

The Empirically-Validated Treatments Movement:
A Practitioner Perspective¹

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I would like to weigh in on the issue of what has been called, sequentially, “empirically-validated treatments” (APA Division of Clinical Psychology, 1995), “empirically-supported treatments” (Kendall, 1998), and now “evidence-based practice” (Institute of Medicine, 2001).

Empirically-validated treatments is a difficult topic for a practitioner to discuss with clinical scientists. In my attempts to discuss this informally, I have found that some clinical scientists immediately assume that I am anti-science, and others emit a guffaw, asking incredulously: “What, are you for empirically unsupported treatments?” McFall (1991, p. 76) reflects this perspective when he divides the world of clinical psychology into “scientific and pseudoscientific clinical psychology,” and rhetorically asks “what is the alternative [to scientific clinical psychology]? *Unscientific* clinical psychology.” (see also Lilienfeld, Lohr, & Morier, 2001).

There are, thus, some ardent clinical scientists (e.g., McFall and Lilienfeld) who appear to subscribe to scientific faith, and believe that the superiority of scientific approach is so marked that other approaches should be excluded. Since this is a matter of faith rather than reason, arguments would seem to be pointless. Nonetheless, clinical

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psychologists have argued over it, a lot, for the last eight years. Punctuating these interactions from the practitioner perspective, the controversy seems to stem from the attempts of some clinical scientists to dominate the discourse on acceptable practice, and impose very narrow views of both science and practice.

Let's start with a brief recapitulation of the events. Division 12, under the leadership of then-President David Barlow, formed a Task Force "to consider methods to educate clinical psychologists, third party payors, and the public about effective psychotherapies" (APA Division of Clinical Psychology, 1995, p. 3). The Task Force came up with lists of "Well-Established Treatments" and "Probably Efficacious Treatments." Not surprisingly, the lists themselves emphasized short term behavioral and cognitive-behavioral approaches, which lend themselves to manualization; longer term, more complex approaches (e.g., psychodynamic, systemic, feminist, and narrative) were not well represented.

The empirically-validated treatments movement has had quite an impact on practitioners. It provided ammunition to managed care and insurance companies to use in their efforts to control costs by restricting the practice of psychological health care (Seligman & Levant, 1998). It has also influenced many local, state and federal funding agencies, who now require the use of empirically-validated treatments. Moreover, this movement could have an even greater impact on practitioners in the future. For example, it could create additional hazards for practitioners in the courtroom if empirically-validated treatments are held up as the standard of care in our field. Further, adherence to empirical-validated treatments could become a major criterion in accreditation decisions and approval of CE sponsors, as the Task Force urged (APA Division of Clinical

Psychology, 1995, p. 3). Some clinical scientists have gone so far as to call for APA and other professional organizations “to impose stiff sanctions, including expulsion if necessary, on practitioners who routinely use therapeutic and assessment practices that are devoid of scientific support” (Lohr, Fowler & Lilienfeld, 2002, p. 8).

Given all of this fallout, it should be no surprise that the Task Force report was soon steeped in controversy. Critics argued first and foremost that the Task Force used a very narrow definition of empirical research. For example, Koocher (personal communication, 7/20/03), observed that “‘empirical’ is in the eye of the beholder, and sadly many beholders have very narrow lens slits. That is to say, qualitative research [and] case studies... have long been a valuable part of the empirical foundation for psychotherapy, but are demeaned or ignored by many for whom ‘empirical validation’ equates to ‘randomized clinical trial’ [RCT]. In addition, a randomized clinical trial demands a treatment manual to assure fidelity and integrity of the intervention; however, the real world of patient care demands that the therapist (outside of the research arena) constantly modify approaches to meet the idiopathic needs of the client...Slavish attention to ‘the manual’ assures empathic failure and poor outcome for many patients.”

Furthermore, Seligman and Levant (1998) argued that, whereas efficacy research programs based on RCT’s may have high internal validity, but they lack external or ecological validity. On the other hand effectiveness research, such as the *Consumer Reports* study (Seligman, 1995), has much higher external validity and fidelity to the actual treatment situation as it exists in the community. Additional effectiveness studies are needed, and could be conducted by the Practice-Research Networks that have recently appeared (Borkovec, Echemendia, Ragusea, & Ruiz, 2001). Finally, others have pointed

that many treatments have not been studied empirically, and that there is a big difference between a treatment that has not been tested empirically, and one that has not been supported by the empirical evidence.

