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Evidence-Based Practice in Psychology

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This article focuses on the 2005 American Psychological Association Presidential Task Force on Evidence-Based Practice in Psychology. After describing the rationale and results of this task force, the authors review the literature that has appeared following the approval of the *Policy Statement on Evidence-Based Practice in Psychology* by the American Psychological Association Council of Representatives, with reference to the implications for practitioners. Finally, the authors discuss the implications of the *Policy Statement on Evidence-Based Practice in Psychology* for graduate students and early career professionals.

Keywords: evidence-based practice in psychology, practitioners, graduate students, early career professionals

The quest to determine what works in psychotherapy is a critical one.¹ Today, evidence for therapeutic interventions can be defined in many ways (Norcross, Beutler, & Levant, 2006). Building consensus on the definition of evidence and ensuring that evidence-based practice in psychology (EBPP) recognizes not only the research but also the clinician's expertise and the patient's preferences, values, and culture is important to the future of the profession and quality patient care. Some psychologists believe that psychological interventions should be based solely on randomized clinical trials, while others believe that other forms of evidence have their value. Some divisions have, or are developing, their own policy statements on evidence-based practice (EBP), but Ronald F. Levant thought that it was vital that the American Psychological Association (APA) speak with one voice on the issue to avoid potential confusion among members, the public, media, legislators, state health officials, and third-party payers.

Some APA members have asked Ronald F. Levant why he chose to sponsor an APA presidential initiative on EBPP in 2005, expressing fears that the results might be used against psychologists by managed care companies and malpractice lawyers. To respond, he drew attention to the larger societal context. The EBP movement in U.S. society is truly a juggernaut, racing to achieve accountability in medicine, psychology, education, public policy, and even architecture. The zeitgeist is to require professionals to

base their practice to whatever extent possible on evidence. Thus, psychology needs to define EBPP or it will be defined for us. Psychology cannot afford to sit on the sidelines.

In fact, EBPP is already being defined. Practitioner leaders learned about the impact of EBPP on state Medicaid-funded mental health programs at symposia at the 2004 APA State Leadership Conference (Reed, Goodheart, Hayes, Bufka, & Levant, 2004). The American Psychological Association Division of Clinical Psychology (1995; see also Chambless et al., 1998) lists of empirically supported treatments have been referenced by a number of local, state, and federal funding agencies, who are beginning to restrict reimbursement to these treatments, as are some managed care and insurance companies. The division's lists were developed using rigorous scientific criteria in order to demonstrate that psychological treatments are as effective or more effective than medication treatments, without the danger of side effects. However, some believe the criteria were too narrow to serve as a primary guide for practice. Not taken into account were some of the broader strands of psychological research evidence (such as effectiveness research and common factors research) and the other two pillars of what the Institute of Medicine (2001) has defined as the foundation of EBP in health care, namely, clinical expertise and patient values. Further, interventions conducted under laboratory conditions with selective participant criteria do not necessarily generalize well in the real world of human services. Moreover, the requirement of a treatment manual excluded many forms of therapy, tailored approaches, or types of patients from consideration. But conceptualizations of EBP are evolving, and psychologists have an opportunity now to influence health care delivery systems, funding, and legislation nationwide.

If psychologists do not take on this task, the challenge will not magically disappear. Rather, someone else will dictate what treatments are acceptable and what types of evidence are privileged. Psychologists will have more leverage with insurers, courts, and policy makers when APA has a clear statement asserting that

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¹ The first section of this article is adapted from Levant (2006, pp. 391–392).

psychology is a science-based profession and preserving the right for psychologists to make the final, evidence-informed decisions in clinical practice.

This presidential initiative aimed to affirm the importance of attending to multiple sources of research evidence and to affirm that good psychological practice based on evidence is also based on clinical expertise and patient values. The mission of the APA Presidential Task Force on Evidence-Based Practice in Psychology was threefold, corresponding to the three components of the Institute of Medicine's (2001; see also Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996) definition of EBP ("Evidence-based practice is the integration of best research evidence with clinical expertise and patient values," p. 147):

1. To consider how a broader view of research evidence, one that inclusively considers multiple research designs, research in public health, health services research, and health care economics, should be integrated into a definition of EBPP.
2. To explicate the application and appropriate role of clinical expertise in treatment decision making, including a consideration of the multiple streams of evidence that must be integrated by clinicians and a consideration of relevant research regarding the expertise of clinicians and clinical decision making.
3. To articulate the role of patient values in treatment decision making, including a consideration of the role of ethnicity, race, culture, language, gender, sexual orientation, religion, age, and disability status, and the issue of treatment acceptability and consumer choice.

