Issues and Controversies Surrounding Recent Texts on Empirically Based Psychotherapy: A Meta-Review


The dodo bird is extinct, but some stay it still lives. For those of you not familiar with psychotherapy research, this reference begs some explanation. The term was put into use in 1936 by Rosenzweig (1936), who was alluding to the dodo bird in Lewis Carroll’s Alice in Wonderland. The dodo bird remarked that “all have won and all must have prizes.” At the time of Rosenzweig’s writing, there was no demonstrably superior form of therapy and, in fact, no demonstration that therapy had any efficacy; therefore, “all have won,” just as the dodo bird remarked.¹

Unlike the dodo bird, this remark has lived on for many years. In 1993, a task force of the American Psychological Association’s Society of Clinical Psychology developed guidelines aiming to apply data-based psychology to the identification of effective therapy. As an outgrowth of that task force, the first book by Nathan and Gorman (1998) that aimed at identifying empirically supported treatments (ESTs) was published, leading to an explosion of similar works. EST guidelines and handbooks have since been published for geriatric patients, adults, and children (Barlow, 2001; Christopherson & Mortweet, 2001; Kazdin & Weisz, 2003). The Division of Counseling Psychology of the American Psychological Association (APA) developed its own guidelines and resultant book (Norcross, 2002), as did the “other” APA (American Psychiatric Association). A best-practices manual has recently been released in behavioral medicine and

¹ Recently, Luborsky and other psychodynamically oriented researchers (1975, 1999) have used the term to note that all therapies had equivalent degrees of effectiveness, not that they were ineffective. The advent of empirically based research has made that stance harder to assume.
represents a two-volume tome of 758 pages on neuropsychiatric and other medical disorders (Gordon & Trafton, 2003). Oxford University Press has just released Roberts and Yeager’s (2004) *Evidence-Based Practice Manual: Research and Outcome Measures in Health and Human Services*, aimed at broadening the scope of evidence-based practice (EBP) research and applying it to many fields not typically focused on EBP, including social services and public health. This is a far-reaching and expansive volume, groundbreaking in its field and covering a broad band of service delivery issues in public health and social services. Roberts and Yeager’s book contains over 100 practical chapters, segmented into 11 sections. Nathan and Gorman’s foundational edition has already been updated into its second edition (Nathan & Gorman, 2002). Texts not entirely addressing themselves to an overview of EBPs have used such available guidelines to format their presentations. Recent books, such as Barlow’s third edition of the *Clinical Handbook of Psychological Disorders* (2001) and Kazdin and Weisz’s *Evidence-Based Psychotherapy for Children and Adolescents* (2003), all utilize a critical review of the literature and a presentation of material with a strong mind toward empirically based support. A related text by Lilienfeld, Lynn, and Lohr (2003) entitled *Science and Pseudoscience in Clinical Psychology* is in essence a critical overview of EST and EBP and applies their respective guidelines to many of the myths and sacred cows of psychologists and psychotherapy belief. Rather than focus on EBPs, the book used the EBP guidelines to highlight those many areas and procedures of mental health service delivery that do not measure up to the guidelines.

Many of these texts are named *handbooks* or *manuals*; however, they are actually overviews with concise chapter reviews of various treatments. Barlow’s *Clinical Handbook* is a resource text, even though it represents itself as a step-by-step treatment manual. Each of its many chapters gives an overview of the literature, an explanation of the treatment, and a summary of the treatment process. It is wise to keep in mind that most chapters presented represent a topic covered by textbooks dedicated to that exclusive area. Readers would be remiss if they believed that, by reading a summary chapter alone, they had sufficient knowledge to provide treatment of a specific disorder. While the same is true for the text by Kazdin and Weisz, their more extensive presentations would give readers with specialized backgrounds an increased capacity to utilize the information therapeutically per their respective area of concern. However, many books, even those that have come to press within the last year, are 1–3 years behind the times. By virtue of the lag between writing and publication, even the most recently released book will have citations that are a few years old. Journals and conventions remain the best vehicles to stay on top of the learning curve, although even some journals may have lag times approaching 2 years.

