches and emphasising their scientifically proven effectiveness.

Scientific research data

Although all the mentioned elements from the three-circle model are equally important, some are of the opinion that the research results should, first and foremost, determine clinical decisions. Lilienfeld [6] states that if the intuition of a psychologist tells him or her to choose intervention Y and they know that the results of properly conducted research confirm the effectiveness of intervention X, then the psychologist should side with this research evidence rather than his or her own intuition.

An evaluation of the reliability of a given treatment approach (particularly in the case of biomedical research) is carried out by reference to the hierarchy of information sources derived from scientific research – the so-called pyramid of scientific research data [2]. The best approaches to treatment were deemed those where the assessment of effectiveness was based on meta-analyses of many studies with randomisation, then, on randomised studies themselves and, subsequently, on non-randomised experimental research with a control group. Reviews of systematic observational studies and, finally, single and multiple case studies

are considered less reliable. The working group set up by the APA in 2005 to deal with evidence-based practice, the Evidence-Based Task Force, came to the conclusion, however, that although certain research regimes are better than others, it does not recommend the research hierarchy presented above as a way of choosing the most reliable results of studies on psychological assistance [2].

The "most reliable evidence of effectiveness" depends on the type of research question that was put. As an example, longitudinal studies are good in finding the prognostic value of a specific treatment approach. However, a different type of study is recommended if the problem concerns the context of a given intervention, thus, analyses of specific environmental factors in which the treatment is applied [2]. Case studies are at the bottom of the scientific research data pyramid, hence, in line with this approach, data concerning the effectiveness of treatment derived from case studies should be approached with the greatest caution. A case study is, however, a recognised research method where strict methodological criteria apply [7]. It may be an important source of data when analysing unusual and rare phenomena and when process analysis is particularly relevant like, for instance, the course of a specific therapeutic intervention.

The patient's preferences

In line with the evidence-based practice approach, when making clinical decisions, a physician or psychotherapist also takes the value system of the patient and their preferences concerning the course of the psychotherapy into account. It is worth pointing this postulation out because it is a clear detraction from the paternalistic model of the patient-physician relationship towards a partnership model. The paternalistic model is deeply rooted in medicine as it goes back to Hippocrates [8]. The years 1980–1990 were a period of particular criticism in medicine of this approach and of emphasising the value of the patient's autonomy. In evidence-based medicine, the privileged position of the physician is not entirely abandoned (this is impossible due to their very nature, where they possess the knowledge on the aetiology of diseases and the best treatment approaches). However, the physician should at least take the patient's perspective into account when planning treatment, namely, what is important to the patient and what treatment-related goals they have. Health may sometimes take on a different meaning for the patient than it has for the physician. The patient may expect an improvement in their well-being or quality of life, but not necessarily to be healthy in the way that a physician would understand it.

Psychotherapy, which of course grew out of medicine, initially adopted its paternalism but in a somewhat more moderate version. With the dawn of post-modernism in psychotherapy came widespread criticism of the expert attitude of a psychotherapist, pointing to its multiple constraints and calling for the therapeutic relationship to be more symmetrical in nature [9]. By way of example, in narrative therapy, the term "psychotherapist" has been abandoned and replaced by "consultant". Contemporary schools of psychotherapy approach the issue of paternalism in different ways, generally rejecting its radical version,

in favour of a contractualistic model where the type of relationship between the therapist and the patient is negotiated and regulated through this very contract [8].

Contrary to common misconceptions, a psychotherapist working according to EBP guidelines is not guided solely by research findings in deciding on the type of assistance but also takes the patient's perspective into account[2]. Clinical decisions are taken together (shared decision-making), which results both from ethical and socio-political premises, as well as from the fact that a shared decision-making process is linked to better therapy outcomes [11]. Thanks to this, the patient gets more involved in the therapy and, being able to understand its course, he or she can better cooperate with the physician or therapist.

The psychotherapist should also consider the impact of the patient's socio-cultural context on the interventions undertaken by him or her [12, 13]. Studies on the effectiveness of a given therapeutic approach are conducted on a specific group of people. The same therapeutic approach does not have to be equally effective for a different group of persons as the study group in terms of certain socio-demographic characteristics. The findings of some studies indicate that the cultural competences of the psychotherapist may have a bearing on the success of the psychotherapy [14].

EBP truly does refer to statistical methods but this does not mean that it loses sight of individual patients. The outcome of the study demonstrates that the implementation of a certain approach to treatment will, in all likelihood, be of benefit to the patient. Of course, this does not guarantee that a given intervention will definitely be effective for a specific patient. Treatment always has to be tailored to the specific case. In medicine, reference is made to a personalised approach (personalized medicine), where the treatment approach is tailored to the specificity of the given patient [15].