This task force included 18 scientists and practitioners from a wide range of employment settings, theoretical orientations, APA constituencies, and ethnic heritages. Carol Goodheart served as the chair. Areas of expertise of task force members include clinical expertise and decision making, health services research, public health and consumer perspectives, treatment outcome and process research, full-time practice, clinical research and diversity, health care economics, and EBP research/training and applications.

Ronald F. Levant was pleasantly surprised and very impressed with how effectively the task force members worked to hear each others' perspectives and seek common ground. The task force had brought together people who would not have been likely to attend each others' programs at the APA annual convention, working in mixed groups to hear and understand the multiple nuances involved in every issue.

The task force developed two documents. The first was a policy statement for APA governance action, which was posted on a Web page and circulated widely for comment and was reviewed at the March Consolidated Meetings of APA Boards and Committees. The task force responded to almost 200 sets of comments and revised the policy statement to take into account the important feedback received in the comments. The second document was a report of the task force, which elaborates on the policy statement, supporting a broad conceptualization of EBPP. Both documents offered the following definition of EBPP: "Evidence-based practice in psychology (EBPP) is the integration of the best available

research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273).

These efforts succeeded. The Council of Representatives at its August 2005 meeting adopted the policy statement (APA, 2005a) and received the *Report of the 2005 Presidential Task Force on Evidence-Based Practice* (APA, 2005b). In addition, the report was published in the *American Psychologist* (APA Presidential Task Force on Evidence-Based Practice, 2006). Of note, the policy statement was adopted verbatim by the Norwegian Psychological Association (Norsk Psykologforening, 2007)

In the balance of this article, we discuss, first, the literature that has appeared following the promulgation of the *Policy Statement on Evidence-Based Practice in Psychology*, with particular reference to the implications for practitioners and, second, we discuss the implications of the *Policy Statement on Evidence-Based Practice in Psychology* for graduate students and early career professionals.

Recent Literature on EBPP: Implications for Practice

Since the release of the policy statement and report of the task force on EBPP, there has been a great deal of discussion regarding the implications of the policy statement. Some of this discussion has taken place in the research literature as well as the gray literature, which includes newsletters, journal comments, and book reviews. This section provides a summary of both literatures on EBPP since the release of the task force report and addresses the implications for practice.

One important issue that needs to be clarified at the outset is the relationship between EBPP and ESTs (*empirically supported treatments*, formerly known as *empirically validated treatments*), as the latter are sometimes referred to in the literature as *evidence-based treatments* and erroneously as *evidence-based practices*. According to the report (APA Presidential Task Force on Evidence-Based Practice, 2006):

EBPP is the more comprehensive concept. ESTs start with the treatment and ask whether this treatment works for a certain disorder or problem under specified circumstances. EBPP starts with the patient and asks what research evidence (including relevant results from randomized clinical trials) will assist the psychologist to achieve the best outcome. In addition, ESTs are specific psychological treatments that have been shown to be efficacious in controlled clinical trials, whereas EBPP encompasses a broader range of clinical activities (e.g., psychological assessment, case formulation, therapy relationships). As such, EBPP articulates a decision making process for integrating multiple streams of research evidence, including but not limited to RCTs, into the intervention process. (p. 273)

Practitioners were excited about the policy statement and report of the task force on EBPP. For instance, Brooke (2006) stated that

Something remarkable has happened this past year in professional psychology. It can give comfort to those unassuming and quietly competent colleagues who have little time for funded research into their work; colleagues who do not like labels, diagnostic or otherwise; people in whose hands we entrusted, with trepidation and increasing confidence, our own psychological well-being and even our lives (p. 23).

He later noted that "the importance of context and clinical expertise are once again recognized by APA as essential to pro-

professional competence in an evidence based practice (p. 23).” Clearly, his sentiment is shared by many clinicians who are excited to have the importance of clinical expertise recognized by APA as a matter of policy.

Hunsberger (2007) commended the task force report for valuing clinical expertise and research data in psychological practice. As a psychologist in independent practice, he argued that “by virtue of daily personal interactions with clients, clinicians are arguably the true experts on the nature and accessing of psychological evidence” (p. 614). He also stated that without an ongoing subjective collaboration, objective data are unreliable. Hunsberger encouraged APA to prioritize subjective emotional and relational skills when selecting and training clinical psychology students.