This critical review examines a select few of the aforementioned books, aiming to note their strengths and weaknesses. It looks critically at the issues and controversies surrounding EST and EBP guidelines as well as their usage and impact on therapists. As EBP has become the current terminology, it will be used to refer to EST and EBP research for the balance of this paper.

With the advent of World War II, the scope and breadth of clinical practice for those who were not psychiatrists began to grow exponentially. With this growth of service delivery, there occurred a parallel growth of nonempirically based therapies in and outside of psychiatry. Tavris (2003) used the term *social contagions* in place of what others have termed *hysterical epidemics* or *moral panics* to describe the reasons behind the various therapies that proliferated in the United States and elsewhere.
Cultures that are intolerant of ambiguity and human foibles began to develop quick and unproven strategies to deal with the myriad problems of living. Many ideas became popularly supported and soon formed a part of cultural (or “pop”) psychology. Researchers who tried to counter many of these popularly supported ideas found significant resistance to their research and in some cases approbation and loss of academic position or funding. One example involves Albert Bandura, a world-renowned researcher best known for his social learning theory. Bandura was invited to join a National Institute of Mental Health study section, with one of his assigned duties to review research grants. Before Bandura’s presence on the panel, behavioral investigations were not funded, seemingly due to the fear of symptom substitution and the prevailing psychodynamic belief that it would somehow be “immoral” to subject human beings to procedures that would inevitably harm them! After Bandura joined the panel, Lovaas’s now well-known studies on autism and Bijou and Baer’s studies of the developmentally disabled were able to receive long-overdue federal support and funding (O’Donohue, Henderson, Hayes, Fisher, & Hayes 2001).

Until lately, it took fortitude and perseverance to be a researcher in the field of psychotherapy efficacy. This was true not only because of the public hue and cry but also because of the dodo bird issue—that no treatment provided compelling data toward its efficacy. Despite current consensus that specific treatments are empirically supported to aid specific problems, there remain significant rifts between researchers and practitioners and between practitioners and policymakers. The pendulum has swung in favor of EBPs; however, the prudent practitioner needs to maintain a scientific mind, even toward EBPs. Key questions need to be addressed, including the pragmatic validity of the EBP guidelines; the purpose and use of EBP findings; and the real-world applicability of the findings, including their acceptance and transfer into the therapeutic process. Norcross, as well as Nathan and Gorman in their initial and second edition, was careful to look at the EBP guidelines and delineate their strengths and weaknesses. EBPs follow a medical model of double-blind studies. Nathan and Gorman outlined the now-classic six levels of research study, detailed in their volume and developed by the APA task force. Type 1 studies are the most rigorous and involve randomized prospective clinical trials (RCT) with comparison groups, including a valid placebo, random assignment, and blind assessment. Studies must also define clear exclusion and inclusion requirements; detail diagnostic criteria; be of sufficient size to have statistical power; and have clearly specified and valid statistical processing. Interestingly, within the behavioral tradition, many studies of high research caliber are excluded, as they utilized small-group or single-case studies using ABAB designs. While these studies are scientifically accepted as proving efficacy, they do not meet the criteria for a Type 1 study and cannot be included in EBP research. Ironically, Type 2 studies, which lack some of the aspects of a Type 1 study and are of lesser power than an ABA study, have found their way into the EBP literature, where no Type 1 studies exist.² Interestingly, fewer Type 1 studies exist as patient pathology becomes more profound or as it typically represents the type of pathology found in real-world outpatient practice—that is, one being based on Axis II variables or V-code problems. V-codes are presenting problems which do not reach the level of a DSM-IV disorder.

² I do not think that this is ironic; I think it is in keeping with the revised definition of EBP as the best available evidence. Absent RCTs, even cohort studies can be accepted as “best evidence.”
Most EST research is targeted to a single diagnosis, with dual diagnosis being an exclusionary factor. This may be a reason for the tepid acceptance of EBP data into the treatment office, as few patients come into therapy with singular disorders addressed in the EBP literature. In reality, a large percentage of patients presenting for therapy come with challenges not addressed in the literature. In areas where an HMO is the prime provider and where individuals have access to treatment independent of diagnosis, more than 40% of clients are given V-codes rather than an Axis I diagnosis. In areas where traditional insurance will not pay for V-code disorders, almost every client will be given an Axis I disorder. The validity of diagnosis is a prime contaminant of EBP carryover into treatment. It is clear that in many areas, diagnosis is driven as much by payment method as it is by criteria of the Diagnostic and Statistical Manual of Mental Disorders (fourth edition; DSM–IV). The reader is well advised to remember that general angst and solutions to problems of living are not addressed in the EBP literature, yet this represents a significant percentage of the practitioner’s caseload.