Clinical experience

The role of clinical experience in making therapeutic decisions seems to be particularly controversial. Experience is usually accorded too big a role, as demonstrated by the research findings on its significance in therapeutic decision-making (a closer examination of this issue can be found in [16]). On the other hand, it is difficult to negate the role of experience: putting it contradictiously, regardless of the research outcomes, we will still want to consult them with a more experienced practitioner (provided that they have not succumbed to routine).

The certain enigmaticity of the "experience" category became the focus of research in terms of what it comprises. Instead of this category, the proponents of EBP suggested that focus should be placed on the specific skills of the therapist that can be operationalised more easily. Those include the following: 1)

[2] It is worth pointing out, for instance, that in the book by Mariusz Grabowski and Andrzej Cacko [10] devoted to EBM, patient's preferences have not been discussed at all.

diagnostic, 2) communication and entering into cooperation, 3) motivating the patient and selecting and applying appropriate therapeutic interventions, and 4) specific skills relating to the implementation of the principles of evidence-based practice. The latter are built on the therapist's ability to correctly phrase questions[3] concerning the therapy conducted by her or him, collect available data allowing an answer to be reached, evaluate such data in terms of their reliability, agree the type of intervention with the patient, and analyse any potential changes or possible modifications to the treatment programme [2].

The psychotherapist cannot be a hostage to the outcomes of research. This would lead to them being reduced to an object, thus, losing interest in conducting the therapy or in the very patient. If the psychotherapist becomes disinterested, there is a much greater risk of them making a mistake as they are no longer in tune with the patient, attentively listening to them. A psychotherapist who is disinterested in the patient loses his or her neutrality. This has a negative impact on the quality of the therapeutic relationship. Studies have shown that this relationship is a key factor driving therapy success [17, 18].

The assumptions of evidence-based practice factor in the autonomy of the physician/therapist. This is not an absolute value as, on the one hand, it is limited by the autonomy of the patients themselves and, on the other, by research results. According to the assumptions of EBP, the perspective of the patient is also significant but it is only one of the three factors that are taken into account when making clinical decisions.

Pros of EBP

The supporters of a scientific data-based approach claim that it allows them to answer the question of what type of therapy is going to be most effective (or effective at all) in the case of a specific patient with given types of problems. In this sense, EBP is the best possible way to secure the good of the patient as it helps in the avoidance of harmful or ineffective therapy methods. Lilienfeld [6] refers to results of research indicating that only about 20% of persons with clinical depression are given the most optimal treatment, whereas 2/3 of patients diagnosed with Autism Spectrum Disorder are participating in therapies with no scientific grounds. A similar situation is probably occurring in the case of other mental disorders. According to Lilienfled [6], this stems from the fact that therapists are not guided in their work by the findings of scientific research, thus, putting their patients unnecessarily at risk.

A psychotherapist who is guided by EBP guidelines – as has been signalled earlier – can potentially avoid the pitfalls associated with relying on their own experience and intuition [1]. Clinical decisions are not dictated by the values that the psychotherapist follows, often unconsciously. The psychotherapist's preferences as to the type of assistance that can be given are of secondary importance because what is key is whether or not scientific research confirms the effectiveness of a given method of treatment. To put it

[3] This is a question about what type of therapeutic intervention to apply in the case of a given patient with specific types of problems.

differently, if a psychotherapist is working in conformance with the assumptions of school X, they will then apply the methods recommended by that school to treat his or her patient and not the methods that had scientifically confirmed effectiveness. Even the very choice of a school of psychotherapy by the psychotherapist is a way of embracing certain values that underpin a given approach. Looking at it from this angle, EBP is an approach that is free of these types of burdens.

EBP also allows the best decisions to be taken from an economic point of view. The financial resources allocated to psychological assistance are generally meagre, hence, it is imperative that they are managed in the most efficient way. EBP proposes a clear schema according to which money can be allocated to a given type of therapy, where approaches with the greatest probability of being effective in treating a given type of disorder are classified as worth funding. The effectiveness of treatment is determined by research. Such a criterion is clear and not vitiated by the personal preferences of social policy decision-makers. Even if we agree that studies on the effectiveness of psychotherapy are in many approaches complex, empirically confirmed methods of therapy do give a higher assurance of effectiveness.

