Evidence-based practice is arguably the most consequential and controversial movement in psychology today (Norcross, Beutler, & Levant, 2005). Although everyone agrees that practice should be informed by evidence (Westen & Bradley, 2005; Norcross et al., 2005), there is much disagreement about what qualifies as evidence (e.g., Reed, 2005; Kihlstrom, 2005; Messer, 2005) and whether certain evidence-based protocols extend to real-world practice (e.g., Westen, 2005a; Stirman & DeRubeis, 2005). This conflict is not a simple dispute to be resolved in the laboratory—it is a “culture war” between different worldviews in the quest for truth, respectability, and economic inclusion (Norcross et al., 2005, pp. 7–8).

Considering its controversial and consequential nature, the evidence-based “war” carries both promises and pitfalls. On the one hand, such evidence-based considerations remind researchers and practitioners of the need to be accountable for their research methods and types of practices. This reminder ought to be refreshing, considering psychotherapy’s history of unexamined and uninvestigated methods and theories (Slife, Wiggins, & Graham, 2005). As scientific researchers and practitioners, we ought to be open to the critical examination of all types of methods and practices, however prized or popular they may be. Moreover, a commitment to critical examination hinders psychology from becoming a relativistic discipline where anything goes (Slife, Wiggins, & Graham).

On the other hand, pressure for evidential basis could potentially lead to an evidence-based framework that uncritically rests upon a limited conception of evidence. Considering the intense disagreement in psychology about what qualifies as evidence, it
is plausible that an evidence-based framework could be biased toward the most popular, powerful, or lucrative conception. This preliminary bias might hinder an examination of the conception itself, such as its philosophical assumptions and whether its methods are best suited for the needs of actual practice. Worse, it would likely subordinate or disenfranchise alternative conceptions of evidence and the methods and practices they imply—because such do not conform to the criteria of the chosen framework, they would be ruled out before an investigation even begins. For these reasons, a framework for evidence-based practice must itself be validated on scientific grounds and should be wary about committing to an overly narrow conception of evidence.

The challenge for psychology, then, is to articulate an evidence-based framework that is both inclusive and objective. It should be sufficiently open and flexible to include the utilization and creation of all necessary research methods and types of practice. At the same time, its desire for inclusion cannot slip into an anything-goes relativism—a commitment to evidential basis requires objective examination of research methods and practices, according to scientific standards.

Unfortunately, such a framework does not currently operate in psychology. Although two prominent evidence-based movements have emerged in the past decade, neither allows for a framework that is genuinely objective and inclusive. This article discusses both movements—the empirically supported treatment (EST) movement and the common-factors movement—contending that neither provides a framework that achieves both objectivity and diversity. To the contrary, each is based on an unexamined conception of evidence that commits a preinvestigatory bias against certain types of methods and practices—that is, certain methods and practices are ruled out before an examination even begins. After introducing each framework and briefly demonstrating each’s respective limitations, I will contend that a third framework—objective methodological pluralism—is better suited at offering an objective and inclusive framework for evidence-based practice.1

**Empirically Supported Treatment (EST) Movement**

The empirically supported treatment movement (EST) defines evidence-based practice as the application of specific, often manualized, treatments that comply with stringent standards of experimental verification (Butcher, Mineka, & Hooley, 2004; Norcross et al., 2005; Safran, 2001). Generally, these treatments are tested according to their efficacy in treating specific psychological disorders, as identified in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; Westen, 2005b).

The EST movement sprung from increasing pressure to justify psychological practices with evidence. Although psychology has always been concerned with evidence-based practice (Norcross et al., 2005), recent years have brought increasing pressure for keeping pace with medical treatments such as prescription drugs (APA, 2006). In an age of increasing anxiety for the justification of health care practices (Norcross et al.), psychological treatment has developed a reputation—however unjustified—of being less reliable and substantiated than medical treatment (APA; Westen & Bradley, 2005).

In an effort to remedy psychology’s second-class citizenship, a succession of task forces within Division 12 (Clinical Psychology) of the American Psychological Association (APA) sought to bolster the scientific validity of specific psychological treatments (APA, 2006). Beginning in 1993, the

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1. For more extensive information, see Wendt, D. C. (2006). Evidence-based practice movements in psychology: Empirically supported treatments, common factors, and methodological pluralism. [Honors thesis.] Available at BYU’s Harold B. Lee Library and Department of Psychology (1001 SWKT).
division “constructed and elaborated a list of empirically supported, manualized psychological interventions for specific disorders” (Norcross et al., 2005). Empirical support for these interventions—commonly referred to as empirically supported treatments (ESTs)—is demonstrated through rigorous laboratory testing of a large random sample, in which each participant is randomly assigned to an experimental group (treatment) or a control group (no treatment, or “wait-list”). By controlling for all variables other than the treatment in question—through random assignment and manualized protocols—it is thought that successful treatments can be experimentally isolated and identified (Butcher et al., 2004).