Another area of practitioner concern is addressed by Norcross’s book, which represents the APA counseling division’s answer to Nathan and Gorman. To qualify for a Type 1 study, treatment must be standardized and deliverable at multiple sites by multiple practitioners. This qualification led to the development of manualized treatment, which has become the bane of many practitioners. One problem of manualized treatments is that they exclude what many believe to be the prime ingredient in psychotherapy—the therapeutic relationship. Norcross was given the daunting challenge of developing an evidence-based rebuttal to the EBP data, putting therapist and patient variables back into the context of effective treatment. Norcross saw the use of the “medical model” and the adherence to the drug model with RCTs as flawed and limited as it pertained to psychotherapy, given that it ignores process and interpersonal data. Few therapists would take umbrage with Norcross’s goals. Alas, his volume has its own flaws and only questionably reaches its goals, much to the chagrin of practitioners who earnestly believe in the reality of therapeutic experience and interpersonal processes. Norcross noted that his volume is composed of “practice friendly” research. Research can be neither friend nor foe, and this bias is a fatal flaw in his edited work. The criteria used for inclusion of supported work are also questionable.

To the scientifically bent practitioner, the most important chapter in his book is the appendix, which is not a narrative chapter but is a compilation of the data on which the various rankings of efficacy used for his book were based. Meta-analyses were used to discriminate between effective and promising factors. A 5-point scale was developed, with 1 representing studies with a low relationship to 5 representing studies with a high and significant relationship. Studies with an average rating of 3 were deemed effective; those with ratings below 3 were labeled promising. Norcross’s book, which represents the findings of the Division of Psychotherapy’s task force, has concluded that the therapy relationship makes a “substantial and consistent” contribution to efficacy outcome. This vision of reality has it share of believers; however, a careful scrutiny of the data suggests, at best, moderate support—and when support does not even reach the moderate level, the euphemistic label of promising becomes troublesome. One can only hope that as the challenges of psychotherapy process research are better addressed, clearer support can be shown than that demonstrated in this text. Even with these criticisms, Norcross’s work is important. The limitations are more a statement.
about the difficulties of psychotherapy research than a negative reflection on the editor and the various contributors to the Division of Psychotherapy’s task force. Norcross, who is an internationally recognized authority on behavior change and psychotherapy, has made many valid points. He noted that the EBPs developed within the behavioral tradition are not mutually exclusive of complementary data on interpersonal variables and would therefore be additive, thereby increasing the degree of control over outcome variance.

An anecdote regarding the potency of therapist variables can be found in a recent review of Norcross’s book (Paul, 2003). In the early 1960s when thermal biofeedback was being researched, researchers maintained scrupulous attention to detail and meticulously followed the manualized protocol. Researchers tried to minimize therapist variables by wearing white lab coats, by standing behind the experimental subjects, and by reading the experimental instructions from prepared notes without expression or enthusiasm. No one was able to produce any experimental effect, and it was therefore concluded that thermal biofeedback could not be supported as an effective control modality. One day, due to the unavailability of a principal researcher, an inexperienced lab assistant was called to run the experiment. Not being fully aware of the strictures of the protocol, this young graduate student stood in front of the subjects, had eye contact, and spoke with enthusiasm. While all else had failed to demonstrate any feedback-assisted change, this individual had success! Clearly, nonspecific effects were at work.

Manualized treatments again aim to eliminate these “confounds.” We do not have sufficient evidence to conclude that comprehensive treatment can be delivered by lesser-trained individuals using a manualized approach. It would be a mistaken bureaucratic conclusion to mandate treatment protocols based on the current state of EBP research.3

We must keep in mind that EBP research is in its infancy. It is of dramatic importance that we have been able, by using RCTs, to demonstrate efficacy of procedures for diagnoses and populations in certain contexts. The fact remains, however, that 50–80% of “cured” patents still retain residual symptomatology. Empirically supported treatments at best affect only 50–70% of patients participating in the studies. The 30% left unchanged and the 20–50% left with significant residual symptomatology still require further (and by definition) nonmanualized treatments.