This, however, creates the risk that all the methods of therapy that have not yet been fully scientifically confirmed as effective, would not be reimbursed. This would lead to a situation where many patients would be completely deprived of psychological care (also in cases where there has been no research on a given method of therapy, which of course does not have to mean that a given method is ineffective). Allocating funding exclusively to EBP should, therefore, go hand in hand with an efficient grant system for studies on the effectiveness of different types of therapy. Without this condition being met, the principle of financing EBP would become a camouflaged way of making spending cuts on psychological assistance.

It is more difficult to contend with the next point made by supporters of EBP, namely, that it teaches critical thinking. New approaches in psychotherapy are constantly appearing and quickly gaining advocates. A psychotherapist has to learn to differentiate between which of them are effective and which are widely promoted only due to a good marketing strategy. Assessment criteria have been developed within EBP to help psychotherapists in such decision-making processes. A modern psychotherapist (just like a physician, in fact) has to be able to assess the reliability of constantly appearing new methods of treatment and research intended to confirm their effectiveness. Psychotherapy is, of course, a vast market of services that are governed by economic laws, similar to the medical market. The latter is a prime example of how easy it is to promote "methods of treatment" of questionable value like, for instance, homoeopathy, application of so-called laevorotatory vitamin C, or treatment with structured water. The same applies to psychotherapy: after all, what is the difference between structured water and the "knowing field"[4]? Psychotherapy is a service that is being sold, which is why it also is subject to various economic laws.

[4] According to Hellinger, a person who is symbolically put in the place of a patient's family member has the same feelings as the person they represent, even though they do not know the patient. The knowing field enables this representation. However, the concept of a knowing field lacks a scientific basis.

The psychotherapists' approach to EBP

Research on psychotherapists' approach to EBP has brought interesting results. Most therapists actually appreciate the values of research findings but do not implement them into their practice. In planning a therapy, they mainly build on the indications of their preferred school of psychotherapy, the advice of their supervisor, intuition, and their own experience [19]. The most sceptical towards evidence-based methods are therapists who were trained before the emergence of EBP, therapists who are at the start of their psychotherapy training, and those believing in the role of clinical intuition.

Why is it the case that therapists appreciate the value of scientific research but fail to harness it in their practice? Let us start from how research findings are communicated. Many scientific articles are written with a hermetic language and their conclusions are presented in a manner preventing practitioners from benefiting from them in their practice. Thus, science is not popularised enough: not in the sense of popular science articles but publications intended specifically for practitioners and experts, presenting research findings in the context of the possibilities for their application.

Lilienfeld and colleagues [19] also point to other causes for such scepticism towards EBP among therapists. Firstly, there is always resistance to change, and EBP does exactly this by introducing new standards that therapists have to get accustomed to. Therapists also carry various misconceptions about EBP. They falsely believe that a psychotherapist trained in EBP is reduced to a person that has to faithfully fulfil strictly defined procedures. EBP does not, however, require strict adherence to textbook guidelines. These guidelines only provide guidance as to how to conduct therapy, and should be approached flexibly. Still other psychotherapists raise the allegation already mentioned earlier that EBP refers to statistical methods, while there are no "statistical patients". Lilienfeld [6], however, gives a counter-argument, namely, that the population of patients is, surely, made up of individual people. In order to demonstrate that probability theory on which statistics is based does, in fact, play a role in the decision-making process of each and every individual (even in the opponents of statistical methods), the author gives the following example, which was borrowed from Paul Meehl[5]. A person playing the game of Russian roulette has two revolvers to choose from: the first has a magazine loaded with four bullets with one empty chamber, and the second has one bullet and four empty chambers in the mag (ibidem). If the rules of probability calculation were indeed irrelevant to individual persons, it would not matter which of the revolvers the person playing Russian roulette would choose.

[5] Paul Meehl was a clinical psychologist, author of many publications on the methodology or research, the philosophy of science, and the generic causes of schizophrenia or methods of arriving at diagnoses.

Critique of the EBP approach

At least three main arguments against EBP can be identified. The first concerns the methodology of research [20]. Studies conducted within the EBP current adopt a simplified model of the mechanisms of mental illness and the changes occurring as a result of psychotherapy. EBP favours approaches where the studied phenomenon can relatively easily be operationalised in the form of variables. Medical research is often based on biomarkers, thus, any analogy to research on psychotherapy is unfounded. Theoretical constructs within psychotherapy are difficult to analyse empirically and require different research methods that not only refer to quantitative but also to qualitative research.

