Academic Article

# A World of Dichotomies: Empirically Supported Treatments or the Common Factors?

## Utilising Evidence Based Practice and Practice Based Evidence to mediate this Discourse and Improve Practitioner Outcomes.

*By Daryl Mahon*

**Introduction**

Psychotherapeutic discourse is often filled with provocative nomenclature and split into false dichotomies. The aim of the current paper is to review one such debate regarding those advocating for the utilisation of diagnostic specific Empirically Supported Treatments (EST) and on the other side, proponents of the Common Factors (CF) approach to therapy who offer up a counter argument. This paper investigates current discourses by illuminating these dichotomies based on a critical review of current literature. Furthermore, an integrative framework will be provided as a method to mediate this discourse based on current literature and within the operationalisation of Evidence Based Practice (EBP), as the framework was originally designed to be utilised. By introducing research at the cutting edge of practice, this paper will align evidence based practice and practice based evidence as two sides of the one coin, and within an integrative practitioner developmental framework.

**Empirically Supported Treatments**

The American Psychological Association describes evidence-based practice "as the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences" (APA, 2005). Originally developed within the medical paradigm (Sacket et al, 1996) in order to improve outcomes. Nevertheless, in recent times EBP has come to be understood as a psychosocial intervention that is supported by evidence of utility in the literature. According to Laska, Gurman and Wampold (2014) in a recent survey of clinical psychology graduate students, the majority identified EBP as synonymous with empirically supported treatments; this understanding was also prevalent with practitioners (Pagoto et al., 2007; Wachtel, 2010; Westen, Novotny, & Thompson-Brenner, 2005). This narrative is furthered by EST proponents who postulate specific ingredient

therapies, for specific disorders (e.g Chambless & CritsChristoph, 2006; Baker et al. 2008; Barlow, 2004; Chambless & Hollon, 1998; Siev, Huppert, & Chambless, 2009). Provocative nomenclature is utilised to support the narrative; words such as efficacy, statistically significant, protocols and fidelity to manualised therapies are propagated as the gold standard. The implicit message is that if you are not using these therapies then you are not 'evidence based'. However, meta-analysis comparing manualised versus non-manualised therapies does not support this contention (Truijens et al, 2018; Vinnars et al, 2005; Navarro, & Phillips, 2000). Indeed with these therapeutic gold standards, one would expect the outcomes within the field to have progressed substantially over the decades, yet, research suggests that outcomes have not improved in 58 years (Weisz, et al, 2019).

Within the EST paradigm the person of the therapist is not considered important as an outcome variable, protocols and fidelity to theory and technique are said to mitigate for differences within and between therapist outcomes and effect sizes. This argument is counter to that of Baldwin and Imel (2013) who contend that the individual therapist accounts for approximately 5% - 8% of the variance in outcome; this is in contrast to Wampold (2001) assertion that a mere 1% of outcome variance is attributed to theory and technique . In addition to these concerns, other research suggests that studies from EST's don't always transition into naturalistic settings due to controls utilised to improve internal validity during randomised control trials; indeed, aggregated mean scores at the group level from studies are problematic in the transition to routine practice (Margison et al, 2000).

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**Common Factors**

Common factors refer to effective aspects of therapy that are shared by diverse schools of thought, they are non-specific. Those who purport a common factor approach point to a large body of evidence from randomised controlled trials and meta-analysis showing equivalents in outcomes between bona fide treatments when compared (e.g. Watts et al, 2013; Smith & Glass, 1977; Stiles, Barkham, Mellor-Clark, & Connell, 2008; Stiles, Barkham, Twigg, Mellor-Clark, & Cooper, 2006; Wampold et al, 1997; Project Match 1998).

Moreover, common factor advocates contend that when the specific active ingredients are removed from empirically supported treatments in dismantling studies, the approaches still show outcomes equal to the full component therapy (e.g Cusack et al, 1999; Cahill et al, 1999; Bell, Marcus & Goodlad, 2013; Ahn and Wampold, 2001). Indeed, the latest fad of trauma informed treatments that include add on adjunctive therapies are not as clinically effective as proponents posit (Ulrich & Gergor, 2016).

