

# **Evidence Based Counselling & Psychotherapy for the 21st Century Practitioner**

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# **Evidence Based Counselling & Psychotherapy for the 21st Century Practitioner**

BY

**DARYL MAHON**

*Outcomes Matter, Ireland*



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# Contents

List of Figures and Tables	vii
Biographies	ix
Acknowledgements	xi
Introduction	xiii

## **Part 1. Setting the Scene for Evidence Based Practice**

<b>Chapter 1 Empirically Supported Treatments: A Brief History</b> <i>Daryl Mahon</i>	3
<b>Chapter 2 Evidence Based Practice: An Overview</b> <i>Daryl Mahon</i>	15
<b>Chapter 3 The Common Factors in Therapy</b> <i>Daryl Mahon</i>	27

## **Part 2. Evidence Based Relationships & Responsiveness**

<b>Chapter 4 Evidence Based Relationships 1: Therapeutic Alliance, Goals and Collaboration, Alliance Rupture–Repair, and Feedback-informed Care</b> <i>Daryl Mahon</i>	39
<b>Chapter 5 Evidence Based Relationships 2: Treatment Credibility and Outcome Expectancy</b> <i>Daryl Mahon</i>	53
<b>Chapter 6 Evidence Based Relationships 3: Emotional Expression, Counter-transference, Self-disclosure, and Immediacy</b> <i>Daryl Mahon</i>	61

<b>Chapter 7 Evidence Based Relationships 4: Empathy, Congruence, Unconditional Positive Regard, and Real Relationship</b> <i>Daryl Mahon</i>	71
<b>Chapter 8 Evidence Based Responsiveness 1: Client Factors</b> <i>Daryl Mahon</i>	85
<b>Chapter 9 Evidence Based Responsiveness 2: Multicultural Considerations</b> <i>Ravind Jeawon and Daryl Mahon</i>	99
<b>Part 3. Innovations for 21st Century Psychotherapy: Practice, Supervision &amp; Training</b>	
<b>Chapter 10 Information Technology and Behavioural Healthcare in the 21st Century</b> <i>Jeb Brown, Ashley Simon and Justin Turner</i>	117
<b>Chapter 11 Deliberate Practice for Enhancing Skill Development in 21st Century Psychotherapy</b> <i>Daryl Mahon</i>	135
<b>Chapter 12 Enhancing Supervision Through the Use of Data</b> <i>Daryl Mahon and Jeb Brown</i>	147
<b>Chapter 13 Simulated Psychotherapy Case Study for the 21st Century Practitioner and Supervisor</b> <i>Daryl Mahon</i>	159
Index	175

# List of Figures and Tables

## Figures

Fig. 1.	EBP in Psychology.	17
Fig. 2.	Contextual Deliberate Practice Model.	173

## Tables

Table 1.	Areas of Concern and Some Solutions.	11
Table 2.	Guidelines from APA.	16
Table 3.	Types of Research Used to Establish Effectiveness of Psychological Therapies.	18
Table 4.	Types of Alliance Ruptures.	44
Table 5.	Five Levels of Empathy.	74
Table 6.	Stages of Change Description.	87
Table 7.	MCO Framework.	108

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# Biographies

## Author

**Daryl Mahon**, is a psychotherapist, lecturer and researcher. Prior to taking up his current role in research, he worked across the social inclusion sector, working with individuals and communities facing marginalisation. Much of his work has centred on substance use with people also involved in the criminal justice system, mental health difficulties and homelessness. More recently, he has been working as an Action Researcher with a European non-profit organisation based in Dublin working in complex systems change to support social services to solve complex problems and scale social innovations and evidence based practices.

He also lectures in Health and Social Care and delivers training to national and international practitioners and organisations. He has published in various peer reviewed areas related to psychotherapy processes and outcomes, trauma and leadership. His recently published best-selling book on Amazon, *Trauma Responsive Organisations: The Trauma Ecology Model* provides an in-depth exploration into trauma responsive organisations. He used the period during Covid to transition from psychotherapy practice to focus exclusively on research, training and lecturing.