Whaley and Davis (2007) highlighted the complementary nature of cultural competence and EBP in mental health services for the psychological treatment of people of color. They argued that despite the inadequate representation of members of ethnic/racial minority populations in evidence-based treatment studies, there is significant scientific and clinical overlap between the cultural competence and EBP literatures. These authors support the use of cultural adaptations of the existing research base for people of color. Whaley and Davis stated that the task force acknowledged the importance of expanding the definition of EBP, and they agreed that a broader definition of EBPP is needed to accurately adapt research findings for people of color. These authors also echoed the task force recommendation to prioritize efficacy and effectiveness research with underrepresented groups.

Of interest, Sobell (2007), a past president of APA’s Division of Clinical Psychology (Division 12), suggested that “Division 12 could take the lead on taking APA’s Evidence-Based Practice (EBP) document to the next level” by incorporating “idiographic approaches to the more nomothetic activity of identifying and promulgating empirically supported treatments” (p. 21).

On the other hand, some researchers expressed concerns about the task force report. For instance, Stuart and Lilienfeld (2007) applauded the task force’s attention to diversity but reported that one aspect of diversity was left out of the task force report. They argued that a broad philosophy of science consideration on EBPP was not part of the discussion. The authors stated that this omission led the task force to make some epistemological assumptions that are not based on evidence or rationale and hence violate the evidence-based decision making process. Stuart and Lilienfeld reported that although the task force indicated that it used empirically supported principles, it did not justify why it made this decision and therefore assumed that an empiricist framework required no justification. The authors also noted that qualitative research techniques, which have different epistemological foundations, are seen as a second-class methodology.

Moreover, Wendt and Slife (2007) commented that the task force report was silent on three important issues that resulted in the omission of the evidence necessary to have an EBP. The authors reported that evidence was not operationalized, the report did not address the problem of iatrogenic treatments, and the report did not address the need for ongoing objective evaluation of clinical cases. In order to correct these concerns, Wendt and Slife recommended that the task force provide a more clear operationalization of scientific evidence, use current research to rule out the use of harmful methods, and use objective criteria to evaluate cases consistently.

In response to several of the comments above, Wampold, Goodheart, and Levant (2007) clarified and elaborated the task force report and policy statement. These authors addressed some of the concerns above and clarified that the main goal of the task force was “to create a scheme that would suggest how evidence should be used to design and offer services that will benefit patients and to assure the public and the health care system that psychologists are providing evidence-based services” (p. 618). Wampold et al. also stated that while not all psychologists will agree with every aspect of EBPP, the task force work represented a very significant accomplishment for the field.

Coming from an EST perspective, and somewhat at variance with the more integrative perspective of the task force, Hunsley (2007b) outlined concerns about the report and provided recommendations for training psychologists for EBPP. The concerns he discussed included the potential loss of professional autonomy, takeover of psychology by special interest groups or individuals with specific theoretical orientations, dehumanization of psychological services, unsuitability of the research base underlying EBPP, and the impossibility of basing psychological services on research evidence. Hunsley (2007b) recommended the following changes: promoting efficient strategies for seeking, evaluating, and appropriately using research evidence; redirecting assessment training efforts to better target the knowledge and skills that have direct relevance of providing and evaluating evidence-based services; and emphasizing the critical importance of learning and using ESTs in combination with other evidence-informed interventions techniques.

Hunsley (2007a) acknowledged the work of the task force in another article and explored some of the main challenges for psychologists who wish to provide evidence-based treatment services. These challenges included (a) How should evidence be used in EBPP? (b) Are participants in treatment studies clinically representative? (c) Is the range of extant evidence-based treatments sufficient for clinical practice? And (d) Do evidence-based treatments actually work in the real world? The author believes that the evidence to date indicates that there are clinically relevant and effective treatment options for many individuals seeking therapeutic services.

Hunsley (2007a) provided several recommendations to overcome these specific challenges. First, he stressed the importance for practitioners to employ a self-critical professional perspective so that practitioners can recognize the limits of their competence within the changing nature of the health care system. Hunsley (2007a) also stated that EBPP is a dynamic process that requires continuing education and consistent quality assurance efforts from clinicians. In order to find the best research evidence, it is essential that clinicians are aware of the research literature. This includes reviewing clinician-friendly summaries of recent studies, using APA databases like PsycINFO and PsycARTICLES, and reading systemic reviews and clinical guidelines from expert sources.

Hunsley (2007a) also stressed the importance of understanding the methods used to develop the reviews and guidelines so that clinicians can trust the resources. He indicated that additional research is needed to examine the question of comorbidity and its effect on evidence-based treatments. Clinicians were also encouraged to use the full range of treatment-relevant research, and not just treatment outcomes. Finally, the author also encouraged clinicians to use treatment-monitoring strategies to assess how treat-

ment is progressing and to use these data to adjust treatments when appropriate. He argued that this technique will increase client improvement rates.

