

Evaluation:
Methodology Paper of the
Scientific Advisory Board on Psychotherapy
According to Section 11 PsychThG (Psychotherapists Act)

Prepared by

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Executive Summary

The purpose of the present paper is to examine the scientific validity of the criteria set forth in the **Methodology Paper of the Scientific Advisory Board on Psychotherapy** (Methodology Paper). The procedures and criteria contained in the Methodology Paper were developed to identify safe and effective psychotherapy treatments with the intent to protect the public and optimize the benefits of psychotherapy.

The scientific evidence for the effectiveness of psychotherapy and how psychotherapy works to produce the benefits (mechanisms of change) are reviewed, with implications for the validity of the Methodology Paper. This review is summarized below:

Area 1:

Title: Differential Effectiveness of Psychotherapy Treatments.

Conclusion: No particular psychotherapy treatment has been shown to be superior to any other legitimate psychotherapy, for any disorder (with some possible minor exceptions).

Implication: The Methodology Paper is deficient because it assumes that some psychotherapy treatments are superior to others

Area 2:

Title: Reliance on Randomized Clinical Trials (RCTs)

Conclusion: Policy decisions that rely on or prioritize evidence from RCTs are flawed generally, and particularly so in psychotherapy RCTs.

Implications: The Methodology Paper is deficient because it prioritizes evidence from RCTs over evidence from naturalistic settings and other evidence.

Area 3:

Title: The Search for Specificity in Psychotherapy

Conclusion: There is little or no evidence that any particular psychotherapy is specific for any disorder; that is to say, the specific ingredients and processes of approved (as well as other) psychotherapy treatments have not been shown to be necessary to produce the benefits of the various treatments.

Implications: The Methodology Paper is deficient because it assumes that designated treatments work through the specific ingredients of the respective treatment.

Area 4:

Title: Defining a Psychotherapy Treatment

Conclusion: The definitions of particular psychotherapy treatment are ambiguous and the treatments within a particular treatment name vary greatly. As well, there is disagreement among experts as to what treatments belong to a certain class of treatments.

Implications: The Methodology Paper is deficient because it assumes that approval of a particular treatment results in the administration of a uniform treatment to patients, when in fact a variety of treatments are contained within a designated named treatment and there is little agreement about which treatments belong to the designated treatment.

Area 5:**Title: Evidence for Ignored Factors**

Conclusion: There are many factors that lead to effective psychotherapeutic treatment and these factors involve aspects of the relationship between the therapist and the patient. The importance of relationship factors for producing benefits of psychotherapy are an order of magnitude greater than the specific factors used to designate treatments. Moreover, there is significant variation in effectiveness of all treatments that is due to the therapist delivering the treatment; that is, some therapists, regardless of the treatment, are more effective than other therapists.

Implications: The Methodology Paper is deficient because it ignores for the most part the relationship factors that are essential for effective psychotherapy and fails to recognize that these factors are common to all psychotherapy treatments. Moreover, the Methodology Paper assumes that therapists uniformly deliver a designated treatment and ignore the fact that some therapists are more effective than others.

Conclusion: The assumptions made for the criteria in the procedures described in the Methods Paper are unscientific—that is, they ignore the evidence for what makes psychotherapy effective. Using the methods described in the Methods Paper unscientifically privileges particular treatments, reduces patient choice, and has not, and cannot, improve the quality of mental health services.

Evaluation:
Methodology Paper of the
Scientific Advisory Board on Psychotherapy

The purpose of this evaluation is to examine the methodology applied by the Scientific Advisory Board on Psychotherapy, as stipulated by the Psychotherapists Act. The evaluation will be informed by the science of psychotherapy as well as by current statistical and design methods.

Preface

Psychotherapy is remarkably effective, a fact established in randomized clinical trials and in clinical settings (Barkham & Lambert, 2021; Minami et al., 2008; Wampold & Imel, 2015). Psychotherapy treatments are as effective as medications for most mental disorders, without the side effects and with longer lasting effects (Cuijpers et al., 2013; DeRubeis et al., 2008; Wampold & Imel, 2015).

