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A Person-Centered Critique of the Common Elements Treatment Approach (CETA) and Other Research- and Evidence-based Psychotherapies[1]

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Abstract

Over the past several decades, there has risen an increasing call for evidence-based practice in the field of psychotherapy, which has inevitably led to a kind of sorting – those models which have not been quantitatively validated, to the historical dustbin of shame; and those which can, into managed care. Psychotherapy research has increasingly become a turf war in which evidence-based practice empires defend their political positions of power while novel practice cadres vie for a share of the market. One aspiring model, the Common Elements Treatment Approach (CETA), offers an excellent example of the kind of models fighting for credibility, visibility, and eventually, viability in the market-place. There is a great deal of need for and promise in much of the evidence-based psychotherapy research being conducted, yet – and this critique applies as well to many modalities that are clearly not evidence-based – the mechanisms of some psychotherapies undermine their therapeutic value. If, for instance, a therapist is not fully present as a warm, accepting, genuine, caring person, the power center of therapy remains turned off. Ultimately, the person-centered process – *not* a series of manualized techniques – is the soul of psychotherapeutic change.

Keywords: person-centered; evidence-based practice; research-based; EBP; CBT; psychotherapy

Over the past several decades, there has risen an increasing call for research- and evidence-based practice (R/EBP) in the field of psychotherapy, which has inevitably led to a kind of sorting – those models which have not been quantitatively validated, into the historical dustbin of shame; and those which can, into managed care. What we are seeing nationwide, and possibly on a global scale, are turf wars that vie for a share of the market. In 2016, I participated in a training process for one such aspiring new model called the Common Elements Treatment Approach (CETA), whose proponents, in my view, offer an excellent sampling of the kind of models fighting for credibility, visibility, and eventually,

viability in the market-place. Here was my experience.

8:45 a.m. to 12.15 p.m. on Day One

On this, the first morning of a two-day training conference, we spent an hour discussing symptoms of anxiety, depression, and post-traumatic stress. After this, facilitators emphasized the importance of utilizing formal clinical measures, including the PHQ-9 and PCL-C. A fair amount of time was devoted to role-playing in small groups how to conduct clinical assessment and present to clients semi-scripted feedback about their clinical measures. The training, thus far, struck me as not offering a unique model of intervention, especially after having heard bold claims by CETA proponents in weeks prior and having been intrigued by the scant CETA literature.

1.15 p.m. to 5.00 p.m. on Day One

After lunch, we were taught how to develop basic crisis plans, how to provide psycho-education, how to draw out more feedback from clients, as well as how to 'normalize' clients' symptoms. We role-played how to present the structure of therapy sessions to a client so as to encourage engagement rather than overwhelm or put the client off. The facilitators instructed us on cognitive coping using the thinking–feeling–behavior triangle, a useful CBT tool for helping clients understand how thoughts, feelings, and behaviors are connected.

A participant raised his hand and asked the presenters whether these components constituted 'evidence-based practices'. The presenter answered that as CBT itself is 'evidence-based' and these components are 'essentially CBT', then 'yes'. Can you make claims of a new 'evidence-based' model on the basis that it is built from component parts of another? – I thought. The last portion of day one was about unpacking trauma memories – a basic lesson on exposure, regarded as a key ingredient in the treatment of anxiety, yet with limited focus on how to use it.

8.30 a.m. to 12.00 noon on Day Two

The beginning of day two began with learning how to help clients identify irrational thoughts. The T–F–B triangle was brought in again as a tool in this endeavor. Time was spent role-playing how to help a client identify discrepancies between current beliefs and what is more accurate in reality. After a break we lightly discussed relaxation techniques, such as deep breathing and muscle relaxation. Before lunch, we discussed gradual exposure using ladders to help illustrate a fear hierarchy with clients. We role-played the use of gradual exposure at-length.

