

Evidence-Based Practice, Talking Therapies and the New Taylorism

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ABSTRACT *This paper explores the development of evidence-based practice (EBP) in the field of talking therapies, and particular its realisation in the Improving Access to Psychological Therapies (IAPT) programme in the National Health Service in England. A critique of EBP is offered, starting with an examination of its epistemological and methodological foundations. The critique is then developed to examine the way EBP is being used to support the implementation of a new form of management ideology, Digital Taylorism, which is based on the codification and routinisation of what was previously considered to be subjective knowledge and practice. The service offered by IAPT, and supported by guidance from the National Institute of Health and Clinical Excellence, is presented as a prime example of this ideology in the field of talking therapies. The paper concludes by considering how EBP can best be confronted. Copyright © 2012 John Wiley & Sons, Ltd.*

Key words: evidence-based practice, talking therapies, Digital Taylorism, Improving Access to Psychological Therapies, ideological critique

INTRODUCTION: WELCOME TO THE FUTURE

Picture for a moment, if you will, the following scene: you are in a large open-plan office with rows of desks and computers. On this particular day about twenty people are sat at their desks peering intently into their computer screens. Some are entering data onto an online database, while others, wearing headsets, are engaged in conversations with some unknown persons, while also typing furiously on their keyboards. A few others are wandering around, apparently quite aimlessly. There are also several administrative staff taking never-ending telephone calls. A manager is on the phone, apparently trying to calm down a irate caller while looking at the database record of this particular individual, and explaining that, “Yes, there is a waiting list, but you will just have to be patient as it’s clear from your record that you are still within the acceptable waiting time for this service.” Another manager is sitting with a rather harassed looking member of staff with a print-out in front of her and asking the staff member why he hasn’t met his targets for this month.

Is this a call centre? No, it is the “hub” of a service run under Improving Access to Psychological Therapies (IAPT), and could be anywhere in England. IAPT is the Department of

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Health's answer to the chronic shortage of counselling and psychotherapy available on the National Health Service (NHS). It has been gradually "rolled out" across England since 2007, and now most Primary Care Trusts (PCTs) have contracted an IAPT service in their area. In case you hadn't guessed it, most of the people sitting at their desks staring intently into their computer screens are therapists, and the information they are entering onto the database is the latest set of data obtained from the questionnaires they are required to give to their clients at the beginning or end of every therapy session. These are standard psychological questionnaires, including the PHQ-9 (for measuring depression) and the GAD-7 (for measuring anxiety). The therapists with the headsets may be conducting initial telephone assessments with clients or may even be offering telephone support—in full earshot of all their colleagues. Quite often they will be reading from scripts and questionnaires that are up on their screens, and entering the clients' responses onto the database. As for the poor therapist being grilled by his manager—well, he obviously doesn't realise that throughput is the name of the game, never mind the quality of the therapeutic relationship with each client.

Welcome to the world of industrialised talking therapy. Welcome to the new Taylorism.

My purpose in telling this story about IAPT, which is based on personal experience, is to introduce the central argument of this paper, which is that the rise of evidence-based practice (EBP) in the field of counselling and psychotherapy (hereafter "talking therapies") has very little to do with truth or science or even best practice. Rather, it is to underpin an approach to management which aims to "de-subjectify" professional knowledge and practice, and turn it into a series of standardised and "manualised" practices that can be replicated anywhere and by anyone. This process has been described as "Digital Taylorism", which like its predecessor aims to turn management into a technocracy based upon empirical science. The difference is that this new Taylorism is focused on "white-collar", professional and knowledge-based jobs, whereas the original Taylorism focused on manual work.

The original Taylorism, also known as scientific management, was a theory of management based on the idea that economic efficiency, and particularly labour productivity, could be improved through the careful analysis and synthesis of workflows. Although it is usually associated with the work of F. W. Taylor in the early part of the 20th century, a number of other key figures were also involved around the same time, including Lillian Gibbreth, Henri Fayod, and even Max Weber, with his theories of bureaucracy. Taylor was one of the first people to distinguish between managerial and non-managerial work. He also believed that empirical research, based on the observation of people at work (the time and motion study) would reveal the best single way to carry out any non-managerial task.

