

## **Three Myths About Empirically Validated Therapies**

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Considerable debate has focused on the concept of empirically validated therapies (EVTs) and the notion that these approaches to addressing human problems will either save or damn the practice of psychotherapy. Much of the rhetoric surrounding the issue reminds me of the fundamental language of Rational Emotive Therapy, as expounded by Albert Ellis. The debate seems too often driven by what Ellis described as deeply held, often unconscious, irrational beliefs. Consider the following three common myths regarding empirically validated treatment strategies.

**Myth #1: EVTs will save the field by proving to the world (at last) that we are true scientists.**

To begin with, there is no universal agreement on what constitutes an EVT. Most researchers would endorse a definition that encompassed a uniform approach to training and treatment (e.g., insuring fidelity and replicability by means of a treatment manual), and research that demonstrates efficacy and effectiveness. But wait! Some will insist that only data from a randomized clinical trial will do. Others insist that the data must first be published in a refereed journal. Still others argue that one published study does not prove anything, and a technique does not qualify as an EVT without several peer-reviewed papers.

Simply stated, clear agreement on the meaning of the term EVT remains elusive and even ethically challenging. For example, in some contexts a traditional randomized clinical trial would raise serious ethics concerns (e.g., testing a new unproven technique against a no-treatment control group in some clinical populations for whom the passage of time without help can worsen the problem). In addition, proponents of EVTs often reject the use of qualitative data, case studies, and similar historically valid approaches to documenting the value of some therapeutic techniques.

**Myth #2: Any practitioner not employing EVTs is incompetent, unethical, or both.**

EVTs hold great value for practitioners because they offer us new tools that can often be easily grasped via the study of treatment manuals or specialized workshops. At the same time, competent and ethical practitioners must invariably tailor their interventions to the unique needs of their clients. The training manual can take the practitioner only so far. Our training in assessment, psychopathology, individual differences, and systems of psychotherapy provides an optimal context for integrating and modifying a range of strategies and tactics to achieve therapeutic goals.

Special irony derives from the very essence of the EVT. Strict adherence to a treatment manual, while important in clinical research to help maintain the fidelity and replicability of the intervention across participants in the study, could compromise individual client needs. In such circumstances slavish adherence to the manual would violate several ethical principles demanding respect for both client needs and client autonomy in the conduct of psychotherapy. Practitioners who follow only manualized intervention protocols ignore their obligation to optimally meet the needs of their specific

clients. In addition, individual clients rarely present as monolithic repositories of a single pure psychopathological diagnosis. I cannot conceive of an EVT manual that addresses the needs of all clients.

**Myth #3: Psychologists must choose! You must be “for EVTs” or “against EVTs.”**

The wise practitioner has nothing to fear from the EVT and should resist focusing too much on any single therapeutic tactic. Decades of psychotherapy research, best typified by the classic studies of Hans Strupp and Alan Bergin, demonstrate the importance of the therapeutic relationship (e.g., empathic connection) over therapeutic orientation or use of specific technique time and again. Practitioners should keep up to date on EVT research, and should consider those techniques as a primary approach in some contexts. For example, when formulating a treatment plan for a three year old child presenting with enuresis, “dry bed training” ought to be considered prior to offering a course of open-ended psychodynamic play therapy. On the other hand, this well validated approach to behavioral treatment of enuresis may well be contra-indicated in situations where the parents lack consistency and are potentially abusive, or when the child has a history of urinary tract infections or urinary reflux.

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**In Summary**

Skilled and ethical practitioners strive to maintain familiarity with new developments and research, but conduct their assessments and interventions in the broader context of their full education, training, and recognition of the client as a unique individual. One should neither become intimidated by the development of new EVTs,

nor allow pseudo-scientific bullying by overly rigid exponents of such techniques.

Remember that the very nature of professionalism involves the exercise of sound judgment. If a simple manual were sufficient to meet the full range of human variation and treatment needs, a technician or paraprofessional could replace the professional clinician. Rather than fret about the development of EVTs, I would encourage practitioners to look at them closely to both explore their potential application and note their limitations.

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