

1 **DRAFT FOR COMMENT ONLY**
2 **Not official policy of the American Psychological Association**

3
4 **2005 Presidential Task Force on Evidence-Based Practice**
5 **American Psychological Statement**

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7 **Draft Policy Statement on Evidence-Based Practice in Psychology**
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9 Evidence-based practice in psychology (EBPP) is the integration of the best available
10 research and clinical expertise within the context of patient¹ characteristics, culture,
11 values, and preferences. EBPP promotes effective psychological practice, improves
12 patient outcomes, and enhances public health by applying empirically supported
13 principles of psychological assessment, case formulation, therapeutic relationship, and
14 intervention.

15
16 **Best Available Research Evidence**

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18 A sizeable body of evidence attests to the effectiveness of psychological practices. APA
19 endorses the use of multiple sources of research evidence, as a variety of research designs
20 and methodologies are important for addressing clinical and policy questions. Best
21 available evidence includes data on the effectiveness of various practices, approaches,
22 and strategies with particular clinical problems, patient populations, and cultural contexts
23 in both laboratory and field settings. In evaluating the best available evidence, it is
24 important to consider limitations of the evidence as well as its applicability to the specific
25 case at hand. It is also important to distinguish between treatments that have not been
26 studied in controlled trials and treatments that have been shown to be ineffective.
27 Existing and widely used psychological practices that have not yet been investigated
28 should be systematically evaluated and barriers to conducting this research should be
29 identified and addressed. It is important to identify and rapidly evaluate treatment
30 innovations as they are developed in the field or the laboratory.

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32 **Clinical Expertise**

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34 Clinical expertise encompasses a number of competencies that promote positive
35 therapeutic outcomes. These include: a) diagnostic judgment, systematic case
36 formulation, and treatment planning; b) clinical decision making, treatment
37 implementation, and monitoring of patient progress; c) interpersonal expertise; d)
38 continual self-reflection and incorporation of new knowledge and skills; and e)
39 understanding the influence of individual and cultural differences on treatment. Expertise
40 develops from clinical and scientific training, theoretical understanding, experience, self-
41 reflection, and continuing professional education and training. It is manifested in all

¹ In order to be consistent with the discussion of evidence-based practice in other areas of health care, we use the term *patient* to refer to the individual (child or adult), couple, family, or group receiving treatment. However, we also recognize that in many situations there are important and valid arguments for using terms such as *client*, *consumer*, or *person* in place of *patient* to describe the recipient of services.

42 clinical activities, including but not limited to: a) forming therapeutic alliances; b)
43 assessing patients and developing systematic case formulations, planning treatment, and
44 setting goals; c) selecting interventions and applying them skillfully; d) monitoring
45 patient progress and adjusting practices accordingly; e) attending to the individual, social
46 and cultural context; and d) seeking available resources as needed (e.g., consultation,
47 adjunctive or alternative services). Integral to clinical expertise is an awareness of the
48 limits of one's knowledge and skills and attention to the heuristics and biases—both
49 cognitive and affective—that can affect clinical judgment (e.g., confirmatory biases and
50 motivated reasoning that can inhibit recognition of the need to alter ineffective treatment
51 strategies).

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53 **Patients' Characteristics, Values, and Context**

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55 To be most effective, relationship principles and specific interventions must be applied in
56 ways that are responsive to the patient's specific problems, strengths, personality,
57 sociocultural context, and other characteristics. Cross-diagnostic characteristics such as
58 functional status, resistance level, stage of change, level of social support, and attachment
59 style are known to be related to therapeutic outcomes. In addition, the following are
60 important to consider in forming and maintaining a treatment relationship and in
61 implementing specific interventions: a) variations in presenting problems or disorders,
62 etiology, concurrent symptoms or syndromes, and behavior; b) age, developmental status,
63 developmental history, and life stage; c) sociocultural and familial factors (e.g., gender,
64 ethnicity, social class, religion, disability status, family structure, and sexual orientation);
65 d) current environmental context and stressors (e.g., unemployment or recent major life
66 event); and e) personal preferences, values, and choices relevant to treatment (e.g., goals,
67 beliefs, worldviews, and treatment expectations). Unique patient characteristics may
68 moderate the effects of psychological practices.

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70 **Integration**

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72 The central goal of EBPP is to enhance psychological practice through effective
73 integration of best available research evidence with clinical expertise to provide services
74 tailored to the unique patient. Successful integration requires that psychologists
75 recognize the strengths and limitations of clinical expertise and different types of research
76 and appreciate the value of multiple sources of evidence. Individual problems, co-
77 occurring disorders and concerns, and clinical presentations frequently require decisions
78 and interventions not directly addressed by the available research. Consequently,
79 psychologists are cognizant of relevant research data but also circumspect in generalizing
80 from research to the clinical setting. The application of research evidence and clinical
81 expertise to a given patient always involves inferences that are probabilistic and therefore
82 continuous monitoring of patient progress and adjustment of treatment as needed is
83 essential. Psychological care in an individual case is informed by research evidence but
84 is determined on the basis of all clinically relevant data, patient choice, and the likely
85 costs and benefits of available treatment options for the individual. EBPP seeks to
86 maximize patient choice among effective alternative interventions. The ultimate

87 judgment regarding a particular intervention or treatment plan must be made by the
88 treating psychologist in collaboration with the patient.
89
90 APA encourages the development of health care policies that reflect this view of
91 evidence-based psychological practice.

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2005 Presidential Task Force on Evidence-Based Practice
American Psychological Association

Draft Position Paper

From the very first conceptions of applied psychology as articulated by Lightner Witmer, who formed the first psychological clinic in 1896 (McReynolds, 1997), psychologists have been deeply and uniquely associated with an evidence-based approach to patient care. As Witmer pointed out (1907/1996, pg. 249) “the pure and the applied sciences advance in a single front. What retards the progress of one retards the progress of the other; what fosters one fosters the other.” As early as 1947 the idea that doctoral level psychologists should be trained as both scientists and practitioners became the American Psychological Association (APA) policy (Shakow, Hilgard, Kelly, Luckey, Sanford, & Shaffer, 1947). Early practitioners such as Frederick C. Thorne articulated the methods by which psychological practitioners integrate science into their practice by ... “increasing the application of the experimental approach to the individual case into the clinician’s own experience (Thorne, 1947, pg. 159). Thus, doctoral level psychological practitioners have been on the forefront of the development of evidence based practice (EBP) for decades.