1.00 p.m. to 2.30 p.m. on Day Two

After lunch, the topic was behavioral activation. This included tools to motivate clients toward change, widely accepted as necessary for therapy to be at all successful with depressed clients. We were told to role-play in small groups how to assign homework activities.

2.45 p.m. to 4.00 p.m. on Day Two

As the training wrapped up, the facilitators began outlining CETA in more detail; that is, the trainers explained the designed order of interventions, contingent on diagnosis. Ultimately, CETA was branded as an approach based on common treatment components widely accepted as either necessary or effective: administering basic clinical measures; engaging clients; helping clients identify their thoughts, feelings, and behaviors, and the linkages between them; helping clients replace distorted thinking; helping clients learn to self-soothe and relax; helping clients heal from trauma through gradual therapeutic exposure; prioritizing safety

throughout therapy; and motivating clients toward change.

4.00 p.m. to 5.00 p.m. on Day Two

At this time, we were chided to sign up to participate in a nine-month bi-weekly phone consultation group. This would involve inputting clients' clinical measures into an online toolkit database for the training institute, and consulting on our use of CETA. The therapists who came with me and I opted out of continuing with CETA. Neither the training nor the model offered them new knowledge, skills, or abilities but rather, in my view, an overly prescriptive, overly uniform approach to treating clients.

EBPs are only useful if they are appropriately matched to practitioners who gain in scope or depth of practice, particularly when their professional developmental level as a psychotherapist indicates the need for a limiting focus, clear parameters for practice, and a semi-scripted methodology. I have concerns, however, about a culture change in the field marked by an increasingly blind assumption of research validity and expanding regulation related to EBP practice.

The largest concern that I have about CETA is not the methods that are present in the model – which are in large part, as the trainer explicitly stated, a re-packaging of the basics of CBT – but the value and cost to agencies in having therapists already trained in, for instance, CBT skills spending additional time becoming certified in CETA, which offers only a less advanced, highly scripted version of these skills. There are more efficient and economical ways to go about brushing up basic clinical skills. Why, then, do we see the increasing spread of such patchwork, manualized practice models in the psychotherapy market-place?

Low Fidelity Isn't Fidelity

I criticize blind and sweeping R/EBP claims and regulation on the basis of the sort of concerns I have presented about my experience and perspective of CETA and other aspiring practice models, some of which hope to ride on the coat-tails of more established and more robust EBPs. Additionally, many models claiming to be evidence-based do so on the basis of small, potentially faulty, and untested research trials. CETA itself admits in one of the only journal articles chronicling its primary trials in southern Iraq and in Thailand near the border of Burma that 'all pilot clients were survivors of systemic violence and/or torture and were predominantly a convenience sample', citing client samples of only twelve pilot research participants in Iraq and 22 in Thailand (Murray et al., 2014, p. 118).

CETA is, in my view, appropriately cast as a trauma-focused brief intervention model for use by lay counselors in post-disaster and post-political imprisonment, yet I witnessed CETA trainers make bold claims that its evidence-based methodology and findings, so-called, are recommended for use by highly trained therapists with *most* community mental health center clients experiencing more or less severe forms of anxiety or depression.

Scott Lilienfeld (2014, Internet file) exposed potential straw-man arguments against use of EBPs when he wrote

> Nothing in evidence-based practice implies that treatment decisions should be based exclusively on the results of single studies; quite the contrary. Instead, the rationale is that all else being equal, treatments that have been shown to work in multiple, independently replicated, well-designed studies (especially when confirmed by meta-analyses, that is, quantitative summaries of the literature) should be accorded higher priority in treatment selection than treatments that haven't.