Despite the benefits of psychotherapy, psychotherapy has several limitations. Psychotherapy is fairly time consuming, typically involving at least one hour per week over the course of several weeks, plus transportation time, if delivered face-to-face. Although adverse events are rare, for most patients psychotherapy can be demanding emotionally, stressful, and effortful. Many patients do not engage with psychotherapy, as the dropout rate is relatively high, especially after the first session (Olfson et al., 2009; Swift & Greenberg, 2012). Although beneficial, not all patients benefit from psychotherapy. The Number-Needed-to-Treat (NNT) for psychotherapy, compared to no treatment, is approximately three (3), indicating that only one in three patients have a better outcome than not receiving psychotherapy (Wampold & Imel, 2015), but it must be kept in mind that the NNT for psychotherapy is superior to many medical interventions, many of which are very expensive and have serious side-effects. Another issue for psychotherapy (as well as psychiatry) is access to mental health treatments, as in many venues, those with diagnosable mental disorders do not receive mental health treatment of any type (Kessler et al., 2005; Mojtabai et al., 2011; Wang et al., 2011; Wang et al., 2005).

Psychotherapy, as a treatment for mental disorders, is a widely accepted practice around the world, paid for by many national or regional government health authorities and insurance companies. The effort internationally is to improve the quality of mental health services and ensure patients are receiving effective therapy. Internationally there have been three means to improve psychotherapy services. The first involves identifying evidence-based treatments and mandating that psychotherapists provide these and only these treatments. The second strategy involves monitoring patient progress and using the resulting information to improve services, primarily by providing information about patient progress to the psychotherapist. The third strategy focuses on individual clinicians and ways in which they can improve their outcomes by improving their therapy skill level. The primary strategy utilized by the Scientific Advisory Board on Psychotherapy (SABP) is to identify evidence-based treatments and mandate their use.

In this evaluation, the scientific basis of the evidence-based treatment strategy is examined with particular attention to methods described in the Methodology Paper as promulgated by SABP. There are several assumptions made by the SABP that will be critically examined.

Differential Effectiveness of Psychotherapy Treatments

The Evidence

Designating one or more psychotherapeutic treatments as evidence-based assumes that some psychotherapy approaches are more effective than others, in general or for specific disorders. This is a logical deduction if one assumes that the specific ingredients of a particular treatment are responsible for the benefits of treatments and that some specific ingredients are more potent than others. However, this is an empirical question rather than a logical one. There are several models formed around the conjecture that all cogent and believable treatment (i.e., believed to be effective by the therapist and the patient), delivered by therapists skillfully, with a similar therapeutic focus on the patient's problems, will be equally effective due to what have become known as the common factors (Frank & Frank, 1991; Garfield, 1995; Orlinsky & Howard, 1986; Wampold, 2015; Wampold & Imel, 2015). Notably, all of these models emphasize that optimally effective treatments delivered to patients will be have a cogent rationale, believable to the patients, for problem focused work (Yulish et al., 2017) and that the particular treatment is not important.

With respect to the scientific evidence for differential effectiveness of psychotherapies, many meta-analyses have addressed this conjecture. The first meta-analysis examining the benefits of psychotherapy found small differences among classes of treatments and these differences were due to study characteristics and not superiority of any particular class of treatments (Smith & Glass, 1977; Smith et al., 1980). Subsequent meta-analyses have corroborated the conjecture that all treatments intended to be therapeutic and provided in a legitimate manner are approximately equally effective, in general (Marcus et al., 2014; Wampold et al., 1997) and for specific disorders, including depression, anxiety, post-traumatic stress disorder, substance use disorders, childhood disorders, among others (as reviewed by Wampold & Imel, 2015). When differences between treatments are detected, the differences are most likely due to study characteristics, definition of treatments, control conditions used, researcher allegiance, and design of clinical trials (Baardseth et al., 2013; Munder et al., 2012; Munder et al., 2019; Munder et al., 2011; Wampold, Flückiger, et al., 2017). There are possible exceptions, including simple phobias and obsessive-compulsive disorder, but even for these two particular disorders the evidence is equivocal.