One approach to implementing EBP in health care systems has been through the development of guidelines for best practice. During the early part of this movement, APA recognized the importance of a comprehensive approach to the conceptualization of guidelines. APA also recognized the risk that guidelines might be used inappropriately by commercial health care organizations not intimately familiar with the scientific basis of practice to dictate specific forms of treatment and restrict patient access to care. In 1992, APA formed a joint task force of the Board of Scientific Affairs (BSA), the Board of Professional Affairs (BPA), and the Committee for the Advancement of Professional Practice (CAPP). The document developed by this task force—the *Template for Developing Guidelines: Interventions for Mental Disorders and Psychosocial Aspects of Physical Disorders* (Template)—was approved by the APA Council of Representatives in 1995 (APA, 1995). The Template described the variety of evidence that should be considered in developing guidelines, and cautioned that any emerging clinical practice guidelines should be based on careful systematic weighing of research data *and* clinical expertise. The Template noted,

The successful construction of guidelines relies on the availability of adequate scientific and clinical evidence concerning the intervention being applied and the diagnostic condition being treated. ...Panels (should) weigh the available evidence according to accepted standards of scientific merit, recognizing that the warrant for conclusions differs widely for different bodies of data. (p.2)

Both the Template and the subsequent revised policy document that replaced it—the *Criteria for the Evaluation of Treatment Guidelines* (APA, 2002)—were quite specific in indicating that the evidence base for any psychological intervention should be evaluated in terms of two separate

138 dimensions: *Efficacy* and *Clinical Utility*. The dimension of *Efficacy* lays out criteria for the
139 evaluation of the strength of evidence pertaining to establishing causal relationships between
140 interventions and disorders under treatment. The *Clinical Utility* dimension includes a
141 consideration of available research evidence and clinical consensus regarding the
142 generalizability, feasibility (including patient acceptability), and costs and benefits of
143 interventions.

144
145 Stricker, Abrahamson, Bologna, Hollon, Robinson, and Reed (1999) used the Template to
146 examine a selection of available treatment guidelines and found wide variation in the quality of
147 their coverage of the relevant literature as well as the scientific and clinical basis, specificity, and
148 generalizability of their treatment recommendations. These authors also found that even
149 guidelines that were clearly designed to educate rather than to legislate, were interdisciplinary in
150 nature, and provided extensive empirical and clinical information did not always accurately
151 translate the evidence they reviewed into the algorithms that determined the protocol for
152 treatment under particular sets of circumstances. Psychologists have been particularly concerned
153 about widely disseminated practice guidelines that recommend the use of medications over
154 psychological interventions in the absence of data supporting such recommendations (Barlow,
155 1996; Beutler, 1998; Muñoz, Hollon, McGrath, Rehm, & VandenBos, 1994; Nathan, 1998). For
156 example, the notion that medications have superior effects in treating depression to those of
157 psychotherapy became the central premise of a generation of treatment guidelines (Agency for
158 Health Care Policy and Research, 1993; American Psychiatric Association, 2000), with
159 psychotherapy recommended only after repeated treatment failures on medication. Multiple
160 studies, however, have demonstrated that psychological interventions are generally as effective
161 in the treatment of depression as medications (Hollon, Thase, & Markowitz, 2002; DeRubeis et
162 al., in press), and may even be more cost-effective in the long run (Hollon et al., in press).
163 Nonetheless, depressed persons are disproportionately more likely to receive medication than
164 psychotherapy (Olfson et al., 2002).

165
166 The general benefits of psychotherapy had been established by meta-analytic reviews during the
167 1970s (Smith & Glass, 1977; Smith, Glass, & Miller, 1980). Nevertheless, a perception existed
168 in many corners of the health delivery system that psychological treatments for particular
169 disorders were either ineffective or inferior to the pharmacological treatment. In 1995, the
170 Division 12 (Clinical Psychology) Task Force on Promotion and Dissemination of Psychological
171 Procedures, in an effort to promote treatments delivered by psychologists, published criteria for
172 identifying empirically validated treatments (subsequently relabeled empirically supported
173 treatments) for particular disorders (Chambless et al., 1996; 1998). This group identified 18
174 treatments whose empirical support was well-established according to these criteria. To be
175 included on this list, treatments had to have been tested in a randomized controlled trial with a
176 specific population and implementation of the treatment needed to be guided by a manual.

177
178 Although the goal was to identify treatments with evidence for efficacy comparable to the
179 evidence for the efficacy of medications, and hence to highlight the unique contribution of
180 psychological treatments, the Division 12 Task Force report sparked a decade of controversy.
181 For example, many psychologists raised concerns about the exclusive focus on brief, manualized
182 treatments, the emphasis on specific treatment effects as opposed to common factors that account

183 for much of the variance in outcomes across disorders, and the applicability to a diverse range of
184 patients varying in comorbidity, personality, race, ethnicity, and culture.

185
186 In response, several groups of psychologists, including other divisions of APA, offered
187 alternative frameworks for integrating the available research evidence. In 1999, APA Division
188 29 (Psychotherapy) established a task force to identify, operationalize, and disseminate
189 information on empirically supported therapy relationships, given the powerful association
190 between outcome and aspects of the therapeutic relationship such as the therapeutic alliance
191 (Norcross, 2001). Division 17 (Counseling Psychology) also undertook an examination of
192 empirically supported treatments in counseling psychology (Wampold, Lichtenberg, & Waehler,
193 2000). The Society of Behavioral Medicine, which is not a part of APA but which has
194 significantly overlapping membership, has recently published criteria for examining the evidence
195 base for behavioral medicine interventions (Davidson, et al., 2003). As of this writing, we are
196 aware that task forces have been appointed to examine related issues by a large number of APA
197 divisions concerned with practice issues.

198
199 At the same time that psychologists have been grappling with how best to conceptualize and
200 examine the scientific basis for practice, EBP has become a central issue in the broader health
201 care delivery system, both nationally and internationally. A number of initiatives at the state
202 level have sought to encourage or require the use of mental health treatments considered to be
203 evidence-based within state Medicaid programs (Carpinello, Rosenberg, Stone, Schwager, &
204 Felton, 2002; Chorpita et al., 2002; Reed & Eisman, in press, Tanenbaum, 2005). A major joint
205 initiative of the National Institute of Mental Health (NIMH) and the DHHS Substance Abuse and
206 Mental Health Services Administration (SAMHSA) is currently focusing on promoting the
207 implementation of evidence-based mental health treatment practices into state mental health
208 systems (e.g., see National Institutes of Health, 2004). These initiatives are based on the
209 assumption that they will decrease costs and improve the quality of care in real-world health care
210 systems, though this has not been demonstrated. At the same time, there are substantial concerns
211 that EBP will be used by governmental bodies and managed care systems to restrict access to
212 care and choice of treatments inappropriately.

