

CHAPTER 3

Evidence-Based Practice in Psychology

What Psychotherapists Can Learn From Research on Treatment and Psychotherapist Responsiveness

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Abstract

Our purpose is to aid psychotherapists in making the best psychotherapeutic choices they can to help their clients and patients become healthier. We conclude that the psychotherapist can (a) build psychotherapeutic skills, (b) enhance relationship skills, (c) diagnose accurately, (d) conceptualize accurately, (e) build a repertoire of abilities to use many evidence-based treatments and know also when they are best applied, (f) develop more competence to discern which treatment should be used for particular clients with a particular diagnoses, and (g) hone skills to match treatments to clients to maximize their strengths, relationship qualities, and willingness to engage in the therapeutic process. In discussing these areas, we examine the history of developing evidence-based practices and speculate about the future, given the large changes that will occur with the Patient Protection and Affordable Care Act.

Key words

common factors, dissemination, effectiveness, efficacy, evidence-based practice, psychotherapy, randomized clinical trials, relationship

Introduction

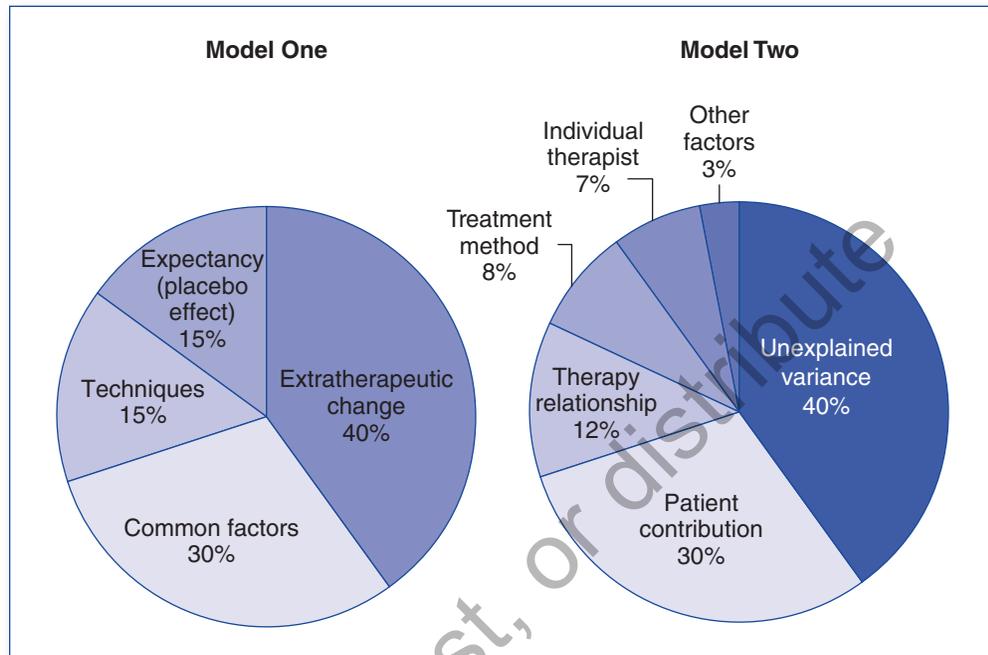
Counselors and psychotherapists need to have current information on clinical research to make the best choices they can when providing psychotherapy and to enhance the effectiveness of their practice. Thus, we provide a state-of-the-art summary of the issues associated with evidence-based practice in psychotherapy.

One of the enduring questions asked by psychotherapists is what causes clients to change? Psychotherapy researchers have attempted to answer this question in part by examining the efficacy and effectiveness of different forms of psychotherapy. In these cases, the main target of investigation was the specific psychotherapeutic technique used. This led to an emphasis on specific interventions that should be used for specific disorders (e.g., cognitive behavioral psychotherapy for depression). These treatments were originally referred to as empirically validated treatments or empirically supported treatments. However, as the field developed, researchers began to explore additional sources of client change, such as the therapeutic relationship, factors common across different interventions, and other factors. We present a detailed summary of these developments in this chapter.

Sources of Client Change

Norcross and Lambert (2011) identified two models that summarize proposed causal agents of improvement in clients in therapy (see Figure 3.1). These models summarized the categories of factors that either address the explained variance or the total variance in measures of client improvement. Model One summarized four areas of *explained* variance: client extratherapeutic change (40%), client expectancy (15%), common factors in psychotherapy (30%), and psychotherapeutic techniques or methods (15%).

Extratherapeutic change might be instigated by friendship counseling, reading, spiritual activities, or other events happening in normal life outside of psychotherapy. Client expectancy involves the placebo effect and other changes that occur as a result of hope or the sense that one is receiving treatment. Common factors in psychotherapy involve two dimensions (thinking and feeling) and three clusters (bond, information, and role), according to an empirical model by Tracey, Lichtenberg, Goodyear, Claiborn, and Wampold (2003). In Model Two, Norcross and Lambert considered that the pie could be sliced in different ways. They reported six areas of total variance, including unexplained variance (40%), as well as explained variance divided differently than in Model One: patient contribution (30%), individual psychotherapist (7%), psychotherapy relationship (12%), treatment method (8%), and other factors (3%).

FIGURE 3.1 Factors Accounting for Variance in Client Improvement

SOURCE: Norcross, J. C., & Lambert, M. J. (2011). Evidence-based therapy relationships. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (pp. 3–21). New York: Oxford University Press.



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Specific treatment techniques or methods do not account for a substantial portion of the variance in client improvement in either model. That finding echoed earlier reviewers. Henry (1998, p. 128) said, “As a general trend across studies, the largest chunk of outcome variance not attributable to preexisting patient characteristics involves individual therapist differences and the emergent therapeutic relationships between patient and therapist, regardless of technique of school of therapy.”

Despite the significant impact of these findings, the idea that treatment effects do not account for much variance in client change has its critics. Many of the identified sources of variance are things that psychotherapists can do nothing about. For example, by and large, psychotherapists cannot affect client extratherapeutic change and might not be able to contribute substantially to client expectancy. Even common factors are not completely under the psychotherapist’s control. Psychotherapists cannot affect much of the unexplained variance or patient contributions, and they cannot fully control their own personal contributions. However, they can influence fairly directly the choice and implementation of psychotherapeutic techniques, treatment method, and part of the psychotherapeutic relationship.

Thus, in a review that emphasizes *psychotherapist-controllable variables*, the variables of focus would be (a) choice of treatment methods and techniques and how those are carried out in the course of psychotherapy, (b) relationship factors that are under the psychotherapist's control, (c) common factors that are partially affected by the therapist, and (d) individual therapist variables (e.g., attitudes, beliefs, moods, expectancies). These factors can be summed up by evidence-based practices and evidence-based responsiveness of the psychotherapists. These are the categories that we scrutinize below.

Evidence for the effectiveness of psychotherapy is needed for competent treatment decision-making for practitioners. It is also needed for competent decisions by people considering whether to seek psychotherapy and when, how, and with whom they should seek treatment. In fact, evidence informs clients (as well as psychotherapists and researchers) about what to look for in treatment. According to the American Psychological Association (2006), "Evidence-based practice in psychology . . . is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273). Thus, conducting practice that is informed by evidence depends on collecting evidence on (a) the client's characteristics, diagnosis, preferences, and culture, (b) patient-acceptable treatment and its efficacy and effectiveness, (c) the match of treatment to client, (d) the psychotherapist's characteristics, experience and expertise, preferences, values, and beliefs, and (e) the relationship between client and psychotherapist, which is inevitably informed by all of the prior factors.

In this chapter, we are interested in the practical actions that the psychotherapist can take to improve the likelihood that the psychotherapeutic experience will be successful for clients. Among these, we conclude that the psychotherapist can (a) build psychotherapeutic skills, (b) enhance relationship skills, (c) diagnose accurately, (d) conceptualize accurately, (e) build a repertoire of abilities to effectively use many evidence-based treatments and know also when they are best applied, (f) develop more competence to discern which treatment should be used for a particular client with a particular diagnosis or set of multiple diagnoses, and (g) hone skills to match treatments to clients to maximize patient strengths, relationship qualities, and client willingness to engage in the therapeutic process. In short, the competencies needed for effective psychotherapy are extremely complex, and they most definitely cannot be reduced to mechanically applying—regardless of how competently—evidence-based treatments for a particular diagnosis or mechanically employing evidence-based responsiveness to clients.