## Contributors

**Jeb Brown** completed his PhD in Counselling Psychology from Duke University in 1978. During the next two decades, he worked in a series of jobs where he was both a clinician and an administrator/supervisor, including as Executive Director for The Center for Family Development, Executive Director of United Healthcare's Behavioural Health Systems in Utah and Director of Clinical Programmes for Aetna Health Plans. In 1998, he founded a consulting firm, the Center for Clinical Informatics, and began work on the ALERT Clinical Information System for PacifiCare Behavioural Health.

The ALERT system survived PacifiCare's acquisition by United Health Care and collaborative work with various academic researchers who were granted access to data within ALERT clinical information system resulted in a stream of peer reviewed articles advancing the methodology for benchmarking treatment outcomes. In 2007, he and Takuya Minami, PhD, founded the ACORN Collaboration and began work on a next generation clinical information system with a goal of greatly expanding the capabilities of older platforms. The Center

for Clinical Informatics maintains the servers and programmes the system. The ACORN platform continues to build off lessons learned over 20 years of research and development, and regular use of the platform by practitioners has been demonstrated to measurably, clinically and meaningfully improve treatment outcomes from one year to the next. Until recently, he continues to maintain a part-time psychotherapy practice.

**Ravind Jeawon**, MIACP, is a licenced, Dublin-based psychotherapist and Founder of Talk Therapy Dublin, a service which aims to provide inclusive counselling supports to clients experiencing distress. His clinical experience began supporting community counselling services in Dublin providing psychotherapy and psychosocial support to communities affected by socioeconomic inequality, organised crime and homelessness. Having spent over three years in this area, he moved into private practice and noticed further demand by minoritised clients looking for responsive counselling linked to issues around ethnicity, race and the experience of migration. This encouraged an increasing interest in multiculturally responsive counselling, prompting him to pursue further training in the area at the Nafsiyat Intercultural Centre in London.

He has expanded his work to include training and the mentoring of students and newly qualified therapists from diverse backgrounds and provides counselling services to the International Organization for Migration in Ireland linked to their voluntary return programme. As a therapist, he continues to advocate for more inclusivity within mental health practice, particularly linked to core trainings and an improvement in multicultural responsiveness from caring professions when providing services to minoritised communities.

**Ashley Simon**, is a Co-owner of ACORN, a mental health analytics platform that tracks client progress and clinician effectiveness. Over her 10 years at ACORN, Ashley has worked as the head of Risk Assessment, QA, has co-authored on the collaboration's psychometric research, and now directs ACORN's content and training initiative. She holds a Master's degree in Middle East Studies and Linguistics, and a Bachelor's degree in Psychology.

**Justin Turner**, is a Co-owner of ACORN. With over a decade of experience at ACORN as the operational manager, Justin oversees a wide array of daily functions. These functions include customer support, employee management and training, database management, form creation, and the creation of informational videos that help to inform clinicians of best practices for improving their clients' outcomes.

# Acknowledgements

This is the second time in a 12-month period that I have sat down to write the acknowledgements part of a fully completed academic book. My reason for invoking this is not one of pride, although proud I am. The reason I bring this to the attention of the reader is to express my gratitude to my family, especially my wife. You don't write one, let alone two academic books during a 12-month period without the support of your family. To the unwavering support of my wife Jessica who puts up with my antics and long hours behind the computer screen, I love you. My children Zianna and Zayne, who never fail to enquire into my progress with my books. My hope is that I will be enquiring into the progress of both of your books in the future.

To my valued colleagues who contributed to chapters. Ravind Jeawon has come on board for the second time and brings his passion for making therapy more multiculturally responsive, thank you. To Dr Jeb Brown, who will be surprised to know that he helped plant the seed for this book, long before we ever met. Your contributions have greatly enriched this book and your life's work is truly impressive. It has been my absolute pleasure getting to know you during our online conversations and writing articles together.