213 214 **The Task Force**

215
216 It was in this context that 2005 APA President Ronald F. Levant, Ed.D. appointed the APA
217 Presidential Task Force on Evidence-Based Practice (Task Force). The Task Force included
218 scientists and practitioners from a wide range of perspectives and traditions, reflecting the
219 diverse perspectives within the field. All Task Force members shared the core value of
220 delivering the best possible care based on the best available evidence. A list of Task Force
221 members is included as Appendix A.

222
223 The Task Force was asked to begin with the definition of evidence based practice adapted from
224 Sackett, Straus, Richardson, Rosenberg and Haynes (2000) by the Institute of Medicine (2001) in
225 its influential report *Crossing the quality chasm: A new health system for the 21st century*:
226 “Evidence-based practice is the integration of best research evidence with clinical expertise and
227 patient values” (p. 147). Although this definition provides a broad perspective and suggests a
228 dynamic balance among its three components, much of the discussion of evidence-based practice

229 in psychology to date has focused exclusively on research evidence and has been limited to a
230 consideration of efficacy research.

231

232 The Task Force charge was as follows:

233

234 1. To consider how a broader range of research evidence, particularly based on
235 effectiveness research, public health research, health services research, and healthcare
236 economics should be integrated in a consideration of evidence in the practice of
237 psychology.

238

239 2. To articulate and explicate the application and appropriate role of clinical expertise in
240 treatment decision-making, including a consideration of the multiple streams of evidence
241 that must be integrated by clinicians and a consideration of relevant research regarding
242 expertise and clinical decision-making.

243

244 3. To articulate and explicate the role of patient values in treatment decision making,
245 including a consideration of the role of ethnicity, race, culture, language, gender, sexual
246 orientation, religion, age, and disability status, and the issue of treatment acceptability
247 and consumer choice.

248

249 Relevant background materials were assembled by APA staff. Task Force members and other
250 interested parties were asked to nominate additional materials. A bibliography of materials
251 reviewed by the Task Force is included as Appendix B. The Task Force held two face-to-face
252 meetings, the first in October 2004 and the second in January 2005. Through an iterative process
253 of small working groups and subsequent review and revision of all drafts by the entire group, the
254 Task Force achieved unanimous consensus in support of its two primary work products. These
255 were: 1) a proposed APA policy regarding evidence-based practice; and 2) the present position
256 paper providing additional background for the policy statement.

257

258 In this report, The Task Force hopes to draw on APA's century-long tradition of attention to the
259 integration of science and practice by creating a document that describes our fundamental
260 commitment to sophisticated evidence-based psychological practice and takes into account the
261 full range of evidence that policy makers must consider. We aspire to set the stage for further
262 development and refinement of EBP for the betterment of psychological aspects of healthcare as
263 delivered around the world.

264

265 **Definition**

266

267 Based on its review of the literature and its deliberations, the Task Force unanimously agreed on
268 the following definition:

269

270 Evidence-based practice in psychology (EBPP) is the integration of the best available
271 research and clinical expertise within the context of patient characteristics, culture,
272 values, and preferences.

273

274 EBPP as defined above promotes effective psychological practice, improves patient outcomes,
275 and enhances public health by applying empirically supported principles of psychological
276 assessment, case formulation, therapeutic relationship, and intervention.

277
278 The following sections explore in greater detail the three major components of this definition—
279 best available research, clinical expertise, and patient characteristics—and their integration.

280

281

Best Available Research Evidence

282

283 A sizeable body of scientific evidence attests to the effectiveness of psychological practices.¹

284 The research literature on the effect of psychological interventions indicates that these
285 interventions are safe, effective, and enduring for a large number of patients² across a wide range
286 of psychological, addictive, health, and relational problems (Barlow, 2004; Nathan & Gorman,
287 2002; Roth & Fonagy, 2004; Wampold et al., 1997). Further, research demonstrates that
288 psychotherapy can and often does pay for itself in terms of medical costs offset, increased
289 productivity, and life satisfaction (Chiles, Lambert, & Hatch, 2002; Yates, 1994).

290

291 Psychologists possess distinctive strengths in designing, conducting, and interpreting research
292 studies that can guide evidence-based practice. Moreover, psychology -- as a science and as a
293 profession -- is distinctive in combining scientific commitment with an emphasis on human
294 relationships and individual differences. As such, psychology can help develop, broaden, and
295 improve the research base for evidence-based practice.

296

297 There is a broad consensus that psychological practice needs to be evidence based, though there
298 are differences of opinion on the extent to which current research provides the evidence needed
299 to direct day-to-day practice. Care must be taken, on the one hand, to be cognizant of relevant
300 research evidence, and on the other, to be circumspect in generalizing from research when
301 interventions are applied in clinical settings or to patient populations that may not be adequately
302 represented in research settings and samples (Westen, Novotny, & Thompson-Brenner, 2004).

303 The body of research evidence will not always address practice needs. Research needs to
304 maintain a strong focus on internal validity while placing an equal emphasis on external validity.

305

306 The major differences of opinion in the field center on: a) the relative weight to place on
307 different research methods; b) the representativeness of research samples; c) whether research
308 results should guide practice at the level of principles of change, intervention strategies, or
309 specific protocols; d) the generalizability and transportability of treatments validated in
310 controlled research to clinical practice settings (Norcross, Beutler, & Levant, 2005); and e) the
311 extent to which judgments can be made about treatments of choice when the number and
312 duration of treatments tested has been limited (Westen, Novotny, & Thompson-Brenner, 2004).

¹ Our focus in this position paper is primarily on intervention and attends less to important issues such as assessment except to the extent that they are particularly relevant for intervention.

² In order to be consistent with the discussion of evidence-based practice in other areas of health care, we use the term *patient* to refer to the individual (child or adult), couple, family, or group receiving treatment. However, we also recognize that in many situations there are important and valid arguments for using terms such as *client*, *consumer*, or *person* in place of *patient* to describe the recipient of services.

313
314 Meta-analytic investigations since the 1970s have shown that most therapeutic practices in
315 widespread clinical use are generally effective for treating a range of problems (Lambert &
316 Ogles, 2004; Wampold, 2001). It is important to distinguish between treatments that have been
317 empirically disconfirmed and those that have not been tested using particular research methods.
318 Specific interventions that have not been subjected to systematic empirical testing for specific
319 problems cannot be assumed to be either effective or ineffective; they are simply untested to
320 date. Nonetheless, good practice and science call for the timely testing of psychological
321 practices in a way that adequately operationalizes them using rigorous scientific methodology.
322 Psychological practices in widespread clinical use that have not yet been tested adequately
323 should be systematically evaluated in the near future, and barriers to their testing should be
324 identified and addressed.