In this chapter, we briefly summarize the evidence relating to the seven practical actions listed above. There are so many therapeutic efficacy studies that a thorough and systematic review is not possible in each of the areas. As an example of the extensive literature base, Hofmann, Asnaani, Vonk, Sawyer, and Feng (2012) recently reviewed the meta-analyses available on the efficacy of cognitive behavioral therapy (CBT). Meta-analysis compares the results from different studies, and each meta-analysis evaluates multiple individual studies. Hofmann et al. published their review in October 2012, which means they likely completed it by the end of 2011. By that time, they had located 269 meta-analyses of CBT. That is *meta-analyses*, not studies! They reviewed a representative sample of 106 of those meta-analyses for adults in the areas of substance abuse disorder, somatoform disorders, eating disorders, insomnia, personality disorders, anger and aggression, dysthymia, bipolar disorder, anxiety disorders, criminal behavior, general stress, distress due to general medical conditions, chronic pain and fatigue, and distress

related to pregnancy complications and female hormonal conditions. They found the strongest support for the efficacy of CBT in the areas of anxiety disorders, somatoform disorders, bulimia, anger control problems, and general stress. Of course, the reviewers found many deficits in the literature—such as few studies that specifically targeted ethnic minorities and low-income samples. From that example, we see that the goal of the present chapter cannot possibly be a systematic review of research on evidence-based practice in psychology, which would include the evidence basis for specific treatments for particular disorders for particular types of clients. We hope, however, that our brief summary and organizing model provide a foundation for evaluating the evidence presented throughout this book as different approaches to psychotherapy and different psychotherapist and client responsiveness factors are discussed.

An Evolution of Evidence-Based Practice

Early Years

Authoritative summaries have detailed the evolution of the emphasis on evidence-based practice in psychology (e.g., Norcross, Vandenbos, & Freedheim, 2011). We want to hit just the high points. Hans Eysenck (1952) probably triggered the onset of the debate on the efficacy of therapy through his highly political and arguably flawed review of psychoanalysis versus eclectic psychotherapy versus (ostensibly) no treatment. Eysenck, wanting to justify the rise of behavior therapy, compared to psychodynamically oriented psychotherapies, noted that

Patients treated by means of psychoanalysis improve to the extent of 44 per cent; patients treated eclectically improve to the extent of 64 per cent; patients treated only custodially or by general practitioners improve to the extent of 72 per cent. There thus appears to be an inverse correlation between recovery and psychotherapy; the more psychotherapy, the smaller the recovery rate. (p. 322)

With that salvo, research on psychotherapy outcomes accelerated with a vengeance. By 1967, efficacy research had moved beyond simple questions of “does it work?” Gordon Paul (1967) concluded a conceptual article with the enduring question: “*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under which circumstances?” (p. 111). One of the turning points in psychotherapy research was the application of the meta-analysis statistical procedure to psychotherapy outcome studies (Smith & Glass, 1977). That provided a way to make numerical comparisons across different treatments and different outcome measures and determine whether various moderating variables (e.g., mode of treatment, number of sessions) affected outcomes. Those statistical findings provided a good way to supply evidence for psychotherapy in the managed mental health care push of the 1980s.

The next big turning point came with the establishment of the Division of Clinical Psychology’s (APA Division 12’s) Task Force on Promotion and Dissemination of Psychological Procedures (1995). The Task Force (which has now become the Committee on Science and Practice) was established to inform consumers, managed care and

insurance companies, and psychotherapists about which treatments were the strongest at dealing with which diagnostic disorders. Although the level of sophistication was still far short of Paul's specific question, the movement was clearly in a responsible, self-policing direction. The result of that task force was the publication of a controversial compendium of treatments that had research evidence to meet different criteria for levels of empirical support (Chambless & Hollon, 1998; Chambless et al., 1996). For example, to be named an empirically supported treatment, a treatment had to be better than a control group or at least as good as a different empirically supported treatment in two independent manual-driven randomized clinical trials (RCTs). Over the years, huge numbers of treatments have been added to the rolls of the empirically supported treatments. The roll is so large that one must search specifically by topic to find treatments that are empirically supported (e.g., Association for Behavioral and Cognitive Therapies, n.d.; Australian Psychological Association, 2010; Society of Clinical Child and Adolescent Psychology, n.d.). In addition, Rozensky (2011) has argued that one implication of the passage and rolling out of the Patient Protection and Affordable Care Act (ACA, Public Law No. 111-148, March 23, 2010) is that psychotherapists are virtually going to be required to use evidence-based practices for accountability to clients and other health care professionals.

Recent Years

According to Lambert (2011), the upshot of the outpouring of research on efficacious treatments is that differences in comparative outcomes of different treatments have been less stark than was originally expected. Early studies (e.g., Smith & Glass, 1977) reached the same conclusion, and it is still true today, despite the creation of multiple new approaches and excellent process research (Wampold, 2001). Lambert (2011) identified three explanations for the failure to find sharp differences in treatments. First, different psychotherapies can achieve the same outcomes through different processes. Second, different outcomes are simply not detectable by current research. Third, common factors within all psychotherapies are responsible for the change—not the specific treatments associated with distinct therapeutic models.

Others who are more likely to be identified as champions of evidence-based treatments (e.g., DeRubeis, Brotman, & Gibbons, 2005; Foa, Gillihan, & Bryant, 2013; Siev & Chambless, 2007) have suggested that the failure to find treatment differences in some cases is the result of flawed methodology of the meta-analyses and studies on which the “dodo bird verdict”—that “Everybody has won and all must have prizes” (Luborsky et al., 2002; Rosenzweig, 1936)—is based. For example, Benish, Imel, and Wampold (2008) conducted a meta-analysis of bona fide psychotherapy treatments for posttraumatic stress disorder (PTSD). Bona fide treatments were those that were based on psychological principles, were manualized, and contained identified active ingredients. Testing bona fide treatments is in contrast to testing treatments against waitlist or other non-treatment controls. Thus, many RCTs included in the meta-analysis compared two effective treatments for PTSD. Benish et al. (2008) concluded that the ingredients specific to a particular treatment might not be as important in the treatment of PTSD as are the factors common to all treatments. Foa et al. (2013) challenged this reasoning, arguing that the logical error here is akin to saying that both push-ups and weight-lifting effectively

build strength, but since there is no difference in the effect, that must mean that those exercises are not the active ingredients but that it is actually the relationship with the personal trainer that is the source of change.

Second, Bryant et al. (2008) found that there were differences between effective treatments for PTSD. They found that a full prolonged exposure treatment for PTSD (in vivo and imaginal exposure plus cognitive restructuring) was superior to in vivo exposure alone, imaginal exposure alone, and in vivo plus imaginal exposure (but without cognitive restructuring). Finding that one can remove cognitive restructuring from the psychological treatment cocktail and lose effectiveness suggests that there is some specific effect for treatment.

Third, Ehlers et al. (2010) noted that some comparisons in Benish et al. (2008) were between treatments that had not been shown to be better than no treatment at all, namely, trauma desensitization, psychodynamic psychotherapy, and hypnotherapy. Comparing three ineffective treatments and finding no difference does not mean that there are no differences among treatments (or that whenever treatment differences occur, they are due to common factors). Foa et al. (2013) argued that this might be akin to comparing push-ups and weight training for increasing aerobic endurance. Likely there would be no differences because push-ups and weight training are not intended to increase aerobic endurance, yet the individual treatments—like desensitization, psychodynamic psychotherapy, and hypnotherapy—are effective for other outcomes than the ones for which they were tested.

Current Thoughts About Integrating Common Factors and Specific Treatments

Despite these logical arguments against common factors, research has shown that common factors are present in psychotherapy, and numerous meta-analyses support the efficacy of many common factors (see Norcross, 2011). Norcross (2011), Wampold (2011), and Wampold and Budge (2012) have sought to value both evidence-based aspects of psychotherapy: the common factors and the specific treatments emphases. Wampold and Budge (2012) proposed a model that drew generally on the idea that people were predisposed to benefit from psychotherapy-like helping relationships. They suggested that psychotherapist, patient, and relationship variables come together to form a more or less trusting context and that changed outcomes were due to (a) the initial therapeutic bond (e.g., top-down and bottom-up processes that create a trusting bond), which provided the context for (b) the real relationship between client and psychotherapist, (c) the creation of expectations, and (d) client participation in healthy actions. Wampold and Budge thus acknowledged that both treatment and responsiveness interact to produce gains in psychotherapy. However, their allegiance is clearly more weighted toward the relationship and responsiveness than toward treatments.

