Journal of Consulting and Clinical Psychology
February 1998 Vol. 66, No. 1, 3-6

Empirically Supported Psychological Therapies

Philip C. Kendall
Temple University

ABSTRACT

This article introduces the special section of the *Journal of Consulting and Clinical Psychology* on empirically supported psychological therapies. After a discussion of the rationale for the selection of the specific terms in the label, several justifications are considered for conducting and learning from empirical evaluations of psychological therapies. Finally, the process that guided the special section is described.

Correspondence may be addressed to Philip C. Kendall, Department of Psychology, Temple University, 1701 North 13th Street, Weiss Hall, Philadelphia, Pennsylvania, 19122.
Received: November 14, 1996
Revised: April 4, 1997
Accepted: June 19, 1997

Raising topics of politics or religion at small social gatherings and projective tests among psychologists reliably reveals robust and conflicting opinions. To this list of engaging and provocative topics, one can add the contemporary focus on the identification of *empirically supported psychological therapies.* This special section, like the report of the American Psychological Association Task Force on Promotion and Dissemination of Psychological Procedures ([Task Force] 1995), is likely to do more than invite "business as usual" (Wilson, 1996 , p. 243).

The present article introduces a special section of the *Journal of Consulting and Clinical Psychology* that addresses empirically supported psychological therapies. By this label, in general, I refer to those psychological treatments that have been exposed to evaluation using the accepted methods of psychological science. Specific word choices were important. For example, the topic has been discussed (and written about) using terms such as *empirically validated, empirically supported,* and *empirically evaluated.* The first term connotes that the treatments are already validated (Garfield, 1996 ; see also Chambless, 1996), in an almost closed and finished fashion, and that the treatments have been proven effective. However, validation is never completed and closed, and psychological therapies do not produce complete success (see the no-cure criticism; Kendall, 1989). Moreover, the process of evaluation is not completed even if several studies provide supportive evidence. The second phrase,

empirically supported therapies, indicates that the treatment has been supported, with the specification that the support comes from an acceptable empirical study. This phrase is akin to that used in Britain (evidence-based therapy) but makes it clear that the evidence in question must be empirical in nature.

The third phrase, empirically evaluated therapies, merely indicates that the treatments have been empirically evaluated, with the connotation that they have been supported; however, this is not explicit. [1] That a treatment has been empirically evaluated connotes support, but this can be misleading; there are therapies that have been evaluated but not found to be supported by the evidence. The phrase *empirically supported therapies* was chosen because it emphasizes empirical research, requires positive outcomes from the research, and does not prematurely close the process of evaluation. In addition, the phrase connotes and underscores the notion that the process of empirical evaluation, rather than the polemical talents or charismatic features of an individual promoter, best serves as the cornerstone for the endorsement and dissemination of psychological treatment procedures.

There are also connotations regarding the term *psychotherapy*. This term can unintentionally connote a certain type of therapy (e.g., traditional or psychodynamic) and unwittingly be seen as delimiting. Through the use of the phrase *psychological therapies* in place of *psychotherapies*, the topic remains open to all forms of psychological treatment.

"Empirical" evaluation, too, is not without connotations. An empirical evaluation using proper statistical analyses can document that a treatment was found to be better than an alternate condition or to be better than no treatment or chance (see also Borkovec & Castonguay, 1998), but this alone may not be sufficient. Statistical tests do not guarantee or suggest that all participants improved or that the improvements were clinically meaningful. Outcomes from empirical evaluations reveal something about the active features of interventions and that the interventions were statistically more potent than comparison conditions. These same evaluations, however, do not indicate whether the degree of change that was beyond chance was also sufficient to return deviant clients to within nondeviant ranges of scores on the relevant measures (e.g., returning initially severe depression scores to within the normal range). To accomplish this latter aspect of empirical evaluation, reports need to include normative comparisons (Kendall & Grove, 1988) and indicate the degree to which a treatment returned distressed clients to within nondisturbed limits on the measures used to assess outcome. Psychological therapies will be advanced following statistical tests that document that change did not occur on a chance basis; statistical significance is needed prior to clinical significance.