Fair enough. Yet a number of research- and evidence-based practice claims in the market-place do remain insufficiently tested, and too many of these remain insufficiently challenged. Additionally, a large number of therapists implementing R/EBPs may well be failing to replicate the methodologies of the particular studies that define them as such. I do not intend this to be a wholesale critique of psychotherapy research design nor of R/EBP-utilizing therapists, but a critique of the widely held assumption that therapists trained and certified in particular R/EBPs are implementing in practice their methodologies to a level of fidelity comparable to that carried out by the therapists participating in the original research studies. The reality is that if they are not, then their practice is not research- or evidence-based, yet very broad allowances are being made in the coding of EBPs within managed care to satisfy the increasingly strict regulatory requirements for the levels of EBP implementation – resulting, I fear, in a net reduction in depth and quality of psychotherapy practice rather than an increase in fidelity to effective psychotherapy intervention.

Many EBPs rigidly structure for therapists and, thereby, for clients, systems of levers to pull, should the client's esteem tip this way or should the client's fears tip that way. In my experience, evidence-based practice cadres often *do not have an interest in the personal agency of the client* – in their capacity to choose for themselves and innate strengths and resilience that can emerge, given the right kind of supportive conditions. While the spirit and principled mindset of a field of evidence-based practice is appropriately postured to mitigate potentially negligent and dangerous practices, far more widely than is commonly acknowledged, R/EBP implementation takes the form of naive acceptances of poorly tested interventions and, in effect, may or may not ultimately ensure better therapy.

A common critique by EBP skeptics in light of researchers' claims of tightly controlled studies goes, 'If your effect is so fragile that it can only be reproduced under strictly controlled conditions, then why do you think it can be reproduced consistently by practitioners operating without such active monitoring or controls?'. If fidelity to a manualized modality cannot be ensured beyond the randomized controlled trials that stamped it 'evidence-based', how do we know, in the market-place, that it *is* so?

Research findings based on the application of treatment manuals have led to endorsement of treatment brands which assume that these are practiced in a manner consistent with the research treatment manuals. Very often, they are not. In effect, the endorsement of a brand name treatment is a short cut to and a means of defining de facto clinical practice guidelines and gaining a market monopoly.

In 2006 the American Psychological Association unveiled a policy which acknowledged that 'A central goal of evidence-based practice in psychology is to maximize patient choice among effective alternative interventions' (p. 284). Many practices claiming to work from an 'evidence base' in practical fact *minimize* client choice. CETA, for instance, guides therapists implementing its model to fidelity to follow a prescribed CETA intervention flow that provides a specific order for interventions on the basis of diagnosis, risking the preclusion of space needed for a client to meaningfully choose. Never once in the course of CETA training or consultation were participants trained on the necessity of maximizing client choice among effective alternative interventions.

Additionally, managed care continues to evolve toward an increasing incorporation of R/EBP requirements. I have witnessed throngs of

agencies rushing to choose the models they wish to invest their resources in, and this often has as much to do with which consortium or initiative a particular agency may benefit from increasing its ties to, as it has to do with anything else. And here is the rub: once agencies hitch their wagons to particular models, the therapists they employ have little choice but to embrace them, and anchor the lion's share of their professional development and practice within that agency to them. Neither the therapists nor the clients, in these scenarios, have much choice. And let me be clear: this is not an anomaly within isolated quarters, but the shape of the vast expanses our current professional landscape.

There is no wholesale dismissal of evidence here, only of the errors of blind acceptance of a widely criticized and underperforming field of psychotherapy research that has oversold to the unscientific public the merits of many findings.

The Babies and the Bath Water

I mentioned earlier that the therapists I took with me to the CETA training and I opted out of continuing with CETA. Well, that is not the end of the story. One of the trainers contacted the corporate office of my organization and complained that in registering for the training, there was an expectation that we would continue on with the nine-month consultation process, and, fearful of any potential negative harm to our agency's reputation, in terms of its participation in state-wide evidence-based practice initiatives, I was told by a corporate administrator that I was given no choice but to enroll myself and my therapists in the full nine-month CETA consultation process. During that process, we utilized CETA with several clients each and inputted required clinical measures and other data into an online database to be used for aggregation and evaluation by the research center administering the consultations.