Even advocates of specific treatments acknowledge that for many diagnoses and for many patients there are no specific evidence-based treatments. For example, Stirman, DeRubeis, Crits-Christoph, and Brody (2003) reviewed clinical charts from a large managed behavioral health care company. They found that 58% of the patients in the clinical sample had primary diagnoses that had not been investigated using RCTs and, hence, for which there was no identified evidence-based treatment.

In addition, advocates of evidence-based treatments emphasize the importance of good relationships with clients; forming, maintaining, and repairing when necessary a good working alliance; ways to manage resistance; and even flexibility. Many treatment manuals are not organized using a step-by-step approach, but they emphasize particular assessments, conceptualizations, and specific interventions that are not intended to be delivered in lock-step, invariant order. Creators of manualized evidence-based treatments are first clinicians, and their treatments typically reflect years of clinical experience and incorporate large amounts of feedback from clinicians who have used the interventions. There is a keen recognition that treatments depend intimately on the client, the therapist, and their relationship, and on how the therapist can flexibly apply the treatment to account for client characteristics and client reactions throughout the ebb and flow of psychotherapy.

Lambert (2011) examined changes in psychotherapy from a historical perspective, and he too acknowledged that both treatments and responsiveness are responsible for client change. After all, virtually no clinician enters psychotherapy with a client thinking that merely establishing a good relationship will dislodge intractable personal and interpersonal problems. The therapist must have something to talk about in the hour and something that the client can carry away into the other 167 hours of his or her week. This both-and perspective is characteristic of most recent work, though there are still polemics on both sides. To this end, we present an organizing model of both treatment and client responsiveness to treatment.

A Model of Treatment and Responsiveness to Treatment

To understand what makes psychotherapy effective, we must consider four elements that describe the interaction between treatment and client responsiveness to treatment. These four elements are listed briefly here and described in detail throughout the rest of the chapter.

First, the cultural and relational context (a) contains many of the common factors, (b) shapes both the client and psychotherapist (and the personal relationships of the client) in how they will form, maintain, and repair (if needed) their relationship, and (c) determines how people respond to each other.

Second, within that context but extending beyond it, is the treatment (techniques and interventions) chosen by the therapist and accepted (or not) by the client. The relationship alone is not enough to change the client in most cases. Rather, there must be something specific to offer to the client, something that has plausibility and must zero in on some mechanism that will provide the client things to do, ways to feel, and ways to think and understand the problem and solution—all of which are different from when the client entered psychotherapy. The techniques, however, cannot produce change without being delivered in a cultural and relational context that makes sense to the client, provides an air of acceptability to the methods (e.g., a designation of an “evidence-based practice” implies there is support for the treatment), defines the therapeutic relationship, and prescribes how the client and psychotherapist will interact around the techniques

and within the remainder of their relationships (including greeting, billing, personal sharing, and the like).

Third, the client must accept the offered techniques and respond to the psychotherapist's offered intervention—either within the psychotherapy session or via psychotherapist-suggested or client-initiated actions outside of psychotherapy. The specific modifications that the client makes might include building and trying out a new balance of coping skills, new relationship skills, different thought patterns, modifications in interpersonal relationships, virtuous or moral behavior during times when one's virtue or morality is tested, or changes in behaviors one is trying to increase or self-regulation of behaviors one is trying to decrease. In addition, the client must be actively engaged both in making meaning of things that happen in psychotherapy, but particularly in things that happen outside of psychotherapy, and in making active and deliberate changes in his or her physical and interpersonal environments. (Box 3.1 provides an exercise for readers to apply their learning by identifying some things a therapist might do to help clients or patients change.)

BOX 3.1

What Can a Psychotherapist Do?

Clients or patients make specific modifications in their lives during psychotherapy. We have listed seven. Give one action you could take as a psychotherapist to better engage a client or patient to promote each change. We have given one example for each. Come up with your own.

Client Actions to Promote Change	An Example	Your Example
A new balance of coping skills	Have client survey the coping skills being used and answer, "How's that working for you?"	
New relationship skills	Use the relationship in the room to practice new ways of relating during a conflict.	
Different thought patterns	Use apps on smartphones to text thoughts to a database that collects thought samples in certain situations in which different emotions are experienced.	
Modifications in interpersonal relationships	Use an interpersonal therapy approach shown to be effective for a particular problem, such as the Cognitive Behavioral Analysis System of Psychotherapy (CBASP; McCullough, 2006).	

Virtuous or moral behavior during times when one's virtue or morality is tested	In an area of client struggle, have the client identify a goal, develop ways to practice the behavior, and create tests that place the virtue under strain.	
Practice changes in behaviors one is trying to increase or self-regulation of behaviors one is trying to decrease	Assign homework to find and read a self-help book to change a desired self-regulatory behavior.	
Active engagement in meaning-making regarding life events	Explore different potential meanings an event could have and the implications of each.	

Fourth, as the client responds to the context, the psychotherapy relationship, and the treatment, the client engages his or her social world differently. The client's new behaviors might violate expectations or disrupt patterned beliefs and behaviors that have long existed. This requires considerable flexibility on the part of the client to sense the changes, discern the possible responses to the changes, make optimal responses to the ongoing set of social changes put into motion, and make sense out of what is happening in the changing personal-social world. Part of making sense of the changes and planning additional modifications, or additional skill-building, is processing life happenings with one's psychotherapist. That yields a feedback loop. We now examine each of the four elements in detail.

Cultural and Relational Context

Bergin and Lambert (1978) reviewed the literature on psychotherapy and concluded, "The largest variation in therapy outcome is accounted for by pre-existing client factors, such as motivation for change, and the like. Therapist personal factors account for the second largest proportion of change, with technique variables coming in a distant third" (p. 180). As part of the cultural and relational context within which psychotherapy takes place, we examine client characteristics, psychotherapist characteristics, and the emergent relationship characteristics.

Client characteristics: Expectations for psychotherapy

Norcross (2011) convened a joint task force from Division 12 (Society of Clinical Psychology) and Division 29 (Psychotherapy) to evaluate meta-analyses of research on major relationship factors. Each meta-analysis was evaluated according to the strength of empirical evidence supporting the factor. The Task Force for Evidence-Based Relationship Factors categorized factors as demonstrably effective (e.g., a high level of evidence supporting the factor), probably effective (e.g., less evidence and inconclusive but weighted toward a conclusion of effectiveness), or insufficient evidence or insufficient quality of existing evidence to judge. We use those terms as we report on the task force findings here.

The task force evaluated the evidence supporting the power of expectations in producing psychotherapy outcomes as having insufficient evidence with which to make a firm determination of effectiveness. We first review the theoretical foundation supporting client expectations as a determinative factor in psychotherapy and then briefly summarize the relevant research evidence.

Jerome Frank (1961), in his classic book, *Persuasion and Healing*, suggested that changes in psychotherapy depend on the mobilization of hope in the client. Frank assumed that clients enter psychotherapy because they are demoralized, and psychotherapy must mobilize their expectations. According to Frank, most of the changes that occur during psychotherapy are indirectly dependent on or directly due to the client's expectations. In medical trials, the *placebo effect* refers to positive changes when patients are provided with a sham "treatment" (e.g., a sugar pill in lieu of an actual medication). When patients receiving a placebo treatment improve more than those in the no-treatment control group, this may be taken as evidence of the healing power of patient expectations. In medicine, this effect is well known and powerful; indeed, new medications are not viewed as effective unless they outperform a placebo "treatment" in a randomized, double-blind trial.

Many RCTs for psychotherapy have included placebo control conditions, paralleling the design of medical trials. Clients in the placebo condition generally have outcomes superior to those in the control group. However, the status of placebo controls in psychotherapy research is ambiguous, as these conditions (if they are to be realistic enough to engender positive expectations for improvement) must include some or all of the common factors reviewed by the task force as important ingredients of any psychotherapeutic intervention (Wampold & Bhati, 2004). Indeed, Wampold, Minami, Tierney, Baskin, and Bhati (2005) examined evidence from placebo-controlled trials of psychotherapy and concluded that, "when properly designed, psychological placebos are as effective as accepted psychotherapies" (p. 835).