This experimental method is called a randomized clinical (or controlled) trial (RCT), widely esteemed as the gold standard of research evidence in medicine (Norcross et al., 2005; Safran, 2001). The RCT’s prevalent use in medicine is not surprising, considering that the RCT is tailored to fit traditional medicine’s theory of disease and treatment: disease is the presence of one or more specific symptoms, and treatment is a specific, uniform procedure for alleviating such symptoms (Bohart, O’Hara, & Leitner, 1998). RCTs are especially esteemed for determining prescription drug efficacy, in which an experimental group is given the treatment drug and a control group is given a placebo. If symptom-alleviation is significantly higher in the experimental group than in the placebo group, then it is thought to be the treatment—not the patient, the doctor, a placebo effect or happy chance—that is responsible for the change. Third-party payment providers can then trust the treatment to be universally effective and subsequently offer coverage for such.

Reportedly, Division 12’s intention was merely to establish that psychological treatments can be as or more effective than medical treatments, not necessarily to produce a monopolistic list of acceptable treatments (APA, 2006). Nonetheless, the division’s project sparked considerable interest in researching and implementing specific treatments, with the hope, in some circles, that psychological practice could be grounded upon a framework consisting solely of ESTs (APA). In fact, some professionals in psychology began contending that “empirically supported treatments are all the profession should allow patients to choose” (Bohart, 2003, p. 1), and many payment providers and funding agencies began limiting funding for certain disorders to ESTs (APA; Norcross et al., 2005; Safran, 2001).

As a result, the EST movement has become so entrenched in psychology that “evidence-based practice” has grown, in some circles, to be synonymous with “empirically supported treatments” (Westen & Bradley, 2005, p. 266). With this equation in place, ESTs and RCTs are not seen as a way to justify psychological methods and practices, but the way.

By conforming to the strict criteria required by RCTs, an EST framework succeeds at establishing a certain level of reliability and credibility. It ultimately fails, however, to be an objective and inclusive framework for evidence-based practice because it is uncritically biased toward a medical-model of treatment that is inconsistent with the needs of many real-world patients and circumstances (Westen & Bradley, 2005; Messer, 2004; Bohart et al., 1998). By being committed, a priori, to a medical-model of treatment, an EST framework (a) demands, without rationale, that real-world practice be reshaped to fit the logic of the RCT and (b) rejects alternative conceptions of evidence and the methods and practices they imply, not because of their potential fruitfulness, but merely because they do not conform to RCT criteria. This section will address these two factors in turn.

Shaping Practice to Fit RCT Criteria

By assuming that RCTs are the only appropriate method for evidence-based practice, an EST framework demands that clinical practice be shaped to fit methodological demands, as opposed to the other way around. In other words, an EST-framework is driven by method, regardless of the real-world situation. This is important, considering the fact that ESTs lack external validity to the majority of real-world patients and situations (Westen & Bradley,
Unlike the real world, RCT patients are limited to those whose symptoms are textbook cases of a single DSM disorder—thus, their results “may apply only to a narrow and homogeneous group of patients” (Butcher et al., 2004, p. 563).

From a mainstream experimental standpoint, the exclusive use of RCTs is understandable—one must eliminate confounding variables such as the presence of other disorders—but from a clinical perspective, the majority of real-world patients cannot be pigeonholed into a single diagnostic category. In fact, the majority of U.S. patients are comorbid (Morrison, Bradley, & Westen, 2003; Westen & Bradley, 2005), meaning they are diagnosed with two or more DSM disorders (Butcher et al., 2004). According to the National Comorbidity Survey (NCS), 56% of patients have had three or more disorders (Butcher et al.).

In response to this question of external validity, advocates for an EST framework insist, without evidence, that practice can be shaped for comorbid patients in a way that is consistent with RCT methodology (Morrison et al., 2003; Bohart, 2003). To make this claim, an EST framework takes its cues from medicine’s common practice of prescribing multiple drugs: the answer lies in treating each disorder on an individual basis. Just as a patient with multiple medical problems can take multiple kinds of prescription drugs, so can a patient with comorbid mental health disorders receive multiple treatments. A person who is diagnosed with both depression and anxiety, for example, would receive two manualized ESTs, one for each disorder (Morrison et al., 2003).

At face value this practice may seem plausible, but it rests upon a problematic assumption of the medical-model, at least as far as it relates to psychology. This assumption is the atomistic assumption of comorbidity (my term), in which disease can be operationalized as one or more self-contained disorders. This allows for comorbid disorders to be understood, diagnosed, and treated on an individual basis. In other words, comorbid patients can be treated as if they have only one disorder (Morrison et al., 2003). Thus, one patient’s combination of depression and anxiety is not considered to be a qualitatively unique whole, but merely the quantitative sum of two self-contained parts (Morrison et al.). With this assumption, researchers and practitioners can presume that a single disorder for a comorbid patient manifests itself in the same way as it would for a noncomorbid patient—thus, both patients can be treated with the same RCT-verified, manualized treatment (Morrison et al.).