Therapist participants shared during multiple case consultations their own concern that they had strayed outside of the bounds of fidelity to CETA, yet again and again, consultants encouraged these therapists, contrary to their protests, that they had demonstrated fidelity. These participants seemed uncomfortable with these conclusions. I certainly was. I assumed that the motive of the facilitators must have been to enhance the data being reported, and to increase both the number of successfully certified CETA clinicians as well as decrease any potential misgivings about the usefulness of the model. From my own understanding based on others' anecdotal experiences, subjective aspects within, and incentives related to ,such research leave the field vulnerable to corruption in study data that may be construed as 'evidence'. We, as practitioners and consumers, should be asking, 'But evidence of *what*?'.

Robert McNamara was the US Secretary of Defense from 1961 to 1968. McNamara saw the world in numbers. He spear-headed a paradigm shift in strategy at the Defense Department to implement large-scale metric tracking, and reporting that, he contended, this would help minimize individual bias amongst department experts. A core metric with which he used to inform strategy and evaluate progress was body-count data. 'Things you can count, you ought to count', argued McNamara. His focus, however, created a problem because many important variables could *not* be counted – so he largely ignored them. This thinking led to wrong-headed decisions by the USA, and resulted in an eventual need for withdrawal from the Vietnam conflict. Daddis (2009) instructed, 'While McNamara contended that factual data had not supplanted judgment based on military experience or intuition, senior uniformed officials perceived their expertise being minimized as systems analysis took hold within DoD' (p. 56). Social scientist Daniel Yankelovich (1972) coined the term the

'McNamara fallacy', pointing out a human tendency to undervalue what cannot be measured, and warning of the dangers of taking the measurably quantitative out of the complexity of its qualitative context:

> The first step is to measure whatever can be easily measured. This is OK as far as it goes. The second step is to disregard that which can't be easily measured or to give it an arbitrary quantitative value. This is artificial and misleading. The third step is to presume that what can't be measured easily really isn't important. This is blindness. The fourth step is to say that what can't be easily measured really doesn't exist. This is suicide. (p. 72)

Sociological researcher William Bruce Cameron (1963, p. 13) put it another way: 'Not everything that counts can be counted, and not everything that can be counted, counts.'

Critics of psychotherapy research such as James Coyne, a psychologist who teaches critical thinking in health research in The Netherlands, warn of methodological design flaws in and false claims regarding the outcomes of vast swathes of psychotherapy research around the globe. Coyne (2014, Internet file) argued:

> As it now stands, the psychotherapy literature does not provide a dependable guide to policy makers, clinicians, and consumers attempting to assess the relative costs and benefits of choosing a particular therapy over others. If such stakeholders uncritically depend upon the psychotherapy literature to evaluate the evidence-supported status of treatments, they will be confused or misled.... [Psychotherapy] randomized controlled trials are underpowered, yet consistently obtain positive results by redefining the primary outcomes after results are known. The typical RCT is a small, methodologically flawed study conducted by investigators with strong allegiances to one of the treatments being evaluated. Which treatment is preferred by investigators is a better predictor of the outcome of the trial than the specific treatment being evaluated. Many positive findings are created by spinning a combination of confirmatory bias, flexible rules of design, data analysis and reporting and significance chasing. Many studies considered positive, including those that become highly cited, are basically null trials for which results for the primary outcome are ignored, and post-hoc analysis of secondary outcomes and subgroup analyses are emphasized. Spin starts in abstracts and results that are reported there are almost always positive.