Not only are all legitimate treatments equally effective in clinical trials, but they are equally effective when transported to clinical settings (Pybis et al., 2017; Stiles et al., 2008). This is true in systems, such as the National Health Service (NHS) in England, that intentionally have rolled out evidence-based treatments (Pybis et al., 2017); the evidence-based CBT failed to outperform generic counseling and humanistic approaches in practice (Pybis et al., 2017; Stiles et al., 2008).

Some venues have avoided the inconvenient fact that there is no evidence that any treatment is superior to another by stipulating that priority is given to treatments that have more evidence. The problem here is that certain treatments are given priority for funding, for political reasons primarily but also because they are already privileged, are in vogue, or have vocal proponents—all factors that have little to do with their effectiveness. Therefore, privilege typically is based on power and funding and not effectiveness. Moreover, what is determined to be an evidence-based treatment varies country by country.

One of the consequences of the equality of treatments intended to be therapeutic is that whenever such a treatment is examined it has been found to be effective, adding to an ever-expanding list of treatments with evidence to support their effectiveness. A corollary of this phenomenon is that even treatments that were intended to be control conditions, without the effective ingredients thought to be remedial for particular deficits, but maintaining a focus on the patient's problems and given by therapists who believe the treatment is effective, they are found to be effective. Indeed, some well-known and accepted treatments, appearing on official lists of psychological treatments with strong evidence, began as control conditions (i.e., without an expectation that they would be effective). This list of surprising evidence-based treatments includes interpersonal therapy (IPT) for depression and other conditions, present-centered therapy (PCT) for PTSD, behavioral activation (BA) for depression and a number of other conditions, and supportive therapy (ST) for depression. The case for PCT is particularly instructive as it was designed to demonstrate the effectiveness of prolonged exposure (PE), designed and tested by Edna Foa and colleagues, and cognitive-processing therapy (CPT), designed and tested by Patricia Resnick and colleagues. PCT was intentionally designed to omit any exposure and cognitive restructuring, the core of CBT treatment for PTSD (and most anxiety disorders), yet in more than six clinical trials, PCT was as effective as PE and CPT, a result verified by meta-analysis (Frost et al., 2014). Even the most rigorous examination of the effects of PE conducted by Foa, PCT was as effective as PE (Foa et al., 2018), with fewer dropouts (Frost et al., 2014; Imel et al., 2013). As another example of an anomaly, eye-movement desensitization and reprocessing (EMDR), a treatment that has been labelled as pseudoscience (Herbert et al., 2000; McNally, 1999), has been shown to be as effective as CBT for the treatment of PTSD.

Hundreds of different psychotherapies have been examined in clinical trials in comparison to wait-list controls (WLC) and not one failed to be more effective. Furthermore, there is no evidence from any clinical trial that any psychotherapeutic treatment has proven to be harmful (Wampold & Imel, 2015). In that sense, identifying a few evidence-based treatments does not protect the public from harm.

Implications

The evidence strongly supports the conjecture that all psychotherapeutic treatments, provided by therapists who believe in the treatment and that focused on the patient's problems, are equally effective. Consequently, any researcher could conduct the research needed to be privileged in a list of evidence-based treatments, provided the necessary research was conducted. However, conducting the research necessary is expensive and typically takes some government

funds. Accordingly, privilege is a function of research funding and thus preordained by priorities of funders, and fails to identify effective treatment from a population of treatment.

Reliance on Randomized Clinical Trials

All systems for identifying evidence-based treatments rely on the results of randomized clinical trials (RCTs) to produce the needed evidence. Indeed, such designs are often called the *gold standard* of psychotherapy research. Unfortunately, policy makers typically fail to appreciate the limitation of RCTs for making policy, putting unfounded faith in the conclusions of RCTs and not appreciating the difficulty in transporting the results of the trials to naturalistic settings. Deaton and Cartwright (2018) have provided the most thorough critique of RCTs for medicine, economics, and other social sciences (n.b., Sir Angus Deaton is an Economic Sciences Nobel Laureate, so his and Cartwright's critique of RCTs is not a diatribe but a comprehensive and learned critique). However, psychotherapy presents additional challenges and one must be cognizant of these issues when designating RCTs as the primary source for identifying evidence-based treatments. The major issues are discussed here.