The atomistic assumption is method-driven because it forces real-world practice (treating a comorbid patient) to fit the logic of the medical-model (via the atomistic assumption), without considering whether this requirement is justified by evidence. If the atomistic assumption were to be evaluated, it would need to be from a wider conception of evidence than mere RCTs: because RCTs do not include comorbid patients, their results alone do not determine whether ESTs are appropriate for comorbid patients. Thus, critics of an EST framework have appealed to a broader framework of evidence—one that can more aptly inform how RCTs relate to actual practice—to show the problems of the atomistic assumption. This framework includes empirical research that suggests that ESTs have limited success for comorbid patients (Morrison et al., 2003; Messer, 2004).

The revelation of the atomistic assumption of comorbidity is just one way that critics have exposed the external validity limitations of an EST framework. Considerable research has demonstrated, for example, that manualized ESTs often hinder the presence of important therapeutic factors, such as the therapist’s genuineness, creativity, and motivation, as well as the patient’s faith in the therapist and the strength of the therapeutic relationship (Piper & Ogrodniczuk, 1999). Other research has shown that success rates of the RCT are inflated due to its disregard of long-term relapse rates and its exclusion of early dropouts before determining efficacy rates (Messer, 2004).
The preceding research casts doubt on the objectivity of an EST-framework, suggesting that such is based on an inherently limited and biased conception of evidence, as opposed to an infallible window to reality. This could be known, however, only by relying upon a conception of evidence that includes, but is not limited to, the RCT.

Rejecting Alternative Conceptions of Evidence

In connection with reshaping real-world practice to match the criteria of a medical-model of evidence, an EST framework fails to consider alternative conceptions of evidence and the methods and practices they imply, not because of their potential fruitfulness, but merely because they do not conform to the medical model’s presumptions of disorder, treatment, and human change. Such types of practice include, but are not limited to, humanistic therapies (client-centered, existential, experiential, gestalt), psychodynamic therapies (Freudian psychoanalysis, interpersonal, self psychology, object relations), and certain marital/family therapies (family systems, structural family; Butcher et al., 2004). Although these therapies are considerably different, they are similar in that they are not concerned, or solely concerned, with treating specific disorders using manualized treatments.

From the perspective of these other therapies, evidence-based practice would be significantly broader than a medical-model approach. Humanistic therapies, for example, are concerned with nondiagnostic issues, such as expanding a patient’s “awareness” and dealing with problems of “alienation, depersonalization, loneliness, and a failure to find meaning and genuine fulfillment” (Butcher et al., 2004, p. 584). A key component of humanistic research and practice is the relationship between the therapist and the patient. As mentioned above, a reliance on manualized treatments impedes the development of a therapeutic relationship, which is essential for humanistic therapies. To cultivate a therapeutic relationship, therapists must remain free to incorporate their own clinical wisdom, according to the specific patient and context. Because of the uniqueness of each patient and therapy session, good practitioners do not robotically apply step-by-step protocols, but instead “are artists who learn how to apply [empirically supported] principles in creative ways” (Beutler, as qtd. in Bohart, 2003, p. 4).

In contrast, a medical-model approach puts an emphasis on universal, “packaged” treatments for well-defined, compartmentalized disorders (Bohart et al., 1998). As mentioned earlier, this model takes its cues from medicine’s study of pharmaceutics, where “one must specify the treatment and make sure it is being applied correctly” (Bohart et al., p. 143). Just as a drug prescription is a specific, portable package in terms of its encapsulated ingredients and usage directions, so must a psychological treatment be “packaged” as an instruction manual with specific procedures and directions. In both cases, every patient receives the exact same thing, and it is this thing that is the agent of change—the health professional is merely a delivery person, and the patient, a passive recipient.

As long as an EST framework is built upon the assumption that packaged treatments—not therapists or patients—are responsible for change, its research agenda will commit a preinvestigatory bias against humanistic and other therapies; such therapies would be ruled out before investigation even begins. The disenfranchisement of these therapies would be troubling for many, if not most, psychotherapists, considering the discipline’s widespread eclecticism and integrationism (Slife & Reber, 2001).