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# Introduction

In the second year of my undergrad training in psychotherapy, two things happened that are relevant to the writing of this book. Firstly, I came across research on the common factors, and I read an article that was written by my now colleague, co-author and chapter contributor to this book, Dr Jeb Brown. Perhaps, I was put off by the response that the lecturer gave me when I brought the common factors up for discussion, or perhaps like the lecturer and many other practitioners, I didn't fully appreciate the relevance and significance of the common factors in therapy. Thus, my focus went elsewhere in the therapy literature. In psychotherapy, this generally means getting caught up in the next modality of therapy that is being marketed as the next great pill to solve a range of psychological issues. Unfortunately, much of psychotherapy research and practice likes to treat therapy like a medicine. That is, certain therapies work like a pill and act as remedial interventions for specific disorders or issues. Thankfully, it was not long before I was back on track and exploring the therapeutic factors that provide for effective psychotherapy, and it is these factors that make up a large part of this book. I seek to move the debate on by exploring what we know about the various factors (non-modalities) that contribute to the change process, and how we as a field can build on this knowledge through innovative deliberate practice training methods, and data-informed supervision.

I have always been curious as to how things work, no more so than with psychotherapy. So, as I delved back into the research on common factors and other aspects of psychotherapy processes and outcomes I was shocked to find that many of the criteria that we place huge value on have are generally not predictive of client outcomes. Years practicing, level of qualification, modality delivered, supervision, personal therapy, licencing body and continuing professional development do not tend to improve the effectiveness of the practitioner. I was both shocked and excited, and began to investigate these areas eagerly, publishing some papers. After spending many years practicing, researching and providing training in psychotherapy processes and outcomes, it makes sense to support this with an academic book. Whether you are a novice psychotherapy trainee, or a seasoned practitioner or supervisor, you will find this book a helpful evidence based resource. Over three sections, the chapters discuss evidence based practice in its various forms, including an analysis of research used, the debate around the effectiveness of specific therapies, commonalities across therapies and the many evidence based relationship variables that are said to contribute to effective psychotherapy. In addition, client factors are also discussed before moving onto

exploring the use of technology, deliberate practice, supervision, and a simulated client case that will illustrate the application of some of the methods and ideas that we have outlined. As such, the book is structured across the following three sections, which describe what it is that an effective twenty-first century practitioner needs to know, do and reflect on to improve the effectiveness of their psychotherapeutic work and client outcomes.

## **Part 1**

The first part of this book explores three key aspects of psychotherapy research and practice. In Chapter 1, I examine the evolution of empirically supported treatments (EST). Not without their criticism, I provide a historical perspective on EST and discuss how ESTs are often positioned as psychology's answer to medicine. That is, ESTs are treatments that are designed to reduce symptomology in the same way medicine provides a pill to treat a sick person. The role of the American Psychological Association in developing these therapies is outlined along with a critique of the role of the randomised control trial as a way to assess effectiveness of treatments.

In Chapter 2, I provide an overview of Evidence based practice (EBP) as defined and operationalised by the American Psychological Association. Crucially, in comparison to EST, EBP is positioned as a verb, as opposed to the noun like use of treatment modalities. The three components of EBP are discussed, namely:

1. The best available evidence; in conjunction with
2. Individual clinical expertise; that is consistent with
3. Client culture, values and preferences.

'Everyone has won, and all must have prizes'. This is the premise of the debate offered by the common factors proponents discussed in Chapter 3. The common factor debate rests on the idea that in general all treatment modalities will tend to be about equally effective because of non-specific treatment elements that are common across diverse treatment approaches. It was Saul Rosenzweig in 1936 who first put forward the idea of commonalities among therapies. Since then, other researchers have built on these ideas, and this chapter tracks the trajectory of this research and the models proposed. The chapter finishes with some ideas regarding common and specific factors in therapy, ultimately, whether therapy gains its effectiveness from specific or common factors is perhaps a misleading dichotomy.