As will be evident in the series of articles that follow, there are criteria that can be applied to the outcome literature (e.g., Chambless & Hollon, 1998) to make decisions with regard to whether or not a treatment has been found to have efficacy and to be effective. There are treatments, within specified areas, that meet the criteria and can therefore be considered empirically supported (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998 ; Compas, Haaga, Keefe, Leitenberg, & Williams, 1998 ; DeRubeis & Crits-Christoph, 1998 ; Kazdin & Weisz, 1998 ; see also Dobson & Craig, in press). But, as will also be evident, there are diverse opinions about the merits and demerits of the empirical evaluation of psychological therapy (Beutler, 1998 ; Borkovec & Castonguay, 1998 ; Garfield, 1998 ; Goldfried &

Wolfe, 1998 ; Persons & Silberschatz, 1998). Before introducing the special section articles, I first mention some of the factors buttressing the need for the empirical evaluation of psychological therapy as well as some cautions that should guide the enterprise.

Why Do We Need the Empirical Evaluation of Psychological Therapy?

Therapists are trained professionals; can they not be expected and sought to provide objective evaluations of the effects of their treatments? Are all therapies similar and similarly effective? What would be the probable result if we did not rely on empirical evaluations of therapy? Considering these preliminary questions provides a framework for the larger issues.

Avoiding Therapist Bias

Empirical evaluations of therapy are necessary to provide measurements of the outcomes of therapy that are independent of the views of those providing the therapies. A major objection to the notion of empirically evaluating psychological treatments can come from therapists who argue that "data" are not needed to tell them what works; they "know" on the basis of their experience. But as psychologists, we are human and are open to the standard biases in inference and decision making and to inaccurate perceptions. Practitioners, for example, can be influenced by their years of having interacted with clients from their roles as knowing professionals. Stated differently, what are the effects on the practicing therapist of years of having implemented behavior change procedures with other people? Unwittingly, unwanted effects can appear (Kipnis, 1994). Although internal attributions for positive outcomes are generally healthy, might therapists be misled by taking credit for client improvements in the absence of controls for alternate explanations of the outcomes?

Researchers, too, can be subject to bias. Consider allegiance effects, in which the outcomes of certain therapies are superior when the evaluations are conducted by individuals with an allegiance to the particular form of psychological treatment. It would not be satisfactory, for example, if the evidence supporting the efficacy of a therapy were produced solely by an individual promoting the treatment. To avoid biases, the criteria for empirically supported psychological therapies require that evidence be derived from research clinics other than or in addition to that of the developer of the treatment (for example, federally initiated [e.g., Treatment of Depression Collaborative Research Program; Elkin et al., 1989] or investigator-initiated [e.g., Heimberg et al., 1997] multicenter trials). Empirically evaluating psychological treatments is a first-line operationalization of the scientist—practitioner model.

Too Many Therapies? Too Many Therapists?

Even a cursory scanning of the literature on psychological therapy reveals an alarming diversity of types of treatment. Taken to the extreme, every therapist could describe what he or she does as a separate form of therapy (i.e., total therapist variability). Rather, the field has delimited, via theory and science, several

approaches that qualify as distinct forms of treatment. Nevertheless, we are still exposed to an inordinately wide array of types of treatment. What variables within these treatments account for positive outcomes if and when they are found?

Many variables have been proposed as explanations of outcome (e.g., therapist factors and treatment techniques), but it has long been clear that what works for one group may not be optimal for another (Kiesler, 1966). Kiesler's (1966) "uniformity myths" are often described in terms of the following question: What form of treatment works best for what type of client? (see also Paul, 1969). Typically, type of therapy has been operationalized by a guiding theory, whereas type of client has been operationalized in terms of diagnoses. Does treatment *X* produce beneficial gains for clients with diagnosis *Y* ? Although such questions are of interest, these specific operationalizations are not required for empirical evaluation. For example, there are other ways of determining homogeneity of participants (classification based on dimensional methods as opposed to categorical methods), and there are methods to assess and evaluate issues such as comorbidity (see Kendall & Clarkin, 1992).