325 326 **Multiple Types of Research Evidence**

327
328 APA endorses multiple types of research evidence (e.g., efficacy, effectiveness, cost-
329 effectiveness, cost-benefit, epidemiological, treatment utilization studies) in evaluating the
330 impact of psychological services. Multiple research designs contribute to evidence-based
331 practice, and different types of research designs are better suited to address different types of
332 questions (Greenberg & Newman, 1996). These include:

- 333
334 ☞ Clinical observation (including case studies) and basic psychological science are both
335 valuable sources of innovations and hypotheses (the context of scientific discovery).
- 336 ☞ Public health and ethnographic research are especially useful for tracking the availability,
337 utilization, and acceptance of mental health treatments as well as suggesting ways of altering
338 them to maximize their utility in a given social context.
- 339 ☞ Systematic case studies are particularly useful when aggregated as in the form of practice
340 research networks for comparing individual patients to others with similar characteristics.
- 341 ☞ Process-outcome studies are especially valuable for identifying mechanisms of change.
- 342 ☞ Randomized clinical trials and their logical equivalents (efficacy research) are the standard
343 for drawing causal inferences on the effects of interventions (context of scientific
344 verification).
- 345 ☞ Studies of interventions as delivered in naturalistic settings (effectiveness research) are well
346 suited for assessing the ecological validity of treatments.

347
348 Evidence based practice requires that psychologists recognize the strengths and limitations of
349 evidence obtained from different types of research. Research has shown that the treatment
350 method (Nathan & Gorman, 2002), the individual psychologist (Wampold, 2001), the treatment
351 relationship (Norcross, 2002), and the patient (Bohart & Tallman, 1999) are all vital contributors
352 to the success of psychological practice. Comprehensive evidence-based practice will consider
353 all of these determinants and their optimal combinations. Psychological practice is a complex
354 relational and technical enterprise that requires clinical and research attention to multiple,
355 interacting sources of treatment effectiveness. There remain many disorders, problem
356 constellations, and clinical situations for which empirical data are sparse. In such instances,
357 clinicians should use their best clinical judgment in interpreting and applying the best available
358 research evidence.

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Future Directions

The ascendancy of evidence-based practice in psychology may well necessitate modification of research programs and funding priorities. These programs and priorities should emphasize research on:

- ✍ Enhancing the established efficacy of psychological treatments combined with, or as an alternative to drug treatments
- ✍ The effectiveness of widely practiced treatments, based on various theoretical orientations and integrative blends, that have not yet been subjected to controlled research
- ✍ Patient-by-treatment interactions (moderators)
- ✍ The generalizability and transportability of interventions shown to be efficacious in controlled research settings
- ✍ The effectiveness of psychological practice with underrepresented populations
- ✍ Distinguishing common and specific factors as mechanisms of change
- ✍ Characteristics and actions of the psychologist and the therapeutic relationship that contribute to positive outcome
- ✍ Criteria for discontinuing treatment
- ✍ Accessibility and utilization of psychological services
- ✍ The cost-effectiveness and cost-benefits of psychological interventions

Clinical Expertise

Clinical expertise is an essential component of EBPP. Cognitive scientists have found consistent evidence of enduring and significant differences between experts and novices undertaking complex tasks in several domains (Bédard & Chi, 1992; Bransford, Brown, & Cocking, 1999; Gambrill, 2005). Experts recognize meaningful patterns and disregard irrelevant information, acquire extensive knowledge and organize it in ways that reflect a deep understanding of their domain, organize their knowledge using functional rather than descriptive features, retrieve knowledge relevant to the task at hand fluidly and automatically, adapt to new situations, self-monitor their knowledge and performance, know when their knowledge is inadequate, continue to learn, and generally attain outcomes commensurate with their expertise.

However, experts are not infallible. All humans are prone to errors and biases. Some of these stem from cognitive strategies and heuristics that are generally adaptive and efficient but can lead to biases and errors. Others stem from emotional reactions, which generally guide adaptive behavior as well but can also lead to biased or motivated reasoning (e.g., Ditto & Lopez, 1992; Ditto et al., 2003; Kunda, 1990). Whenever psychologists involved in research and practice move from observations to inferences and generalizations, there is inherent risk for idiosyncratic interpretations, overgeneralizations, confirmatory biases, and similar errors in judgment (Dawes, Faust, & Meehl, 2002; Grove et al., 2000; Meehl, 1954; Westen & Weinberger, 2004).

The individual therapist has a substantial impact on outcomes, both in clinical trials and in practice settings (Crits-Christoph et al., 1991; Kim, Wampold, & Bolt, in press, Huppert et al.,

405 2001; Wampold & Brown, 2005). The fact that treatment outcomes are systematically related to
406 the provider of the treatment (above and beyond the type of treatment) provides strong evidence
407 for the importance of understanding expertise in clinical practice as a way of enhancing patient
408 outcomes.

410 **Components of Clinical Expertise**

411
412 Clinical expertise encompasses a number of competencies that promote positive outcomes.
413 These include: a) diagnostic judgment, systematic case formulation, and treatment planning; b)
414 clinical decision making, treatment implementation, and monitoring of patient progress; c)
415 interpersonal skills; d) continual self-reflection and incorporation of new knowledge and skills;
416 and e) understanding the influence of individual and cultural differences on treatment. Clinical
417 expertise is manifested in most clinical activities, including but not limited to forming a
418 therapeutic alliance; setting treatment goals; selecting interventions and applying them skillfully;
419 monitoring patient progress and adjusting practices accordingly; terminating treatment
420 thoughtfully and appropriately; attending to the individual, social, and cultural context; and using
421 available resources (e.g., consultation, adjunctive or alternative services) as needed.

422
423 ***Diagnostic judgment, case formulation, and treatment planning.*** The clinically expert
424 psychologist is able to formulate clear and theoretically coherent case conceptualizations; assess
425 patient pathology as well as clinically relevant strengths; understand complex patient
426 presentations; and make accurate diagnostic judgments. Expert clinicians revise their case
427 conceptualizations as treatment proceeds and seek both confirming and disconfirming evidence.
428 Clinical expertise also involves identifying and helping patients acknowledge psychological
429 processes that contribute to distress or dysfunction.

430
431 Treatment planning involves setting goals and tasks of treatment that take into consideration the
432 unique patient, the nature of the patient's problems and concerns, the likely prognosis and
433 expected benefits of treatment, and available resources. The goals of therapy are developed in
434 collaboration with the patient and consider the patient and family's worldview and sociocultural
435 context. The choice of treatment strategies requires knowledge of interventions and the research
436 that supports their effectiveness as well as research relevant to matching interventions to patients
437 (e.g., Beutler, Alomohamed, & Moleiro, 2002; Blatt, Shahar, & Zurhoff, 2002; Norcross, 2002).
438 Expertise also requires knowledge about psychopathology, treatment process, and patient
439 attitudes, values, and cultural context that can affect the choice and implementation of effective
440 treatment strategies.