One of the key aspects of Taylor's theory is the replacement of management of "initiative and incentive" by "scientific" or "task" management (Taylor, 1911). Taylor argued that prior to his ideas the role of management had been to "extract" the "initiative", i.e. the knowledge and expertise of each worker through the use of incentives such as higher wages, a career structure and bonuses. In contrast to this, the role of scientific management was to develop a more uniform system of knowledge and expertise through systematic observation, rationalisation and codification of the workers' "initiative". In other words, the workers' knowledge and expertise were to be "objectified" and become the "property" of management.

Taylor placed great emphasis on the importance of the task, which he saw as "perhaps the most prominent single element in modern scientific management" (Taylor, 1911, p. 39). The manager's role, under scientific management, was to define the tasks each worker was to carry

out, and also to specify how these tasks should be executed and how long they should take. As we shall see, all this seems strangely familiar when it comes to Taylorism's modern incarnation.

In the rest of this paper I will outline the key concepts of EBP, and then explore a number of critiques of this approach. The reason for doing this is to demonstrate the problematic nature of EBP from an *epistemological* point of view, which undermines its privileged claim to truth and science, and thus exposes its ideological base. I will then introduce the idea of Digital Taylorism and its relationship to EBP and the IAPT programme. I will conclude by discussing some possible responses to the challenges posed by EBP.

EVIDENCE-BASED PRACTICE AND THE HIERARCHY OF EVIDENCE

The "classic" definition of EBP that is often cited is that of David Sackett and colleagues in an editorial in the *British Medical Journal*:

Evidence-based medicine (practice) is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 71)

Although they acknowledged that EBP is not restricted to randomised controlled trials (RCTs) and meta-analyses, and "involves tracking down the best external evidence with which to answer our clinical questions" (p. 72), they quickly went on to argue that RCTs, and especially the systematic review (meta-analysis) of several RCTs, provide the "gold standard" of treatment efficacy and that "when asking questions about therapy that we should try to avoid the non-experimental approaches, since these routinely lead to false positive conclusions about efficacy" (p. 72).

Even though the authors provide no justification for these arguments, they have since entered the annals of EBP mythology as self-evident truths. Linked to this "privileging" of RCTs is the idea of a *hierarchy of evidence*, which, as Evans explained in his paper on the subject, was first developed in 1979 by the Canadian Task Force of the Periodic Health Examination (Evans, 2003). Since then, the idea of such a hierarchy, with the meta-analyses of RCTs at the "top", has also become a self-evident and unquestioned "truth". To quote Evans:

When evaluating the effectiveness of an intervention, the RCT is considered to provide the most reliable evidence. It is considered the most reliable evidence because the processes used during the conduct of an RCT minimize the risk of confounding factors influencing the results. As a result of this, the findings generated by RCTs are likely to be closer to the true effect than the findings generated by other research methods. (Evans, 2003, p. 78)

To gain a sense of how this kind of thinking is now being routinely applied in the field of talking therapies, one only has to look at the guidance material produced by the National Institute of Health and Clinical Excellence (NIHCE) in the UK. NIHCE is effectively the

main arbiter of any kind of clinical treatment provided by the NHS, including psychological treatments. The IAPT programme I mentioned earlier uses only interventions that have been sanctioned by NICE.

To give an example of this, I want to take a brief look at the NICE guidelines for adult depression (NICE, 2010a). The first interesting point to note is the composition of the Guidance Development Group (GDG), which had the ultimate responsibility of collating and analysing the evidence and finalising the guidelines, even though they also sought advice from other experts. Of the 35 members (allowing for some turnover), 20 were non-clinicians, including researchers, health economists, project managers and a pharmacist. There were only two service users and one carer, and only two talking therapists (one cognitive behavioural therapist and one unspecified). The others were psychiatrists, clinical psychologists and nurses.

Appendix 21 of the guidance outlines in some detail the methods used to develop the guideline for adult depression (NICE, 2010b). Of particular interest, in terms of the GDG's position on "evidence", is Section 3.4.2 *Synthesising the Evidence* and Section 3.4.3 *Developing Statements and Graded Recommendation*.