It seems that EBP relies too heavily on research findings and pays too little attention to the theories underpinning it. Every well-conducted study refers to theory [1]. It is theory that explains what works in psychotherapy and why it works, while empirical research is tasked with merely verifying this. We may use the metaphor that empirical studies are tools. Every tool, however, has certain limitations when applied. Imperfections in the manner a study is conducted (thus, in the manner the tool is used) do not mean that a theory is fallible. Are we not erring in rejecting a theory just because it is difficult to verify its assumptions?

EBP research is criticised for its low external validity. Effective methods that stand up to tests in laboratory conditions turn out to be much less effective in clinical practice, where there are several uncontrolled factors at play. If the study is to meet high methodological standards, it should ensure a high internal validity[6] that, in turn, as Brzeziński [1, p. 445] pointed out, makes it "unreal", "artificial", and "of a strongly reduced external value". In contrast, low external validity calls into question the value of the results obtained. Research is also conducted on homogeneous groups of patients (usually in terms of the type of reported symptoms). It is difficult to find a group of patients in clinical practice that would have homogeneous, consistent symptoms.

Methods that are helpful to patients with specific types of disorders are promoted within EBP. There are excellent textbook series for practitioners, published around the world (e.g., the Hogrefe series: *Advances in Psychotherapy – Evidence-Based Practice*). These textbooks, however, are based on a nosological division of mental disorders. Perceiving the value of such an approach, one should bear in mind that classifications of therapeutic methods according to medical diagnoses are less useful when it comes to many different problems. This is because patients often reach out to therapists also to seek various kinds of advice concerning coping with various types of "life's difficulties", and not with specific mental disorder symptoms. EBP turns out to be much less useful when it comes to dealing with such problems. In the case of the difficulties and challenges of life that elude medical classification, there often is insufficient evidence

[6] Internal validity refers to the extent to which a study is free of distortions like, e.g., linked to the way the study is organised or to its course [21].
External validity is "the extent to which the results of a study can be generalised to and across various populations, situations, and conditions" [21, p. 37].

for the effectiveness of therapy (e.g., due to it being more difficult to operationalise variables). It is also worth bearing in mind that non-specific factors are a significant element of psychotherapy and these elements may stimulate change, despite the lack of documented effectiveness of the given approach to therapy [17, 18].

The second group of criticism of EBP refers to the seemingly neutral worldview of this approach. Its proponents believe that when guided by research results in clinical decision making, a psychotherapist maintains complete impartiality. His or her worldview exerts no influence whatsoever on their choice of treatment. However, the results of each study rely on interpretation, and how they are interpreted depends – at least to a certain degree – on the views of the person analysing the research findings. Regardless of the declared neutrality, we may always consider who and why has put such a research question, why a given theoretical perspective has been chosen when planning research, as well as why a specific method and not another one has been chosen to interpret the results [3]. There is also always a certain grant allocation policy that refers to specific values behind the funding of scientific research (including the field of psychotherapy).

A reference to science is also intended to authenticate a given approach. EBP, as Schedler [20] contends, has nonetheless become a marketing slogan facilitating the sale of a given product (in this case, a therapeutic approach). The opponents of EBP immediately expose themselves to the allegations of chicanery as it is difficult to dispute "evidence" (whatever that would mean). The proponents of EBP have appropriated to themselves the term "scientific evidence", thereby automatically putting their opponents on anti-scientific positions in the ongoing debate.

As Józefik [22] notes, psychotherapy also is a cultural discourse, as it stems from culture and forms its integral part. This is because psychotherapists always belong to a specific culture, hence, everything they do always, inevitably, relates to it. Thus, research on psychotherapy is, in the same way, not free of the impact of the socio-cultural context. Hence, evidence-based practice cannot be neutral in relation to values. Values such as pragmatism, utilitarianism, and neoliberalism seem to lie at the base of EBP [3]. In fact, we may risk the claim that the very choice of the profession of a psychotherapist is indicative of advocating specific values. After all, it is difficult to imagine a psychotherapist who does not value dialogue, cooperation, or caregiving.

Those that challenge EBP point out that psychiatry is sometimes treated as a medical pariah, hence the great importance attached by some of its representatives to qualifying it as "scientific" [3]. This applies even more to psychotherapy, which is not a science [22]. EBP brings psychotherapy close to the standards accepted in science (especially in life sciences), which, for some, is a synonym of its higher value (since we hold everything "scientific" in particularly high regard and place our trust in it). EBP is to raise the stature of psychotherapy and give psychotherapists the sense that they are "equal partners" of somatic medical practitioners. Thus, a hidden, although certainly not the most important or only aim of

implementing EBP, may be raising one's own prestige in the eyes of other representatives of the medical sciences.

