

Evidence-Based Treatments and the Substance Abuse Treatment Provider

Peter E. Nathan
University of Iowa

Wisconsin Teleconference
July 24, 2008

- Evidence-based practices now feature prominently in both psychological and medical practice including in the treatment of substance abuse.
- Two issues will be addressed in this Teleconference:
 - **What are evidence-based practices?**
 - **Do they have relevance to the substance-abuse provider?**

History of Evidence-Based Medical Practice

- Most of us assume that medicine has long been evidence-based.
- However, it was only in 1992 that “the manifesto of the evidence-based-medicine movement” appeared (Patterson, 2002).
- The emphasis on evidence-based psychological treatments so evident today developed shortly thereafter.

History of Evidence-Based Medical Practice

- The roots of evidence-based medical practice is usually traced to a *JAMA* article (Guyatt, 1992) that advocated evidence-based medical practice over medicine as an art.
- The article “ignited a debate about power, ethics, and responsibility in medicine that is now threatening to radically change the experience of health care” (Patterson, 2002).

History of Evidence-Based Medical Practice

- For most of its history, the guiding principle in medicine was Aristotelian (Patterson, 2002).
 - Doctors first tried to understand the disease, then they tried to think of an intervention.
- The Aristotelian method worked, for example, when the role of insulin deficiency in juvenile diabetes was identified more than 100 years ago.
 - The treatment that suggested itself, insulin replacement, was a huge success.

History of Evidence-Based Medical Practice

- However, the Aristotelian method doesn't always work. Everyone, physicians included, tends to see what they expect to see.
 - If it makes sense that a treatment should work, then it will often be perceived as working.
- Examples include bloodletting, purging, insulin-coma therapy and, most recently, hormone-replacement therapy.
 - While these “treatments” made sense, they turned out to be ineffective and, in some instances, harmful.

History of Evidence-Based Medical Practice

- The change in medicine over the past decade has been away from the art in medicine and toward the science in medicine.
- “... there are reliable, validated data, and then there are data that aren't reliable and validated, and that's really what matters” (Patterson, 2002).

- How do we know when a medical or psychological practice is based on reliable and valid data?
- That is, how do we know when a practice is evidence-based?

How Do We Know When a Treatment is Evidence-Based ?

Research establishing Evidence-Based Treatments generally includes these key methodological features:

- **Randomized assignment of patients** to treatment and comparison groups, so that any differences in outcomes among the groups reflect differences in the power of the treatments rather than any systematic bias in patient assignment;
- Provision for an active **comparison treatment**, in preference to a no-treatment control, to provide the strongest test of whether the experimental treatment is superior to the established comparison treatment;

How Do We Know When a Treatment is Evidence-Based ?

- **Consistent, documented delivery of treatments**, to ensure that the treatments whose effectiveness is being compared are being delivered as designed, with fidelity;
- Use of **multiple outcome measures**, so that all relevant behavioral changes attributable to the treatments will be reflected;
- **Appropriate treatment follow-up**, so that the “staying power” of the experimental and comparison treatments - their longevity – can be compared.

How Do We Know When a Treatment is Evidence-Based ?

- These methodological features, while necessary, are not sufficient to establish that an experimental treatment has shown empirical support.
- The experimental treatment must also lead to significantly better outcomes for significantly more patients than comparison treatments.
- These findings, moreover, must ultimately be replicated by more than a single team of investigators.

Why Should We Prefer Evidence-Based Treatments?

- It is only human nature to assume that the treatments we have learned to deliver are the most useful.
- Yet they may not actually be the most useful, because we have probably not compared them in any systematic way to alternative treatments.

Why Should We Prefer Evidence-Based Treatments?

- Evidence-based treatments have been compared systematically to alternative treatments by reliable and valid methods.
- Hence, evidence-based treatments should provide us assurance of superior efficacy.

History of Research on Psychological Treatments

- The long history of successful efforts to ascertain outcomes of pharmacological treatments, strongly influenced by FDA requirements for empirical demonstrations of safety and efficacy, has clearly influenced research on psychological treatment outcomes.
- Research on psychopharmacological agents derives from a tradition of high quality research, generally characterized by randomized, controlled clinical trials.