It is clear in Section 3.4.2 that the review process is evaluating studies that used measurable outcomes for researching the treatment of depression, which ideally(!) would be based on RCTs, and even more ideally, on *meta-analyses* of RCTs. The Appendix contains a hierarchy of evidence and a grading scheme table which list five types of evidence in four levels (level 2 has two sub-levels), and three "grades" of evidence (A, B, C). These range from the "highest" Level 1 (Grade A) evidence, which is that obtained from a single RCT or (ideally) a meta-analysis of a set of RCTs, through to the "lowest" Level 4 (Grade C) evidence, which is that obtained from "expert committee reports or opinions and/or clinical experiences of respected authorities", and would include case study material.

The reason meta-analyses are held in such high esteem by proponents of EBP is that they are seen as a way of reducing the effect of bias and errors in individual studies through using well-established statistical methods to combine the findings from a number of studies (Crombie & Davies, 2009). Furthermore, it is claimed that they bring greater transparency and openness to the evaluation process, because, in theory at least, all the decisions involved in the review process are open to public scrutiny. However, in reality, only someone with a good knowledge of research methodology and statistics is likely to be able to take advantage of such transparency!

CRITICISMS OF EVIDENCE-BASED PRACTICE

There are certainly no shortage of critiques of RCTs and EBP, both from within the field of talking therapies and outside of it. Interestingly enough, a lot of the serious criticism of EBP has come from the nursing profession, which may be a reflection of the medical origins of EBP and the fact that a great deal of nursing knowledge and practice falls outside of its positivistic paradigm.

A number of critics draw on the work of the post-structuralists and deconstructionists such as Baudrillard, Deleuze, Guattari, Foucault, and Derrida to critique the EBP movement and the hierarchy of evidence (Devisch & Murray, 2009; Holmes, Perron, & O'Byrne, 2006; Rolfe, 2005). Devisch and Murray, for example, made the rather interesting point that, although for proponents

of EBP its claims are “self-evident truths”, there is actually no “evidence” for it, in the sense that there are, and probably never will be, any randomised controlled trials of RCTs. In other words, we cannot judge the hierarchy of evidence on its own terms. According to Devisch and Murray, this is something the proponents of EBP are well aware of and, in some bizarre twist of logic, use this lack of evidence as evidence in itself—“this “evidence” being so “self-evident”, it seems, that to question it would be foolish” (Devisch & Murray, 2009, p. 951).

Devisch and Murray argued that for proponents of EBP “evidence” is that obtained through the (quantitative) measurement of observable phenomena, and that the “E” of evidence-based practice “acts as the authoritative cipher, the synonym, for evidence in general: $E = truth = reality$ ” (2009, p. 952, emphasis in original). However, when it comes to justifying this type of naive empiricism, the proponents of EBP are unable to do so, and end up falling back on references to “common sense” and “intuition”—precisely the types of arguments they so readily dismiss in others. In doing so, Devisch and Murray argued, EBP “auto-deconstructs” itself: in others words, it is brought down by its own contradictions regarding the nature of “evidence”.

Other critics of EBP focus on the way it privileges a positivistic epistemology, and, in the process, ignores other epistemologies or paradigms. Earle-Foley, for example, based her argument on what she described as the “four paradigms of knowledge”: positivism, post-positivism, critical theory, and constructivism (Earle-Foley, 2011). She went on to argue that only EBP really “fits” a positivist or post-positivist paradigm. She noted that when the EBP “movement” began in the early 1990s “evidence” was seen as being derived from quantitative research and that “other sources of knowledge such as nursing intuition, expertise, and clinical judgement have been discounted in relation to decision making” (Earle-Foley, 2011, p. 38).

Wall, writing also from a nursing perspective, argued that EBP does not sit comfortably with feminine knowledge: “Women’s ways of knowing and nurses’ ways of knowing open up a range of possible sources of knowledge for practice that are not readily incorporated into the discourse of “evidence-based” practice” (Wall, 2008, p. 41).

I think very similar arguments could be used in the field of talking therapies, i.e. that therapists’ ways of knowing—and of course, a large number counsellors and psychotherapists are women—does not sit comfortably with the rationalist, scientific framework of RCTs and EBP.