Although the effectiveness of placebo treatments is at least partly attributable to the healing power of positive expectations, these expectations are not properly considered to be solely client factors, as they are formed in response to the conditions of the sham treatment (e.g., talking with a trusted authority who administers some treatment and expresses confidence that it will help). The literature reviewed by Constantino, Glass, Arnkoff, Ametrano, and Smith (2011) focused on differences in psychotherapy clients' *preexisting* expectations for therapy, and their relation to therapeutic outcomes. Expectation in this context is defined as a pre-therapy affective feeling about the probable success or failure of the treatment.

Even expectations about *how* psychotherapy or counseling will take place might affect outcomes, though the research is not as well developed in that regard. Thus, clients or potential clients might hold both role and process expectations. Role expectations include expectations about how one should act as a client and how one should act as a psychotherapist. Process expectations include expectations about the duration of psychotherapy and what might transpire in the work of psychotherapy (e.g., would one lie on a couch, meet regularly, have access to the psychotherapist at all hours, do homework, cry, have insights). Tinsley, Workman, and Kass (1980) created an Expectations About Counseling (EAC) measure that assayed the role and process expectations of counseling in four areas: client attitudes and behaviors (motivation, openness), psychotherapist attitudes and

behaviors (acceptance, confrontation), psychotherapist characteristics (expertness, trustworthiness), and outcome and process (immediacy, concreteness, and degree of success).

Constantino et al. (2011), in a review and meta-analysis of research on outcome expectancies and psychotherapy outcome, included studies that had explicit measures of client expectations either prior to psychotherapy or after the first session. The studies of actual counseling also had to measure symptom change, not just infer it. Constantino et al. reviewed 46 samples involving over 8,000 clients. The overall effect size was $r = .12$ (Cohen's $d = 0.24$). This indicated a small, but positive, effect of positive outcome expectations. They tested five potential moderators, but none was found to moderate the expectancy-outcome relationship. The moderators were diagnosis, treatment orientation (CBT versus other), treatment modality (individual, group, or other), design type (comparative clinical trial, open trial, or naturalistic setting), and publication date (before or after 2000). Overall, expectations matter, but clients' pre-therapy expectations may be less important than the positive expectations engendered by interactions with therapists in the early stages of treatment.

Therapist characteristics

In their analysis of psychotherapy, Duncan, Miller, Wampold, and Hubble (2010) concluded that the person of the psychotherapist is at least as important as empirically supported treatments and interventions to producing good outcomes with clients. We agree that the psychotherapist is indeed important. However, there are forms of psychotherapy in which the treatment relationship differs substantially from a one-on-one counseling relationship. For instance, bibliographic interventions do seem to help clients (e.g., Jeffcoat & Hayes, 2012), and often the "relationship" in those interventions is quite different than it is with psychotherapy. Similarly, supportive psychotherapy also can be effective (Gibbons et al., 2012), and the "intervention" is quite different than in the typical evidence-based treatment. Across different types of psychotherapeutic relationships, we need to do all we can to maximize the working alliance with clients and to facilitate their progress through both the relationship and the interventions we use.

Facilitative conditions of the therapeutic process: empathy, positive regard and affirmation, and congruence/genuineness. The task force found strong support for the importance of psychotherapist empathy (demonstrably effective; Elliott, Bohart, Watson, & Greenberg, 2011), moderate support for positive regard and affirmation (probably effective; Farber & Doolin, 2011), and only modest support for congruence/genuineness (promising, but with insufficient research; Kolden, Klein, Wang, & Austin, 2011) as therapeutic factors predictive of outcomes. Empathy for the client is one of the best established therapeutic factors, starting with Carl Rogers's emphasis on empathy in the 1950s and 1960s (Rogers, 1951) and with a resurgence in research interest in the 1990s through the work of Les Greenberg (Bohart & Greenberg, 1997) and others. The strength of support for the research rivals that of the working alliance, though Elliott et al. (2011) reviewed only the research since 1992. The effect size relating therapist empathy to client outcome was $r = .22$ for 224 comparisons, which is a small-moderate effect size (though descriptors such as "small" and "moderate" depend on the use to which one might wish to put an effect size). Moderators that explained the strength with which empathy was related to client outcome included CBT ($r = .32$) theoretical orientation. The relationship was less strong for psychotherapists with a

psychodynamic orientation ($r = .18$). It mattered who rated the empathy. Client perceptions were more strongly predictive of an empathy-client outcome perspective ($r = .32$) than were therapist perceptions ($r = .20$). Perceived similarity of client and psychotherapist mediated the empathy-outcome relationship. That is, empathy affected counseling outcome by acting through perceived similarity of client and psychotherapist. Not all clients respond equally well to empathic expression by the psychotherapist. Sometimes the client did not appear to want the psychotherapist to call attention verbally to the expression of empathy. Elliott et al. (2011) concluded their review of empathy by noting that sometimes the most empathic thing a psychotherapist can do is not express empathy at all. The literatures on positive regard and affirmation (18 studies; probably effective) and genuineness/congruence (16 studies; promising, but with insufficient research) were much more limited, and conclusions about the importance of these therapeutic factors are less definitive.

Client feedback. Recently, therapists of a variety of theoretical persuasions have highlighted the importance of monitoring clients' progress throughout psychotherapy. Many behavioral therapies and CBT have recommended this practice for years. Feedback is sought throughout the therapeutic process, including information on concerns with the therapeutic alliance, reports on readiness or stage of change, degree of social support, how the treatment plan appears to be working, and whether medication is working. The task force evaluated the research support for collecting client feedback (Lambert & Shimokawa, 2011) as demonstrably effective, the highest level of evidential support. Effect sizes between various types and timing of feedback from clients and outcome of psychotherapy ranged from $r = .23$ to $r = .34$.

Management of countertransference. Psychotherapists bring their own agendas to psychotherapy, and sometimes those agendas threaten to impede the counseling process. Effective psychotherapists seek to manage their countertransference. That is, they seek to become aware of their own issues that might be driving their reactions to the client and either process those with the client or with a supervisor or self-impose restraint on their reactions. The task force evaluated the evidential strength for managing countertransference (Hayes, Gelso, & Hummel, 2011) as promising, but with insufficient research. Of 126 studies assessing therapist countertransference, only 10 related countertransference to outcome, and the effect size was small ($r = -.16$). The less a psychotherapist's own personal issues intruded, the better the outcome. Among 11 studies, the relationship between managing countertransference and transference was $r = -.14$. Whether psychotherapists were able to effectively process and deal with their own personal issues was only weakly related to whether they experienced intrusive personal issues. Managing transference was strongly related to outcome of psychotherapy ($r = .56$). Although the results suggested that managing one's personal issues and not letting them intrude in psychotherapy was important to the therapeutic outcome, the results were found in only seven studies. The task force evaluated the evidence for this factor as promising.

Relationship factors

As noted earlier, Wampold and Budge (2012) suggested that client and psychotherapist variables come together in the context of an emerging therapeutic relationship. The

development of the relationship is facilitated by aspects of agreement on therapeutic processes and goals, setting the stage for client change.

Working alliance in psychotherapy. The task force evaluated the evidential strength of the working alliance in psychotherapy (Horvath, Del Re, Flückiger, & Symonds, 2011) as demonstrably effective. Working alliance “represents an emergent property of collaboration between therapist and client. As such, it is not the outcome for a particular intervention; its development can take many forms and may be achieved almost instantly or nurtured over a longer period of time depending on the kind of therapy and the stage of treatment (Bordin, 1994)” (Horvath et al., 2011, p. 28). Horvath et al. identified over 7,000 references investigating the working alliance, so the connection between the strength of alliance and psychotherapy outcome is well substantiated. The clear support for the importance of the working alliance freed Horvath et al. to seek moderators and mediators of the relationship between working alliance and psychotherapy outcome.

In the over 14,000 treatments Horvath et al. (2011) included in their meta-analysis, the effect size relating working alliance to outcome was $r = .28$. They identified several moderators. One interesting finding was that time of assessment moderated the relationship. Alliance assessed during the early (sessions 1–5) and middle stages of treatment was less strongly predictive of outcomes compared with alliance assessed at the end (last four sessions).

