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Commentary

Ethics of Fidelity in the Use of Evidenced-Based Treatment with Ethnoracially Diverse OEF/OIF/OND Veterans: A Commentary

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Fidelity to treatment and eclecticism are two of the most diametrically opposed constructs when it comes to evidence-based psychotherapy with diverse OEF/OIF/OND veterans. For evidenced-based treatments, fidelity refers to the steadfast implementation of as specified in manuals or protocols developed overtime from rigorously designed research. The intent of fidelity to this specific type of treatment is to promote reliability and validity of the clinical interventions used with patients. Ethically, the desire to achieve the judicious application of evidenced-based psychotherapies (EBP) is a response to a clarion call to service delivery vigilance against any of the many forms of eclecticism. Eclectic refers to clinical work that reflects a philosophical orientation to practice that actively embraces the flexible disregard for core components of an evidence-based model. By default, an evidence-based model requires fidelity to treatment. Independently, the eclectic technique has no substantial base of research to support its application within EBP. Contrary to the tenet of fidelity, the eclectic often haphazardly relies on non-empirically supported techniques for a clinical concern that are often also unsystematically applied within an EBP model. More often than not, these are randomly exercised techniques as part of an open-ended treatment option for the eclectic.

To little surprise, fidelity is weakened under eclectic treatment because of the reflexive abandonment of implementing the core components of EBP. An eclectic's biggest offense is a seemingly convenient ignorance or minimization of their ethical responsibility to properly inform the patient of what is occurrning. At the same time, there is a wanton failure to reduce subsequent criticism of this misguided treatment. For the most part, the eclectics struggle to provide a convincing case defense of their practice that is based on either an EBP theoretical framework or diagnostically informed clinical exigency. Keep in mind, the eclectics' actions are primarily made questionable or problematic because the services are delivered under the guise of being evidence-based, but with indiscriminant technique additions to the patients' treatment. Although well-intentioned, the unapologetic or uninformed eclectic is not immune to the cultural blend of therapeutic errors that are much harder to defend to veterans due to the paucity of research supporting them.

Unfortunately for diverse veterans, comorbid severe psychopathology (CSP) leads to highly disabling psychosocial impairment (i.e., functioning) that is challenging to treat. To appropriately address CSP, evidence-based psychotherapies (EBPs) are widely available throughout the Veterans Administration (VA). Clinically, for CSP, it is often required to simultaneously treat overlapping DSM-5 disorders. The VA offers at least seven evidence-based treatments (EBT) that are approved for PTSD (CPT, PE, CPT and PE via Telemental health), depression (ACT, CBT and IPT) and serious mental illness (SST). Essentially these approaches function as the gold standards for mental health treatment with veterans from all service eras. There is a wealth of evidence that indicates EBPs are effective. In other words, there is a substantial research base to support clinical techniques that target ethnoracially diverse veterans with CSP. EBP proceeds from the premise that providers understand the critical role that experimental clinical studies assume in undergirding these treatment approaches when they are properly used. The fact also remains clear that EBTs rely on two promises for veterans. First, the VA approved approaches are derived from, and supported by, scientific evidence. Second, all the EBT techniques have been evaluated via empirical methods. By the very definition of best practice guidance, an EBP is prescriptively structured. This means that providers must adhere to the approved basic tenets of the EBP as specified. Theoretically, a provider must strictly follow the treatment process as outlined in the authorized professional resources designated for a particular EBP approach. That is, in practice a provider would essentially stick to the script that was developed overtime through research in order for the patient to experience the maximum therapeutic dosage from that treatment model.

In reality, a provider adding a Gestalt two-chair or some other technique to CPT/CBT/PE would not be adhering to the requisite EBP manual's guidance (i.e., not delivering CPT/CBT/PE). At a superficial glance, it might seem to the provider that a patient could somehow benefit from what amounts to as an eclectic jumping off technique used within an EBP. Yet, this errant clinical decision was more likely than not made without substantial research evidence or fully defensible knowledge of potential unwanted clinical aftereffects.

Any provider's deviations from approved EBT is problematic for at least three other reasons. First, the treatment departure invalidates the authenticated application of that specific EBP approach meaning that it can no longer operate as effectively or be promoted as fidelity to treatment. Regrettably, these types of occurrences are quite common in mental health treatment, especially for providers who seem less informed about the available EBP clinical scholarship literature or fail to sufficiently recognize the full scope of consequences for their misinformed treatment decisions. Second, the provider needs to be able to explain how this eclectic jumping off point is being clinically assessed for culturally responsive therapeutic effectiveness.

They must also determine how the particular technique was selected since neither it nor other similar techniques are found in any of the available EBP resources. Finally, the provider concocting the use of these treatment blends may have erroneously convinced themselves that this eclectically added technique is somehow clinically warranted. However, they have instead ignited an expedited ethical obligation to empirically justify this treatment modification decision to the patient. In other words, an informed consent ethical threshold has been reached. To remain ethically compliant, the provider should have anticipated and disclosed to the patient this departure from the outset of treatment. The provider may also do this as part of a subsequent modified intervention plan, but such an action would warrant an all-encompassing clinical rationale that is buttressed with reasonable evidence. The main ethical beneficence for the patient would ostensibly be a documented basis for understanding that they were "not" receiving the fully recognized EBT treatment version. Instead, they have been exposed to a cherry picked and unproven eclectic knock off technique within EBP.

When comparing eclecticism and fidelity to treatment, especially with reference to ethnoracially diverse veterans, one cannot help but feel it is unethical to use a eclectic technique within that clinical context. Not only does it become difficult to explain the divergence from EBP to the patient, but it often becomes fraught with questions about whether or not the therapy will truly benefit the veteran. Eclecticism should only be employed when there is absence of EBT and, even then, only by experienced providers ideally with plans to research the new method. If this is done, the fact that the treatment is not evidenced-based should be explained to the patient, in order to achieve full informed consent. Although continued advances are being made in EBP, further investigation into these ethically complex issues related to fidelity and eclecticism should help to shed light on the future treatment of ethnoracially diverse veterans and broad clinical populations alike.

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