In response to the proliferation of EST's, common factor proponents put forward an argument that therapeutic outcomes are the result of factors common to all bona fide psychotherapeutic approaches. Indeed, theoretical orientation/ techniques account for a minority percentage of variance in outcomes circa 1% (Laska, Gurman and Wampold, 2014; Wampold, 2001). As Lambert (2013 P.43) contends, "It will not generally matter which kind of psychotherapy is offered as long as it is a bona fide theory-driven intervention". The discourse within the common factor paradigm offers differentiated frameworks to conceptualise this phenomena (see Rosenzweig, 1936; Duncan, Hubble, Miller, 2010; Wampold & Imel, 2001; 2015; Duncan & Moynihan, 1999). Chambless & CritsChristoph, (2006 p.199) refute the common factor proposition on what would seem a rigid adherence to philosophical science based research; "Of all the aspects of psychotherapy that influence outcome, the treatment method is the only aspect in which psychotherapists can be trained, it is the only aspect that can be manipulated in a clinical experiment to test its worth, and, if proven valuable, it is the only aspect that can be disseminated to other psychotherapists". Nonetheless, the debate regarding if therapy works through the activation of specific factors, or through the interdependent variables of common factors remains, as we currently do not have the statistical power or methodologies in research needed to evidence causality (Cuijpers, et al, 2019). However, dismantling studies and equivalent outcomes within the literature provide strong

evidence against the specific ingredient propositions

Duncan (2014) puts forward the following conceptual framework (see figure 1) to understand the common factors and their interactions.

> The percentages are best viewed as a defensible way to understand outcome variance but not as representing any ultimate truths. They are meta-analytic estimates of what each of the factors contributes to change. Because of the overlap among the common factors, the percentages for the separate factors will not add to 100%." (p. 23).

**Practice Based Evidence**

Outcomes are an area to come under increasing scrutiny by academics, managed care providers and commissioning bodies in recent times. Swisher (2010) explains the concept of Practice-Based Evidence as, "the real, messy, complicated world is not controlled. Instead, real world practice is documented and measured, just as it occurs, "warts" and all. It is the process of measurement and tracking that matters, not controlling how practice is delivered". Psychosocial interventions delivered within therapeutic settings are well established within the extant literature as having strong evidence of efficacy and effectiveness (Lambert, 2013; Lambert & Ogles, 2004; Fonagy, Roth, & Higgitt, 2005). Meta-analytic studies conclude that recipients of such interventions greatly benefit when compared to non-treated individuals with aggregated effect sizes ranging from 0.75- 0.85 (Hansen, Lambert, & Forman, 2002; Wampold & Imel, 2015; Lambert, 2013).

Nevertheless, the overall effectiveness of counselling and psychotherapy has not progressed and developed in relation to client outcomes in over four decades, despite the emergence of hundreds of empirically supported treatments (Weisz et al, 2019; Wampold, Mondin, Moody, & Ahn, 1997). This data can be inferred to suggest that there is something other than specific therapy ingredients based on diagnosis-treatment paradigms at play. This is further reinforced with longitudinal research in naturalistic settings suggesting that on the whole, therapists became slightly less effective over time (Goldberg et al, 2016). Moreover, a body of research illustrates that approximately 5-10% of those engaged in counselling and psychotherapy actually deteriorate while in treatment (Hansen & Lambert, 2003; Hansen, Lambert & Foreman, 2002; Lambert & Ogles, 2004; Mohr, 1995). More worryingly, this statistic is higher for young people (Nelson et al, 2013). Lambert (2017) postulates that 30% of patients fail to respond during clinical trials, and as many as 65% of patients in routine care leave treatment without a measured benefit.