History of Research on Psychological Treatments

- There is an extensive, albeit mixed, history of success in documenting the role of **common factors** in treatment outcomes.
 - Patient and process variables have been particularly difficult to relate to outcomes.
- And there is now a substantial, albeit more recent, history of efforts to ascertain **outcomes of psychosocial treatments**, coincident with:
 - significantly enhanced outcome methodologies.
 - substantially more robust treatments.

Factors that Influence Psychotherapy Outcomes

- Common (Non-Specific) Factors
 - Therapist Variables
 - Patient Variables
 - Therapeutic Processes
- Treatment Factors
 - The Focus of this Presentation

Common Factors: Therapist Variables

- **Examples of Therapist Variables** include:
 - Empathy, warmth, unconditional positive regard (Rogers, 1961)
 - Therapist values, attitudes, and beliefs (Beutler, Machado, & Neufeldt, 1994)
 - Allegiance to a specific treatment (Luborsky et al., 1999)
- Therapist variables have been estimated to account for up to 30% of psychotherapy outcome variance (Lambert, 1992), but their assessment and predictive power remain problematic in the eyes of some.

Common Factors: Patient Variables

- **Examples of Patient Variables** include:
 - Age, gender, education, diagnosis, motivation to change, etc.
- Patient variables have not shown a consistent, robust relationship to therapeutic outcomes.
- NIAAA's Project MATCH failed to find evidence for patient-treatment matches, despite extensive prior data suggesting their existence.

Common Factors: Therapeutic Processes

- **Examples of Therapeutic Processes** include:
 - expectations of success in therapy, the nature of the relationship with therapist, etc.
 - Strupp (1973): “Therapists’ reactions to patients’ behavior and attitudes is most important in determining positive therapeutic outcomes.”
 - Orlinsky and Howard (1986): “Process variables, including the strength of the therapeutic bond, help explain positive outcomes.”
- Therapeutic processes have been especially difficult to measure reliably.

Advances in Psychotherapy Research Methodology

Substantial advances in psychotherapy outcome research methodology have taken place over the past 50 years, notably including:

- Eysenck’s 1952 and 1960 critical reviews of both psychotherapy outcomes and outcome research methodology.
- Luborsky et al. (1973) and the Dodo Bird phenomenon: All treatments are comparably effective.
- Smith & Glass’s meta-analysis (1977): Some treatments are more effective than others.

Advances in Psychotherapy Research Methodology

Rachman & Wilson (1980)

- “A significant contribution of behaviour therapy has been the development of innovative research strategies for the study of treatment outcome.”
- “...there are well-established methods for reducing anxieties and fears of various sorts, good progress has been made in establishing an equally powerful method for dealing with obsessions and compulsions.”

Advances in Psychotherapy Research Methodology

- Barlow (1981): “Clinical research has had little or no influence on clinical practice.”
- Howard et al. (1986) and the dose-effect relationship (1980): “The greater the dose of psychotherapy, the greater its effect.”
- Stiles et al. (1986): “All treatments are comparably effective.”
- Seligman (1996) and others: “To efficacy studies must be added effectiveness studies.”

One Important Consequence: Practice Guidelines

- A number of practice guidelines identifying evidence-based treatments have now been published, including:
- Agency for Health Care Policy & Research (1993). *Depression in primary care.*
- Division 12, American Psychological Association (1995, 1996, 1998). *Training in and dissemination of empirically validated psychological treatments.*
- *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders Compendium 2006 (APA, 2006).*

Evidence-based treatments have entered the mainstream

- Christophersen, E.R. & Mortweet, S.L. (2001). *Treatments that work with children: Empirically supported strategies for managing childhood problems*. Washington, DC: APA.
- Hofmann, S.G. & Tompson, M.C. (2002). *Treating chronic and severe mental disorders: A handbook of empirically supported interventions*. New York: The Guilford Press.
- Nathan, P.E. & Gorman, J.M. (1998, 2002, 2007). *A Guide to Treatments that Work* (1st, 2nd, & 3rd Editions). New York: Oxford University Press.

Political and economic realities also now affect evidence-based practice.

- Medicare, Medicaid, and HMOs began to make increased demands for accountability and evidence of efficacy in the late 1980s; these demands increased in the 1990s, and have continued to do so to the present.
- These demands coincided with the publication of practice guidelines by AHCPR, the American Psychological Association, the American Psychiatric Association, the Department of Veterans Affairs, and several managed care companies.