The pattern by which alliance might change is related to psychotherapy outcome. First, it is *necessary* to begin the relationship with a “good enough” relationship. Ironically, what “good enough” is and when the actual “beginning” of the therapeutic relationship is are not precisely known. The goodness of the relationship might depend on many factors that are not under the control of the client or psychotherapist. Additionally, research has shown that judgments of trust happen within seconds of meeting another person (Benedetti, 2011). Daniel Kahneman (2011) refers to these rapid judgments as part of System 1 cognition, which is intuitive and often based on minimal cues that are not processed at a conscious level. In contrast, System 2 cognition is based on deliberate rational analysis. Second, an increasing alliance predicts success (e.g., Kramer, de Roten, Beretta, Michel, & Despland, 2009). Third, Gelso and Carter (1994) hypothesized that a pattern of an early rising alliance, followed by a dip (perhaps indicating a rupture in the alliance), but then a subsequent increase (seemingly indicating that the rupture in the alliance had been repaired) predicted a positive outcome of psychotherapy. While some evidence has supported this, the finding for therapeutic repair of a ruptured alliance is not as clear as it is with a steadily rising alliance. In fact, the task force considered this establishment-rupture-repair pattern specifically. The task force evaluated the evidence relating outcome to repairing ruptured alliances (Safran, Muran, & Eubanks-Carter, 2011) as insufficient research to make a definitive statement. A pattern in which the alliance followed a steadily declining path did not bode well for either success (if the client remained in psychotherapy) or even completing the course of psychotherapy.

The psychotherapist wants to establish a positive working relationship at the start of treatment. That often means carefully discerning the client’s expectations and experiences. It is not uncommon for psychotherapists to misread their clients’ perceptions of the alliance. Those missed cues place the future alliance in jeopardy. Psychotherapists must often modulate the demands they make on their clients during early sessions to get

the relationship well under way. In addition, it is necessary to challenge many clients, but doing so in the very early stages of psychotherapy might provoke misunderstanding and a poor working alliance that dooms the relationship. If the client becomes hostile and negative, it is imperative that the psychotherapist responds nondefensively, neither internalizing nor ignoring the client's concerns.

Bordin's (1976) early conceptualization of the therapeutic alliance incorporated agreement on tasks and goals. Since then, however, that aspect has been separated from the working alliance. The task force evaluated goal consensus and collaboration separately from the working alliance, but both share a cooperative and collaborative summative experience, so we include them together here. Based on 15 studies and over 1,300 participants, the task force evaluated goal consensus and collaboration (Tyron & Winograd, 2011) as probably effective ($r = .32$). It is thus recommended that psychotherapists begin to work on client problems only after treatment goals and ways to approach those goals have been agreed upon. They should seek client feedback and monitor collaborative and participative engagement of the client.

Tailoring psychotherapy to client culture, religion or spirituality, preferences, stage of change, coping style, and reactance/resistance. It is important to the formation of the working alliance that the psychotherapist makes an effort at the beginning of psychotherapy to consider compatibility and acceptability of various treatment approaches. That might mean tailoring the assignment of the client to a particular type of counselor. The intake interview in a counseling service might provide a sense of the client's preferences for culture, religion or spirituality, and treatment approach. It can be important to assign clients appropriately, if particular psychotherapists are available.

The ratings of evidential strength for tailoring the relationship to client preferences (Swift, Rodriguez, & Bernal, 2011), culture (Smith, Callahan, & Vollmer, 2011), and client religion and spirituality (Worthington, Hook, Davis, & McDaniel, 2011) were all demonstrably effective. The beginning of psychotherapy is particularly crucial, for if no match to client preferences is evident, the client can fail to attach to the psychotherapist and the working alliance might die stillborn.

Once psychotherapy is under way, accommodation to the client must continue. For example, the psychotherapist might try continually to assess the client's stage of change and make adjustments depending on the degree of motivation that the client seems to be exhibiting. For example, the evidential strength for tailoring the relationship to client stage of change (Norcross, Krebs, & Prochaska, 2011) was categorized as probably effective. Likewise, as psychotherapy continues, the counselor gets a clearer sense of the way that the client might cope with stresses and strains and the way that the client might deal with therapeutic challenges. The task force evaluated tailoring the relationship to client coping style (Beutler, Harwood, Kimpara, Verdirame, & Blau, 2011) as probably effective.

Clients do not respond positively to everything that a psychotherapist does. Resistance and reactance are often encountered during psychotherapy. Clients might develop a particular style of resistance—actively fighting or passively sabotaging, for instance. The psychotherapist might try to tailor directives or interventions to the client's style of resistance. The task force evaluated tailoring psychotherapy to client reactance/resistance (Beutler, Harwood, Michelson, Song, & Holman, 2011) as demonstrably effective.

Overall assessment of relationship factors. Psychotherapy relationships are complicated. Among the many things that can be done to improve those relationships are enhancing clients' positive expectations through signs of expertness (i.e., displayed diplomas, awards) and the way one acts toward the client; employing facilitative conditions, especially empathy; and soliciting feedback throughout the process. Research on counselor credibility indicates that counselor behaviors, especially nonverbal behaviors signaling attentiveness and interest, are stronger predictors of perceived credibility than status markers (such as displayed diplomas or office furnishings; Hoyt, 1996). The Competencies Conference, convened in 2002, was an effort to define key psychotherapist skills believed to enhance effectiveness, including effective establishment of the therapeutic relationship (Kaslow et al., 2004).

Certainly, one of the important points to arise from the review of responsiveness factors is not a new one—do all one can to promote a strong collaborative working alliance. This also involves tailoring the treatment to the client's personal characteristics and worldview. In addition, it is important to have therapeutic content to offer the client and to present it in a collaborative way that the client can use. Now we turn to the content and focus on evidence-based practices.

Techniques and Interventions

As we stated earlier, relationship factors alone are not sufficient to produce an effective psychotherapy. Therapists must do something for their clients. They must have some techniques and interventions that they can offer the clients in response to their concerns and problems. But what should be done, in what situations, and with which clients? There are many ways to answer these questions; for this review we focus on attempts to identify evidenced-based practices.

Evidence-based practice means presenting one's best case. Basic research on the basis for change and even the potential mechanisms for change is needed to show that a treatment is working for the reason it claims to work. David and Montgomery (2011) described how malaria was first attributed to "bad wind," and the treatment that was derived from the theory was to shut the windows. Of course, shutting the windows worked because that kept out the mosquitoes, the real cause of malaria. Most treatments are created by drawing on basic research and theory. The case from basic research, that the treatment needs to treat the real cause, is an important aspect of the overall argument for evidence-based treatments.

When making the case for a treatment's being evidence based, it is necessary to consider the range of evidence of specific effects of treatment. The types of empirical evidence for a treatment can vary from case study, to $N = 1$ designs, to $N = 1$ with multiple baselines, to therapist-yoked waiting-list designs, to various types of clinical trials (with and without randomization), to large national RCTs, to uncontrolled field trials, to effectiveness trials, and to dissemination trials. These types of evidence do not array neatly on a hierarchy of quality of evidence. Rather, evidence-based practice in psychology is based on trying to adduce the most and best quality of evidence, drawing from all that is available. For many people, the national RCT is the ultimate form of evidence because it has high levels of both internal and external validity for efficacy trials. Frequently, we make a distinction between the *efficacy* of the treatment and its *effectiveness*. However, after efficacy has been established (with emphasis on internal

validity), the field needs effectiveness and dissemination trials (which test a treatment as it is used in practice), not merely the accumulation of repeated RCTs.

Efficacy trials

The *sine qua non* of an efficacious treatment is how it performs in controlled clinical research. Usually this means moving beyond case studies and $N = 1$ designs to large RCTs. Even if a treatment is deemed to have enough empirical support to be evidence based, the evidence often is from artificial or analogue settings, or is from highly controlled RCTs. RCTs are the gold standard for clinical research, but they have been critiqued on a number of grounds (for critiques, see Goldfried & Wolf, 1996; Howard, Moras, Brill, Martinovich, & Lutz, 1996; Seligman, 1995), which may be grouped into challenges about subjects, treatments, and performance measures. Critics say that the subjects in RCTs are often not like real psychotherapy patients. Rather, relative to community psychotherapy patients, RCT patients are not as disturbed and often have fewer comorbid diagnoses. Critics also say that treatments are too rigid and inflexible, and the requirement of random assignment of clients to treatment means that clients have less choice among treatments than do those in the community. Finally, critics argue that RCTs focus on only the presenting and targeted diagnosis whereas clients and psychotherapists in the community are more concerned with a variety of broader indices of mental health, adjustment, and well-being.

These critiques, which were offered mostly in the 1990s, have been addressed in more recent efficacy studies. For example, the participants in more recent RCTs are comparable to community patients. For example, Foa et al. (2013), in an RCT of prolonged exposure for PTSD, did not exclude patients with comorbid diagnoses and two-thirds of the patients had a comorbid disorder. The presence of a comorbid disorder did not usually impede the treatment's success. Even when comorbidity did affect the outcome, people with comorbid diagnoses still benefitted from treatment. Finally, evidence has accumulated in effectiveness studies (those delivered by practitioners in the community) that have shown that effect sizes in the community are comparable to effect sizes in RCTs.