Barlow, in his excellent Clinical Handbook, makes the ongoing case for both the art and the science of psychotherapy. EBPs, however, can focus on only the science. Norcross attempted to focus on the art, and as noted, additional work on that elusive domain needs to be done. Whereas it is important to work within the context of empirically supported clinical standardization, working with individual differences is a theme common to many of the new texts on EBP. Barlow’s Clinical Handbook is unique for a behavioral text in that it uses previously eschewed formats and is organized around DSM–IV diagnoses. Each chapter presents epidemiological data regarding the given pathology and addresses patient and therapist variables as well as treatment settings. Comorbidities with other disorders are also detailed.

Before this work, most behaviorally based books used a behavioral analysis, not a diagnosis-based analysis. Barlow and the many

---

3 Having said that, I believe that no practitioner can ignore the fact that some treatment protocols have developed sufficient power to repeatedly prove their efficacy, even when therapist variables are eliminated. Not using these procedures in cases where they are germane is likewise not therapeutically appropriate.
contributing authors in his volume are able to show that in addition to behavioral assessment, a disease assessment is able to identify distinct treatment plans for many listed pathologies. Adherence to the DSM–IV format and medical model makes this a text valuable for not only psychologists and social workers but also for psychiatrists and those in residency programs. In Barlow’s Handbook, Miklowitz’s chapter on obsessive–compulsive disorder (OCD) leans heavily on the medical model, with medication being a key ingredient in the treatment protocol. Barlow, a staunch behaviorist, includes nonbehavioral treatments, such as Gillies’s chapter on interpersonal psychotherapy, owing to its demonstrated clinical efficacy. Linehan, Cochran, and Kehrer wrote the chapter on dialectical behavior therapy for borderline personality disorder. This chapter is one of the best and clearest presentations of Linehan’s theories. Linehan described her theory as biosocial rather than biological or cognitive, and the contextual base and empirical–heuristic distinctions are well laid out. Equally well done is her description of the dialectic process and its role in understanding patients’ paradoxes and in developing treatment for dialectic polarities. As in Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999) metaphor, parable, myth, analogy, and storytelling are well presented. The section on validating the patient and providing a sense of understanding and acceptance is a gem, important reading for all therapists regardless of orientation or modality.

Kazdin and Weisz’s book Empirically Based Psychotherapies for Children and Adolescents is a recent and excellent example of how research on EBP has influenced current psychotherapy books. This book sets a new standard for rigor, clarity, and level of expertise. A world-class field of contributors forms the panel of invited contributors. Each author presents information regarding how, why, and for whom treatments work. Carrying the flame lit by Norcross, interpersonal therapist and patient variables are addressed. In stating the problem area, each author addresses the saliency of the disorder in clinical terms and from a human perspective. The treatments presented are carefully detailed; each chapter includes directions for further research; and, in cases where manuals can be purchased or obtained, sources for their acquisition are provided.

The first chapter, “Evidence-Based Psychotherapies for Children and Adolescents,” is by the editors, Kazdin and Weisz. They note that psychotherapy can be dated to as early as 350 BCE. The formal delineation of psychotherapy as a distinct area of study dates back about 100 years. Almost all discussions of the development of therapy focus on adults. Freud’s early work on children comprised indirect works developed from his interviews with his patients’ parents or from his work with his own daughter, Anna—who became a major contributor to the literature on child psychotherapy by her direct studying of children and by her adaptation of psychoanalytic concepts in child psychotherapy.