A particularly important aspect of RCTs in medicine is double-blinding. That is, neither the patient nor the treating clinician is aware of the assignment of the patient to the various conditions (actually, it is a triple blind because the evaluator/data analyst are blinded as well). Blinding is an absolute necessity for the validity of RCTs (medicine would never admit an unblinded study as evidence), yet all psychotherapy trials are not blinded, as the therapist knows the treatment being delivered and the patient is aware of exactly what is done in therapy. This fact leaves psychotherapy RCTs vulnerable to many consequential confounds, as discussed later in this section.

Another issue for RCTs is the design of the RCT, particularly the choice and design of control conditions. Psychotherapy trialists have a choice of several types of control conditions, including another legitimate psychotherapy (the results from such comparisons were reviewed in the previous section), wait-list conditions (WLC), Treatment-as-usual (TAU), and psychological placebos. Outcomes of the trial depend on the choice of the control group (Michopoulos et al., 2021). As well, considerable variability exists within each type of control condition, which has an impact on the outcome (Cuijpers et al., in press). Most importantly, how the researcher designs the control condition can influence the outcome (cf. Cuijpers et al., 2019; Munder et al., 2018, 2019). Of course, each type of control condition answers a different question.

Due to the fact that there is so much variability in the control conditions, there is great latitude for researchers to influence the outcomes of RCTs. Indeed, it is now well established that the researcher's allegiance to a treatment influences the outcome of the trial, particularly by the manner in which the study is designed, including the construction of the control condition (Munder et al., 2013; Munder et al., 2012; Munder et al., 2011). Indeed, the purported superiority of CBT for some disorders is an artifact of control condition design, among other factors (Wampold, Flückiger, et al., 2017). Moreover, large effects for particular treatments have never been replicated (Frost et al., 2020), which raises further concerns about using RCTs to identify effective treatments.

A further problem with RCTs is that the conditions of the RCT are dissimilar to the clinic setting to which the results must apply in order for the conclusions of the RCT to have the potential to improve the quality of mental health services. Generalizability to applied settings, often referred to as external validity, is quite limited in psychotherapy. The usual consideration for generalizability is the nature of the patient sample in the RCT—how similar to patients in clinical settings is the sample studied in the RCT? Typically, the patients are very different. For example, in clinical trials for depression, patients who have personality disorders, have suicidal ideation, are using substances, are taking antidepressant or other psychotropic medication, have psychotic features, or are receiving other forms of mental health treatment are excluded. However, the characteristics of the patients is only one threat to external validity and there are an array of others, including the setting itself (e.g., a university based clinic compared to public agency), the case load of the therapists (often in RCTs the caseload is limited), the extra training and supervision of the therapists, monitoring the adherence and competence of the therapists, the actual treatment being delivered (therapist in clinical settings do not provide the treatment the way it is given in an RCT, a problem discussed further in a following section), among others. Unfortunately, these are the very elements that are required to ensure internal validity and publication of the trial. However, the biggest threat to the external validity of the study is the selection of the therapists. In an RCT, generalization is made not only to a population of patients but the sample of therapists in the trial must generalize to the population of therapists (Serlin et al., 2003; Wampold & Serlin, 2000). The issue of therapists will be discussed below, as it is ignored in psychotherapy research and importantly in schemes to identify evidence-based treatments.