Therapist variability (see Beutler, Machado, & Neufeldt, 1994), even when treatment is evaluated favorably, can influence whether the treatment will be adequately provided. Empirical evaluation of therapy is a step in the right direction, but it does not guarantee that empirically evaluated treatments will be effective when applied by different therapists. Garfield (1996) argued that it is not enough to know that specific techniques are effective, because there is substantial variability across therapists. Empirical evaluations are designed to reduce or eliminate therapist factors, and cumulative analyses can assess and evaluate their influence. This latter approach is consistent with the tenor of the empirical evaluation movement: Let scientific evaluation make determinations about what treatments, provided by whom, are best applied to what types of client problems (see also Chambless et al., 1996).

What If We Do Not Seek Empirical Evaluation?

Consider what the mental health field would be like for psychologists if we did not use criteria for making evaluative decisions and if we did not consider scientific research evaluation to be a cornerstone of our clinical applications. To what category would the professional practice of clinical psychology be assigned: to philosophy, psychic reader, advisor? Our empirical basis sets and maintains a preferred high standard for the profession, and our practice of professional psychology benefits from this foundation.

There is also a need for the empirical evaluation of psychological therapies to make them part of the larger health care system (see also Beutler, 1998). As Barlow (1996) stated,

> If we do not promote and disseminate existing evidence for the efficacy of our psychological interventions, then we will put psychotherapy at a severe disadvantage and risk a substantial deemphasis if not elimination of psychological interventions in our health care delivery system. (p. 237)

Researchers with varied allegiances need to study the outcomes of those forms of therapy most likely to be effective, most theoretically sound, and most supported to date. For new or not as yet empirically supported therapies, it falls to the proponents of these interventions to undertake the evaluation of their approaches using the accepted methodologies (e.g., randomized clinical trials). As you contemplate your position with regard to the empirical evaluation of psychological therapies, consider whether there is an acceptable alternative.

Potential for Use and Abuse

The field of psychological therapy has a nascent yet sound base of evidence that can guide and facilitate treatment decisions. But consider for a moment what it would be like if all of the available data were to be fully ignored. On what basis, then, would a treatment decision be made? In contrast, what if the data mandated that certain treatments be provided?

Are these uses–or abuses–of empirically supported therapies? On what basis, and at what time, would it be ethical to provide an as-yet-unevaluated treatment when there are already data that support an alternate therapy? Who will oversee the deployment of empirically supported versus nonsupported therapies? Clinicians may adopt the label of an empirically supported therapy but continue to provide treatments that have not been examined. Rapid and rabid relabeling of the type of treatment provided might result in a procrustean fit within an endorsed approach, yet do little to change actual practice.

What if the empirical evaluation of psychological therapies is taken too far? What if the identification of empirically supported treatments leads to a restrictive list of treatments, restrictive in the sense that only the identified therapies could be taught in graduate schools, applied in clinics, be reimbursed by third parties, or be subjected to further empirical research? Such an outcome is clearly unwanted and unwarranted, because it would put a dead bolt on the door to progress. The goals of the search for empirically supported interventions, like the goals of the APA Task Force (1995) , do not include the creation of a closed list of therapies to be taught, practiced, reimbursed, or studied further. As Chambless (1996) stated, the goal is not to produce a "mandated list of treatments" (p. 230). Fears tied to taking the identification of empirically supported therapies too far, however, do not justify avoiding the need to identify those treatments that have been supported by empirical research to date (see Beutler, 1998).

Efforts are required to take the knowledge that we have and transport it from research-oriented clinics and journals to practice-focused clinics and practitioner training settings (see Sobell, 1996). Interventions found to be efficacious need to be transported to service-providing settings. This transportability process, itself, may require research evaluation. To what extent do treatment manuals facilitate transportability, and to what degree should flexibility play a role in applications using treatment manuals? Adhering to a manual does not guarantee quality therapy, yet quality may be an issue in outcome (Kendall & Hollon, 1983). Learning treatment from a manual may facilitate the acquisition of skills, but it does not require a slavish adherence to the manual. Are treatments found to be efficacious in producing desirable gains in a research clinic transportable to a community service setting? What factors affect the transportability of treatment (Kendall & Clarkin, 1992 ; Kendall & Southam-Gerow, 1996)?

Most of the research to date, as Barlow (1996) and Garfield (1996) have noted, indicates that although efficacy for some treatments for some disorders has been established, effectiveness (or clinical utility) requires more work.