## **Part 2**

The second section in this book deals with the substantive variables that have shown to impact on the outcome of psychotherapy. Altogether, I discuss 22 different factors that practitioners must consider under the heading of evidence based relationships, and evidence based responsiveness. In order to achieve this within the publishing guidelines, yet also provide the necessary information, a

structured approach that provides a brief overview of each construct, along with the most up-to-date research, and the impact of the variable on psychotherapy outcomes is summarised. As such, the purpose is not to delve deep into each construct in detail, but rather, to provide a basic description to help the practitioner understand the variable being discussed, its empirical foundations and several top tips. The substantial bibliographies in each chapter will provide areas for further reading. Considering the breadth of constructs across this text, and given my aim to have this book act as a practical evidence based resource for the average practitioner to dip in and out of, having bite size chunks that practitioners can draw on is the best way to achieve this.

The first four chapters in Part 2 explore the research pertaining to evidence based relationships. Chapter 4 discusses the big impactful variables of the therapeutic alliance, goals and collaboration, alliance rupture–repair, and feedback-informed treatment. Chapter 5 explores how the idea of expectancy is conceptualised in psychotherapy, through treatment credibility and outcome expectancy, two key common factors that do not get discussed enough in the literature. Internal experiences can be considered to be the theme of Chapter 6, the relationship aspects of emotional expression, counter-transference, self-disclosure and immediacy are examined.

Finally, in Chapter 7, the big impactful variables of empathy, genuineness, unconditional positive regard and the real relationship are considered. Like previous chapters in this section, the research basis, impact and top tips are provided.

The second section of Part 2 focuses on evidence based responsiveness. While practitioners must be responsive to clients in various different ways, this part of the book provides an examination of responsiveness based on what we can consider to be client characteristics. In Chapter 8 and using the same format as in evidence based relationships, I set out the relevant research and impact of, attachment style, coping style, reactant level and stage of readiness for change. Furthermore, the process of adapting treatment based on client preferences is considered. Multicultural responsiveness is dealt with in Chapter 9, Ravind Jeawon and I felt it necessary to have a whole chapter dedicated to this important area of psychotherapy practice. Ravind joins me once again to author a multicultural chapter, after co-authoring a chapter in my previous book on trauma responsive organisations.

### **Part 3**

Part 3 of this book is where the idea of the twenty-first century practitioner really comes into its own. The final section of the book has four exciting chapters that will outline various innovative practices in the training and supervision of practitioners, in addition to the use of technology in therapy, and a simulated client case study demonstrating the application of many of the processes and practices discussed. I am grateful to have Dr Jeb Brown contribute Chapter 10 on the use of technology in psychotherapy. Anyone with an interest in the use of ‘big data’ for the purpose of psychotherapy will enjoy both the historic perspective, and the current innovations. Jeb also co-authored with me, a chapter on the use of data

in supervision for the purpose of providing more effective care, and to inform deliberate practice.

Deliberate practice is a concept still in its infancy as applied to the initial training and ongoing continuous development of seasoned practitioners. Chapter 11 provides a rationale for the use of deliberate practice in the acquisition of psychotherapy skills and expertise. The processes and principles involved in this training regime are discussed, and I link it to the big impact variables outlined in the previous chapters as an initial method for skills acquisition. The use of routine outcome data in supervision is described in Chapter 12. Dr Jeb Brown and I provide the reader with picture of what the supervisory relationship in the twenty-first century can look like by using data to inform supervision and a deliberate practice training regime. Finally, Chapter 13 provides a simulated client case study for the twenty-first century practitioner and supervisor. A narrative commentary of a client–practitioner session illustrates the application of many of the variables discussed in this book, in addition to a practitioner–supervisor session focussed on using data and clinical information to inform supervision and deliberate practice to improve the acquisition of skills, and to enhance expertise and improve outcomes.

Part 1

# **Setting the Scene for Evidence Based Practice**

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## Chapter 1

# Empirically Supported Treatments: A Brief History

*Daryl Mahon*

### Abstract

Psychotherapy is perhaps the most known and identifiable with one of the field's originators Sigmund Freud who is often accredited as being the inventor of the talking cure. However, it was many decades after psychoanalysis was first used by Freud that robust research and evidence was applied to psychotherapy, and its findings used to support practice in various contexts. While psychoanalysis is still practiced, the field has moved on and includes many hundreds if not thousands of approaches to healing. What has not improved, in general, is the between school rivalry regarding the efficacy and effectiveness of the different approaches. While it is now accepted that in general terms all approaches are about equally effective, certain research is often provided with more legitimacy than others. Mainly, the randomised control trial (RCT) is considered the gold standard in research terms, especially when it comes to establishing the efficacy and effectiveness of different psychotherapies. Empirically supported treatments (ESTs) are in prime position to take advantage of these political decisions, and this chapter will introduce the reader to these debates.