Common-factors Movement

Because of the biases and exclusiveness of an EST framework, many researchers and practitioners have vehemently opposed restricting evidence-based practice to ESTs (e.g., Bohart, 2003; Greenberg & Watson, 2005; Messer, 2004; Morrison et al., 2003; Westen & Bradley, 2005).
Common-factors advocates have argued that a focus on specific treatments for specific disorders is only one way of conceptualizing psychological practice (e.g., Bohart, 2003; Westen & Bradley, 2005; Messer, 2004; Safran, 2001). An alternative approach is to discover and validate factors of therapeutic change that are common across treatments. These “common factors” include therapist techniques and characteristics such as empathy (Bohart et al., 1998), patient characteristics such as “active self-healing abilities” (Bohart, 2005, p. 218), and the relationship between therapist and patient (Norcross & Lambert, 2005; APA, 2006).

An attention to common factors is based on a different worldview than an EST framework, in which responsibility for change is not attributed to a specific treatment alone, but also to the therapist, the patient, and their dynamic relationship (APA, 2006). Psychotherapy researchers have claimed to measure and empirically validate common factors, and argue that the presence of these factors is often a more successful determinant of change than is mere adherence to ESTs (Norcross et al., 2005). Thus, from this view, the answer for evidence-based practice is to discover and apply common factors within all types of therapy, not impose a one-size-fits-all strategy (Bohart, 2003; Westen & Bradley, 2005).

A common-factors approach is appealing, considering that the majority of practitioners consider themselves eclectics and integrationists who value a wide array of research methods, therapeutic techniques, and theoretical orientations (Slife & Reber, 2001). Eclectic and integrationist practitioners believe that openness to a pluralism of methods, including ESTs, allows them to better help the wide range of patients and problems they encounter (Slife & Reber).

Because of its wide appeal, the common-factors movement has made a considerable impact in recent years. Most recently, the common-factors movement has played a significant role in shaping APA’s new policy on evidence-based practice in psychology (EBPP). The policy’s supplementary report, authored by the APA Presidential Task Force on Evidence-Based Practice (2006), makes it clear that a comprehensive strategy for EBPP “will consider [many] determinants [of effective practice] and their optimal combinations,” such as “the treatment method, the individual psychologist, the treatment relationship, and the patient” (APA, 2006, p. 275). The report’s endorsement of these and other common factors shows that this APA policy is in line with the worldview of the common-factors movement: responsibility for change is not attributed to a specific treatment alone, but also to the therapist, the patient, and their dynamic relationship.

Consistent with the common-factors movement, the APA policy explicitly values the inclusion of a diversity of methods. By “start[ing] with the patient” (APA, 2006, p. 273), the APA policy is thought to free itself from relying on a single method’s worldviews about the nature of illness and effective treatment. This allows it to be informed from a diversity of methods, including—but not limited to—ESTs (APA) and their respective conceptions of evidence. This accommodation to diversity is not surprising, considering APA’s goal for the policy to include a consideration of each valid perspective in the discipline (“A presidential,” 2005).

In comparison to an EST framework, the common-factors movement (including the APA policy) is based on a wider conception of evidence that allows it to more objectively avoid bias and better match the diverse needs of the discipline. After a close evaluation, however, it is clear that the APA policy is also a biased framework and is

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2. These advocates represent a pluralism of views, each with a variety of nuances (Messer, 2004), but they are similar in their concern about an EST-framework’s “emphasis on specific treatment effects as opposed to common factors that account for much of the variance in outcomes across disorders” (APA, 2006, p. 272). Due to this similarity, I have conceptualized this group as representing a single movement—the common-factors movement.
not diverse enough for the wide range of practice in psychology. Just as an EST framework uncritically restricts acceptable evidence to a *single method* (RCT), so does the APA policy uncritically restrict acceptable evidence to a *single epistemology*.

The epistemology on which the policy is based is a narrow brand of *empiricism*. According to this epistemology, “we can only know, or know best, those aspects of our experience that are sensory” (Slife, 2006; see also Slife et al., 2005, p. 84). Given popular demands that natural science disciplines be grounded in empiricism, the policy’s exclusion to empirical methods is understandable. As I will show, however, this exclusion is not based on evidence—analogous to a desire for RCTs, this APA policy merely assumes that empiricism is the only appropriate epistemology for evidence-based practice, in spite of the existence of other promising epistemologies. This mistake is consistent with much of psychology’s history (Slife et al.), in which empiricism has been misunderstood as meaning objective or impartial, “in the sense of exposing what is actual or real” (Slife et al.). In other words, empiricism has not been seen as a particular epistemology or philosophy at all, but as a transparent window to the way things are (Slife et al.).

The APA policy perpetuates an equation of empiricism with reality, seeing no need to provide a rationale for its repeated, implicit equation of “evidence” with “empirically supported.” The report document (APA, 2006) claims, for example, that “the purpose of EBPP is to promote effective psychological practice . . . by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention” (APA). Here, as in several other places, the task force asserts *that* it endorses the application of empirically supported principles, but fails to explain *why*. In fact, nowhere in the policy or in its underlying report is a rationale given for a commitment to empirical research, and nowhere is a consideration given for even the possibility of the contribution of “non-empirical” research to EBPP. If the task force does in fact view empiricism as a particular epistemology, nowhere does it justify, or even explicate, its exclusive commitment to it.