Current Status of Evidence-Based Psychological Practice

Practice guidelines have been adopted, increasingly, by managed care companies, by the Veterans Administration, and by other governmental agencies.

Evidence-Based Psychological Practice: Current Status

- Increasing efforts are being expended to require practitioners to follow practice guidelines, and practice guidelines are becoming more prescriptive.
 - APA accreditation criteria now specify that these treatments be taught.
 - The new DVA guidelines for treatment of serious mental illness, substance abuse and dependence, and PTSD are evidence-based and quite prescriptive.
 - Demands from HMOs for evidence of efficacy for additional psychosocial treatments are increasingly being felt.

“The aim of science is not to open the door to infinite wisdom, but to set a limit to infinite error”

Brecht, *Life of Galileo*, 1939

To mistrust science and deny the validity of the scientific method is to resign your job as a human. You'd better go look for work as a plant or wild animal.”

P.J. O'Rourke, 1991

Psychological Treatments that Work

- Research on psychological treatments that work is designed to answer two questions.
 - 1. What psychological treatments work?
 - 2. How do we know they work?

Psychological Treatments that Work

- Research has identified empirically supported treatments for a large number of common, troubling disorders.
- Two books will be used here to exemplify the evidence base for EBTs:
 - ***TTW***: *A Guide to Treatments that Work, 3rd edition* (Nathan & Gorman, 2007)
 - ***APA***: *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders Compendium 2006* (APA, 2006).

TTW

- *TTW* chapter authors identified evidence-based psychosocial interventions for 13 syndromes.
- Additional chapters identified the evidence base for pharmacological treatments for 14 syndromes.
- On average, authors cited 180-200 published references for each syndrome, with a range from 68 to 312.

Syndromes for which *TTW*
authors identified evidence-based treatments

ADHD	Personality Disorders
Anxiety Disorders	PTSD
Bipolar Disorder	Schizophrenia
Dementia	Sexual Dysfunctions
Eating Disorders	Substance Use Disorders
Obsessive-Compulsive Disorder	Unipolar Depression
Pathological Gambling	

TTW Evaluative Criteria

- *TTW* chapter authors were asked to decide whether a particular treatment was evidence-based according to a set of criteria included in the volume's Preface.
- Those criteria essentially included the design features already summarized earlier in this talk. Type 1 studies included all of these criteria; Type 2 studies lacked one or two of these criteria.
- Understandably, *TTW* authors emphasized Type 1 studies, although they also gave some credit to Type 2 studies that were otherwise without serious shortcomings.

APA

- *APA* authors evaluated evidence-based psychosocial interventions for 12 syndromes .
- Evidence-based pharmacological interventions for the same 12 syndromes are also evaluated in the volume.
- On average, more than 600 published references were consulted for each syndrome, with a range from 135 to 1789.

Syndromes for which *APA* identified evidence-based psychosocial interventions

Acute Stress Disorder and PTSD	HIV/AIDS
Alzheimer's Disease and Dementias of Later Life	Major Depressive Disorder
Bipolar Disorder	Panic Disorder
Borderline Personality Disorder	Schizophrenia
Delirium	Substance Use Disorders
Eating Disorders	Suicidal Behaviors

Criteria for Inclusion in *APA* as Evidence-Based Treatments

- ***[A] Randomized, double-blind clinical trial:*** A study of an intervention in which subjects are prospectively followed over time; there are treatments and control groups; subjects are randomly assigned to the two groups; and both the subjects and the investigators are “blind” to the assignments.
- ***[A-] Randomized clinical trial:*** Same as above but not double blind.
- ***[B] Clinical trial:*** A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally. Does not meet standards for a randomized clinical trial.

Other Types of Studies in *APA*

- *[C] Cohort or longitudinal study:* A study in which subjects are prospectively followed over time without any specific intervention.
- *[D] Control study:* A study in which a group of patients and a group of control subjects are identified in the present and information about them is pursued retrospectively or backward in time.
- *[E] Review with secondary data analysis:* A structured analytic review of existing data, e.g., a meta-analysis or a decision analysis.
- *[F] Review:* A qualitative review and discussion of previously published literature without a quantitative synthesis of the data.
- *[G] Other:* Opinion-like essays, case reports, and other reports not categorized above.