441
442 ***Clinical decision-making, treatment implementation, and monitoring of patient progress.***
443 Clinical expertise entails the skillful and flexible delivery of treatment. Skill and flexibility
444 require knowledge of and proficiency in delivering psychological interventions and the ability to
445 adapt the treatment to the particular case. Flexibility is manifest in tact, timing, pacing, and
446 framing of interventions; maintaining an effective balance between consistency of interventions
447 and responsiveness to patient feedback; and attention to acknowledged and unacknowledged
448 meanings, beliefs, and emotions.

449

450 Clinical expertise also entails the monitoring of patient progress (and of changes in the patient's
451 circumstances, e.g., job loss or major illness) that suggests the need to adjust the treatment
452 (Lambert, Bergin, & Garfield, 2004). If progress is not proceeding adequately, the psychologist
453 alters or addresses problematic aspects of the treatment as appropriate (e.g., problems in the
454 therapeutic relationship or in the implementation of the goals of the treatment). If insufficient
455 progress remains, the therapist considers alternate diagnoses and formulations, consultation,
456 supervision, or referral. The clinical expert makes decisions about termination in timely ways by
457 assessing patient progress in the context of the patient's life, treatment goals, resources, and
458 relapse potential.

459
460 ***Interpersonal skill (expertise).*** Central to clinical expertise is interpersonal skill, which is
461 manifest in forming a therapeutic relationship, encoding and decoding verbal and nonverbal
462 responses, creating realistic but positive expectations, and responding empathically to the
463 patient's explicit and implicit experience and concerns. Interpersonal expertise involves the
464 flexibility to be clinically effective with patients of diverse backgrounds. Interpersonally skilled
465 psychologists are able to challenge patients in a supportive atmosphere that fosters exploration,
466 openness, and change.

467
468 The clinical expert fosters the patient's positive engagement in the therapeutic process, monitors
469 the therapeutic alliance, and attends carefully to barriers to engagement and change. The clinical
470 expert recognizes barriers to progress and addresses them in a way consistent with theory and
471 research (e.g., exploring therapeutic impasses with the patient or addressing problems in the
472 therapeutic relationship).

473
474 ***Continuous self-reflection and incorporation of new knowledge and skills.*** Clinical expertise
475 requires the ability to reflect on one's own experience, knowledge, hypotheses, inferences,
476 emotional reactions, and behaviors and to use that reflection to modify one's practices
477 accordingly. Integral to clinical expertise is an awareness of the limits of one's knowledge and
478 skills as well as the recognition of the heuristics and biases (both cognitive and affective) that
479 can affect clinical judgment (e.g., biases that can inhibit recognition of the need to alter case
480 conceptualizations that are inaccurate or treatment strategies that are not working). Clinical
481 expertise involves taking explicit action to limit the effects of these biases.

482
483 Developing and maintaining clinical expertise, and applying this expertise to specific patients,
484 entails continuously incorporating new knowledge and skills derived from: a) research and
485 theory, b) systematic clinical observation, disciplined inquiry, and hypothesis testing, c) self-
486 reflection and feedback from other sources (e.g., supervisors, peers, patients, other providers, or
487 the patient's significant others where appropriate), d) monitoring of patient outcomes, and e)
488 continuing education and other learning opportunities (e.g., practice networks, patient advocacy
489 groups).

490
491 ***Awareness of, respect for, and appropriate action related to individual, social, and cultural***
492 ***differences.*** Clinical expertise requires an awareness of the individual, social, and cultural
493 context of the patient, including but not limited to age and development, ethnicity, culture,
494 gender, sexual orientation, religious commitments, and socioeconomic status (see Patient
495 Characteristics section). Clinical expertise allows psychologists to adapt interventions and

496 construct a therapeutic milieu that respects the patient’s worldview, values, preferences,
497 capacities, and other characteristics (Arnkoff, Glass, & Shapiro, 2002; Sue & Lam, 2002).

498

499 **Future Directions**

500

501 Although much less research is available on clinical expertise than on psychological
502 interventions, an important foundation is emerging (Goodheart, in press; Skovholt & Jennings,
503 2004; Westen & Weinberger, 2004). For example, research on case formulation and diagnosis
504 suggests that clinical inferences, diagnostic judgments, and formulations can be reliable and
505 valid when structured in ways that maximize clinical expertise (Eels et al., in press; Persons,
506 1991; Westen & Weinberger, 2004, in press). Research suggests that sensitivity and flexibility in
507 administering treatments produce better outcomes than rigid application of manuals or principles
508 (Castonguay et al., 1996; Henry et al., 1993; Huppert et al., 2001). Research on biases and
509 heuristics in clinical judgment highlight procedures that clinicians can employ to minimize those
510 biases (Garb, 1998). Because of the importance of therapeutic alliance to outcome (Horvath &
511 Bedi, 2002; Martin, Garske & Davis, 2000; Shirk & Karver, 2003), it is useful to understand the
512 personal attributes and interventions of therapists that strengthen the alliance (Ackerman &
513 Hilsenroth, 2003).

514

515 Many aspects of clinical expertise require systematic investigation, much of it likely fostered by
516 a collaborative and mutually respectful spirit between researchers and expert practitioners. Some
517 of the most pressing research needs are the following:

518

519 ~~✎~~ Studying the practices of clinicians who obtain the best outcomes in the community, both
520 in general and with particular kinds of patients or problems

521 ~~✎~~ Identifying technical skills utilized by expert clinicians in the administration of
522 psychological interventions that have proven to be effective

523 ~~✎~~ Improving the reliability, validity, and clinical utility of diagnoses and case formulations

524 ~~✎~~ Studying conditions that maximize clinical expertise (rather than primarily on limits to
525 clinical expertise)

526 ~~✎~~ Determining the extent to which errors and biases widely studied in the literature are
527 linked to decrements in treatment outcome

528 ~~✎~~ Developing well-normed measures that clinicians can use to quantify their diagnostic
529 judgments, measure therapeutic progress over time, and assess the therapeutic process

530 ~~✎~~ Distinguishing expertise related to common factors shared across most therapies and
531 expertise specific to particular treatment approaches.