I hope the reader will simply take for granted that I do not intend to throw the baby out with the bathwater – that there are, of course and indeed, many good reasons our field should be expanding research in, and implementation of, evidence-based practices. I assume, however, that on the basis of what I have written thus far, many readers are at risk of concluding that I am simply ignoring the case for evidence-based practice and research. That being said, let me erase that assumption. The continued development of niche cadres of research- and evidence-based practices, within proper bounds and with proper accountability, has great promise. In short, I see three primary benefits of EBP:

1. Research-backed therapy interventions operationalized in manuals and delivered by trained therapists offer significantly increased efficacy in treating certain disorders (Wampold, 2001; Roth & Fonagy, 1997; Nathan & Gorman, 1998).
2. Consistency in treatment intervention can reduce therapist variability, which will likely increase efficacy in treating certain disorders (Luborsky & Barber, 1993).
3. When we emphasize the need for evidence-based skill sets, we elevate in value and priority the significance of ensuring effective therapeutic treatment with clients, including our knowledge about what works and with whom (Norcross, 2002).

To be clear, then, and lest I gain reputation for what I am against: I support online toolkits that integrate and track data collection as part of psychotherapy research and case consultation; I support any time systems of care that promote and validate the complementary paradigm of 'practice-based evidence', providing a means for therapists to generate support of what works for clients based on professional experience; I support grant funding for promising practices; I support serious implementation of confidential and peer-reviewed feedback systems; I support specialized practice cadres which promote niche clinical skills and clinical integrity intending to promote positive therapeutic outcomes; and I support epistemological pluralism, a contrast to placing value through reductionism on only certain aspects of therapeutic outcome – one of my primary criticisms of CETA.

Conclusion

Ultimately, faith, hope, relationship, and an unfathomable number of other factors that are impossible to quantify or procedurize, many external to the therapeutic enterprise, may catalyze therapeutic transformation. We must, therefore, be cautious of increasing demands for 'evidence', and remain wary of evidence-based claims. Many evidence-based practice models are designed with often-times unrealistic controls in mind. For instance, some R/EBPs such as CETA rely on diagnostic controls in which therapists are to follow certain intervention protocols on the basis of a client's particular diagnostic formulation. Yet what controls exist to ensure *diagnostic* precision? Over my years of practice I have witnessed countless cases in which clients have been assigned disparate diagnoses across systems of care, in which psychotherapists, clinical psychologists, neuropsychologists, psychiatric providers, and primary-care providers have committed to incompatible diagnostic conclusions, in which time and again proactive and conscientious cross-silo, interdisciplinary case collaboration has proven ineffectual to remedy.

Ultimately, we must grapple with the more substantive and unassailable reality that there is a vast gulf between the diagnosable problems as seen through the lens of clinical expertise, and the essence and worth, strengths and hopes of the person before me.

If a psychotherapist's technique is too technical, his or her efforts to help may be worthless. Therapy in this case may be little more than a poor excuse for scientific experimentation. There is a great deal of need for, and promise in, much of the evidence-based psychotherapy research being conducted, yet – and let me be clear that this critique also applies to many modalities that are clearly not evidence-based – the mechanisms of some psychotherapies undermine their therapeutic value. If a therapist is not fully present as a warm, accepting, genuine, caring person, then the power center of therapy remains turned off and, for all practical purposes, ineffective. This is because, ultimately, the person-centered process – *not* a series of manualized techniques – is the soul of psychotherapeutic change.

Note

1 This article is an adapted excerpt from the chapter entitled 'The Empathor's New Clothes: when person-centred practices and evidence-based claims collide" from the book *Re-Visioning Person-Centred Therapy: Theory and Practice of a Radical Paradigm* (Routledge, 2018). Permission has kindly been granted by the original publisher to reprint this edited version here.

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Blake Griffin Edwards is a licensed marriage and family therapist in Washington State and behavioral health executive at Columbia Valley Community Health. Blake has authored numerous publications on psychotherapy, and his articles have been featured by the American Academy of Psychotherapists, the American Association for Marriage and Family Therapy, the Association for Family Therapy and Systemic Practice, the Association for Humanistic Psychology, Society for Existential Analysis, and the Irish Journal for Humanistic and Integrative Psychotherapy. Blake also writes a blog for https://www.psychologytoday.com/gb called 'Progress Notes' (at https://tinyurl.com/y6gykcyc). Blake lives with his wife and twin daughters in north-central Washington State, USA.