Implications

All methods to identify evidence-based treatments for dissemination rely primarily on RCTs, without realizing the flaws of such designs. Deaton and Cartwright (2018) offered numerous examples how this strategy has led to poor policy decisions (i.e., suboptimal health and economic outcomes) in medicine and economics, a situation that is exacerbated by the problems with psychotherapy RCTs. Advocates of particular treatments are able to design RCTs to the advantage of their preferred treatment (i.e., researcher allegiance), a phenomenon that has been documented (Wampold, Flückiger, et al., 2017). RCT evidence can be useful for various purposes but has distinct issues when used to designate certain treatments as evidence-based, without careful attention to other evidence (e.g., naturalistic studies, process studies). For instance, naturalistic studies have shown that therapists in clinical settings, delivering a variety of treatments, obtain outcomes as good as outcomes as evidence-based treatments delivered in the context of clinical trials, in fewer sessions (Minami et al., 2008), which suggests that naturalistic evidence (outcomes obtained by clinicians) should be considered vis-à-vis RCT evidence. In light of the fact that clinicians achieve commendable outcomes (i.e., meets benchmarks set by clinical trials), it makes little sense to mandate the clinicians only deliver particular treatments.

The Search for Specificity in Psychotherapy

Strategies for identifying particular evidence-based treatments typically assume, and in many cases require, that it be established that the treatment is specific. That is, the ingredients of

the treatment must demonstrably be responsible for the benefits of the treatment. The general thesis is that a given psychopathology is the result of a particular psychological deficit (e.g., disordered or maladaptive cognitions) or condition (emotional dysregulation) and that the ingredients of the treatment remediate the deficit or address the condition. There are a number of ways in which specificity can be addressed (Wampold & Imel, 2015), each of which will be discussed briefly here.

The first way that specificity may be demonstrated is by comparing two treatments, say A and B. If the ingredients of Treatment A are more potent than the ingredients of Treatment B, then A will be more effective than B. As discussed above, no treatment has consistently been shown to be superior to another treatment, for any disorder, and consequently this method has not detected specificity for any treatment.

The second way to establish specificity is to use a *dismantling design*. A *dismantling design* compares the full compendium of the treatment (all the components of the treatment, as it would be given in an ideal manner) to the treatment without one or more of the crucial ingredients. This design is closest to the placebo controlled RCT of medicine (i.e., comparison of the active medication to a condition without the active medication). In a seminal study, a dismantling design was used to examine the specificity of Beck's cognitive therapy (CT) for depression by comparing the full CT package to two dismantled conditions: (a) CT without schema change and (b) CT without schema change and without cognitive restructuring (Jacobson et al., 1996). Surprisingly (to the authors), CT was not more effective than the treatment without the two most important ingredients. Results from dismantling designs for various disorders have produced similar results—the specific ingredients in these treatments are not necessary to produce optimal results. This lack of specificity has been corroborated by two meta-analyses of dismantling studies (Ahn & Wampold, 2001; Bell et al., 2013).

A third way to establish specificity is to examine related therapy processes and outcome, which would establish mechanisms of change. About a decade ago, Alan Kazdin, a well-known behavior therapy researcher bemoaned the fact that after decades of psychotherapy research the field had failed to identify the mechanisms of change (Kazdin, 2007, 2009). Since that time, statistical methods for examining longitudinal growth models have been developed and these methods have the potential to reveal how various process variables are related to outcome over the course of therapy (e.g., Curran & Bauer, 2011; Wang & Maxwell, 2015). Nevertheless, there is no convincing evidence from these studies that any particular treatment works through some designated mechanism of change (see Wampold & Imel, 2015, for a review of these studies), although application of these procedures may reveal mechanisms of change, although these mechanisms may not be treatment specific.

The final way that has been used to establish specificity is to create a control treatment without any specific ingredients, which goes by various names including psychological placebo, alternative treatment, supportive counseling, among others. This strategy, for many reasons, is fatally flawed, as discussed by several methodologists (Kirsch, 1997, 2005; Kirsch et al., 2016; Wampold & Imel, 2015). Essentially the strategy is flawed because the control treatment is not intended to be therapeutic, has no structure or rationale that is convincing to either the patient nor

the therapist, is not focused on the patient's problems (i.e., has no goals or agreement about the work of therapy), and often fails to resemble any treatment delivered in a clinical setting (Yulish et al., 2017). Interestingly, when these treatments are designed to better resemble a legitimate treatment, they become as effective as evidence-based treatments (Baskin et al., 2003; Wampold et al., 2010).

