Practice-Based Evidence: Back to the Future

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Researchers are shifting from the medical model of studying *treatments,* to a practice-based model focusing on the nature and needs of a *person* in a therapeutic relationship. As seen from the articles in this special issue, this has been a central tenet of Re-ED since founded by Nicholas Hobbs fifty years ago.

James Doncaster, guest editor

Confusion abounds about what qualifies as "evidence" of effective interventions. The president of the American Psychology Association [APA] notes that "much of the research that guides evidence-based practice is too inaccessible, overwhelming, and removed from practice" (Goodheart, 2010, p. 9). Yet lists of evidence-based treatments are being used to control funding in treatment, human services, and education. Stated simply, such policies are based on shaky science. Certainly there is no shortage of evidence that some methods are destructive, like withholding treatment or placing traumatized kids in toxic environments. But a wide variety of therapeutic interventions can have a positive impact if conducted within a trusting alliance.

There are two very different views of what evidence is most important. Research in the traditional *medical model* compares a proposed *treatment* with alternates or a placebo. If a prescribed number of published studies give a statistical edge, the treatment is anointed as "evidence-based." This is followed by endorsements from the National Institute of Health, the Department of Education, or other authoritative bodies.

Providing lists of curative *treatments* may work for medicine, but this is not how to find what works in complex therapeutic relationships. Mental health research has shown that the process of enshrining

specific treatment models as evidence-based is based on flawed science (Chan, Hróbjartsson, Haahr, Gøtzsche, & Altman, 2004). Dennis Gorman (2008) of Texas A & M University documents similar problems with school-based substance abuse and violence prevention research which he calls *scientific nonsense.*

Julia Littell (2010) of the Campbell Coalition documents dozens of ways that sloppy science is being used to elevate specific treatments to evidence based status. Here are just a few of these research flaws:

Allegiance Effect:
Studies produced by advocates of a particular method are positively biased.

File Cabinet Effect:
Studies showing failure or no effects are tucked away and not submitted for publication.

Pollyanna Publishing Effect:
Professional journals are much more likely to publish studies that show positive effects and reject those that do not.

Replication by Repetition Effect:
Reviewers rely heavily on recycling findings cited by others, confusing rumor and repetition with replication.

Silence the Messenger Effect:
Those who raise questions about the scientific base of studies are met with hostility and ad hominem attacks.

When researchers account for such biases, a clear pattern emerges. *Widely touted evidence-based treatments turn out to be no better or no worse than other approaches.* Solid science speaks—success does not lie in the specific method but in common factors, the most important being the helping relationship.

Re-ED uses human relationships to change the world one child at a time.

Our field is in ferment as the focus of research is shifting. Instead of the study of *treatments,* the *child* now takes center stage. The *practice-based model* focuses on the nature and needs of an individual in an ecology (Brendtro & Mitchell, 2010). Effective interventions use *research* and *practice expertise* to target *client characteristics* including problems, strengths, culture, and motivation (APA, 2006). Research and evaluation measure progress and provide feedback on the quality of the therapeutic alliance (Duncan, Miller, Wampold, & Hubble, 2010).

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Re-ED is rooted in *practice-based evidence.* It taps a rich tradition of research, provides tools for direct work with youth, and tailors interventions to the individual child in an ecosystem (Cantrell & Cantrell, 2007; Freado, 2010). Fifty years after they were developed by Nicholas Hobbs and colleagues, the Re-ED principles offer a still-current map for meeting modern challenges. Re-ED does not impose a narrowly prescribed regimen of treatment, but uses human relationships to change the world one child at a time.

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PRINCIPLES OF RE-ED

Trust between a child and adult is essential, the foundation on which all other principles rest.

Life is to be lived now, not in the past, and lived in the future only as a present challenge.

Competence makes a difference, and children should be good at something, especially at school.

Time is an ally, working on the side of growth in a period of development.

Self-control can be taught and children and adolescents helped to manage their behavior.

Intelligence can be taught to cope with challenges of family, school and community.

Feelings should be nurtured, controlled when necessary, explored with trusted others.

The group is very important to young people, and it can be a major source of instruction in growing up.

Ceremony and ritual give order, stability, and confidence to troubled children and adolescence.

The body is the armature of the self, around which the psychological self is constructed.

Communities are important so youth can participate and learn to serve.

A child should know some joy in each day.

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