*Keywords:* Psychotherapy; empirically supported treatments; randomised control trial; evidence based practice; meta-analysis; evidence based treatments

### Chapter Learning Outcomes

- (1) Appreciate the historical application of research to psychotherapy practice.
- (2) Introduce the reader to ESTs.

## Introduction

Psychotherapy is an effective treatment modality and has become a more professionalised service throughout the world. However, the research foundations for its efficacy are steeped in a long rivalry from within the profession. Competing theoretical orientations can be traced back to the Freudian era and are still very much in existence today. The claims of the superiority of one theory over another were a hot argument between Freud and his group, the therapy and practice of therapy was hotly and vehemently disputed. They were not alone, as the behaviourists joined the calls and criticised the analysts, while the humanistic theorists equally convinced of their approach provided a different way to view distress and healing. Behavioural ideas were incorporated into cognitive models and the third wave approaches sought alternative explanations. The next step of course was integrationist approaches which asked the question, ‘what works for this person, delivered by that therapist?’ The result is that there are now thousands of theories used to explain and treat human distress.

Norcross and Newman (1992, p. 3) provide the following analysis:

Rivalry among theoretical orientations has a long and undistinguished history in psychotherapy, dating back to Freud. In the infancy of the field, therapy systems, like battling siblings, competed for attention and affection in a ‘dogma eat dogma’ environment .... Mutual antipathy and exchange of puerile insults between adherents of rival orientations were much the order of the day.

## Emerging Research

Hans Eysenck (1952) in a review of the extant literature concluded that eclectic and psychoanalytic therapies were no more effective than no treatment at all. Controversy was to follow, with calls for potential clients to be informed of these findings on ethical grounds. In many respects, the within field fighting contributed to the lack of effectiveness of psychotherapeutic interventions being established within the research literature in the years to follow. This rivalry is not new. Going back to the earliest days of psychotherapy, we have seen how such rivalry split the various schools of psychoanalysis in the time of Freud and his colleagues.

Notwithstanding these issues, in time, the empirical support for psychotherapy began to emerge. Largely, this evidence was due to innovations in research power such as the RCT and the meta-analysis. RCTs are an experimental methodology where a person is randomly assigned to an active treatment, a control, or a waitlist to examine the effectiveness of the experiential treatment compared to another control (Wampold, 2013), as such, casual inferences can then be drawn. During the 1970s, hundreds of such studies had been carried out confirming the

effectiveness of psychotherapy, regardless of the type of approach to treatment (Bergin, 1971), these studies of equivalence as they are known, have been replicated throughout the literature (Leonidaki & Constantinou, 2022; Stiles et al., 2008; Wampold et al., 2017; Watts et al., 2013). However, it was the emergence of the meta-analysis that allowed studies to be pooled together to give an overall effect size for psychological therapies, and this method demonstrated the field's prowess.

The meta-analysis brings together similar studies that are often relatively homogenous and pools together their effect sizes and reports on overall effectiveness. A seminal study (Smith & Glass, 1977) utilised this statistical analysis to review 375 studies and found that the average treated person was more better off than 60–82% of those receiving no treatment. In the years since Eysenck's (1952) claims that psychotherapeutic practices were not effective healing agents, much has been debated. Discourses have evolved, shifted, and reflected on several key debates. We now know that psychotherapy is an effective treatment modality (Lambert, 2013; Lambert & Ogles, 2004; Wampold & Imel, 2015). In fact, therapists in naturalistic settings reach the often cited 0.80 effect size benchmark from highly controlled RCTs (Wampold & Imel, 2015). Hence, psychotherapy has been established as an effective treatment modality on par with some medical treatments such as heart bypass surgery and chemotherapy for breast cancer (Lipsey & Wilson, 1993). Indeed, this is not where the comparison to the medical model ends, controversy around ESTs based within a medical paradigm of specific treatments for specific disorders is a hot topic within the psychotherapeutic discourse and has an interesting history.