This is a curious omission. If EBPP is exclusively committed to a single epistemology, why not come right out and say it? Indeed, why not call the movement *empirically* based practice in psychology? Perhaps the task force wants to have its cake and eat it too—to cater wholeheartedly and uncritically to one epistemology (empiricism) but talk about it in a way that implies it does not see it as an epistemology at all. This is similar to an EST framework and its equation of empirical support as RCT-verified. The problem with both frameworks is their equation of a narrow conception of evidence with a broader reality. An EST framework is exclusively committed to RCTs but assumes that such encompasses the broader field of empirical support (hence the broad designation, empirically supported treatments). Similarly, the APA policy is exclusively committed to empiricism but assumes that such encompasses the broader field of evidential basis in psychology (hence the broad designation, evidence-based practice in psychology).

Thus, the problems with the APA policy’s commitment to empiricism are comparable to those from an EST framework’s commitment to the RCT. In particular, the APA policy (a) demands, without evidence, that clinical practice be shaped to fit an empiricist epistemology and (b) marginalizes the inclusion of non-empirical epistemologies and their methods and practices, not because of their potential fruitfulness for evidence-based practice, but merely because they do not conform to the logic and criteria of empiricism.

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3. This conception of empiricism is a fairly traditional one and is the way the term is typically used in psychology. More liberal usages of empiricism differ somewhat, such as William James's radical empiricism, which encompasses “the whole of experience,” including non-sensory experiences such as thoughts, emotions, and spiritual experiences (Slife, 2006). In mainstream psychology, however, the term *empiricism* is commonly used to refer to sensory experience only. Thus, throughout this paper, I will use *empiricism* to refer to sensory experience and *non-empiricism* to refer to non-sensory kinds of experiences.
By assuming that empiricism is the only appropriate epistemology for evidence-based practice, the APA policy demands that clinical practice be shaped to fit empirical criteria. However, just as the majority of real-world patients cannot be neatly categorized as a number of disorders, so are the majority of real-world experiences not able to be neatly categorized according to the logic of empiricism. In fact, the vast majority of real-world phenomena of interest for evidence-based practice are not, strictly speaking, empirical in nature; rather, they are unobservable experiences, meaning they are not sensory in nature (Slife et al., 2005). Such phenomena include many, if not all, of the common factors of therapeutic change, especially those concerning the therapeutic relationship (Slife et al.).

Common-factors advocates and the APA task force have endorsed the investigation and implementation of such unobservable experiences for evidence-based practice (APA, 2006), but only in a way that is consistent with the logic of empiricism. From an empiricist standpoint, the way to handle an unobservable experience is to “operationalize” it. An operationalization is an observable, quantitative set of operations intended to represent an unobservable construct. For example, one might operationalize depression as a certain score on a questionnaire, or intelligence as a score on an intelligence test. Although operationalization is widely considered to be essential for the reliability and progress of a scientific discipline, this claim is not at all based on empirical evidence. Indeed, there is no empirical way of knowing whether, or in what manner, an operationalization relates to the original, unobservable, construct of study.

The APA policy ignores this problem, however, asserting that “good practice and science call for the timely testing of psychological practices in a way that adequately operationalizes them using appropriate scientific methodology” (APA, 2006, p. 274). No justification is given for this claim—it is merely assumed a priori. In this respect, the uncritical demand for operationalization is as problematic as the insistence that ESTs work for comorbid patients. Likewise, it rests upon an assumption that is as unfounded as the atomistic assumption of comorbidity.

This assumption is the observability assumption of unobservables (my term)—that unobservable meanings and phenomena can in fact be operationalized into observable phenomena (Slife et al., 2005). Like the atomistic assumption, the observability assumption is a preinvestigatory bias that does not sufficiently represent real-world phenomena. Similarly, there appears to be no justification for it at all, apart from its conformity to the logic of empiricism. Indeed, one cannot resort to empirical evidence on this matter, because it is not an empirical question—this would be akin to justifying the atomistic assumption with RCT evidence. If one were to justify the observable assumption, it would require theoretical expertise concerning the nature of unobservable meanings—and just as the RCT is not concerned with comorbid patients, so is empiricism not concerned with unobservables.

If one assumes, for example, that an operationalization is connected or related in any way to an unobservable meaning, this connection must itself be a non-empirical, unobservable one. Suppose, for example, a researcher seeks to study “happiness” (an unobservable meaning) using a self-report questionnaire score (an operational definition). The score would be, at best, an observable manifestation of happiness, but even this cannot be known from an empiricist framework because the relationship between the observable and the unobservable is a non-empirical question (Slife et al., 2005). Likewise, the insistence for operationalization is a non-empirical claim; at best, it must rely on a logical or theoretical argument that can never be confirmed nor denied by empirical evidence alone.