Research on psychotherapy with children has enjoyed a history of about 50 years, as Levitt (1957) had identified only 18 studies focusing on children and adolescents. By his 1963 review, only 22 studies were identified. The results of those studies were not encouraging, as no treatment (i.e., the passage of time) seemed equally effective to any treatment of the time. These data are consistent with other adult findings of the time (Eysenck, 1952) in that about two-thirds of all patients improved, as did two-thirds of those on waiting-list controls. As noted, the 1960s experienced a large number of studies utilizing the experimental analysis of behavior and single-case, multiple-baseline paradigms. Proof of efficacy began to be developed, has grown exponentially, and now includes RCTs and Type 1
studies. Up to the last 100 years, children were simply seen as small adults. This, fortunately, is no longer the case, as researchers writing about child therapy are increasingly sensitive to developmental issues as well as to developmental neuropsychiatric issues to which therapists would best attend.

Within Kazdin and Weisz’s book, certain chapters and authors deserve special comment. Clark, Debar, and Lewinsohn are to be commended for making their treatment manual available via the Internet. They, like others within the behavioral field, now acknowledge the role of biological and developmental factors in the understanding, diagnosis, and management of childhood disorders. Interpersonal psychotherapy (ITP), mentioned in Barlow’s Handbook, also finds its way into Kazdin and Weisz’s book, with a chapter by Mufson and Dorta. They utilize a DSM–IV approach to diagnoses and, more important, provide evidence for how diagnostic realities such as “double depression” become moderators of treatment outcome. As Mufson and Dorta present a style of treatment not known to many, more clarifying examples of therapy dialogue would have been helpful, as would an expansion and greater coverage of the background and framework of their presented theory.

Kazdin and Weisz asked each author to provide a section addressing mediators and moderators of treatment outcome. Weisz, with coauthors Southam-Gerow, Gordis, and Connor-Smith in their chapter on depression, provide wonderfully detailed and comprehensive coverage of the moderating effect of skill deficits. Especially exemplary is their detailing the importance of identifying individual differences and tailoring treatment procedure to fit the behavioral and developmental characteristics of youth.

In Kazdin and Weisz’s book, chapters are separated by recent nosology, basing disorders on internalizing and externalizing disorders. This is in agreement with recent neuropsychological data that identified typologies of excessively inhibited and excessively excitable nervous systems as the polarities of a continuum. Those with excessive cerebral inhibition to stimulation are found more vulnerable to developing externalizing behavioral disorders, such as attention-deficit/hyperactive disorder (ADHD) and acting-out disorders, whereas those who are low in central inhibition (and are therefore reactive to external stimulation) are subject to various anxiety disorders. Anastopolous and Farley provide us with a well-done chapter on ADHD, reflecting current thinking and including not only behavioral but neurobiological data in their discussion of moderators. They give an honest appraisal of the long-term efficacy of behavioral treatment, and they integrate medical management and the efficacy of medication into their discussion.

Christopherson and Mortweet’s book Treatments That Work: Empirically Supported Strategies for Managing Childhood Disorders is a less ambitious book than that by Kazdin and Weisz. Christopherson was a student of Nathan Azrin and was mentored by Gerald Paterson, both formidable names in the field of child psychotherapy. This book, published 2 years before the Kazdin and Weisz text, is not a comprehensive overview of ESTs. It targets the seven behavioral issues that the authors believe are most typically seen in child therapy practice: disruptive behaviors; anxiety; habit disorders and tics; sleep disorders; encopresis and enuresis; pain management; and adherence to medical regimes. This, unlike all the other texts mentioned, is not an edited volume but is one written by the two authors. Like the others, it uses a format, one that defines the problem area using diagnostic symptoms from the DSM–IV and then discusses the prevalence and cause of the disorder and the pharmacological and nonpharmacological strategies for management.
To the credit of the authors, they identify their book as a reference book, a resource and training tool. The book omits chapters on depression and OCD. Because of its limited scope, the authors are able to develop each chapter in depth. That depth, however, is limited owing to the target audience: graduate students and referring physicians as well as practitioners wishing a “quick” overview of efficacious procedures. One of the authors has significant experience in behavioral medicine and has included chapters on working with bowel and bladder problems in children. The chapters addressing these problems are well written and have copious references, rating scales, charts, diagrams, and strategies. Equally positive is the inclusion of chapters on pain management and medical adherence in children. The book reviews in some detail pain assessment and current strategies to assist in dealing with pediatric pain and chronic disease states. In dealing with adherence to medical regimens, the authors present a developmental approach as well as a skill-building approach that utilizes rapport building, assessment, information, and problem solving. An additional plus is the attention paid to developing low-literacy materials. This book is not, however, in the same scope as the other texts mentioned; it is included in part because of its subject and in part because of its including behavioral medicine chapters not often found in other books.