The final evidence against specificity comes from studies that measure adherence to protocol and treatment-specific competence in clinical trials of evidence-based treatments. Presumably, if treatment ingredients were important, adherence to the protocol and treatment-specific competence in delivering the ingredients would be associated with better outcomes, but that is not the case. In a meta-analysis of adherence and competence, neither was related to outcome (Webb et al., 2010).

Implications

Given the state of evidence, requiring a demonstration of specificity that has not been made by any psychotherapeutic treatment. If one believes, as the evidence suggests, that the particular specific ingredients are not the mechanisms of change, as reviewed in a later section, then demonstration of specificity would disqualify all treatments from being designated as evidence-based.

Defining a Psychotherapy Treatment

When antidepressant medication (ADM) is studied in a clinical trial, the treatment is standardized in the sense that 40mg of fluoxetine daily in one study is the same treatment as 40 mg of fluoxetine in another study, and is the same as 40mg of fluoxetine given to a patient in a clinical setting. Although many factors may differ from one trial to another, and from the trials and clinical practice, the active treatment (i.e., 40mg/day) is constant. The delivery of a psychotherapeutic treatment is entirely different.

What are the defining features of a psychotherapy? To many, a treatment is defined by the manual that guides delivery of the treatment, but manual are guides, some more detailed than others. A manual-guided treatment will vary from patient to patient, therapist to therapist, one clinic to another, and very definitely from clinical trials to practice settings. It is well known that therapists trained to deliver manual-guided treatment tend to drift away from the manual over time.

The variation of a treatment across patients, therapists, clinics, and settings is only the beginning of the problems. Typically, what is designated as an approved psychotherapeutic treatment is a class of treatments, such as Cognitive Behavior Therapy (CBT). But there is no agreement about what defines CBT and what particular treatments fall into the class of CBT. In meta-analysis, what is classified as CBT varies from one meta-analysis to another. For example, eye-movement desensitization and reprocessing (EMDR), which has been described as pseudoscience as discussed earlier, has been classified as CBT (Baardseth et al., 2013). What various treatments fall under the rubric CBT (as well as any other treatment class) is ambiguous and affects conclusions about various treatments (see Baardseth et al., 2013; Wampold,

Flückiger, et al., 2017). In addition, there is significant disagreement amongst experts as to which treatments could be classified as CBT (Baardseth et al., 2013). Moreover, the classification problem is not static, as what characterizes any treatment class changes and evolves over time (Hofmann & Asmundson, 2008; Hofmann & Barlow, 2014). Moreover, the effectiveness of treatment varies over time; indeed, the effectiveness of CBT has been decreasing over time (see e.g., Johnsen & Friberg, 2015).

The issue of what qualifies as an exemplar of a particular treatment determined to have been an evidence-based treatment has been discussed in the section on RCTs, but it is useful to emphasize the point here. Even if a particular treatment is well defined and determined to be effective in RCTs, a treatment, using the same name as the tested treatment, may vary considerably from the prototype. In clinical trials, adherence to the protocol is required and assessed; indeed, adherence failure is often invoked to explain post-hoc the failure of a treatment to perform as expected (Laska et al., 2014). For example, when CBT did not outperform humanistic treatments in the NHS, advocates of CBT claimed CBT therapists were not delivering CBT faithfully (Clark et al., 2008; despite the evidence that adherence is not related to outcome).