How, then, would one evaluate whether an unobservable meaning is connected to an observable operationalization? Here we can take cues from the common-factors movement’s denunciation of the atomistic assumption—we must appeal to a wider
framework of evidence, one that includes the study of unobservable meanings. As I will demonstrate, reputable methods—qualitative methods—exist which intentionally avoid operationalization and involve the study of unobservables. Thus, if unobservable meanings are in fact a subject of interest for psychological practice, then the proper approach is to turn to qualitative methods “rather than to turn unobservable meanings into something they are not” (Slife & Wendt, 2005).

The APA policy’s insistence for operationalization highlights just one way that the common-factors framework is driven by the constraints of empiricism. It is discussed as an example here to demonstrate how psychologists are interested in non-empirical content, but are nonetheless restricted to an empiricist epistemology in method (Slife et al., 2005). This restriction causes the reshaping of unobservable phenomena to fit empiricist methodology, without considering whether alternative method philosophies are more appropriate—just as the conception of comorbidity is inappropriately reshaped by an EST framework.

Marginalization of Non-empirical Philosophies and Methods

Just as an EST framework ignores the fact that certain conceptions of evidence are outside the realm of RCTs, so does a common-factors empiricist framework ignore the fact, established earlier, that unobservable phenomena are inherently—now and forever—outside the realm of empirical methods. Like an EST framework, this mistake commits a preinvestigatory bias against alternative conceptions of evidence.

For example, in its report’s discussion of appropriate methods for EBPP, the APA task force appears to ignore the existence and potential of non-empirical methods. This can be seen in the task force’s evaluation of qualitative methods. Although commonly misunderstood as originating from an empiricist methodology, qualitative methods are based on an alternative philosophy of science that neither requires nor prefers operationalization (Slife et al., 2005). Early qualitative researchers were interested in unobservable phenomena themselves, not their supposed manifestations. Therefore, they have developed alternative, qualitative methods that are better suited than empirical methods to understand and investigate these meanings, including their connection to observable experiences (Slife & Wendt, 2005).

Although the task force’s report includes qualitative research on its list of acceptable methods, it fails to understand and value qualitative research as a non-empirical method. When one considers, for example, the report’s insistence for operationalization, it is puzzling to know how exactly non-empirical qualitative methods would inform evidence-based practice. The report is hardly informative on the matter, stating merely that “qualitative research can be used to describe the subjective, lived experiences of people, including participants in psychotherapy” (APA, 2006, p. 274). How do descriptions of “subjective, lived experiences” inform evidence-based practice? From the task force’s report, the answer is unclear—one can only surmise, given the policy’s requirement of operationalization, that qualitative research could lead to the development of new or improved operationalizations that can then be isolated, investigated, and implemented for evidence-based practice. Such a view is driven by an empiricist epistemology, causing a distorted and marginalized conception of the role of qualitative research.

Another clear signal that the task force misunderstands and misrepresents qualitative research—and that also indicates the APA policy’s empiricist framework—is the use of the word subjective in describing the purpose of qualitative research. Of all the methods the task force recommends, the word subjective is reserved only for qualitative research, implying that all other recommended methods are “objective.” In the midst of a discipline that champions objective inquiry, a relegation of being subjective is a second-class citizenship at best (Slife, 2006). A relegation of subjective, in this case, makes sense
only from an empiricist framework; from a non-empiricist framework, empiricist conceptions of “objective” and “subjective” are largely irrelevant (Slife, 2006). This is because an empiricist’s definition of “objective” is generally synonymous with “empirical.” From a non-empirical perspective, however, the subject matter of qualitative researchers is hardly subjective. The qualitative researcher is not interested, for example, in investigating a subjective interpretation of “love”; she is interested in studying the objective, non-sensory experience of love itself. Therefore, although the task force recommends the use of qualitative methods for EBPP, it does so only in a way that is grounded in empiricism, thereby distorting the nature and history of qualitative research.

That the APA policy misunderstands and misrepresents qualitative research calls into question whether it truly “acknowledge[s] the valid points from all sides of the debate” (“A presidential,” 2005, p. 59). Instead, the policy is committed to an empiricist epistemology that causes it to have a preinvestigatory bias against non-empiricist philosophies and the methods they imply. This bias can lead to the misinterpretation and marginalization of a given method—as is the case for qualitative methods—or it can exclude the method altogether, before investigation even begins.

In summary, the common-factors movement and APA policy are driven by the epistemology of empiricism, and this commitment is analogous to an EST framework’s commitment to RCTs. Because the policy does not consider whether an empiricist framework is consistent with the nature of real-world patients and circumstances, it reshapes, marginalizes, or ignores non-empirical phenomena and methods in order to adhere to the logic of empiricism.