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Randomised control trials and meta-analysis within the literature on routine outcome measurements suggests that intentionally eliciting live feedback from clients within sessions can improve therapy outcomes, reduce dropout rates, and identify those at risk for deterioration (Berking, Orth, & Lutz 2006; Harmon et al., 2007; Hawkins, Lambert, Vermeersch, Slade, & Tuttle, 2004). Moreover, research posits that practitioners do not adequately predict the deterioration of clients, those at risk of drop out and null outcomes when they assess clients informally (Ostergard, Randa & Hougaard, 2018). Thus, the utilisation of such processes and procedures will serve to improve

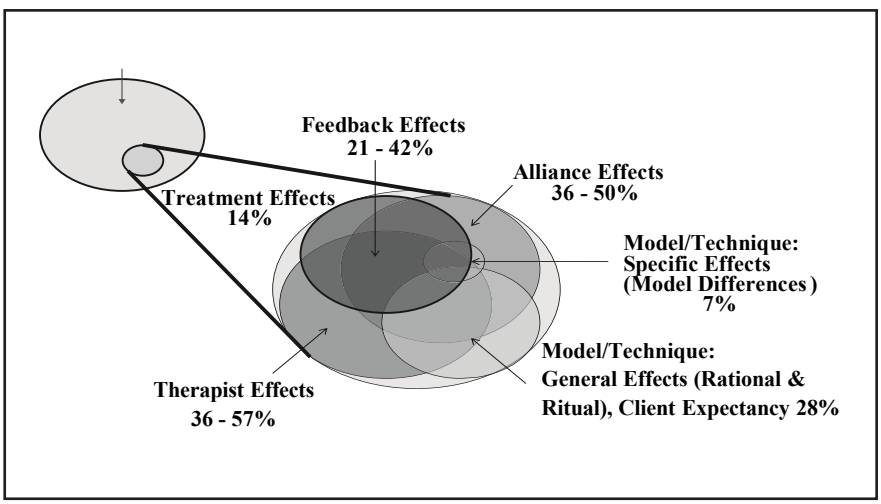


**Figure 1 - Common Factors Conceptual Framework**

outcomes for practitioners. This is further reinforced by several studies that contend that the use of such feedback systems produce outcomes that are 2.5 times better than treatment as usual (e.g Brattland, et al, 2018) and that its use can cut rates of those at risk of deterioration and drop out by 50% (Berking, Orth, amp, Lutz 2006; Harmon et al., 2007; Hawkins, Lambert, Vermeersch, Slade, Tuttle, 2004).

According to Phelps, Eisman, & Kohout, (1998) despite the numerus measurement methodologies at the disposal of therapists few clinicians utilise them, and outcome data collection is rare. Hatfield and Ogles (2004) conducted a national survey of psychologists and found that uptake of such instruments was limited due to perceived barriers such as; time and money, and practicalities of their in session brevity. Interestingly, this links to wider issues of underutilisation of Routine Outcome Monitoring (ROM) data by therapists (Lambert, 2017; Simon et al, 2012; de Jong et al, 2012). Carlier and Van Eeden (2017) suggest that training should be provided to clinicians in administration, interpretation and using feedback to discuss treatment, stagnation, decline and goal setting with clients.

In response to some of these concerns, Miller and Ducan (2000) developed two short 4 question instruments to measure outcomes based on a shortened version of the Outcome Questionnaire 45. The first, the *Outcome Rating Scale* (ORS) captures data on client progress that can be aggregated in order to determine therapists overall effectiveness. *The Session Rating Scale* (SRS) assess the quality of the therapeutic alliance which is a key indicator of the effectiveness of therapy (Wampold, 2014), it is based on a shorter version of the *Working Alliance Inventory.* Both instruments can be administered in different modes (individual, couple and group therapy; with adults, children and adolescents; and across differential clinical presentations. Moreover, each scale has clinical cut off rates depending on the clients' age linked to normative data. Taken together, both these reliable and validated (Duncan et al, 2004; Miller et al, 2004) psychometrically sound outcome measures make up the main components of a pan-theoretical approach, Feedback Informed Treatment (FIT) which has Evidence Based Practice status in the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry.

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**Evidence Based Practice Operationalised**

Thus far, we have examined one of the main discourse debates within psychotherapy. Common factors and empirically supported treatments pitted against one and other, fighting for position as the most prominent method. However, this paper contends that such rivalry is based on a false dichotomy as both aspects are interdependent and necessary for therapeutic change to occur. Therefore, this paper puts forward a framework for practitioner integration based on the full utilisation of the evidence based practitioner framework including practice based evidence and empirically supported treatments.

In order to achieve a fully integrative approach we must turn back to the evidence based practice framework and the common factor model. Evidence-based practice as the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences" (APA, 2005).