The argument that RCTs restrict choice of treatment more than in the community is arguably inaccurate. In the community, clients rarely choose their treatment. Typically people come to psychotherapy based on a referral by a physician, clergy person, other mental health professional, or friend. The referral is usually to a person, not to a type of treatment. The client usually does not know what type of treatment the practitioner practices. Thus, coupled with the finding that when people are recruited into an RCT, they are told the range of possible treatments to which they are agreeing to submit, this suggests that community and RCT clients have similar levels of freedom to choose treatments (Persons & Silbershatz, 1998).

Similarly, the argument that RCTs are more focused on narrow outcomes is no longer—if it ever was—the case. Most RCTs now routinely include a variety of adjustment and well-being measures in addition to the outcome measures for the target of treatment (for a brief review, see Foa et al., 2013).

Effectiveness trials

When presenting a full case for an evidence-based practice, one needs to show that the treatment actually works in the community with real clients and real psychotherapists

(i.e., is effective). Although effectiveness studies tend to be somewhat controlled (perhaps comparing the treatment of interest with the psychotherapist's own preferred treatment), they are likely to relax some of the tight controls of RCTs. For example, effectiveness studies tend to be conducted in psychotherapy offices within the community, with less emphasis on client selection to achieve a representative sample of people usually attending psychotherapy. The participating psychotherapists are less likely to receive the degree of training and supervision as in RCTs. Concerns other than measuring client improvement are also assessed—such as quality of treatment delivery, acceptability of the treatment to the clients and psychotherapists, and cost-effectiveness of the treatment. Those additional criteria might determine the success of a treatment—so that effectiveness is determined not just by whether the client's target symptoms improve, but also by whether the psychotherapist can deliver the treatment efficiently and cost-effectively. Other considerations might include whether the new treatment is more accessible by different populations or can help move more patients effectively through a practice without a decrement in effectiveness.

Effectiveness trials also allow researchers to answer practical questions. These include questions such as how much psychotherapists will use the training materials, whether psychotherapists can use the manual and practice the treatment without supervision, how much time in addition to the face-to-face client-psychotherapist contact time is needed to carry out the treatment with fidelity, and how fast the psychotherapist can become proficient in moving “off-book.”

Dissemination

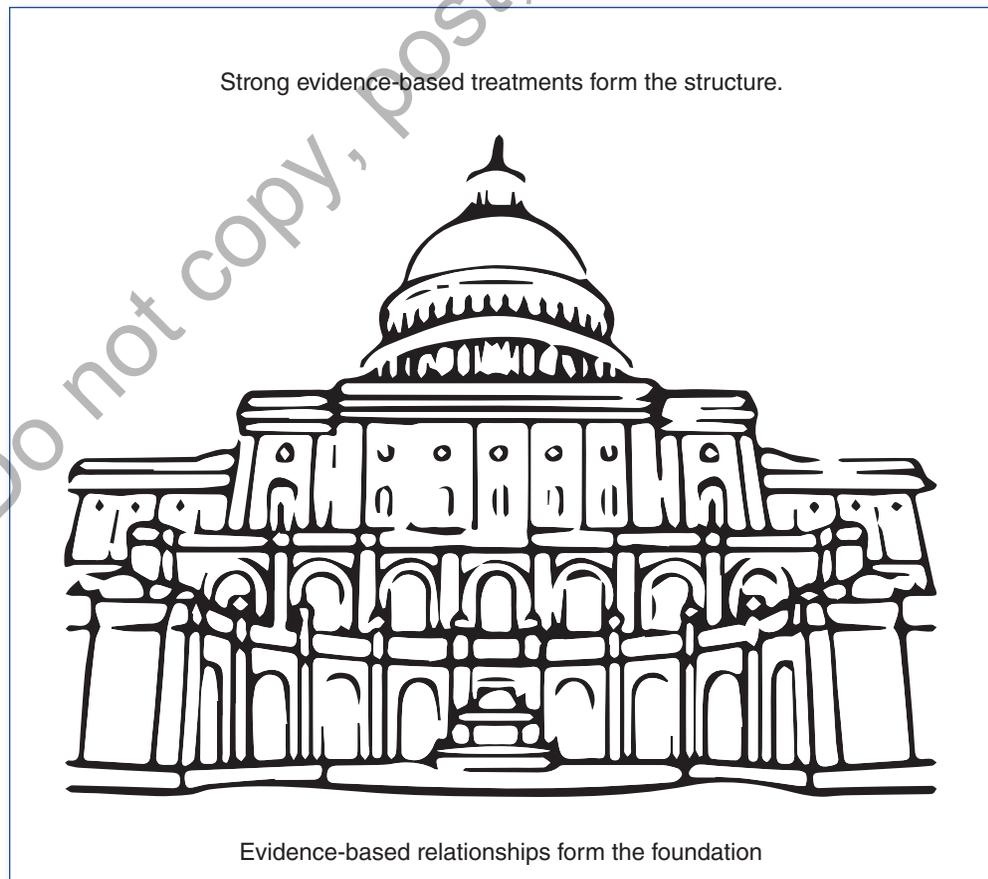
Once treatments have been shown to be efficacious in RCTs and also to be effective (using additional criteria) within psychotherapists' offices with real clients, the treatments need to be disseminated to wider populations. For example, state mental health organizations might decide that a particular treatment (or set of treatments) is sufficiently supported by efficacy and effectiveness research that it should be recommended (or mandated) for providers in their system (i.e., Biegel et al., 2003; Chorpita et al., 2002). Systems such as the Veterans Health Administration might decide that its services will recommend (or mandate) one or more particular treatments for specific disorders. Other large systems like Pacific Clinics Behavioral Healthcare or Stars Behavioral Health Group might adopt an evidence-based treatment. In the evidence-based practice literature, dissemination has, in many ways, become *the* current question. For counseling psychology to be up-to-the-minute in clinical science, we must acknowledge the importance of moving to the phase of clinical science where we take dissemination seriously. Thus, we are at least pointing to the broader discussion of how to do effective dissemination.

Attending to dissemination raises some important questions, which due to space constrictions we can only hint at here: (a) How do people in leadership decide to adopt a specific evidence-based practice? (b) How does the practice get disseminated widely through the unit (whether state, federal system, or state-based private healthcare organization) with good treatment fidelity? (c) What are the obstacles to wide adoption and use of the evidence-based practice? (For a summary and discussion of dissemination, see McHugh and Barlow [2012].)

Summary of treatment techniques and interventions

Although the therapeutic relationship provides the main system that influences clients to change, there must be some content that describes the problem and logically presents a reasonable cure. Some treatments are indeed effective at producing more changes than result from merely being in a nonstructured helping relationship. Those strategies are tested via rigorous methods involving low-level empirical support, RCTs, effectiveness trials, and eventually dissemination trials. These findings mean that, for certain people with certain diagnoses, psychotherapists can rely on standardized manuals to intervene in ways that engage their clients. Evidence-based practices are not available for all disorders, and flexible psychotherapists have to tailor evidence-based practices to individual differences in the same way that psychotherapist and relationship factors must be tailored to individual client differences. Working together, evidence-based responsiveness and practices (and other emerging treatments that are in the process of moving toward accumulation of evidence) can provide the client with a chance for optimal engagement and can provide activities for the client to do—both in psychotherapy and in the time outside of psychotherapy. Figure 3.2 illustrates how

FIGURE 3.2 Evidence-Based Treatments Build Upon Evidence-Based Relationships in Therapy



evidence-based relationships form the foundation of therapy while strong evidence-based treatments build on that foundation to create a lasting therapeutic structure.

The Client's Response

In the third element of our model, the client must accept the offered techniques and respond to the psychotherapist's offered intervention—either within the psychotherapy session or as psychotherapist-suggested or client-initiated actions outside of psychotherapy. The specific modifications that the client makes include building and trying out new coping skills, new relationship skills, different thought patterns, modifications in interpersonal relationships, virtuous behavior (i.e., behavior that the client seeks to develop that benefits both the client and others), and new behaviors one is trying to increase or self-regulation of behaviors one is trying to decrease. Sometimes this extra-psychotherapy engagement occurs as the client spontaneously attempts to act differently in his or her daily life. At other times, this occurs because the psychotherapist either assigns homework or the client and psychotherapist arrive collaboratively at some homework. Regardless of type of psychotherapy, the client must be actively engaged in making meaning of things that happen inside of and outside of psychotherapy. The client must attempt to make active and deliberate changes in his or her physical and interpersonal environments.