Another criticism of EBP, and in particular the use of RCTs, is that this is simply not an appropriate methodology when studying the efficacy of most talking therapies, the notable exception being cognitive behavioural therapy (CBT). For example, in his paper on EBP and psychotherapy Starcevic (2003) pointed out that the technology of RCTs is very strict and includes:

- Comparison of the group of patients being studied for treatment efficacy (the experimental group) with a group who are receiving no active treatment (the control group)
- Strict diagnostic homogeneity of the groups of patients and an emphasis on diagnostic precision
- Randomization into experimental and control groups of patients
- Double-blind design of research
- Standardization of treatment procedures so that all patients receive treatment in the same way.

He went on to argue that *none* of these criteria hold for psychotherapy studies, for reasons which are worth quoting in full:

- Psychiatric diagnosis is usually not the main factor that determines the use of psychotherapy and diagnostic precision is not emphasized in psychotherapy. As a result, psychotherapy patients are not as diagnostically homogeneous as patients in RCTs and often have additional disorders that would exclude them from RCTs.
- In the psychotherapy studies there is no counterpart to a placebo that is used in the pharmacotherapy studies. The non-specific (and presumably placebo-like) psychological treatments, administered to patients in control groups, are not “neutral” in the way that placebo is pharmacologically “neutral” because they produce psychological effects, regardless of whether these are clinically significant.
- Randomizing patients in the psychotherapy usefulness (efficacy) studies is troublesome because clinical practice is not randomized; also, randomization creates an artificial situation because it ignores the fact that psychotherapy patients actively choose their own treatment.
- A double-blind design is impossible in psychotherapy research. Patients cannot be blind as to what psychological treatment they are receiving because they actively participate in it; likewise, therapists cannot be blind because they know what treatments they administer. (Starcevic, 2003, p. 279)

In different ways, all these criticisms of EBP and the hierarchy of evidence are touching on a more fundamental question regarding the nature of “evidence”. Much of the debate and argument about the merits or otherwise of RCTs in particular and EBP in general seem to revolve about what we mean by “science”. The attraction of EBP, at least to its supporters, seems to be that it is based on “science” and is thus “objective”, as opposed to the “subjective” opinions of individual practitioners and the problems of generalising the findings of individual case studies.

A meta-analysis of RCT studies, however, is an elaborate and sophisticated process, which requires a great deal of reconstruction and abstraction of data. Throughout the whole process decisions are made by individuals and groups regarding the operationalisation of variables, the construction of metrics, which statistical test to use, etc. There is nothing “objective” about this process: at best it is form of shared subjectivity (DeCoster, 2004). In other words, knowledge derived from quantitative data is as constructed and “discursive” as that derived from qualitative data and clinical experience. Furthermore, what do forest plots (a way of displaying meta-analyses data), statistical equations, and so on, really tell us about the nature of the therapeutic experience?

As Alvesson and Sköldbörg (2009) pointed out, the argument that science is a social enterprise and that knowledge is socially produced was being made several decades ago by Kuhn, Lakatos, and others. These arguments formed part of a more general critique of *positivism*, a critique which, in various guises, continues to this day. One of the key ideas of positivism, which seems have become engrained in public consciousness and, it would seem, in the minds of policy makers, is that of *empiricism*, the idea that evidence is obtained through observation of the “external” world, and science is essentially the systematisation of data. The two key ideas here are that data should be observable and measurable: ideas which still dominate much scientific—and management—thinking. In fact, it is this idea, that of observable and measurable data, which underpins the whole framework of EBP.

As many critics of positivism, including Alvesson and Sköldbörg, and also proponents of critical realism such as Roy Bhaskar (Bhaskar, 1997), have argued, one of the fundamental

flaws of empiricism is that it ignores the fact that all observation, all data, is *theory-laden*, and, particularly in the case of experiments, involves a quite elaborate social and psychological process. Also, as Devisch and Murray (2009) pointed out, truth is always *mediated*: any kind of evidence, quantitative as well as qualitative, is mediated through a complex set of social, psychological, cultural and ideological relationships and “filters”. As the example of the NIHCE guidelines for depression demonstrates, there is a complex process involved in deciding what counts as “evidence”, which involves numerous discussions, is based on particular assumptions, and so on.

