

Epistemic Hypocrisy and the Evaluation of Talking Therapy via Evidence Based Medicine

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Like many other medical interventions, the efficacy of talking therapy is now largely evaluated via the methodology of Evidence Based Medicine (EBM). EBM favours quantitative rather than qualitative data. For instance, a therapy is considered efficacious if there is a measurable alleviation of symptoms on numerical scales such as the Hamilton Depression Rating Scale. Qualitative data, such as patient interviews or patient testimony as recorded in case studies is considered to be of much lower quality and rarely plays a role in determining the efficacy of therapeutic interventions, particularly for the purposes of allocating healthcare funding.

I will argue that though there may be good reasons for putting aside qualitative data in the case of medical interventions more generally, in the case of talking therapy it is hypocritical and misguided. Talking therapies rely on clients accessing their inner experience via introspection, the results of which are considered legitimate or veridical for the purposes of treatment. Yet, qualitative data that may be gleaned from introspection, such as the client's reports on whether they found the therapy efficacious or harmful are rarely solicited. Why is it that introspection is considered legitimate for the purposes of treatment but not for establishing the efficacy of the treatment?

There is an important difference between other medical interventions such as pharmaceuticals and talking therapy. In the case of therapy, the mechanism by which the intervention produces its effect is not epistemically inaccessible to the client. Patients are unable to describe, say, how a painkiller brings about its effect via introspection. However, they can use introspection to describe how talking therapy has changed aspects of their inner experience. Though the mechanism is not fully epistemically transparent to the client, there is good reason to think it is not epistemically opaque as in the case of pharmaceuticals. Though such data may have limitations, there is a strong case for further research in this area.

Additionally, during a course of talking therapy, patients routinely examine how certain experiences, or the thoughts they may have had as a result of these experiences, in turn lead to changes in their affect and behaviour. These reports gathered from introspection are considered accurate descriptions of the patient's inner experience. Patient reports on their experience of therapy and how it has altered their patterns of behaviour and affect, should be similarly considered accurate and legitimate descriptions. Consequently, there is an unjustified lack of parity in how qualitative data gathered from introspection is considered legitimate for the purposes of treatment but not evaluation of those treatments.

Finally, there is a growing demand for acknowledging the lived experience of patients in mental healthcare and medicine more broadly. In focusing only on limited quantitative data when evaluating therapeutic interventions, patient experiences are neglected in a way that may alienate patients.