Some of the research on the client's engagement and involvement outside of therapy has focused on the investigation of homework within cognitive behavioral therapies. Reviews have shown repeatedly that the outcome of CBT with various client problems is related to whether people do the homework assigned by, or collaboratively agreed upon with, their psychotherapists. For example, Kazantzis, Deane, and Ronan (2000) reviewed and meta-analyzed 27 studies involving homework in psychotherapy ($N = 1,702$). They found effect sizes for use of homework (versus none) and outcome of $r = .36$. Compliance with homework was also related to psychotherapy outcome ($r = .22$). Moderators for the homework-outcome relationship were type of problem (the presence of higher levels of anxiety, depression, and "other" all significantly increased the importance of homework for positive outcomes) and type of homework (using exposure and social interaction as homework significantly increased the importance of homework for positive outcomes). Kazantzis, Whittington, and Dattilio (2010) replicated and extended the meta-analysis. They analyzed 46 studies and found a larger effect size for CBT with homework than without it. One study found that the relationship between homework and outcome was mediated by working alliance (Dunn, Morrison, & Bentall, 2006).

Little systematic research exists on what constitutes active engagement or extratherapeutic involvement in theoretical approaches other than CBT. This is to some degree a matter of theoretical approach (for reviews and summaries, see Sharf, 2012). Some theories of therapeutic change give more weight to causal events that occur within the environment. This might include most CBT and behavioral therapies, family therapies, and community psychology. Other therapies give more weight to internal processes (e.g., psychoanalytic therapies, rational-emotional therapy, constructivist therapies, narrative therapies, gestalt therapies) or in-session interactions (e.g., interpersonal process theories, some psychodynamic theories). For example, some psychotherapies, like interpersonal process approaches (Teyber & McClure, 2011), emphasize in-session interactions and pay less attention to client actions outside of psychotherapy (except as

the client brings them into the session). Thus, they do not measure extratherapeutic events, and little is known about what does or does not go on outside of psychotherapy with these clients.

We should not be surprised that events and internal processing that happen during the 167 hours of the week people are not seeing a psychotherapist should have large effects on people's ways of handling psychological disorders. However, we know very little about what kinds of extra-therapy events affect people's coping with psychological disorders and what kinds of internal processing of these events are helpful.

Responses of the Client's Social World

As clients respond to the psychotherapy relationship and the treatment, they act in new ways and thus engage their social world differently. This might result in violating expectations within the family, friendship, couple, or work environment. New actions might disrupt various patterns of behavior that have long endured and to which others have adapted. Theories of family systems therapy have been at the forefront of observing the ways that family members (and members of other social units in a client's life) strive to maintain systemic homeostasis (for summaries of many others, see Sharf, 2012; Smith-Acuña, 2011). People tend to exert pressure—sometimes subtle and sometimes not—to encourage clients to move back into a comfortable (if not healthy) zone of interaction.

Clients must attend to those pressures that seek to move them back into troubled relationships or troubled behaviors. This requires considerable flexibility on the part of the clients, who must sense the social changes, discern their own potential responses to the changes, make optimal responses to the ongoing set of social changes that have been put into motion, and make sense out of what is happening in the changing personal-social world. Much of this adjustment is via System 1 cognition (i.e., intuitive, nonrational cognition, which comprises the majority of cognition) rather than System 2 cognition (i.e., deliberate rational analysis; Kahneman, 2011). Thus, therapy can easily go awry if the psychotherapist does not process with the client what is happening in the client's social world prior to termination. Like the other actions that the client takes outside of psychotherapy, little is known about these coping responses and how therapists might help clients to navigate these events.

Part of making sense of the changes and planning additional behavioral or cognitive modifications is processing life happenings with one's psychotherapist and further modifying one's schemas, motivations, and emotions. This yields a powerful feedback loop that can help clients to make changes, understand those changes, and then solidify those changes in their lives.

The Complex Interactions Among These Factors

Although addressed separately in this review and generally in the research, the factors that make psychotherapy effective are not independent. Many interactions are at work and the cultural/relationship factors, interventions used, and clients' responses are all interconnected (Norcross & Lambert, 2011). Integrating these interacting factors is a major therapeutic challenge, especially for the developing psychotherapist. One way to

meet this challenge is through ongoing self-assessment. Therapists can use Box 3.2 to assess themselves on the skill areas they hope to attend to in the upcoming year.

BOX 3.2	
Assess Yourself	
Consider each of the goals listed here. To what degree do you now believe that you need to increase your knowledge or competency in each area?	
0 = not at all, 1 = a little, 2 = some, 3 = quite a lot, 4 = a great deal	
Target Area for Improvement	Self-Assessment (0–4) of Need to Address This Area in the Upcoming Year
Build more psychotherapeutic skills	
Enhance my relationship skills	
Improve my ability to diagnose accurately	
Increase my ability to conceptualize accurately	
Build a larger repertoire of abilities to use many evidence-based treatments effectively and to know also when they are best applied	
Develop more competence to discern which treatment should be used for a particular client with a particular diagnosis or multiple diagnoses	
Hone my skills to match treatments to patients to maximize their strengths, relationship qualities, and willingness to accept rationales, and to mobilize expectancies, enhance motivation to work inside and outside of psychotherapy, and motivate clients to succeed	

One of the truths of modern psychology is that much of what governs human behavior is not rational, logical, or explicit, but intuitive and based in System 1 cognition (Kahneman, 2011). This intuitive processing can lead to cognitive errors like using the availability heuristic (e.g., making decisions on the basis of the most available information even if it is not logically the best information). Another kind of cognition occurs within System 1 cognition, too. It occurs intuitively, implicitly, outside of normal awareness, and in response to minimal cues. It is the cognition of expertise. Experts typically require about 10,000 hours of concentrated effort to move their reasoning from more explicit concentration to more automatic reasoning (Kahneman & Klein, 2009). (To provide perspective, if a therapist conducted psychotherapy for four hours a day for five days

a week for 50 weeks a year, expertise could be attained in 10 years.) Experts typically reason faster than do people of moderate ability and those who are novices at an activity. In addition, experts consider fewer incorrect or inefficient choices, but they zero in on the most optimal choices in relatively few cognitive moves. They see patterns instead of focusing on step-by-step mechanics. It is likely that expertise in psychotherapy follows these same laws of cognitive expertise.

While therapists are building expertise at psychotherapy, they are likely to operate by more or less explicit guidelines or informal “rules” learned through trial and error, theory-informed experience, and supervised practice involving feedback from expert supervisors. In this chapter, we have attempted to make some of the relationship factors as explicit as possible, but as psychotherapists gain expertise, they might use different unconscious, implicit, and intuitive guidelines that might be impossible to articulate. Nevertheless, under the assumption that research summarizes a vast amount of human experience, we draw upon the research we reviewed in previous sections of this chapter to formulate some suggestions for moving psychotherapists closer to expertise.

Here are some practical guidelines for enhancing relationship and treatment factors. As a first order of importance, a psychotherapist must attend to the relationship as a precursor and context for any subsequent methods, techniques, or interventions that are delivered by the psychotherapist and experienced by the client (whether or not they have the designated status of evidence-based). This involves forming a good working alliance. Forming an alliance might mean being particularly sensitive to the relationship and the way that treatment might interact with the client’s personality, presenting problems, and diagnoses. The psychotherapist must be open to tailoring the treatment to client cultural, religious or spiritual, ethnic and racial, socioeconomic, and other personal characteristics. While considering such tailoring, the psychotherapist must also exhibit cultural humility (see Hook, Davis, Owen, Worthington, & Utsey, 2013). Cultural humility is having cultural knowledge, awareness, sensitivity, and competency, but treating the client as an individual with a personal story to tell rather than overgeneralizing from the psychotherapist’s cultural knowledge and experience.

In addition, client preferences are very important and need to be accommodated to the extent possible. Client expectations of positive outcomes and also of their personal responsibility for being engaged in their own treatment need to be considered. The psychotherapist must foster these positive expectancies through responsive behavior and professional demeanor, but also through meeting client expectations and repairing ruptures to the working alliance. Collecting ongoing feedback about client progress and attitudes is vital. People expect to be asked to provide feedback, and they expect that the psychotherapist will take it seriously to guide treatment.