A Broader Framework: Objective Methodological Pluralism

Thus far, I have argued that neither the EST movement nor the common-factors movement has produced a framework that matches the APA task force’s ideals of objectivity and diversity. Such ideals are prevented by the fact that each movement constitutes a preinvestigatory bias against a broader, and necessary, conception of evidence. Thus, the discipline is still in need of a proper framework for evidence-based practice—one that is broad enough to include not only the investigation and implementation of research methods and types of practice, but also their underlying epistemologies. Such is required to avoid the error of uncritically limiting acceptable evidence to a preconceived method or epistemology.

The remainder of this paper will discuss a potentially successful framework, objective methodological pluralism (OMP).4 As evidenced by its name, OMP is concerned with being “objective,” rather than with (subjectively) shaping the world to fit the demands of a chosen method or methodology. It is important to understand, however, that for OMP the meaning of objective is more broadly understood than it is from an empiricist framework. The objectivity of empiricism is often simply equated with an adherence to empiricist methodology, which is assumed—rather than known—to be the objective “reveler of the actual and the truthful, not the bearer of some ideological or economic methodology” (Slife et al., 2005, p. 83). This conception of objectivity is inadequate, as is evident when considering the limitations of empiricism; indeed, empiricism itself is both an ideological and economic methodology (Slife et al.).

4. Psychotherapy researcher Brent Slife (Slife et al., 2005, pp. 93–95; Slife, 2006; Slife & Wendt, 2005) has articulated OMP in more depth than will be included in this paper. Here I wish to briefly discuss how OMP promises to be a genuinely objective and diverse framework for evidence-based practice.
In contrast to an empiricist framework, OMP’s objectivity is not due to an adherence to a single methodology, but from its aim to be guided by “the truth of our practical experience” (Slife, 2006). In other words, OMP seeks to be driven by the “object of study” (Slife), not a preordained understanding about how to best measure such (Slife et al., 2005). Only by being object-driven, as opposed to method- or methodology-driven, can a framework for evidence-based practice best avoid an ideological or economic methodology.

To be object-driven, OMP requires one to first consider the nature of the object of study, and then utilize or invent the research method or type of practice that is most compatible with the object’s nature (Slife et al., 2005). This would require determining, for example, whether the object of study is, strictly speaking, a sensory observation (e.g., heart rate, behavioral habits) or a non-sensory meaning (e.g., empathy, therapeutic relationship; Slife, 2006). If “the postulated characteristics of the object” (Slife et al., p. 94) are knowable through sensory observation, then traditional empirical methods might be the preferred route (Slife & Wendt, 2005). However, for the study of unobservable meanings—which, again, constitute a vast portion of the phenomena of interest for evidence-based practice—qualitative methods would be more appropriate.

In examining the object of one’s study, researchers and practitioners might ask the following types of questions: What is the nature of the object? Is it a phenomenon that is knowable through empirical observation alone? Or is it an unobservable meaning? If an unobservable meaning, does it also consist of observable manifestations? If so, how are such manifestations related to the unobservable meaning? From an OMP perspective, such questions would be asked before committing to a preconceived method, philosophy, or ideology. Such an approach differs starkly from an EST or common-factors approach, both of which depend on a commitment to a preconceived method or epistemology. This dependency prohibits each framework from considering epistemological, philosophical, or value questions in the first place.

An example will illustrate how the OMP and common-factors approaches might compare—and how OMP best avoids being driven by a preconceived method or epistemology. Suppose that a researcher wishes to examine the role of a therapist’s “empathy” in effective psychotherapy (a proven factor of effective therapy, according to the common-factors movement) (Bohart et al., 1998). From the onset, the common-factors approach is constrained to begin with an operational definition of empathy, according to “appropriate scientific methodology” (APA, 2006, p. 274). To establish an empirically demonstrable definition, the researcher would determine certain variables that are assumed—rather than known—to relate to empathy and then determine their efficacy via traditional experimental methods.

An OMP approach, in contrast, would first be concerned with the nature of empathy, rather than automatically adhering to the empirical method and its requirement for operationalization. The researcher might ask, “What am I really interested in?” In this case, she might determine that one cannot assume that empathy is, at bottom, a sensory observation. She might consider, of course, constructing an empirical operationalization of

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5. One might prefer the term “subject-driven,” “phenomena-driven,” “question-driven,” “concept-driven,” or “patient-driven” (Stephen Yanchar, personal communication, June 26, 2006). There is no problem with these terms, but “object-driven” (Slife’s term) will be used throughout this paper to emphasize the objectivity of an object-driven approach.