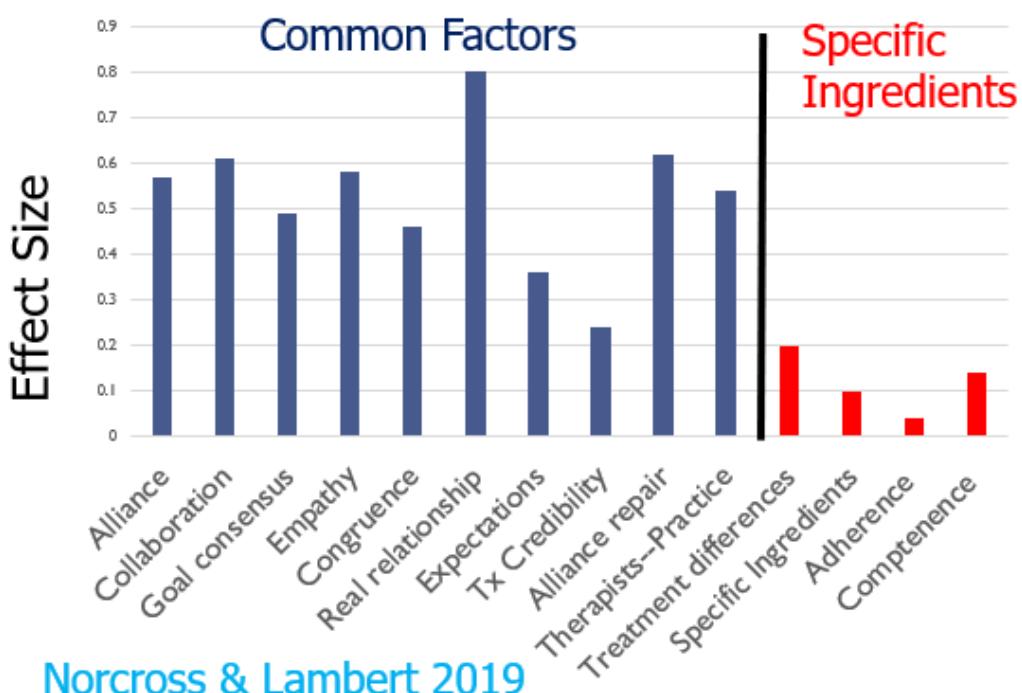
Implications

There is considerable latitude and imprecision in the definition and classification of a particular treatment. Any designation of Treatment A as evidence-based assumes that a treatment with the name “A” is a known and is a constant entity, and not one that is open to interpretation, variation from one setting to another or from one therapist to another, and that changes over time, either in its composition or its effectiveness. Designation of a particular treatment for special status ignores important conceptual and empirical aspects of psychotherapy.

Evidence for Ignored Factors

As discussed here, schemes to designate treatments as evidence-based treatment make the strong assumption that the specific ingredients of the treatment are causal to the benefits of the treatment. Earlier, the lack of evidence for specific ingredients was discussed. Given that psychotherapy is a remarkably effective and that the specific ingredients do not appear to be responsible for the benefits, the logical question is what the components of an effective psychotherapy are.

There is convincing evidence that relationship factors are critical components of successful psychotherapy, regardless of treatment being delivered. Recently Norcross and Lambert (2019) published a volume, each chapter of which was a meta-analysis of the evidence for various relationship factors as predictors of psychotherapy outcome. Figure 1 presents the



Norcross & Lambert 2019

effect sizes converted to standardized mean differences (SMDs) for these factors, with SMDs for factors related to specificity included for comparison. As presented here, many relationship factors have a strong association with outcome, including the therapeutic alliance, alliance repair, collaboration, goal consensus, empathy, congruence, the real relationship, expectations for change created, and the perceived treatment credibility. As well, the effects for these relationship factors are meaningfully larger (an order of magnitude greater) than the effects for the specific ingredients that are emphasized in evidence-based treatment schemes.

A threat to the validity of the relationship factors is that the preponderance of the evidence is derived from correlational data. However, as Deaton and Cartwright (2018) emphasize, policy decisions should be made from a variety of research methods rather than from designs that exclusively rely on randomized designs. Second, many of these effects are robust, with examination of and ruling out of multiple confounds. For example, the importance of a strong working alliance is based on a meta-analysis of 295 studies and over 30,000 patients, is not due to early symptom relief, precedes change in symptoms over the course of therapy, is important for all therapeutic approaches, and is equally important for all disorders (Flückiger et al., 2018; Flückiger et al., 2012; Flückiger, Del Re, et al., 2020; Flückiger, Rubel, et al., 2020). Moreover, the importance of the relationship for health outcomes has been established experimentally in medicine and in placebo studies (Wampold, 2018).