So, to operationalise this framework what must our practitioners do? Integrate the best available evidence? The literature provides us with rigours evidence of several factors that work in therapy. However, when it comes to the theoretical orientation aspect of what works the current debate splits opinion. What we can say is the following; the average treated client is better off than approximately 80% of untreated people; research provides strong evidence for bona fide therapies and there utilisation, however, the role of specific ingredients versus common factors as change agents may not be as important as the integration of both into a uniformed model. To this end, practitioners are best placed to choose therapies that best fit their worldview (allegiance effect); that they can explain the rationale for the use with clients; and that offer up a theoretical explanation to the clients presenting issue with a set of corresponding techniques/ rituals. However, interventions must be acceptable to clients' cultural values, and preferences, and make sense to their idea of the presenting issues, onset and possible treatment options. Evidence supports these factors as producing favourable outcomes mediated through the therapeutic alliance, client expectancy, instillation of hope, placebo effect

and practitioner allegiance to the therapy. Providing this within the confines of the clinicians' expertise means that the practitioner uses all their experience and knowledge garnered through education, clinical experience and ongoing research in conjunction with the person they are working with and their worldview.

Finally, practitioners will be best placed by utilising a Routine Outcome Monitoring system to track client progress, identify those at risk of deteriation, and drop out and those responding to interventions. In addition, data from ROM can be utilised for therapists to actively and intentionally improve upon areas needing further development by providing baseline outcome stats. Chow et al. (2015, p. 337) refer to this method of therapist development as Deliberate Practice. "Consistent with the literature on expertise and expert performance, the amount of time spent targeted at improving therapeutic skills was a significant predictor of client outcomes". Moreover, eliciting feedback in this manner not only invites clients to be full participants in the therapy endeavour, it also offers a common ground between the internal validity of research trails of EST's and the evidence based practice of integrating EST's into real world practice to fit individual characteristics, preferences, values and the multitude of complexities humans bring to the therapy endeavour.

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## REFERENCES

Ahn, H., & Wampold, B. E. (2001). Where oh where are the specific ingredients? A meta-analysis of component studies in counseling and psychotherapy. *Journal of Counseling Psychology, 48,* 251–257. doi: 10.1037/0022-0I67.48.3.251

American Psychological Association (2005): Evidence Based Practice, American Psychologist 0003-066X/06/$12.00 Vol. 61, No. 4, 271–285 DOI: 10.1037/0003-066X.61.4.271

Baker, T. B., McFall, R. M., & Shoham, V. (2008). Current status and future prospects of clinical psychology: Toward a scientifically principled approach to mental and behavioral health care. *Psychological Science in the Public Interest, 9*, 67–103. doi:10.1111/j.1539-6053.2009 .01036.x

Baldwin, S. A., & Imel, Z. E. (2013). *Therapist effects: Findings and methods*. In M. J. Lambert (Ed.), Bergin and Garfield's handbook of psychotherapy and behavior change (6th ed., pp. 258 –297). New York: Wile

Barlow, D. H. (2004). Psychological treatments. *American Psychologist, 59*, 869–878. doi:10.1037/0003-066X.59.9.869

Bell, E. C., Marcus, D. K., & Goodlad, J. K. (2013). Are the parts as good as the whole? A meta-analysis of component treatment studies. *Journal of Consulting and Clinical Psychology, 81,* 722–736. doi:10.1037/ a0033004

Berking, Matthias & Orth, Ulrich & Lutz, Wolfgang. (2006). How effective is systematic feedback of treatment progress to the therapist? An empirical study in a cognitive-behavioural-oriented impatient setting. *Zeitschrift für Klinische Psychologie und Psychotherapie, 35*. 21-29. 10.1026/1616-3443.35.1.21.

Brattland, H., Koksvik, J. M., Burkeland, O., Gråwe, R. W., Klöckner, C. ,Linaker, O. M., Ryum, T., Wampold, B., Lara-Cabrera, M. L., Iversen, V. C. (2018). The effects of routine outcome monitoring (ROM) on therapy outcomes in the course of an implementation process: A randomized clinical trial. *Journal of Counselling Psychology, 65*(5), 641-652.