Nathan and Gorman’s second edition highlights the rapidity with which new findings are now being generated. Even though this is a relatively new edition, one must keep in mind that most of its citations are pre-2000, with only a few being from 2000. As noted, even current texts demonstrate a serious lag between findings and publication, and newer data always exist than that presented in the latest volume or edition. Between 1998 and 2002 (the time between editions), approximately 30% of the text was updated. Nathan and Gorman kept the format of the first edition and juxtapose behavioral and medical findings for the disorders presented. As in Barlow’s Handbook, a medical classification following the DSM–IV is utilized, making this a text for medical and nonmedical providers. Nathan and Gorman’s text is an encyclopedic reference volume; it does not represent itself as a handbook. The reader can find an area of interest and be provided with citations and information regarding the state of the art at the time of the chapter’s writing. One is struck with the thoroughness of all the chapters and the care and detail of presentation. Contrary to the volume by Norcross, which puts a summary of the data in an appendix, Nathan and Gorman’s book begins with a summary of the data on treatments that work, identifies the standard of proof utilized, and refers to the chapter and its authors. Unlike Kazdin and Weisz’s work, which provides a rationale for the order and sequence of their chapters, Nathan and Gorman’s book starts with children, then geriatrics, and then various pathologies, without an apparent plan to their presentation. While their format may be random, it is certainly thorough and covers behavioral disorders, various anxiety disorders, psychoses, affective disorders, OCD, dissociative disorders, ADHD, eating and sleep disorders, sexual dysfunction, personality disorders, posttraumatic stress disorders, and conduct disorders (including substance abuse). The author list is a who’s who of the various specialty fields. Pharmacological management is paired with psychotherapeutic interventions in almost half of the covered topics.

Hinshaw, Klein, and Abikoff provide a chapter on nonpharmacological treatments for ADHD. They review the pros and cons regarding comorbid anxiety as a moderator of treatment. While insufficient data exist, it does appear that children with anxiety do respond
more favorably to behavioral management than do children with low anxiety. This makes sense and fits with the current thinking that as anxiety decreases, the severity of ADHD worsens; children with low anxiety tend not to respond to negative consequence, thereby needing reinforcement programming. Carefully looking at the data, we encounter the sobering fact that 20–35% of children are nonresponders. The literature is clear that a combined treatment of medication and behavior therapy produces the most robust gains. Classroom management and direct contingency management produce reliable but situation-specific gains with poor carryover to other circumstances. The involvement of family and community support is a reliable mediator of response increases. The primacy of family input and participation is also documented by Kazdin in his review of psychological treatments for conduct disorder. Greenhill and Ford deal with the pharmacological treatments of childhood ADHD and with anxiety comorbidity, noting that data are mixed. More important, they note that at present there are no neurological, physiological, or psychological predictors of medication success. Success of medication in treatment of ADHD ranges 70–90%. The data clearly support medication with behavioral treatment in ADHD.

Another juxtaposition of behavioral and pharmacological chapters places Franklin and Foa’s cognitive–behavioral treatment (CBT) of OCD with Dougherty, Rauch, and Jenike’s chapter on pharmacological treatment of OCD. The “gold standard” of exposure–response prevention as the key behavioral intervention is well documented. The first-line medical management of OCD with selective serotonin reuptake inhibitors (SSRIs) is detailed. The data at this time are described as “overwhelming” in support of SSRI usage. Whereas CBT and SSRIs each produce identifiable gains, only behavioral and combined protocols lead to sustained gains. Barlow, Raffa, and Cohen note a robust response to exposure presented as in vivo desensitization in the management of panic disorder. Noted is a positive response rate of 86% for in vivo exposure plus CBT.