Three evidence-based psychosocial treatments are most widely-used

- These treatments have been the most extensively documented to date.
 - Exposure-based methods and CBT for panic and phobic disorders, OCD, and PTSD
 - Cognitive-behavioral treatments and IPT for major depressive disorder
 - Cognitive-behavioral coping skills, motivational enhancement, and twelve-step therapies for alcohol abuse and dependence

Exposure-Based Methods and CBT for Panic Disorders, Phobic Disorders, OCD, & PTSD

- Sources of Evidence (Barlow, Allen, & Basden, 2007; Franklin & Foa, 2007; Najavits, 2007)
 - A substantial number (50+) of excellent RCTs have established the efficacy of exposure-based procedures and CBT for panic disorders, phobic disorders, OCD, and PTSD.
- Nature of the Evidence
 - Self-reports of symptom reduction and quality of life enhancements and changes in scores on symptom rating scales all demonstrate sustained changes post-treatment.

Cognitive-Behavioral Methods and IPT for Major Depressive Disorder

- Sources of Evidence (Craighead, Sheets, Brosse, & Ilardi, 2007)
 - BT, CBT, and IPT have all been shown, by several methodologically superior RCTs as well as by at least four meta-analyses, to be effective for MDD.
- Nature of the Evidence
 - The treatments yielded substantial reductions in BDI and HRSD scores, significant decreases in numbers of patients meeting MDD diagnostic criteria post-treatment, and maintenance of effects well after the end of treatment.

Cognitive-Behavioral Coping Skills, Motivational Enhancement, and Twelve-Step Therapies for Alcoholism

- Sources of Evidence (Finney, Wilbourne & Moos, 2007)
 - Project MATCH (1,600+ patients); VAMCCS Study (3,000+ patients): Both studies were multisite RCTs with multiple outcome assessments and long follow-ups.
- Nature of the Evidence
 - Project MATCH: CBT, MET, TSF were all associated with substantial reductions in drinking days and amount of alcohol consumed each drinking day at 6, 12, and 39 months post-treatment.
 - VAMCCS: CBT, mixed CBT/12-step, and 12-step therapies delivered under “normal” conditions yielded sustained positive outcomes a year post-treatment.

Treatments that Work manuals for therapists and patients

- Under the editorship of David Barlow, Oxford University Press began the *Treatments that Work* series of treatment manuals for therapists and patients about 18 months ago.
- The latest series catalogue lists more than 35 manuals, including:
 - Overcoming the trauma of your motor vehicle accident
 - Managing bipolar disorder
 - Mastering your adult ADHD
 - Overcoming pathological gambling

Critics and Advocates

- Both critics of and advocates for evidence-based psychological treatments have been heard from.
- Both have said things worth hearing.

What Have Critics of Evidence-Based Psychological Treatments Said?

- “The emphasis on validated therapies ... implies a greater knowledge of the (patient, therapist, or relationship) variables that produce or facilitate positive change...than is warranted by the state of our knowledge” (Garfield, 1996).
- Standards of practice will reduce innovation, “the lifeblood of advances in the development of new therapeutic interventions” (Davison & Lazarus, 1995).

What Have Critics of Evidence-Based Psychological Treatments Said?

- “Instead of focusing on disembodied techniques, we must study ... the human relationship (the “therapeutic alliance”) between ...patient and ... therapist ...” (Strupp, 1989).
- ...the present body of scientific evidence is not sufficiently developed to serve as the sole foundation for practice...We (need to) bring to bear...what is often referred to as clinical judgment (Levant, 2003)

What Have Advocates for Evidence-Based Psychological Treatments Said?

- “...developing and implementing empirically-validated treatment methods would seem imperative in securing the place of psychological therapy in future health care policy and planning” (Wilson, 1995).
- Empirical validation of psychological treatments is especially important “because the public and federal and state policy makers mistakenly believe that few...are efficacious” (Barlow, 1994).

What Have Advocates for Evidence-Based Psychological Treatments Said?