Cahill, Shawn & H Carrigan, Maureen & Frueh, B.Christopher. (1999). Does EMDR Work? And if so, Why?: A Critical Review of Controlled Outcome and Dismantling Research. *Journal of Anxiety Disorders, 13*. 5-33.

Carlier, I. V. E., van Eeden, W. A. (2017). Routine Outcome Monitoring in Mental Health Care and Particularly in Addiction Treatment: Evidence-Based Clinical and Research Recommendations. *J Addict Res Ther 8*. 332. doi:10.4172/2155-6105.1000332

Chow, D. L., Miller, S. D., Seidel, J. A., Kane, R. T., Thornton, J. A., Andrews, W. P. (2015). The role of deliberate practice in the development of highly effective psychotherapists. *Psychotherapy, 52*(3). 337-45. doi: 10.1037/pst0000015

Chambless, D. L., & Crits-Christoph, P. (2006). The treatment method. In J. C. Norcorss, L. E. Beutler, & R. F. Levant (Eds.), *Evidence– based practices in mental health* (pp. 191–200). Washington, DC: American Psychologicsl Association.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66*, 7–18.

Chambless, D. L., Sanderson, W. C., Shoham, V., Johnson, S. B., Pope, K. S., Crits-Christoph, P.,... McCurry, S. (1996). An update on empirically validated therapies. *The Clinical Psychologist, 49*, 5–18

Cuijpers P, Reijnders M, Huibers, JH (2019) The role of the common factors in psychotherapy outcomes *Annual Review of Clinical Psychology,* 15(1). 207-231

Cusack, K. & Spates, C. R. (1999). The Cognitive Dismantling of Eye Movement Desensitization and Reprocessing (EMDR) Treatment of Posttraumatic Stress Disorder (PTSD). *Journal of anxiety disorders. 13*. 87-99. 10.1016/S0887-6185(98)00041-3.

De Jong, K., van Sluis, P., Nugter, M. A., Heiser, W. J., & Spinhoven, P. (2012). Understanding the differential impact of outcome monitoring: Therapist variables that moderate feedback effects in a randomized clinical trial. *Psychotherapy research, 22*(4), 464–474. doi: 10.1080/10503307.2012.673023

De Jong, K. (2016). Challenges in the Implementation of Measurement Feedback Systems. *Administration and Policy in Mental Health and Mental Health Services Research, 43*(3). 467-470.

Duncan, B. (2014 ). On Becoming a Better Therapist: Evidence-Based Practice One Client at a Time (2nd Ed.). USA: American Psychological Association.

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (2010). The heart and soul of change: Delivering what works in therapy (2nd ed.). Washington, DC: American Psychological Association

Duncan, B. L., Miller, S. D., & Sparks, J. (2004). The Heroic Client: A Revolutionary Way to Improve Effectiveness through Client-Directed, Outcome-Informed Therapy (2nd Edition). San Francisco: Jossey-Bass.

Duncan, B. & Moynihan, D. W. (1994). Applying outcome research: Intentional utilization of the client's frame of reference. *Psychotherapy: Theory, Research, Practice, Training, 31*. 294-301. 10.1037/h0090215.

Duncan, B. L., Hubble, M. A., Miller, S. D. (Eds) (2010). *The heart & soul of change: delivering what works in therapy* (2nd ed.). Washington, DC: American Psychological Association

Hawkins, E. J., Lambert, M. J., Vermeersch, D. A., Slade, K. A. & Tuttle, K. C. (2004). The therapeutic effects of providing patient progress information to therapists and patients. *Psychotherapy Research, 14*(3), 308-327, DOI: 10.1093/ptr/kph027

Fonagy P., Roth, A., Higgitt, A. (2005). Psychodynamic psychotherapies: evidence-based practice and clinical wisdom. *Bulletin of the Menninger Clinic, 69*(1):1-58.

Goldberg, S. B., Rousmaniere, T., Miller, S. D., Whipple, J., Nielsen, S. L., Hoyt, W. T., & Wampold, B. E. (2016). Do psychotherapists improve with time and experience? A longitudinal analysis of outcomes in a clinical setting. *Journal of Counseling Psychology, 63*(1), 1-11.http://dx.doi.org/10.1037/cou0000131

Hansen, N. B., Lambert, M. J., & Forman, E. M. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice, 9*(3), 329-343.