Styła [23] advances yet another argument, which is especially important as it is supported by research findings. He asserts that the best results of psychotherapy cannot be improved and the introduction of scientifically-based therapy does not increase the effectiveness of psychotherapy on the whole. A comparison of the results of meta-analyses on the effectiveness of psychotherapy over the years reveals that the effectiveness of therapy does not, in fact, increase at all. This author [23], therefore, argues that it is not so much searching for new methods as paying more attention to the development of interpersonal skills of the therapist that will improve the effectiveness of psychotherapy.

Conclusions

EBP has, undoubtedly, become a too significant current in psychotherapy for it to be treated as a marginal phenomenon. The discussion pertaining to this current is important and valid as it paves the way to making conscious, responsible decisions in psychotherapy. A psychotherapist who rejects the assumptions of EBP is not acting unethically (as some proponents of this approach would deem.) What is unethical is the rejection of EBP that results from ignorance and lack of knowledge, and not from a conscious questioning of the assumptions underpinning this approach to therapy. Evidence-based practice, as has been emphasised numerous times in this article, is sometimes erroneously confused with an approach that refers only to the results of empirical research, being insensitive to the specificity of the patient and the socio-cultural context from which he or she has evolved, and with an approach that is restricts the autonomy of the therapist.

EBP confronts psychotherapists with important questions concerning the criteria that should be set in order to render a given type of therapy as verified and effective. New therapy approaches are constantly on the rise, the proponents of which *ex cathedra,* based solely on their personal experience, claim that the school of psychotherapy promoted by them is effective, or also refer to single studies that allegedly confirm this effectiveness. In so much as the *explicit* statement: "I believe that my therapeutic approach is beneficial to patients" can be acknowledged as acceptable since the psychotherapist clearly emphasises her/his point of view, the very fact of making reference to random research and making inferences based on their general conclusions has to be deemed bad practice. Therefore, it truly is worth giving the criteria, according to which a new type of therapy can be recognised as effective, much more careful thought and attention. This particularly concerns publications in scientific journals for practitioners, but also psychotherapy training. Not enough attention is paid during their course to the careful examination of research findings. This can also be put down to the fact that even the persons conducting the training consider discussions on the results of research on the effectiveness of psychotherapy within given schools to be of secondary importance.

Yet another controversial issue that psychotherapists are confronted with when dealing with EBP concerns informing the client/patient about the fact that the effectiveness of the proposed method of therapy has not yet been fully confirmed by results of empirical research. When taking any medicine, a patient is always informed by the manufacturer of its action and side-effects. What is more, the patient knows that the medicine has been scrupulously analysed within clinical trials (which does not exactly always guarantee the safety and efficacy of its action). This is not the case when it comes to psychotherapy, however. Carelessness in offering unverified therapeutic methods sometimes reaches inadmissible levels. One may assume that the same therapists who promote such methods would not agree to take untested medicines or medication offered by a physician, taking only his word for it. The question is, therefore, how to inform the patient of the effectiveness of therapy so as to, on the one hand, reinforce their motivation to take part in the psychotherapy and, on the other, clearly discuss the pros and cons and limitations of the type of assistance offered to them.

Research on psychotherapy and, more broadly, on various kinds of mental and interpersonal mechanisms is, undoubtedly, incredibly complex. This complexity, however, often becomes too easy an excuse to abandon research altogether. Illusory is the claim, which itself results from superficial knowledge, that scientific medical research focuses on phenomena that are simpler to analyse. Social studies currently offer complex research agendas, harnessing both quantitative and qualitative methods [24]. This allows increasingly more complex research questions to be answered. It is also worth noting that research in psychotherapy and on psychotherapy is not just the concern of scientists alone. On the contrary – such studies should be of prime interest to psychotherapists themselves and it is they who could constitute a strong pressure group insisting on such research being carried out.

I will end these deliberations on evidence-based therapy with a question: How can the results of scientific research be incorporated without losing the individual approach to every client/patient and their problems? This question refers to yet another one that was posed by Józefik [22, p. 743], namely: “Is it necessary for psychotherapy to be a science?” During a session, psychotherapists create the space for their patients to reflect on themselves, their own life, and their relationships with others. There is also room in psychotherapy for both scientific research, the results of which support the selection of effective therapeutic methods, and reflections on the individual patient. Going back to Józefik’s question [22]: it is not necessary for psychotherapy to be a science but psychotherapists also cannot ignore science, otherwise, psychotherapy will stop developing and will become a museum of ideas that have been excluded from science.

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