- “The time has come to develop methodological criteria by which to identify strong studies validly reflecting effective treatments” (Nathan, 1996).
- “We are facing a crisis, once again, within APA. In the past year, while campaigning for President, I have become aware of some very strong opposition to the definition of psychology as a discipline built on an emerging and developing scientific foundation.” (Beutler, 2003)

Continuing Controversies in Evidence-Based Professional Psychology Practice

- Efficacy vs. Effectiveness Studies
- The “Dodo Bird” Effect
- Research Assumptions
- Treatment Factors vs. Common Factors in Practice
- Art vs. Science in Practice

Efficacy vs. Effectiveness

- Some practitioners and researchers claim that efficacy studies may not reflect therapy outcomes (effectiveness) in “the real world” (e.g., Levant, 2003; Westen & Morrison, 2001). If supported, these claims mean that:
 - treatments established as evidence-based only by efficacy research can be discounted.
 - the evidence-based movement, based largely on the results of efficacy studies, can be called into question.
 - advocates for “clinical judgment” rather than science in decisions on treatments will feel empowered.

The “Dodo Bird” Effect

- Some researchers have claimed that all therapies are equally effective (the “Dodo Bird” Effect: Luborsky, Singer, & Luborsky, 1975). If these claims are substantiated,
 - practice guidelines will likely diminish in influence.
 - researchers and trainers will re-emphasize research on and training in common factors.
 - third-party insurers will likely continue their efforts to reimburse only lowest cost providers of psychosocial treatment.

Treatment Factors vs. Common Factors

- Some research has demonstrated that common factors are at least as influential as treatment factors in determining treatment outcomes (e.g., Lambert & Barley, 2001; Strupp, 1989). If this research is validated,
 - training programs may shift training emphases to teach generic therapist skills.
 - lowest-cost providers who can claim to have learned these skills will likely continue to be most highly valued.

Art vs. Science

Some claim that science cannot be shown definitively to be more effective than intuition as a basis for choosing psychosocial treatments. If these claims are supported,

- professional psychology may return to an earlier training and practice model, when treatment research was seen as unnecessary and superfluous.

In Summary: Empirically Supported Treatments have had Some Negative Effects...

- Practitioners whose preferred mode of treatment is not evidence-based may feel – and in some cases be – disenfranchised.
- Practitioners may conclude that innovation in psychosocial treatment has been negatively affected.
- In places with few practitioners able to provide evidence-based treatments, some patients may have been denied services.

...But Their Positive Effects Have Been Substantial

- Substance abuse and mental health workers who employ evidence-based therapeutic methods likely gain greater treatment authority.
- Reimbursement of agencies and substance abuse and mental health providers who use these methods is probably more secure.
- Increased parity in reimbursement for evidence-based substance abuse and mental health practices may be another result.

A Modest Proposal

- Questions about the length and breadth of evidence-based treatments need to continue to be asked and, if possible, answered.
- Meanwhile, given both society's need for accountability and the distinct possibility that evidence-based treatments may have the efficacy claimed for them, we ought to continue to value them, even while continuing to explore better ways to identify them.

“The essence of science:
ask an impertinent question,
and you are on the way to a
pertinent answer.”

Bronowski, *The Ascent of Man*,
1973

References

- Barlow, D.H. (1994). Psychological intervention in the era of managed competition. *Clinical Psychology: Science and Practice*, 1, 109-122.
- Barlow, D.H., Allen, L.B., & Basden, S.L. (2007). Psychosocial treatments for panic disorders, phobias, and generalized anxiety disorder. In P.E. Nathan & J.M. Gorman (Eds.), *A guide to treatments that work*, 3rd ed. New York: Oxford University Press.
- Beutler, L.E. (2003). Statement by APA Presidency Candidate.
- Carroll, K.M. (1999). Behavioral and cognitive behavioral treatments. In B.S. McCrady & E.E. Epstein (Eds.), *Addictions: A comprehensive guidebook* (pp. 250-267). New York: Oxford University Press.
- Christophersen, E.R. & Mortweet, S.L. (2001). *Treatments that work with children: Empirically supported strategies for managing childhood problems*. Washington, DC: APA.