The most important therapeutic factor is the one that typically ignored in research and is universally overlooked in evidence-based treatment schemes, namely the therapist providing the treatment. Therapist effects refers to the phenomenon that some therapists consistently achieve better outcomes than others, regardless of the treatment being delivered and the characteristics of the patient. Meta-analyses have documented sizable therapist effects in naturalistic settings but

in clinical trials as well (Baldwin & Imel, 2013; Johns et al., 2019; Wampold & Owen, 2021). That is to say, one of the most important factors in the benefits of psychotherapy is the therapist him- or herself (see figure 1). Some CBT therapists achieve better outcomes than other CBT therapists, some psychodynamic therapists produce better outcomes than other psychodynamic therapists, and some humanistic therapists produce better outcomes than other humanistic therapists. The stunning conclusions regarding therapists is that the therapist is more important than the treatment.

The presence of therapist effects in both RCTs and clinical practice raises the question of what characterizes the more effective therapists. The evidence suggests rather strongly that relationship capabilities are what makes an effective therapist; more effective therapists are able to form stronger alliance across a range of patients and use a more sophisticated set of interpersonal skills in challenging situations (Schöttke et al., 2017; Wampold, Baldwin, et al., 2017; Wampold & Owen, 2021).

Another aspect of psychotherapy that is ignored in evidence-based practice schemes is that to be optimally effective, psychotherapy must be adapted to the patient. Different types of patients benefit from different types of treatments or adaptations of treatments (Norcross & Wampold, 2019). There is strong evidence that treatments must be selected or adapted to the patient's culture, the patient's preference for a particular treatment, the patient's religion or spiritual beliefs and practices, the patient's reactance level, stage of change, and coping style (Norcross & Wampold, 2018).

Implications

Evidence-based practice schemes ignore the fact that relationship factors are vital to delivering effective therapists. Designating a treatment as effective and mandating that the particular treatment be used in practice ignores the fact that the therapist delivering the treatment is a critical factor in effectiveness and what characterizes effective therapists is not adherence to a protocol or treatment-specific competence but rather it is relationship skills. As discussed earlier, all treatments are approximately equally effective and what makes a particular treatment beneficial is the relationship skill of the therapist. Moreover, designating a treatment or treatments limits patient and therapist choice. Honoring patient preferences is related to outcome (Swift et al., 2018). Finally, different types of patients, with the same disorder, will optimally respond to different treatments—designating the use of one or two treatments assumes that these treatments are universally effective for all patients.

Another consequence of therapist effects is around generalizability of RCT results to practice settings. As mentioned earlier, therapists in clinical trials typically are selected for their skill, given special training, supervised, and monitored. That is, these therapists and the context in which these therapists work limit the generalizability of RCT conclusions (Serlin et al., 2003; Wampold & Serlin, 2000). Moreover, efforts to improve therapist competence in CBT does not improve outcomes (Branson et al., 2015), providing additional evidence that nonspecific therapist skills are what makes psychotherapy effective.

Conclusions

As presented here, evidence-based treatment schemes, including the German PsychThG (Psychotherapists Act) privilege certain treatments in a manner that ignores the scientific evidence of how psychotherapy works. Emphasis is on determining which treatments produce the benefits of psychotherapy, based on the particular therapeutic factors contained in those treatments. Such a scheme privileges treatments for which there are treatment manuals, research fundings, and more specific therapeutic techniques, ignoring the fact that such treatments have never demonstrated superiority over other, less structured and more relationship-oriented treatments. Furthermore, the emphasis on particular treatments ignores the well-established fact that it is the particular psychotherapist who makes the treatment successful. Moreover, effective therapists have a sophisticated set of interpersonal skills that are applicable in challenging interactions with the patient and consequently designating a particular treatment as scientifically recognized ignores how psychotherapy works to produce the benefits of the treatment.

The Methods Paper mentions the psychotherapy relationship and the effectiveness of the treatment in practice, but these considerations clearly are secondary to controlled research in artificial conditions. Moreover, the controlled research that is emphasized has never produced consistent evidence that one treatment is superior to any other legitimate treatment or that any particular treatment works through the purported specific ingredients.

Using the methods described in the Methods Paper unscientifically privileges particular treatments, reduces patient choice, and has not, and cannot, improve the quality of mental health services.

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