EVIDENCE-BASED PRACTICE AND THE NEW TAYLORISM

In spite of all these criticisms of EBP and RCTs, however, at present EBP shows no sign of abating. In fact, as I pointed out at the beginning of this paper, it seems to have found its ultimate embodiment in IAPT. As Cooper (2011) pointed out in a recent article advocating the expansion of RCTs into the field of relational therapies, policy makers are just not listening to alternative arguments. He cited three reasons for this stance:

First, I saw very little evidence of a shift of interest towards qualitative research: indeed, to a great extent, these colleagues seemed more interested in developing increasingly rigorous and sophisticated methods of quantitative inquiry. Second, I realised that these people were actually very smart and well informed, and could argue very cogently for their position. Third, and most importantly for me, I saw the deep ethical commitment and care behind the position that these people were taking. These were not, as I had assumed somewhere in the back of my mind, Machiavellian social manipulators, but academics, researchers and policymakers who were absolutely committed to developing the best, and most widely accessible, care possible; and genuinely believed that RCTs were the best means of achieving this. I might disagree with them, but I realised that these were people fundamentally on the same side as me. (Cooper, 2011, p. 12)

It is not totally clear which “side” Cooper is on in this debate. Much of his article seems to be based on a struggle between his desire that, on the one hand, there should indeed be greater recognition of alternative methodologies, and that quantitative research can never capture the reality of the therapeutic relationship and so on; and that, on the other hand, one has to be a realist and pragmatist regarding EBP. He ended his article by stating: “the issue here is not about philosophical or methodological principles—it is a much more pragmatic one: the right for people in psychological distress, whatever their financial status, to be able to access relational forms of therapy” (Cooper, 2011, p. 16).

As I hoped to have shown in this paper, there is actually a great deal about EBP that has to do with philosophical and methodological issues. However, Cooper was quite right to point out that, at the present time at least, EBP seems to be well entrenched. One of the main reasons for this, I would argue, has nothing to do with science or truth, and a great deal to do with economics and the organisation of work.

In their response to Cooper’s article, House, Rogers, and Maidman (2011) made reference to the rise of the “New Managerialism” and the audit culture that has swept through the public sector in recent years. This is the world of management by spreadsheet, audit, performance management, measurable outcomes, and so on. Much of it relies on quantitative data and the mantra “you can only manage what you can measure”. However, there is another aspect

of such “new managerialism” which has only recently started to receive the attention it deserves, and which relates to the underlying ideology behind many of these techniques and methodologies. It is based on what could best be described as the *objectification of subjective knowledge* or, to put it another way, the *de-subjectification of knowledge*. It is also evidence that, one hundred years on, Taylorism is alive and well.

Because this form of Taylorism is now being applied to what is often described as “knowledge work”, Brown, Ashton, and Lauder (2010) have coined the term “Digital Taylorism” to describe this process of de-subjectification. The basic thrust of their argument is that the world is now entering a second phase of globalisation (the first was in the 1980s and early 1990s), in which management and knowledge work is no longer the exclusive province of the developed world. In other words, in the past it was only the unskilled jobs, e.g. assembly work, that were outsourced to the developing world, while the control, research and development and business services remained in Western Europe and North America. Nowadays, however, all of these functions can be found anywhere across the globe. Much of the intellectual labour as well as the manual and unskilled labour is now “outsourced” to places like China and India, where highly qualified university graduates are doing jobs for a fraction of the cost that they would entail in Western Europe or North America:

Just as mechanical Taylorism enabled companies to capture the knowledge of manual craft workers and re-configure it through the use of assembly lines to reduce the cost of manufacturing, Digital Taylorism is providing similar opportunities for companies to reduce the cost of various kinds of knowledge work currently undertaken by middle class managers and professionals. Here, advances in computing power and software design are enabling companies to digitalise knowledge which can be utilised across the globe, wherever there is sufficiently educated labour. (Brown et al., 2010, p. 15)

One of the key facets of Digital Taylorism is the “routinisation” of knowledge. Whereas in the past knowledge was essentially subjective, in the sense that it entailed the interpretation of information and data by individual practitioners, now it becomes objectified, through the creation of standards, routines and toolkits, which can be shared and implemented across services and, indeed, across the globe. To quote Brown and colleagues again:

Digital Taylorism enables innovation to be translated into routines that might require some degree of education but not the kind of creativity and independence of judgement that is often associated with the knowledge economy. In order to reduce costs and assert proprietary rights, companies are experimenting with new ways to move from knowledge work to working knowledge; that is, from the idiosyncratic knowledge that a worker has and applies, to working knowledge, where that knowledge is codified and routinised, thereby making it generally available to the company rather than being the “property” of an individual worker. (Brown et al., 2010, p. 15)

I would argue that we are now witnessing the spread of Digital Taylorism to the world of talking therapies, and in England this is embodied in the IAPT programme, which is also the perfect incarnation of EBP. However, any therapeutic practice that is subjected to routinisation, standardisation, measurement, performance management and audit, i.e. that can be reproduced anywhere, regardless of the therapist, is a form of Digital Taylorism.

How does Digital Taylorism relate to the idea of EBP? EBP encourages the development of metrics or measurements which can be used to evaluate the efficacy of a particular intervention.

This is an important part of Digital Taylorism: measurement is linked to evaluation, which is linked to standardisation and routinisation. “Objective” measures mean that it no longer matters who is providing the therapy, as long as there is a measurable outcome which conforms to accepted criteria; then the lived experience of the therapeutic relationship becomes secondary at best and irrelevant at worst.

Although the work of NIHCE and its production of guidance documents relating to particular forms is a major factor in the propagation of EBP, IAPT itself has produced a number of documents which epitomise the ideas behind Digital Taylorism. For example, there are a number of “competency framework” documents for a range of psychological intervention and, although IAPT is often seen as being synonymous with CBT, these frameworks also cover couples therapy (IAPT, 2010a), interpersonal therapy (IAPT, 2010b), and a form of psychodynamic therapy, i.e. brief dynamic interpersonal therapy (IAPT, 2010c).

This last document gives a good flavour of the EBP approach as embodied in IAPT. The introduction states that:

The aim of DIT (Brief Dynamic Interpersonal Therapy) has been to identify common denominators of a brief psychodynamic approach and to help practitioners structure these around a focal unconscious conflict related to the onset and/or maintenance of depression. DIT thus aims to provide psychoanalytically/dynamically trained practitioners with a structure within which to conduct a time-limited, manualised psychodynamic therapy with depressed patients. (IAPT, 2010c, p. 3)

The document then introduces a rather complex “competency map”, which is divided up into “Generic Therapeutic Competencies”, “Basic DIT Competencies”, “Specific Techniques” and “Metacompetencies”. The rest of the document is an elaboration of this “map” in an extraordinary level of detail. Thus, for example, one of the “Generic Competencies” is a “capacity to maintain the (therapeutic) alliance” (p. 11), which is a sub-competency of “Ability to engage client”. This is then broken down into 11 bullet points, including:

- An ability to recognise when strains in the alliance threaten the progress of therapy
- An ability to deploy appropriate interventions in response to disagreements about tasks and goals
- An ability to deploy appropriate interventions in response to strains in the bond between counsellor and client.

... and so it goes on, over 30 pages of competencies, sub-competencies and bullet points, all prescribing how therapists should behave and conduct themselves in relation to their clients. This is what is meant by the “codification and routinisation” of knowledge to which Brown et al. (2010) have referred. As I pointed out at the beginning of this paper, IAPT therapists are also required to record client data in the form of questionnaire scores at the beginning or end of each session. This then allows a quantitative picture of the client’s progress to be developed and stored on the patient management database, thus further adding to the evidence base. Furthermore, therapists are given targets for how many clients they should treat over a particular time period, and how many of these clients should be “moving to recovery”, which is another statistical measure.

In principle at least, any therapist should be able to “administer” the same treatment to any client in any location, and obtain a similar outcome. This completely destroys counselling or psychotherapy as a lived experience based on a relationship between two human beings. What we are left with is, rather, a truly industrialised, production-line based therapy. Therapists become technicians who “administer” standardised techniques, with measurable outcomes, and are no longer required to exercise their own professional judgement. Moreover, with the advent of technologies such as computerised CBT and the rise of on-line therapy, we are moving ever closer to the dream (nightmare) of a truly digital therapy.