Comments on the Special Section

I do not wish to abstract or paraphrase the articles that follow. Such an effort would reduce the complexity of the issues and discussions and could result in premature closure on active dialogues. Rather, I invite you to engage the entire special section with the time and thought that it requires.

The special section has three parts. The first part contains this article and one other that were designed to introduce the topic and to provide a contemporary statement of the criteria to use when considering empirically evaluated treatments (Chambless & Hollon, 1998 ; see also Task Force, 1995).

The second part contains articles that address topic areas in which therapeutic interventions have been evaluated. Through the criteria provided by Chambless and Hollon (1998) , literatures were examined to identify the treatments that are empirically supported. Topics (e.g., adult disorders) guided our organizational system; theories of therapy, for example, were not used to steer the reviews. That is, potential contributors were sought from among respected, informed, and reliable scholars who are knowledgeable on each of the topics, and author teams were arranged by the special section editors; we intentionally selected and arranged for teams of authors who represented multiple theoretical views or who had expertise with different disorders. Author teams are not "advocates" of a specific approach; rather, they consist of authors with nonredundant viewpoints. Accordingly, the author teams could not take a unitheoretical stance and had to work out several issues among themselves as part of the process of reviewing the literature.

The third part offers diverse commentaries on the issues emerging from the identification of empirically supported psychological therapies. Commentaries serve an especially important role in this special section. Those encouraged by the movement to identify empirically supported therapies need to consider the wide range of implications associated with this effort (e.g., training, reimbursement, and ethics). The wide range of implications are considered, and again a diversity of viewpoints was sought. The commentaries do not endorse a single-minded perspective but instead consider both the favorable and unfavorable issues facing the empirical evaluation and training of psychological therapy (e.g., Calhoun, Moras, Pilkonis, & Rehm, 1998 ; Davison, 1998).

Psychological therapies benefit from the knowledge generated through basic psychological research, as well as evaluations of treatment outcomes, and this affiliation is clear in the promotion of evidence-based treatments. The mental health field, and clinical psychologists in particular, should be proud of the efforts that have been directed toward the empirical evaluation of therapy and the outcomes that have emerged. It is my hope that we avoid being hypercritical and recognize the larger and more important point: We can help to advance the field of psychological therapy by careful evaluation and cautious interpretations

of the data.

References

Barlow, D. H. (1996). The effectiveness of psychotherapy: Science and policy.(*Clinical Psychology: Science and Practice, 3,* 236—240.)
Baucom, D. H., Shoham, V., Mueser, K. T., Daiuto, A. D. & Stickle, T. R. (1998). Empirically supported couple and family interventions for marital distress and adult mental health problems.(*Journal of Consulting and Clinical Psychology, 66,* 53—88.)
Beutler, L. (1998). Identifying empirically supported treatments: What if we didn't?(*Journal of Consulting and Clinical Psychology, 66,* 113—120.)
Beutler, L. E., Machado, P. & Neufeldt, S. (1994). Therapist variables.(In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 229—269). New York: Wiley.)
Borkovec, T. D. & Castonguay, L. G. (1998). What is the scientific meaning of empirically supported therapy?(*Journal of Consulting and Clinical Psychology, 66,* 136—142.)
Calhoun, K. S., Moras, K., Pilkonis, P. A. & Rehm, L. P. (1998). Empirically supported treatments: Implications for training.(*Journal of Consulting and Clinical Psychology, 66,* 151—162.)
Chambless, D. L. (1996). In defense of dissemination of empirically supported psychological interventions.(*Clinical Psychology: Science and Practice, 3,* 230—235.)
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., Baker, M., Johnson, B., Woody, S. R., Sue, S., Beutler, L., Williams, D. A. & McCurry, S. (1996). An update on empirically validated therapies.(*Clinical Psychologist, 49,* 5—14.)
Compas, B. E., Haaga, D. A. F., Keefe, F. J., Leitenberg, H. & Williams, D. A. (1998). Sampling of empirically supported psychological treatments from health psychology: Smoking, chronic pain, cancer, and bulimia nervosa.(*Journal of Consulting and Clinical Psychology, 66,* 89—112.)
DeRubeis, R. J. & Crits-Christoph, P. (1998). Empirically supported individual and group psychological treatments for adult mental disorders.(*Journal of Consulting and Clinical Psychology, 66,* 37—52.)
Davison, G. C. (1998). Being bolder with the Boulder model: The challenge of education and training in empirically supported treatments.(*Journal of Consulting and Clinical Psychology, 66,* 163—167.)
Dobson, K. (Ed.) & Craig, K. (Ed.) (in press). *Best practice: Developing and promoting empirically supported interventions.* (Newbury Park, CA: Sage)
Elkin, I., Shea, M. T., Watkins, J., Imber, S., Sotsky, S., Collins, J., Glass, D., Pilkonis, P., Leber, W., Docherty, J., Fiester, S. & Parloff, M. (1989). National Institute of Mental Health Treatment of Depression Collaborative Research Program: General effectiveness of treatments.(*Archives of General Psychiatry, 46,* 971—982.)
Garfield, S. L. (1996). Some problems with "validated" forms of psychotherapy.(*Clinical Psychology: Science and Practice, 3,* 218—229.)
Garfield, S. L. (1998). Some comments on empirically supported treatments.(*Journal of Consulting and Clinical Psychology, 66,* 121—125.)
Goldfried, M. R. & Wolfe, B. E. (1998). Toward a more clinically valid approach to therapy research.(