Hansen, N.B. & Lambert, M.J (2003) An Evaluation of the Dose–Response Relationship in Naturalistic Treatment Settings Using Survival Analysis. *Ment Health Serv Res* 5(1) https://doi.org/10.1023/A:1021751307358

Harmon, S. C., Lambert, M. J., Smart, D. M., Hawkins, E., Nielsen, S. L., Slade, K., Lutz, W. (2007). Enhancing outcome for potential treatment failures: Therapist-client feedback and clinical support tools. *Psychotherapy Research, 17*(4). 379–392. doi: 10.1080/10503300600702331.

Hatfield, D. R., & Ogles, B. M. (2004). The Use of Outcome Measures by Psychologists in Clinical Practice. *Professional Psychology: Research and Practice, 35*(5), 485-491

Hawkins, E., Lambert, M., Vermeersch, D., Slade, K., Tuttle, K. (2014). The therapeutic effects of providing patient progress information to therapists and patients. *Psychotherapy Research 14*.

Imel, Z. E., & Wampold, B. E. (2008). The common factors of psychotherapy. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counselling psychology* (4th ed.). New York: Wiley.

Ioana A. Cristea, Eirini Karyotaki, Mirjam Reijnders & Steven D. Hollon (2019) Component studies of psychological treatments of adult depression: A systematic review and meta-analysis. *Psychotherapy Research, 29*(1), 15-29. DOI: 10.1080/10503307.2017.1395922

Lambert, M. (2017). Maximizing Psychotherapy Outcome beyond Evidence-Based Medicine. *Psychother Psychosom, 86*(2), 80-89. doi: 10.1159/000455170

Lambert, M. J. (2013a). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), Bergin and Garfield's handbook of psychotherapy and behavior change (6th Ed.). New York: Wiley

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th Ed). New York: Wiley

Laska, K. M., Gurman, A. S., & Wampold, B. E. (2014). Expanding the lens of evidence-based practice in psychotherapy: A common factors perspective. *Psychotherapy, 51*(4), 467-481.

Margison, F, Barkham, M, Evans, Chris McGrath, Graeme & Mellor-Clark, John & Audin, Kerry & Connell, Janice. (2000). Measurement and Psychotherapy: Evidence-based Practice and Practice-based Evidence. *British Journal of Psychiatry, 177*. 123-130. 10.1192/bjp.177.2.123.

Macran, S. and Shapiro, D. A. (1998), The Role of Personal Therapy for Therapists: A Review. *British Journal of Medical Psychology*, 71, 13-25. doi:10.1111/j.2044-8341.1998.tb01364.x

Miller, S., Duncan, B. & Brown, J. (2003). The Outcome Rating Scale: A Preliminary Study of the Reliability, Validity, and Feasibility of a Brief Visual Analog Measure. *Journal of Brief Therapy*, 2. 91-100.

Mohr, D. C. (1995), Negative Outcome in Psychotherapy: A Critical Review. *Clinical Psychology: Science and Practice*, 2 1-27. doi:10.1111/j.1468-2850.1995.tb00022.x

Nelson, P. L., Warren, J. S., Gleave, R. L., & Burlingame, G. M. (2013). Youth psychotherapy change trajectories and early warning system accuracy in a managed care setting. *Journal of Clinical Psychology*, 69(9), 880–895.

Norcross, J. C., & Lambert, M. J. (2011). Psychotherapy relationships that work II. *Psychotherapy*, 48, 4 – 8. doi:10.1037/a0022180

Norcross, J. C., Beutler, L. E., & Levant, R. F. (Eds.). (2005). Evidence-Based Practices in Mental Health: Debate and Dialogue on the Fundamental Questions. Washington, DC: American Psychological Association

Østergård, O. K., Randa, H. and Hougaard, E. (2018). The effect of using the Partners for Change Outcome Management System as feedback tool in psychotherapy-A systematic review and meta-analysis. *Psychotherapy Research*, OI: 10.1080/10503307.2018.1517949

Pagoto, S. L., Spring, B., Coups, E. J., Mulvaney, S., Coutu, M. F., & Ozakinci, G. (2007). Barriers and facilitators of evidence-based practice perceived by behavioral science health professionals. *Journal of Clinical Psychology, 63,* 695–705.