Another medical–psychological face-off is presented in the chapter by Nemeroff and Schatzberg, dealing with pharmacological treatments for unipolar depression; and in the chapter by Craighead, Hart, Craighead, and Ilardi, on psychosocial treatments for major depressive disorder (MDD). Nemeroff and Schatzberg’s chapter deserves careful reading. They note that, as with ADHD, there are no biological markers that assist in predicting treatment response to any particular antidepressant. Some initial work with the use of positron emission tomography may in time enable an accurate prediction of response to SSRIs. Nemwooff and Schatzberg note that women of childbearing age are routinely excluded from RCTs, as are those with comorbid medical disorders. This excludes over 50% of the population from these studies. These authors looked carefully at the criteria used for positive response, noting than in most studies a 50% decline in Hamilton Depression Rating or related scales is listed as a success. They correctly noted that even though individuals can be listed as positive responders, they may be left with significant residual symptomatology. In CBT treatment of MDD, 50–70% of participants no longer meet DSM–IV criteria for MDD. As with OCD, CBT or CBT plus medication leads to more durable results.

Finney and Moos present an important chapter dealing with psychosocial treatments for alcohol-use disorders. Until recently, no RCTs existed utilizing Alcoholics Anonymous’s 12-step approach. However, the authors present some preliminary data supporting the 12-step program as a valid partner to CBT and motivational enhancement therapy. Through the emergence of individual differences, skill
teaching becomes a positive moderator in patients with severe psychiatric dysfunction; in particular, communication skills training becomes a positive moderator for individuals who have little education, high anxiety, and strong urges to drink.

In summary, we have come a long way, yet we have a long way to go. Researchers can take pride in the gains made over a relatively short period. We cannot, however, lose sight of the unanswered questions; we must be circumspect in our utilization of EBP data. EBP research, by nature of the criteria used to judge effectiveness, can cut itself off from psychotherapy providers due to the format of the research itself—namely, manualized approaches and RCTs. While outcome research has developed some robust procedures and findings, process research lags behind and is in need of intensive design and study. Contrary to the position of Lilienfeld, Lynn, and Lohr, who adopt a somewhat therapeutically nihilistic stance, it appears premature to categorically state that interpersonal variables do not matter. They seem to take us back to the conundrum of the dodo bird, concluding that almost nothing works, so all must be equal. We do currently have specific procedures for specific, potent problems. This is a decided advance in the science of psychotherapy. It is now incumbent on all who deliver treatment to be aware of these techniques and procedures and to use them when appropriate. These EBPs tend to focus on anxiety disorders, including OCD, phobic behaviors, and depression. EBPs do not guide us with much of what patients and clients present in a typical outpatient setting. Interestingly, the public seems to think that psychotherapy is helpful. It is here that interpersonal and therapist variables remain important, if not yet fully documented. Additional work is clearly needed. The recent concern regarding the transfer of information from EBP research into standard clinical practice needs to be addressed by training institutions and the various field guilds and organizations who try to keep their members current and effective. The texts reviewed in this article are meant to bring what is known to the forefront so that the spirit of science and empiricism can flourish and lead to accurate treatments and beneficial impact within mental health and social service areas.

### Summary of Pros and Cons of EBP Research

**Pros**

+ Emphasizes utilization of protocols with proven efficacy
+ Enhances use of scientist–practitioner model
+ Enables the clear explication of treatment methods
+ Emphasizes the reproducibility of results among various treatment sites
+ Encourages research into efficacy and component analysis of critical procedures
+ Enables comparison of diverse treatments
+ Leads therapists to look at supported treatments from alternative schools of therapy

**Cons**

- Even where EBP has shown efficacy, there remains a substantial (approximately 30%) number of individuals who are nonresponders; and of those who do respond, many are still symptomatic.
- Manualized presentation eliminates patient and therapist variables from treatment variance.
- Presentation of EBP data can inadvertently lead to an overzealous presentation of real-world efficacy and potentially to untoward insurance company demands.
for specific procedures despite their not being appropriate.

- Reliance on RCT occasionally leads to one’s ignoring alternative research strategies with documented efficacy.
- The impact of EBPs has limited impact on “problems of living” personality disorders and V-code complaints.

Howard Paul, PhD, ABPP
Clinical Associate Professor, Dept. of Psychiatry
Robert Wood Johnson Medical School,
University of Medicine and Dentistry of New Jersey
Graduate School of Applied and Professional Psychology,
Rutgers University

doi:10.1093/brief-treatment/mhh032

References