Some authors have confused EBPP with ESTs. For instance, Gotham (2006) reported that most practicing psychologists do not use "EBPs" and that academic psychology programs provide varying levels of training in "EBP"; however, this author did not reference the APA policy statement or report in the article, and it is clear from the citations that she was talking about ESTs.

Similarly, Aarons and Sawitzky (2006) assessed the association of organizational culture and climate with attitudes toward adopting "EBP"; however, they also did not reference the APA policy statement or report and never defined what they meant by "EBP"

On the other hand, Rishel (2007) moved the discussion of EBPP into the arena of prevention. She argued that "the field of prevention science should adopt this framework [EBPP] as well to best position itself to support the need for, and effectiveness of, prevention efforts in the area of mental health" (p. 155). The author recommended three steps needed to develop evidence-based prevention practice in the area of mental health. These are to identify common outcome measures, conduct comprehensive follow-up evaluation, and operationalize program characteristics. Thus, Rishel encouraged psychologists in the prevention field to implement and use EBP in their work.

Furthermore, there are two recently edited books that have been published on this complex and controversial debate. The first, edited by Goodheart, Kazdin, and Sternberg (2006), is *Evidence-Based Psychotherapy: Where Theory and Practice Meet*. The first editor, Carol Goodheart, served as the chair of the task force, and the volume is closely linked to the task force policy and subsequent debate. A recent book review by Fertuck (2007) indicated that this book is an important addition to the debate on EBP in psychotherapy and highlights issues that extend well beyond the role of psychotherapy in EBP. The second book, edited by Norcross, Beutler, and Levant (2006), is titled, *Evidence-Based Practices in Mental Health: Debates and Dialogue on the Fundamental Questions*. Again the editors of this book were deeply involved with the task force work and organized the book to address the fundamental questions in the debate on EBPP. Given that EBPP will have an enormous impact on mental health practice, training, and policy, it is essential that practitioners, researchers, graduate students, and professionals be aware of the detailed debate on EBPP.

Implications for Graduate Students and Early Career Professionals

Recommendations for graduate students and early career professionals are provided as follows. The first recommendation is for graduate students and early career professionals to read the original materials produced by the task force on EBPP. There are many views about EBP. It is important for graduate students and early career professionals to understand the actual task force policy statement and report. This will provide the most accurate information about the task force's work, and it will empower graduate students and early career psychologists to better informed and able to make their own judgments about EBPP.

The next recommendation is to become familiar with the terms in this area. It can be challenging to understand the various terms

and practice implications related to each approach, and as has been discussed above, these terms are at times confused in the literature. As noted earlier, it is essential to distinguish between the terms empirically supported *treatments* (ESTs; and its variants *empirically validated treatments*, *evidence-based treatments*) and evidence-based *practice* in psychology. ESTs are "specified interventions designated as having demonstrated efficacy for individuals with specific psychological disorders" (Wahler, Kalodner, Wampold, & Lichtenberg, 2000, p. 657). The hallmark of ESTs is that the demonstration of efficacy through two randomized controlled clinical trials required before a treatment is determined to be empirically supported. This is a very rigorous standard for experimentally examining psychological treatments; however, it leaves much out of the equation for practicing psychologists who treat clients in a real world context. The APA EBPP policy has a more inclusive definition of evidence and can be seen as an empirically supported treatments-plus model. The "plus" components are the clinician's expertise and the patient's preferences, values, and culture. Thus, the accumulated expertise of practicing psychologists is valued and can be viewed as an essential ingredient in selecting the most relevant evidence to apply to a particular case. Patient characteristics are also stressed and included as part of the EBPP framework. Hence EBPP envisions clinicians using the research and their expertise in collaboration with patients.

The EBP health care model is increasingly accepted by health care systems (Chwalisz, 2003). The task force report and policy statement have integrated the EBP model into psychology (Hunsley, 2007a). Given the growing appreciation for EBP, it is important that graduate students and early career professionals ask clinical supervisors to model EBP. Chwalisz (2003) encouraged experienced psychologists, early career professionals, and graduate students to play a vital role in utilizing, generating, and disseminating EBP.

Finally, graduate students and early career professionals are strongly encouraged to participate in research on the efficacy and effectiveness of various treatments. Effectiveness research in particular is highlighted because these studies stress external validity and usually occur in clinics that provide psychological service to the community. Although there are some effectiveness studies available for conditions such as bulimia, depression, insomnia, and substance abuse (Hunsley, 2007a), there is a dearth of research on many important areas including how ethnic minority populations and other diverse groups respond to ESTs.

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