## Specific Ingredients

Specific ingredients refer to those aspects of a treatment modality that are proposed to be the mechanisms of change. With regard to research, most studies examining specific factors in therapies have done so through cognitive behavioural therapy (CBT) and anxiety and depression. In a review of 30 meta-analyses, Kazantzis et al. (2018) synthesised the outcome process with regard to CBT, largely within the treatment of anxiety and depression. They found the strongest support for cognitive and behavioural strategies as processes of change in depression and anxiety. In another meta-analysis that included 35 studies, Lemmens, Müller, Arntz, and Huibers (2016) examined the mechanisms of change in CBT and other therapies. The strongest findings from this review support mechanisms of change related to negative automatic thoughts, dysfunctional attitudes, worry, rumination, and the use of mindfulness.

Using 26 studies, Cristea et al. (2015) performed a meta-analysis of the effects of CBT on dysfunctional thinking, which is often suggested to be the core process in CBT. However, when compared to other psychotherapies in the study, there was no significant differences, which could mean that dysfunctional thinking is not exclusive to CBT. Spinhoven et al. (2018) conducted a meta-analysis of 36 studies that investigated the effects of various forms of CBT on repetitive

negative thinking compared with various other treatment types. They found significantly larger effect sizes for CBT treatments such as rumination-focussed CBT and original CBT compared with treatments such as antidepressant medication and counselling. When thinking about these studies, it is important to realise that much of the evidence is correlational, and that we are still not at a point where we are carrying out the type of complex research needed to draw inferences about causality. As [Cuijpers, Reijnders, and Huibers \(2019\)](#) suggest, ‘evidence for the mediational role of the various constructs (specific and non-specific) is largely mixed and that better designed studies are urgently needed to understand the mechanisms of psychotherapy’. However, as we will see in subsequent chapters, we may have arrived at a point where we can draw inferences about causality as it relates to the therapeutic alliance.

## The Road to ESTs

Evidence based practice (EBP) within the counselling and psychotherapy professions can be traced back to the evidence based medicine movement. [Leff \(2002\)](#) informs us of three key issues that influenced the medical field and the promotion of this paradigm.

- (1) Reforms of physician training in 1910 lead to a call for curriculum to be underpinned by science.
- (2) In 1948, the *British Medical Journal* published what was the first RCT.
- (3) The final influence was the creation of the Food and Drug Administration agency and the double blind RCT, which is considered the gold standard research trial for establishing efficacies’ interventions.

Throughout the 1990s evidence based medicine was further integrated into the system based on the work of people like Archi Cochrane and David Sackett, with the former being influential in embedding the RCT as the standard for evidence based interventions, and the latter being one of the driving forces behind articulating and conceptualising EBP in medicine. At the same time that Sackett and colleagues were moving to an evidence-practice paradigm in medicine, psychiatry through the American Psychiatric Association were attempting to categorise and promote practice guidelines across discrete ‘disorders’. However, in contrast to what was occurring in medicine, psychiatrists’ evidence of a biological basis was non-existent, and was exclusively based on consensus between those ‘around the table’. With the subsequent treatments derived from these decisions. Thus, psychiatry went about legitimising their approach to mental health not through a scientific paradigm but based on consensus between practitioners ([Duncan & Reese, 2012](#)).