WHAT IS TO BE DONE?

I would like to conclude by briefly exploring a number of responses to EBP and its relation to Digital Taylorism. In my introductory comments I stated that I thought one of the main reasons to mount a critique of EBP was to undermine its claims to truth and science.

With regard to this point, I do think it is a worthwhile exercise to question the epistemological and methodological foundations of EBP, even if, as Cooper has argued, no one is listening. One of the justifications for EBP and its hierarchy of evidence is that it is based on science, which, as it turns out, is a very narrow, and in many ways outmoded view of science, i.e. a form of empiricism. In my view, the more this justification can be challenged, the more EBP will have to find other ways to account for itself, and, in the process, its ideological underpinnings can be exposed. Of course, as many generations of Marxists and fellow social critics can testify, ideological critique in itself is not enough. Without it, however, is hard to see how there can be any chance of a coherent and effective political strategy.

As well as mounting a critique of EBP, there are also a growing number of practitioners and academics with allegiances to a range of exploratory and relational therapies who argue that the best way to confront EBP is on its own terms; in other words, to provide the evidence that a broad range of therapeutic interventions are effective. For example, in the psychoanalytic field Leichsenring has published a number of papers purporting to demonstrate the efficacy of both short-term and long-term psychodynamic therapies based on a series of meta-analyses (Leichsenring, 2005; Leichsenring & Rabung, 2008; Leichsenring, Rabung, & Leibing, 2004).

Others have sought to promote a different concept of EBP, effectively inverting the term and looking at forms of practice-based evidence. For example, with reference to the current dominance of EBP, in a paper discussing his book on research (Lees & Freshwater, 2008), Lees has argued that:

The dominance of one paradigm is unhealthy. So it (the book) has the fundamental aim of establishing a more balanced approach to healthcare research and practice in which the voice of the practitioner is accepted as having equal validity to that of the academic and bureaucrat. We want to promote an “epistemology of practice” in order to counterbalance the notion of “technical rationality” that underpins the dominant paradigm. (Lees, 2010, p. 10)

Likewise, in their response to Cooper’s article on RCTs, House and colleagues have suggested that instead of “embracing” RCTs (the thrust of Cooper’s argument):

We might instead develop and enhance services and networks of therapists which offer free or low-cost “relational, explorative” counselling and psychotherapy alongside other forms of human condition work coupled with a serious engagement with the “client voice” and a new consideration of the “psychological commons”—shared, freely available wisdom that is not “fenced off” as the property of experts and professional interest groups. (House et al., 2011, p. 29)

The idea of practice or practitioner-based evidence does have a certain appeal. It seems far more preferable than trying to “fit” exploratory and relational therapies into the “straight-jacket” of conventional EBP and its hierarchy of evidence, as researchers such as Leichsenring seem to be (perhaps unwittingly) trying to do. As House and colleagues and other commentators have pointed out, this strategy is liable to backfire because, by their very nature, relational therapies tend to fare badly under properly structured RCT research conditions.

However, much as it might be helpful to have an alternative set of research methodologies waiting in the wings, so to speak, ready for the time when the hegemony of EBP starts to crumble, I am not convinced that this is sufficient on its own to bring about EBP’s demise—just as mounting a critique of the epistemology of EBP is not sufficient either, albeit absolutely necessary. The reason I argue this is that it seems to me that there is another step beyond confronting the ideological foundations of EBP, i.e. relating it to the ideas and practices of Digital Taylorism.

This step is in many ways far more difficult than simply stripping away the pseudo-scientific veneer of EBP. Rather, it is to confront a more fundamental question: What is the attraction to so many people, including a large number of practitioners, of evidence-based practice in the first place? What is the attraction of “objective” knowledge? Why do enough people, including all those therapists who have “signed up” to EBP and its associated practices, apparently find this a better proposition than confronting another form of knowledge, the knowledge that EBP tries to suppress through its hierarchy of evidence? In other words, what do they find so unsettling and disturbing about the forms of knowledge that emerge from the lived experience of the therapeutic relationship: knowledge that cannot be quantified, subjected to meta-analyses, processed on databases and presented on spreadsheets? I think that, until these questions are properly addressed, EBP, and Digital Taylorism, will retain their hegemony.

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