Likewise, the client is also continuously monitoring the psychotherapist’s behavior. If the psychotherapist does not employ empathy, understanding, and other facilitative conditions, the working alliance will likely suffer. Psychotherapists can still be tough and challenging at times, but care must be taken to monitor the client’s reactions.

Although there is little empirical evidence to inform this practice, we believe that psychotherapists must pay attention to what might or might not be happening outside of the psychotherapy hour. Some psychotherapeutic approaches give particular importance to what occurs within the psychotherapy hour. Their theories of change consider few extratherapeutic events that could affect the client, unless the events are highly relevant

to the hypothesized psychotherapeutic change. Typically, the extratherapeutic events are taken to be grist for discussion in psychotherapy, where real change is thought to occur. For other psychotherapeutic approaches, having the client apply changed behaviors, thoughts, motives, and feelings in those extratherapeutic events is seen as the primary change mechanism—not what is occurring in psychotherapy.

Choice of treatment approach is still crucial. We are keenly aware that evidence-based practices are not currently the end-all of treatment choice. Many diagnoses have few or no treatments that have even been investigated for efficacy, effectiveness, or potential for widespread dissemination. Treatments are often chosen for reasons other than diagnosis, and many clients have multiple diagnoses. Even if a powerful evidence-based practice is available for a diagnosis, it is unclear whether it will work with the client's particular set of multiple diagnoses, the cultural and personal constellation of the client's characteristics, or the client's life history. If evidence-based practices are well established and seem appropriate for a particular client, the burden of proof that some other treatment should be used—within the context of an excellent and responsive psychotherapy relationship—is on the person who seeks to use an alternative treatment.

Status of the Field—What Is Now Needed?

Norcross and Wampold (2011) summarized the status of the Task Force on Evidence-Based Psychotherapy Relationships. Many of the relationship elements have not attained the status of demonstrably effective. Additional research is needed on the elements that were judged to be probably effective and promising, but with insufficient research to make a determination. Many of the reviews and meta-analyses of existing research presented a sophisticated and nuanced view of the relationship element. For example, empathy was considered to be a demonstrably effective relationship element. Yet Elliott et al. (2011) observed that some clients do not consider reflecting accurate empathy into their story as positive. Such empathic reflection can be perceived as intrusive, interruptive, and annoying and it might damage the working relationship. Such subtleties deserve further elucidation.

Evidence-based practices are being identified with increasing frequency. They are becoming so numerous that it is virtually impossible to keep up with all of the practices for all diagnoses and for all other considerations—such as which can be best adapted for clients of different ages, ethnicities, or religions. Accessing the wealth of information that is available, for example, through the Internet, is essential. As more evidence-based practices are identified, how does one discern which might be the best for a particular client or even type of client? Box 3.3 suggests five activities that might help in this regard.

Even assuming that a psychotherapist could discern that an evidence-based practice is preferred for a particular person, can the practitioner carry out that practice with fidelity and with competence? To what degree might a psychotherapist deviate from a manual without causing harm? To what degree might the psychotherapist recognize indications and contraindications for a treatment? All of these questions require more study.

At the larger system level, other questions arise. Can effective evidence-based practices be disseminated throughout large mental health systems? Some of the most interesting research these days is in the area of dissemination (McHugh & Barlow, 2012).

BOX 3.3**Five Things to Try**

1. Use the Internet to find a list of evidence-based practices that could be used for a client who is depressed and anxious, has a substance abuse disorder, and has experienced trauma in her time in the military. (Find this list before you read on.) If you simply used the symptoms in a Google search, you probably found the NAMI (National Alliance on Mental Illness) website. Imagine a client who has experienced these symptoms for a year. She will certainly have searched the Internet and read extensively. Consider the implications for your treatment of a woman who has simply read the NAMI brochure and comes to psychotherapy with you? Will the treatment you provide be consistent with what she has read?
2. Counseling psychology has historically valued (a) cultural competence in dealing with a diverse clientele, (b) strength-based treatment, and (c) promotion of agency in clients. How do the recommendations by Rozensky (2011), described in greater detail below, to think of clients as patients and counselors and psychologists as part of a larger health care service team, mesh (or not mesh) with these traditional emphases? How about with other emphases that have characterized the counseling field?
3. For ease of reference, make a list of the demonstrably effective relationship factors and matching factors, based on the discussion in this chapter.
4. Suppose you wanted to collect feedback from each client by having the client complete five questions in the waiting room when he or she shows up for a psychotherapy session. The client will hand you the completed questionnaire at the beginning of the session. The client's answers can informally update you on the client's status. What five questions might you ask? Try to assess how the client is doing with his or her main symptoms, feelings of global well-being, strengths employed in dealing with his or her problems, and satisfaction or concerns with psychotherapy thus far.
5. What if you are not using an evidence-based practice to treat a specific client problem? The client comes to psychotherapy having searched the Internet and has found a different approach than you are using that has some evidence supporting it. The client asks why you aren't using the evidence-based practice? What do you say?

Additional studies of how dissemination might best occur are needed. Research on evidence-based practice has found that following manuals is not typically a lock-step mechanical activity. One still does creative, flexible psychotherapy and uses clinical judgment about when to deviate from the manual. Yet evidence-based practices, especially those that have been evaluated through RCTs, effectiveness trials, and dissemination trials, represent the wisdom of thousands and thousands of psychotherapists who have treated many clients each. This is a gold mine of experience, and one must be very sure of oneself to go contrary to that experience.

With implementation of the Patient Protection and Affordable Care Act (ACA), mental health care, as we know it, has changed drastically. Rozensky (2011) has been a frequent interpreter of the meaning and implications of the ACA for the practice of those who are health care providers. Among the many implications, he observes that mental health treatment will be viewed as part of overall health care rather than the

traditional way of thinking, in which psychologists and counselors treat mostly mental health problems and a few physical health applications. Instead, Rozensky argues that, with the ACA, *treatment* will become *health care services*, *clients* will become *patients*, and psychologists and counselors will have to demonstrate interprofessional team-based competencies, use evidence-based practices, obtain board certification credentials, speak the language of the health care system, and affiliate with organizations that provide wrap-around patient-based treatment. Clearly, evidence-based practices will be even more important in the ACA world than previously. Enhancing patient responsiveness (it is difficult for us to think of clients as patients, yet this is the economic reality of the future) is also just as necessary for competent practice. The ACA will expand the delivery of health care services to patients far beyond what was true before the law was implemented. Being multiculturally competent with diverse patients will be even more central to health care services provision than ever before.

We observe once again that events outside of psychotherapy can greatly influence the course of psychotherapy. These include events like exposure to information available on the Internet regarding assessment, diagnosis, and treatment. These extra-psychotherapeutic events will affect relationships with clients by affecting their knowledge and expectations. Yet little research exists on what events might make the most difference. Furthermore, the extra-psychotherapeutic event of the ACA has, in many ways, changed not just the law but also the entire way that treatment might be contextualized, communicated, and carried out.

We cannot help but note that, as counseling psychologists who have always valued not just helping people to try to solve their problems and heal their psychological disorders but also helping them to grow, there is still appallingly little research on helping people grow through psychotherapy. With positive psychology now a force to be reckoned with (Seligman & Csikszentmihalyi, 2000), the traditional stance of counseling psychologists on growth is also given new relevance. Additional research into this area is sorely needed.

If we were concerned that all the research on psychotherapy might be virtually done, and all that is left is to mop up the details, or if we were concerned that psychotherapy, which has been around since Freud, might be stagnant and ossified, then we need not be worried. Much remains to be discovered in this field. Let's keep moving forward.

Additional Materials

Books

- Gelso, C. J., Williams, E. N., & Fretz, B. R. (2014). *Counseling psychology* (3rd ed.). Washington, DC: American Psychological Association.
- McHugh, R. K., & Barlow, D. H. (Eds.). (2012). *Dissemination and implementation of evidence-based psychological interventions*. Oxford: Oxford University Press.
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Websites Listing Evidence-Based Practices

Association for Behavioral and Cognitive Therapies, www.abct.org/Information/?m=mInformation
 Evidence-Based Behavioral Practice, www.ebbp.org
 Society of Clinical Child and Adolescent Psychology (Division 53 of the American Psychological Association), www.effectivechildtherapy.com
 Society of Clinical Psychology (Division 12 of the American Psychological Association), www.psychologicaltreatments.org

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