References II

- Craighead, W.E., Sheets, E.S., Brosse, A.L. & Ilardi, S.S. (2007). Psychosocial treatments for major depressive disorder. In P.E. Nathan & J.M. Gorman (Eds.), *A guide to treatments that work*, 3rd ed. New York: Oxford University Press.
- Davison, G.C. & Lazarus, A.A. (1995). Clinical innovation and evaluation: Integrating practice with inquiry. *Clinical Psychology: Science and Practice*, 1, 157-168.
- Eysenck, H.J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology*, 16, 319-324.
- Eysenck, H.J. (1960). *Behavior therapy and the neuroses*. Oxford, UK: Pergamon Press.

References III

- Finney, J.W., Wilbourne, P.L. & Moos, R.H. (2007). Psychosocial treatments for substance use disorders. In P.E. Nathan & J.M. Gorman (Eds.), *A guide to treatments that work*, 3rd ed. New York: Oxford University Press.
- Franklin, M.E. & Foa, E.B. (2007). Cognitive behavioral treatments for obsessive compulsive disorder. In P.E. Nathan & J.M. Gorman (Eds.), *A guide to treatments that work*, 3rd ed. New York: Oxford University Press.
- Garfield, S.L. (1996). Some problems associated with “validated” forms of psychotherapy. *Clinical Psychology: Science and Practice*, 3, 218-229.
- Hofmann, S.G. & Thompson, M.C. (2002). *Treating chronic and severe mental disorders: A handbook of empirically supported interventions*. New York: The Guilford Press.

References IV

- Howard, K.I., Kopta, S.M., Krause, M.S., & Orlinsky, D.E. (1986). The dose-effect relationship in psychotherapy. *American Psychologist, 41*, 159-164.
- Lambert, M.J. & Barley, D.E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy, 38*, 357-361.
- Levant, R.F. (2003). The empirically-validated treatments movement: A practitioner perspective. Statement by APA Presidency Candidate.
- Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that “everybody has won and all must have prizes?” *Archives of General Psychiatry, 32*, 995-1008.
- Najavits, L.M. (2007). Psychosocial treatments for Posttraumatic Stress Disorder. In P.E. Nathan & J.M. Gorman (Eds.), *A guide to treatments that work*, 3rd ed. New York: Oxford University Press.

References V

- Nathan, P.E. (1996). Validated forms of psychotherapy may lead to better-validated psychotherapy. *Clinical Psychology: Science and Practice*, 3, 251-255
- Nathan, P.E. & Gorman, J.M. (1998). *A guide to treatments that work*. New York: Oxford University Press.
- Nathan, P.E. & Gorman, J.M. (2002). *A guide to treatments that work* (2nd ed.). New York: Oxford University Press.
- Nathan, P.E. & Gorman, J.M. (2002). *A guide to treatments that work* (3rd ed.). New York: Oxford University Press.
- O'Farrell, T.J. & Fals-Stewart, W. (1999). Treatment models and methods: Family models. In B.S. McCrady & E.E. Epstein (Eds.), *Addictions: A comprehensive guidebook* (pp. 287-305). New York: Oxford University Press.

References VI

- Patterson, K. (2002). What doctors don't know (almost everything). *New York Times Magazine*, 5/5/02, 74-77.
- Rachman, S. & Wilson, G.T. (1980). *The effects of the psychological therapies*. Oxford, UK: Pergamon Press.
- Seligman, M.E.P. (1995). The effectiveness of psychotherapy: The *Consumer Reports* study. *American Psychologist*, 50, 965-974.
- Smith, M.L. & Glass, G.V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist*, 32, 752-760.
- Strupp, H.H. (1989). Psychotherapy: Can the practitioner learn from the researcher? *American Psychologist*, 44, 717-724.

References VII

- Westen, D. & Morrison, K. (2001). A multidimensional meta-analysis of treatments for depression, panic, and generalized anxiety disorder: An empirical examination of the status of empirically supported therapies. *Journal of Consulting and Clinical Psychology, 60*, 875-899
- Westen, D., Morrison, K., & Thompson-Brenner, H. (in press). The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin*.
- Wilson, G.T. (1995). Empirically supported treatments as a basis for clinical practice: Problems and prospects. In S.C. Hayes, V.M. Follette, R.M. Dawes, & K.E. Grady (Eds.), *Scientific standards of psychological practice: Issues and recommendations* (pp. 163-196). Reno, NV: Context Press.