532

533 **Patient Characteristics, Preferences, and Context**

534

535 Normative data on “what works for whom” (Nathan & Gorman, 2002, Roth & Fonagy, 2004)
536 provide essential guides to effective practice. However, to be most effective, interventions must
537 be applied in ways that are responsive to the patient’s specific problems, strengths, personality,
538 sociocultural context, and other characteristics (Norcross, 2002). Psychology’s long history of
539 studying individual differences and developmental change, and its growing empirical literature

540 related to human diversity (including culture³ and psychotherapy), place it in a strong position to
541 identify effective ways of integrating research and clinical expertise with an understanding of
542 patient characteristics essential to EBP (Sue, Zane, & Young, 1994; Hall, 2001). EBPP involves
543 consideration of patients' values, religious beliefs, worldviews, goals, and preferences for
544 treatment with the psychologist's experience and understanding of the available research.
545

546 Several questions frame current debates about the role of patient characteristics in EBPP. The
547 first regards the extent to which cross-diagnostic patient characteristics, including personality
548 traits, moderate the impact of empirically tested interventions. A second, related question
549 concerns the extent to which cultural differences necessitate different forms of treatment or
550 whether interventions widely tested in majority populations can be readily adapted for patients
551 with different ethnic or sociocultural backgrounds. A third question concerns maximizing the
552 extent to which widely used interventions adequately attend to developmental considerations,
553 both for children and adolescents (Weisz & Hawley, 2002) and for older adults (Zarit & Knight,
554 1996). A fourth question is the extent to which variable clinical presentations, such as
555 comorbidity and polysymptomatic presentations, moderate the impact of interventions.
556

557 Underlying all these issues is the question of how best to approach the treatment of patients
558 whose problems may both resemble and differ from those of the samples studied in research.
559 One approach is to apply interventions initially developed and tested in one population (e.g.,
560 adult, primarily Caucasian patients with major depressive disorder) to other populations (e.g.,
561 adult Latinos or inner-city female adolescents suffering from major depression) without
562 modifying them and then to examine whether and how the interventions require modification.
563 Alternatively, interventions might be modified prior to implementation based on knowledge of
564 the target population according to the principles of multicultural psychology. A different
565 approach is to devise new strategies when ethnographic, epidemiological, and/or developmental
566 data suggest that the tested intervention is likely to fail or that an alternative way of approaching
567 the problem may be more likely to succeed with a particular population.
568

569 **Patient Characteristics and Preferences**

570
571 Available data indicate a variety of patient-related variables influence outcomes, many of which
572 are cross-diagnostic characteristics such as functional status, level of resistance, and stage of
573 change (Norcross, 2002). Other patient characteristics are essential to consider in forming and
574 maintaining a treatment relationship and in implementing specific interventions: a) variations in
575 presenting problems or disorders, etiology, concurrent symptoms or syndromes, and behavior; b)
576 age, developmental status, developmental history, and life stage; c) sociocultural and familial
577 factors (e.g., gender, ethnicity, social class, religion, disability status, family structure, and sexual
578 orientation); d) current environmental context and stressors (e.g., unemployment or recent major
579 life event); and e) personal preferences, values, and choices relevant to treatment (e.g., goals,
580 beliefs, worldviews, and treatment expectations). Available research on both patient matching

³ Culture, in this context, is understood to encompass a broad array of phenomena (such as shared values, history, knowledge and customs) that result in a particular group of individuals having a shared sense of identity. Racial and ethnic groups may have a shared culture but those personal characteristics are not the only characteristics that define cultural groups (e.g. deaf culture, inner-city culture). Culture is a multifaceted construct, and cultural factors cannot be understood in isolation from the class and personal characteristics that make each patient unique.

581 and treatment failures in clinical trials of even highly efficacious interventions suggests that
582 different strategies and relationships are likely to prove better suited for different patients (Groth-
583 Marnat, Beutler, & Roberts, 2001; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Gamst, Dana, Der-
584 Karaberian, & Kramer, 2000, Norcross, 2002).

585
586 Many presenting symptoms—for example depression, anxiety, school failure, bingeing and
587 purging—are similar across patients. However, symptoms or disorders that are phenotypically
588 similar are often heterogeneous with respect to etiology, prognosis, and the psychological
589 processes that create or maintain them. Moreover, most patients present with multiple symptoms
590 or syndromes rather than a single, discrete disorder (e.g., Kessler, Stang, Wittchen, Stein, &
591 Walters, 1999; Newman, Moffitt, Caspi, & Silva, 1998). An emerging body of research also
592 suggests that personality differences underlie some variations in symptomatic expression and
593 account for a substantial part of the comorbidity widely documented in research (e.g., Brown,
594 Chorpita & Barlow, 1998; Krueger, 2002). The presence of concurrent conditions sometimes
595 moderates treatment response and sometimes does not, and interventions intended to treat one
596 symptom often affect others. Psychologists must attend to the individual person to make the
597 complex choices necessary to conceptualize, prioritize, and treat multiple symptoms. It is
598 important to know the person who has the disorder in addition to knowing the disorder the
599 person has.

600
601 EBPP also requires attention to factors related to the patient’s development and life-stage. An
602 enormous body of research exists on developmental processes (e.g., related to attachment,
603 socialization, and cognitive, social-cognitive, gender, moral, and emotional developme nt) that
604 are essential in understanding adult psychopathology and to treating children, adolescents,
605 families, and older adults (e.g. Toth & Cicchetti, 1999; Sameroff, Lewis, & Miller, 2000; APA,
606 2004).

607
608 Evidence-based practice in psychology requires attention to many other central patient
609 characteristics, such as gender, culture, ethnicity, family context, religious beliefs, and sexual
610 orientation (APA 2000, 2003). These variables shape personality, values, worldviews,
611 relationships, psychopathology, and attitudes toward treatment. A wide range of research
612 literature can inform psychological practice, including ethnography, cross-cultural psychology
613 (e.g., Berry, Kagitcibasi, & Segall, 1997), cultural psychiatry (e.g., Kleinman, 1977),
614 psychological anthropology (e.g., LeVine, 1983; Moore & Matthews, 2003; Strauss & Quinn,
615 1992), and cultural psychotherapy (Sue, 1998; Zane, Sue, Young, Nunez, & Hall, 2004). Culture
616 influences the nature, expression, and patients’ understanding of health and illness. Cultural
617 values and beliefs also influence patterns of seeking and using help, fears and expectations about
618 treatment, and desired outcomes.

619
620 The patient’s social and environmental context, including recent and chronic stressors, is also
621 important in case formulation and treatment planning. Sociocultural and familial factors, social
622 class, and broader social, economic, and situational factors (e.g., unemployment, family
623 disruption, lack of insurance, recent losses, prejudice, or immigration status) can have an
624 enormous influence on mental health, adaptive functioning, treatment seeking, and patient
625 resources (psychological, social, and financial).