Phelps, R., Eisman, E. J., & Kohout, J. (1998). Psychological practice and managed care: Results of the CAPP practitioner survey. *Professional Psychology: Research and Practice, 29*(1), 31-36.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry.* 6(3). 412–415.

Sackett, D. L., Rosenberg, W. M. C., Gray, Muir Gray, J. A., Haynes, R. B. & Richardson, W. S. Evidence based medicine: what it is and what it isn't. *British Medical Journal 312* :71.

Siev, J., Huppert, J. D., & Chambless, D. L. (2009). The dodo bird, treatment technique, and disseminating empirically supported treatments. *The Behavior Therapist, 32*, 69 –76.

Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist, 32*(9), 752-760.

Stiles, W. B., Barkham, M., Mellor-Clark, J., & Connell, J. (2008). Effectiveness of cognitive-behavioural, person-centred, and psychodynamic therapies in UK primary-care routine practice: Replication in a larger sample. *Psychological Medicine, 38,* 677–688. doi:10.1017/ S0033291707001511

Stiles, W. B., Barkham, M., Twigg, E., Mellor-Clark, J., & Cooper, M. (2006). Effectiveness of cognitive-behavioural, person-centred and psychodynamic therapies as practised in UK National Health Service settings. *Psychological Medicine, 36,* 555–566. doi:10.1017/S0033291706007136

Swisher AK. Practice-based evidence. *Cardiopulm Phys Ther J, 21*(2): 4.

Truijens, F., Zühlke-van Hulzen, L., Vanheule. S. (2018) To manualize, or not to manualize: Is that still the question? A systematic review of empirical evidence for manual superiority in psychological treatment. *J Clin Psychol, 75*(3):329-343. doi: 10.1002/jclp.22712. Epub 2018 Oct 28.

Vinnars, B., Barber, J. P., Norén, K., Gallop, R., Weinryb, R. M. (2005). Manualized supportive-expressive psychotherapy versus nonmanualized community-delivered psychodynamic therapy for patients with personality disorders: bridging efficacy and effectiveness. *J Psychiatry 162* (10), 1933-1940.

Wachtel, P. (2010). Beyond "ESTs": Problematic assumptions in the persuit of evidence based practice. *Psychoanalytic Psychology, 27,* 251–272. doi:10.1037/a0020532

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Erlbaum

Wampold, B. E., & Brown, G. S. (2005). Estimating therapist variability: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology, 73*, 914 –923. doi:10.1037/0022-006X.73.5 .914

Wampold, B. E., & Serlin, R. C. (2014). Meta-analytic methods to test relative efficacy. Quality & Quantity. *International Journal of Methodology, 48*, 755–765. doi:10.1007/s11135-012–9800-6.

Wampold, B. E., Imel, Z. E., Laska, K. M., Benish, S., Miller, S. D., Flückiger, C., ... Budge, S. (2010). Determining what works in the treatment of PTSD. *Clinical Psychology Review, 30*, 923–933. doi: 10.1016/j.cpr.2010.06.005

Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "All must have prizes". *Psychological Bulletin, 122*, 203–215

Wampold, B. E. & Imel, Z. E. (2015). *The great psychotherapy debate: the evidence for what makes psychotherapy work (2nd Ed.)*. New York: Routledge

Watts, B.V., Schnurr, P. P., Mayo, L., Young-Xu, Y., Weeks, W. B. & Friedman, M. J. (2013). Meta-analysis of the efficacy of treatments for posttraumatic stress disorder. *J Clin Psychiatry, 74*(6), 541-50. doi: 10.4088/JCP.12r08225

Weisz, J. R., Kuppens, S., Ng, M. Y., Vaughn-Coaxum, R. A., Ugueto, A. M., Eckshtain, D., Corteselli, K. A. (2019). Are Psychotherapies for Young People Growing Stronger? Tracking Trends Over Time for Youth Anxiety, Depression, Attention-Deficit/Hyperactivity Disorder, and Conduct Problems. *Perspect Psychol Sci, 14*(2) 216-237.

Westen, D., Novotny, C. M., & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin, 130,* 631–663. doi:10.1037/0033-2909.130.4.631