Journal of Consulting and Clinical Psychology, 66, 143—150.)
Heimberg, R. G., Liebowitz, M. R., Hope, D. A., Schneier, F. R., Holt, C. S., Welkowitz, L., Juster, H. R., Campeas, R., Bruch, M. A., Cloitre, M., Fallon, B. & Klein, D. (1997). *Cognitive-behavioral group therapy versus phenelzine in the treatment of social phobia: I. Twelve-week outcome.* (Manuscript submitted for publication)
Kazdin, A. E. & Weisz, J. R. (1998). Identifying and developing empirically supported child and adolescent treatments.(*Journal of Consulting and Clinical Psychology, 66,* 19—36.)
Kendall, P. C. (1989). The generalization and maintenance of behavior change: Comments, considerations, and the "no-cure" criticism.(*Behavior Therapy, 20,* 357—364.)
Kendall, P. C. (Ed.) & Clarkin, J. (Ed.) (1992). Comorbidity and treatment implications [special section].(*Journal of Consulting and Clinical Psychology, 60,* 833—908.)
Kendall, P. C. & Grove, W. (1988). Normative comparisons in therapy outcome.(*Behavioral Assessment, 10,* 147—158.)
Kendall, P. C. & Hollon, S. (1983). Calibrating therapy: Collaborative archiving of tape samples from therapy outcome trials.(*Cognitive Therapy and Research, 7,* 199—204.)
Kendall, P. C. & Southam-Gerow, M. (1996). Issues in the transportability of treatment.(*Journal of Consulting and Clinical Psychology, 63,* 702—708.)
Kiesler, D. (1966). Some myths of psychotherapy research and the search for a paradigm.(*Psychological Bulletin, 65,* 110—136.)
Kipnis, D. (1994). Accounting for the use of behavior technologies in social psychology.(*American Psychologist, 49,* 165—172.)
Paul, G. (1969). Behavior modification research: Design and tactics.(In C. Franks (Ed.), *Behavior therapy: Appraisal and status.* New York: McGraw-Hill.)
Persons, J. B. & Silberschatz, G. (1998). Are results of randomized controlled trials useful to psychotherapists?(*Journal of Consulting and Clinical Psychology, 66,* 126—135.)
Sobell, L. C. (1996). Bridging the gap between scientists and practitioners: The challenge before us.(*Behavior Therapy, 27,* 297—320.)
Task Force on Promotion and Dissemination of Psychological Procedures, Division of Clinical Psychology (1995). Training in and dissemination of empirically-validated psychological treatments: Report and recommendations.(*Clinical Psychologist, 48,* 3—23.)
Wilson, G. T. (1996). Empirically validated treatments: Reality and resistance.(*Clinical Psychology: Science and Practice, 3,* 241—244.)

1

Could it be that someone would talk about an empirically evaluated therapy simply because a study was done, even if the study's outcomes were nonsupportive? I think not.