A few years later, John Norcross, then-President, of Division 29 (Psychotherapy), countered by establishing a Task Force on Empirically Supported Therapy Relationships in 1999, which emphasized the person of the therapist, the therapy relationship and the non-diagnostic characteristics of the patient (Norcross, 2001). Lambert and Barley (2001) summarized this research literature, pointing out that specific techniques (namely those that were the focus of the studies underlying the Division 12 Task Force Report) accounted for no more than 15% of the variance in therapy outcomes. On the other hand, the therapy relationship and factors common to different therapies accounted for 30%, patient qualities and extra therapeutic change accounted for 40%, and expectancy and the placebo effect accounted for the remaining 15%.

Westen and Morrison (2001) reported a multidimensional meta-analysis of treatments for depression, panic disorder, and GAD, in which they found that “the majority of patients were excluded from participating in the average study,” due to the presence of comorbid conditions (p. 880). Approximately 2/3 of the patients in the studies they reviewed were excluded, which seems like a high percentage, but is actually a bit lower than national figures for comorbidity. Meichenbaum (2003) noted that fewer than 20% of mental health patients have only one clearly definable Axis I diagnosis. Thus, the vast majority of cases seen by practitioners do not meet the exact diagnostic criteria used in the RCT’s that established efficacy for various treatments.

Furthermore, the empirically-validated treatments on these lists have typically been studied using homogeneous samples of white, middle class clients, and therefore have not often been shown to be efficacious with ethnic minority clients.

So what does this all mean? Suppose we had lists of empirically-validated treatments for all DSM Axis I diagnoses (which we are actually a long ways away from). We would then have treatments for only 20% of the white, middle class, patients who come to our doors, namely those who meet the diagnostic criteria used in studies that validated these treatments. That's bad enough, but that's not all. In order to limit services to only these 20% of the white, middle class, patients who come to us, the average practitioner would have to spend many, many hours, perhaps years, in training to learn these treatments. And, in the end, these treatments would only account for 15% of the variance in therapy outcomes in these patients. One can readily see why few practitioners embraced the empirically-validated treatments movement.

My view is although one of psychology's strengths is its scientific foundation, the present body of scientific evidence is not sufficiently developed to serve as the sole foundation for practice. Practitioners must be prepared to assess and treat those who seek our services. To be sure, we all get referrals of clients that we decide to refer to others because we don't think that we are the best clinician for that case, but those who are in general practice have to work with the clients that come to us. Whether we operate from a single theoretical perspective or are more eclectic, we bring to bear all that we know from the empirical literature, the clinical case studies literature, and prior experience, as well as our clinical skills and attitudes, to help the client that is sitting in front of us. This is what is often referred to as clinical judgement. Some condemn clinical judgement as

subjective. To them I say that clinical judgement is simply the sum total of the empirical and clinical knowledge and practical experience and skill which clinicians bring to bear when it is our job to understand and treat a particular and very unique person.

Fox (2003) goes even further, pointing out that in many learned fields science and practice are often separate endeavors, and that practice often has to precede science. Physicians were treating cancer long before they had much of an idea of what it was, and were using pharmaceutical agents like aspirin long before the pharmacodynamics were known. To quote Fox (2003):

The fact of the matter is that if clinicians restrict themselves to applying only narrowly validated or known techniques, they will never be of much value to society. Lest you think that statement is an invitation to charlatanism, remember that clinicians do not have the luxury to start from what is known. They must start with the needs of the people who come to them and then apply all the knowledge, information and skill they have to help resolve those problems.

On the other hand, we do have a problem of accountability in health care, one that will surely affect psychology. For example, the current lag between the discovery of more effective forms of treatment in health care and their incorporation into routine patient care is, on the average, 17 years. DeLeon (2003) predicts that health care in the 21st century, abetted by technology, will be characterized by even greater accountability for practitioners, due to the combined effects of the increasingly well-informed health care consumer, who gathers relevant health care information from the internet, the increasingly well-informed practitioner, who will be able to obtain best practice information from a PDA, and increased monitoring of health care practices, to flush out

variation in treatment for specific diagnoses. In this environment we are going to need better ways to evaluate practice. I would suggest that we consider using the broad and inclusive definition of evidence-based practice adopted by the Institute of Medicine (2001). This definition consists of three components: *best research evidence*, *clinical expertise* and *patient values*. The definition does not imply that one component is privileged over another, and provides a broad perspective that allows the integration of the research (including that on empirically-validated treatments and that on empirically supported therapy relationships) with clinical expertise and, finally, brings the topic of patient values into the equation. Such a model that values all three components equally will better advance knowledge related to best treatment, and provide better accountability.

As always, I welcome your thoughts on this column. You can most easily contact me via email: Rlevant@aol.com.

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Biographical Sketch

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