626

627 Psychotherapy is a collaborative enterprise, in which patients and clinicians negotiate ways of
628 working together that are mutually agreeable and likely to lead to positive outcomes. Thus,
629 patient values and preferences (e.g., goals, beliefs, and preferred modes of treatment) are a
630 central component of EBPP. Patients can have strong preferences for types of treatment and
631 desired outcomes, and these preferences are influenced by both their cultural context and
632 individual factors. One role of the psychologist is to ensure that patients understand the costs
633 and benefits of different practices and choices (Haynes, Devereaux, & Guyatt, 2002). Evidence-
634 based practice in psychology seeks to maximize patient choice among effective alternatives.
635 Effective practice requires balancing patient preferences and the psychologist's judgment, based
636 on available evidence and clinical expertise, to determine the most appropriate treatment.

637

638 **Future Directions**

639

640 Much additional research is needed regarding the influence of patient characteristics on treatment
641 selection, therapeutic processes, and outcomes. Research on cross-diagnostic characteristics,
642 polysymptomatic presentations, and the effectiveness of psychological interventions with
643 culturally diverse groups is particularly important. We suggest the following research priorities:

644

645 ~~///~~ Patient characteristics as moderators of treatment response in naturalistic settings

646 ~~///~~ Prospective outcome studies on treatments and relationships tailored to patients' cross-
647 diagnostic characteristics, including aptitude by treatment interaction designs

648 ~~///~~ Effectiveness of interventions that have been widely studied in the majority population
649 with other populations

650 ~~///~~ Examination of the nature of implicit stereotypes held by both psychologists and patients
651 and successful interventions for minimizing their activation or impact

652 ~~///~~ Ways to make information about culture and psychotherapy more accessible to
653 practitioners

654 ~~///~~ Maximizing psychologists' cognitive, emotional, and role competence with diverse
655 patients

656 ~~///~~ Identify successful models of treatment decision-making in light of patient preferences

657

658

659 **Conclusion**

660

661 The central goal of EBPP is to enhance psychological practice through effective integration of
662 best available research evidence with clinical expertise to provide services tailored to the unique
663 patient. Successful integration requires that psychologists recognize the strengths and limitations
664 of clinical expertise, the strengths and limitations of different types of research, as well as the
665 influence of the patient and his or her preferences, characteristics and actions. Much has been
666 learned over the past century from basic and applied psychological research as well as from
667 observations and hypotheses developed in clinical practice. Many strategies for working with
668 patients have emerged and been refined through the kind of trial and error and clinical hypothesis
669 generation and testing that constitute the most scientific aspect of clinical practice. Yet clinical
670 hypothesis testing has its limits, reflecting its lack of replicability and potential for confirmatory
671 bias; hence the need to integrate clinical expertise with best available research.

672 Perhaps the central message of this task force report, and one of the most heartening aspects of
673 the process that led to it, is the consensus achieved among a diverse group of scientists,
674 clinicians, and scientist-clinicians from multiple perspectives that EBPP requires an appreciation
675 of the value of multiple sources of scientific evidence. In a given clinical circumstance,
676 psychologists of good faith and good judgment may disagree about how best to weight different
677 forms of evidence; therefore, only systematic and broad empirical inquiry—in the laboratory and
678 in the clinic—will, over time, point the way toward best practice in integrating best evidence.
679 What this document reflects, however, is a reassertion of what psychologists have known for a
680 century: that scientific method is the best tool we have for learning about what works for whom,
681 and that scientific method is a way of thinking and observing systematically.

682
683 Individual problems, co-occurring disorders and concerns, developmental considerations, and
684 different social-cultural circumstances frequently require decisions and interventions not directly
685 addressed by the available research. Consequently, psychologists are cognizant of relevant
686 research data and utilize their clinical expertise to generalize existing knowledge to clinical
687 settings. Just as clinical judgment is fallible, the nomothetic nature of research always creates
688 gaps between what we know in general and what we know in particular. The application of
689 research evidence and clinical expertise to a given patient and clinical situation always involves
690 inferences that are probabilistic. Continuous monitoring of patient progress and adjustment of
691 treatment as needed are therefore essential to EBPP.

692
693 Just as psychologists must weigh clinical expertise and different forms of evidence, they must
694 attend to a range of outcomes and available clinical and patient resources that may sometimes
695 suggest one strategy and sometimes another, and they must attend both to the strengths and
696 limitations of available research vis-à-vis these different ways of measuring success.
697 Psychological outcomes may include not only symptom relief and prevention of future
698 symptomatic episodes but also quality of life, adaptive functioning in work and relationships,
699 ability to make satisfying life choices, personality change, and other goals arrived at in
700 collaboration between patient and clinician.

701
702 Psychotherapy is a collaborative endeavor, and psychological care for an individual case reflects
703 not only the best research, clinical expertise, and an understanding of the patient and his or her
704 socio-cultural context but attention to patient goals, values, and preferences. Psychological care
705 in an individual case is informed by research evidence but is determined on the basis of all
706 clinically relevant data, patient choice, and the likely costs and benefits of available treatment
707 options for the individual. EBPP seeks to maximize patient choice among effective alternative
708 interventions. The ultimate judgment regarding a particular intervention or treatment plan must
709 be made by the treating psychologist in collaboration with the patient.

710
711 EBPP is a means to enhance the delivery of services to patients within an atmosphere of mutual
712 respect, open communication, and collaboration among all stakeholders, including practitioners,
713 researchers, patients, health-care managers, and policy-makers. Our goal in this document, and
714 in the deliberations of the Task Force that led to it, was to set both an agenda as well as a tone for
715 the next steps in the evolution of EBPP.

716
717

References

- 717
718
719 Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques
720 positively impacting the therapeutic alliance. *Clinical Psychology Review, 23*, 1-33.
721
722 Agency for Health Care Policy and Research. (1993). *Depression in primary care: Vol. 2.*
723 *Treatment of major depression* (Clinical Practice Guideline No. 5, AHCPR Publication No.
724 93-0551). Rockville, MD: U.S. Department of Health and Human Services.
725
726 American Psychiatric Association. (2000). Practice guideline for the treatment of patients with
727 major depressive disorder (Revision). *American Journal of Psychiatry, 157*(Suppl.), 1-45.
728
729 American Psychological Association. (1995). *Template for developing guidelines: Interventions*
730 *for mental disorders and psychosocial aspects of physical disorders*. Washington, DC:
731 American Psychological Association
732
733 American Psychological Association. (2000). Guidelines for psychotherapy with lesbian, gay,
734 and bisexual clients. *American Psychologist, 55*, 1440-1451.
735
736 American Psychological Association. (2002). Criteria for evaluating treatment guidelines.
737 *American Psychologist, 57*, 1052-1059.
738
739 American Psychological Association. (2003). Guidelines on multicultural education, training,
740 research, practice, and organizational change for psychologists. *American Psychologist, 58*,
741 377-402.
742
743 American Psychological Association. (2004). Guidelines for Psychological Practice With Older
744 Adults. *American Psychologist, 59*, 236-260.
745
746 Arnkoff, D. B., Glass, C. R., & Shapiro, S. J. (2002). Expectations and preferences. In J. C.
747 Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and*
748 *responsiveness to patients*. (pp. 335-356). New York: Oxford University Press.
749
750 Barlow, D. H. (1996). The effectiveness of psychotherapy: Science and policy. *Clinical*
751 *Psychology: Science and Practice, 1*, 109-122.
752
753 Barlow, D. H. (2004). Psychological treatments. *American Psychologist, 59*, 869-879.
754
755 Bédard, J., & Chi, M. T. (1992). Expertise. *Current Directions in Psychological Science, 1*, 135-
756 139.
757
758 Berry, J. W., Segall, M. H., & Kagitcibasi, C. (1997). *Handbook of cross-cultural psychology:*
759 *Social behavior and applications*. (2nd ed.). Boston: Allyn & Bacon.
760
761 Beutler, L. E. (1998). Identifying empirically supported treatments: What if we didn't? *Journal*
762 *of Consulting and Clinical Psychology, 66*, 113-120.