6. Of course, these types of questions should be considered and reconsidered throughout the process of one’s study. An important feature of OMP is its “active and ongoing dialogue about the method values needed to illuminate the objects of inquiry” (Slife et al., 2005, p. 94). In this respect, “various informal investigations and methods could aid in making these decisions, and some value systems even ‘tried on’ to see how helpful they are” (p. 94). The bottom line is that such value systems and methods “would themselves be continuously on trial” (p. 94).
empathy (e.g., vocal properties of therapists that are judged by their patients to have empathy). But she decides against such, determining that she is not interested in manifestations and subjective reports of empathy—she desires an objective study of empathy itself. If her study is to include empirical, operational designs, then it must also include a rationale for how such operations relate to empathy. Such hypothetical relationships, the researcher decides, are inherently unobservable; they lie beyond the realm of empirical methods, because the object of study itself—empathy—is an unobservable meaning, not an empirically demonstrable entity.

With this realization, our hypothetical researcher can do no more if she is trained solely in empirical methods—just as a nails-only carpenter is at a loss when it comes to screws. With expertise in qualitative methods, however, she might be able to determine or create a method that is suitable for examining unobservable meanings. Such a study might include empirical factors, (e.g., practitioners’ vocal properties or patients’ Likert-scale judgments) but they would not be automatically equated with empathy but seen as mere parts or manifestations of a larger, unobservable meaning. Thus, a qualitative approach would need to involve and examine a theoretical connection between such empirical manifestations and the unobservable meaning of “empathy,” as well as examine the relationship between “empathy” and successful practice. This would require, of course, an objective approach to the study of “successful practice”—another unobservable meaning, and one that is “rarely considered in psychology” (Slife, 2006).

Now, it is important to note that OMP does not pretend to be free of assumptions or biases. At bottom, OMP is a pragmatic framework, based on a philosophy that “takes its cues from the practical context of research rather than the abstract propositions of epistemology” (Slife et al., 2005, p. 94). This type of pragmatism is grounded, in many respects, to the tradition of William James (p. 94). I do not expect that OMP’s underlying commitment to pragmatism would worry many practitioners in the discipline, especially considering, once again, that the vast majority are at least somewhat pragmatically eclectic or integrationist (see above). Moreover, OMP’s pragmatism should not be terribly troubling to both researchers and practitioners who value the APA policy’s requirement of adapting therapy to the practical needs of clinical circumstances and individual patients. Indeed, the APA policy itself is also underlain in a commitment to pragmatism—how else can one understand its claim that EBPP, unlike ESTs, “starts with the patient and asks what research evidence . . . will assist the psychologist in achieving the best outcome”? (APA, 2006, p. 273).

The difference, however, between OMP and EBPP is that OMP is ultimately grounded in pragmatism, whereas EBPP is ultimately grounded in empiricism. Therefore, when EBPP claims that it “starts with the patient,” what it really means is that it starts with the patient in a way that presupposes the sufficiency of an empirical methodology. Thus, its conception of the very meaning of “patient” and what it means to “start with the patient” are already grounded in an empiricist framework. Thus, from the very beginning, unobservable meanings of “start[ing] with the patient,” including the methods and practices they might imply, are never considered, in spite of the fact that an attention to...
such meanings are a logical extension of “the truth of our practical experience” (Slife, 2006), as argued previously.

Unlike APA’s conception of EBPP, OMP is open to the entire range of real-world clinical phenomena, both sensory observations and unobservable meanings. This openness allows OMP to be a truly diverse framework for evidence-based practice—it is not inherently biased against any method or epistemology that is useful for evidence-based practice. Instead, OMP seeks only to be pragmatic, open to whatever methods and epistemologies are a practical outgrowth of “the truth of our practical experience” (Slife, 2006).

Because the truth of the experience of real-world practice is concerned with unobservables, it is therefore necessary for OMP to be concerned with unobservable methods, as well as the epistemologies that guide those methods. This pragmatic openness prevents OMP from being driven by a restrictive epistemological or methodological ideology (Slife et al., 2005). As a consequence, OMP is a more diverse framework than an empiricist common-factors conception of evidence.

### Conclusion

When compared to an EST framework, the common-factors movement and the APA policy are a step forward for evidence-based practice toward its ideals of objectivity and diversity. Upon close evaluation, however, it is evident that the APA policy makes similar mistakes. Both are based on limited, biased conceptions of evidence that constitute a preinvestigatory bias against alternative conceptions and the methods they imply. An EST framework is built upon a medical-model of evidence that is biased toward RCT-based treatments for specific disorders, causing it to fail to appreciate and consider alternative research methods and types of practice that are built upon non-medical-model conceptions of evidence. Analogously, the common-factors movement and APA policy are built upon an empiricist model of evidence that is biased toward sensory observable criteria of evidence, causing them to fail to appreciate and consider non-empirical methods and practices, such as qualitative research. Ultimately, objective methodological pluralism (OMP) is a more promising framework for matching the APA task force’s criteria of objectivity and diversity.

### References