Concurrently, psychologists rushed to find methods to counter psychiatry’s magic pills, establishing ESTs. In what has been described by [Duncan and Reese \(2012\)](#) as ‘perhaps fearing psychiatry’s historical hegemony in health care’ ESTs were promoted as a ‘common cause’ for a clinical profession fighting

exclusion'. Suggesting that care should be 'proven', not consensus treatments, a special task force (Chambless, 1993) acting under the auspices of American Psychological Association (APA) Division 12 (Society of Clinical Psychology) set forth its conclusions about what constituted scientifically valid treatments. Drawing on the concept of evidence based medicine, and on the idea that the quality of client care is improved when practitioners use treatments with empirical support as noted by [Sackett, Richardson, Rosenberg, and Haynes \(2000\)](#), the Task Force first selected a set of criteria by which to identify the presence of adequate scientific evidence. Thus, the Task Force concentrated its efforts on research demonstrating that a particular treatment has proven to be beneficial for clients in RCTs and based their categorisation of these therapies under three headings: strong, modest, and controversial. The Task Force reviewed available research and catalogued treatments of choice for specific diagnoses based on their efficacy criteria, in the same manner as the US Food and Drug Administration before them. To date, a list of over 80 ESTs for 27 of the 157 diagnoses in the *DSM-5* have been created, which, as far as outcomes are concerned, has done little by the way of improving therapist effectiveness ([Schukard, Miller, & Hubble, 2017](#)).

## Empirically Supported Treatments

What do we mean when we refer to ESTs? Therapies that can be manualised, with supposedly specific ingredients for specific 'disorders' based on the medical model paradigm of symptom reduction ([Norcross & Wampold, 2019](#)). As Shean (2016, p. 1) posits:

RCT studies favour therapies that focus on specific symptoms and can be described in a manual, administered reliably across patients, completed in relatively few sessions, and involve short-term evaluations of outcome.

ESTs can be found by their abbreviated names. For example, Dialectical Behaviour Therapy, Acceptance and Commitment Therapy among others. Importantly, ESTs have the following characteristics, they are: manualised treatments based on protocols; delivered with fidelity; have supposedly specific ingredients; used for specific presenting issues, and are short-term interventions. The following research criteria (adapted from [Tolin, McKay, Forman, Klonsky, & Thombs, 2015](#)) are needed to assess if ESTs are considered well established and probably effective.

- (A) At least two good between-group design experiments demonstrating efficacy in one or more of the following ways:
  - (1) Superior (based on statistical significance alone) to pill or psychological placebo or to another treatment.

- (2) Equivalent to an already established treatment in experiments with adequate statistical power, considered to be approximately 30 per group.
- (B) A large series of single-case design experiments ( $n > 9$ ) demonstrating efficacy. These experiments must have:
- (1) Used good experimental designs.
  - (2) Compared the intervention to another treatment as in A.1.

Further criteria for both (A) and (B) are as follows:

- (1) Experiments must be conducted with treatment manuals.
- (2) Characteristics of the client samples must be clearly specified.
- (3) Effects must have been demonstrated by at least two different investigators or investigating teams.

For the American Psychological Association (2002, p. 1054).

Randomized controlled experiments represent a more stringent way to evaluate treatment efficacy because they are the most effective way to rule out threats to internal validity in a single experiment.

However, this position has various major flaws. For example, unlike in medicine where the RCT rains supreme, in therapy it is impossible to have a double-blind study, or even a single blind for that matter. How would we blind either the therapist to the type of treatment they are providing, or the client who is receiving therapy? In medicine, this is achieved by providing the patient with a placebo pill, in therapy this is not possible. Thus, in therapy research, treatment manuals are used, therapists are trained in their use, internal validity is maintained, and the therapist themselves are not deemed important. However, as we will see in further chapters, the therapist is perhaps the biggest variable in the treatment process and attempting to control the therapist as an unimportant variable is not the correct approach to take.

As we can see, ESTs are put forward in the same way that psychiatry uses certain pills for certain ills, however, as we will see later, psychotherapy is nothing like psychiatry, and disorder specific treatments may not be the gold standard approach that prevails when they are compared to another valid/bona fide treatment approaches. Controversy remains, with some advocates positing that ESTs are no more effective than the hundreds of other theoretical approaches within the field (Sakaluk, Williams, Kilshaw, & Rhyner, 2019). Further, Tackett and Miller (2019) and Sakaluk et al. (2019) call into question the actual evidence for ESTs, issues of methodology in RCTs, such as comparing treatments to