- 763
764 Beutler, L. E., Alomohamed, S., Moleiro, C., & Romanelli, R. K. (2002). Systemic treatment
765 selection and prescriptive therapy. In F. W. Kaslow (Ed.), *Comprehensive handbook of*
766 *psychotherapy: Integrative/eclectic, Vol. 4.* (pp. 255-271). New York: Wiley
767
- 768 Blatt, S. J., Shahar, G., & Zurhoff, D. C. (2002). Anaclitic/sociotropic and
769 introjective/autonomous dimensions. In J.C. Norcross (Ed.), *Psychotherapy relationships*
770 *that work: Therapist contributions and responsiveness to patients.* (pp. 315-333). New
771 York: Oxford University Press.
772
- 773 Bohart, A., & Tallman, K. (1999). *How clients make therapy work: The process of active self-*
774 *healing.* Washington DC: American Psychological Association.
775
- 776 Bransford, D., Brown, A. L., & Cocking, R. R. (Eds.). (1999). *How people learn: Brain, mind*
777 *experience, and school.* Washington, DC: National Academy of Sciences.
778
- 779 Brown, T. A., Chorpita, B. F., & Barlow, D. H. (1998). Structural relationships among
780 dimensions of the DSM-IV anxiety and mood disorders and dimensions of negative affect,
781 positive affect, and autonomic arousal. *Journal of Abnormal Psychology, 107,* 179-192.
782
- 783 Carpinello, S. E., Rosenberg, L., Stone, J., Schwager, M., & Felton, C. J. (2002). New York
784 State's campaign to implement evidence-based practices for people with serious mental
785 disorders. *Psychiatric Services, 53,* 153-155.
786
- 787 Castonguay, L. G., Goldfried, M. R., Wiser, S., Raue, P. J., & Hayes, A. M. (1996). Predicting
788 the effect of cognitive therapy for depression: A study of unique and common factors.
789 *Journal of Consulting and Clinical Psychology, 64,* 497-504.
790
- 791 Chambless, D. L., Baker, M. J., Baucom, D. H., Beutler, L. E., Calhoun, K. S., Crits-Cristoph,
792 P., et al. (1998). Update on empirically validated therapies, II. *The Clinical Psychologist,*
793 *51,* 3-16.
794
- 795 Chambless, D.L., Sanderson, W.C., Shoham, V., Bennett Johnson, S., Pope, K.S., Crits-Cristoph,
796 P., et al. (1996). An update on empirically validated therapies. *The Clinical Psychologist,*
797 *49,* 5-18.
798
- 799 Chiles, J. A., Lambert, M. J., & Hatch, A. L. (2002). Medical cost offset: A review of the impact
800 of psychological interventions on medical utilization over the past three decades. In N. A.
801 Cummings, W. T. O'Donohue, & K. E. Ferguson (Eds.), *The impact of medical cost offset*
802 *on practice and research.* Reno, NV: Context Press.
803
- 804 Chorpita, B. F., Yim, L. M., Donkervoet, J. C., Arensdorf, A., Amundsen, M. J., McGee, C., et
805 al. (2002). Toward large-scale implementation of empirically supported treatments for
806 children: A review and observations by the Hawaii empirical basis to services task force.
807 *Clinical Psychology: Science and Practice, 9,* 165-190.
808

- 809 Crits-Christoph, P., Baranackie, K., Kurcias, J. S., Carroll, K., Luborsky, L., McLellan, T., et al.
810 (1991). Meta-analysis of therapist effects in psychotherapy outcome studies.
811 *Psychotherapy Research, 1*, 81-91.
812
- 813 Davidson, K. W., Trudeau, K. J., Ockene, J. K., Orleans, C. T., & Kaplan, R. M. (2003). A
814 primer on current evidence-based review systems and their implications for behavioral
815 medicine. *Annals of Behavioral Medicine, 26*, 161-171.
816
- 817 Dawes, R. M., Faust, D., & Meehl, P.E. (2002). Clinical versus actuarial judgment. In T.
818 Gilovich & D. Griffin (Eds.), *Heuristics and biases: The psychology of intuitive judgment*.
819 (pp. 716-729). New York: Cambridge University Press.
820
- 821 DeRubeis, R. J., Hollon, S. D., Amsterdam, J. D., Shelton, R. C., Young, P. R., Salomon, R. M.,
822 et al. (in press). Cognitive therapy vs. medications in the treatment of moderate to severe
823 depression. *Archives of General Psychiatry*.
824
- 825 Ditto, P. H., & Lopez, D. F. (1992). Motivated skepticism: Use of differential decision criteria
826 for preferred and nonpreferred conclusions. *Journal of Personality and Social*
827 *Psychology, 62*, 568-584.
828
- 829 Ditto, P. H., Munro, G. D., Apanovitch, A. M., Scepansky, J. A., & Lockhart, L. K. (2003).
830 Spontaneous skepticism: The interplay of motivation and expectation in responses to
831 favorable and unfavorable medical diagnoses. *Personality & Social Psychology Bulletin*,
832 *29*, 1120-1132.
833
- 834 Eels, T. D., Lombart, K. G., Kendjelic, E. M., Turner, L. C., & Lucas, C. (in press). The quality
835 of case formulations: A comparison of expert, experienced, and novice cognitive-
836 behavioral and psychodynamic therapists. *Journal of Consulting and Clinical*
837 *Psychology*.
838
- 839 Gambrell, E. (2005). *Critical thinking in clinical practice: Improving the accuracy of judgments*
840 *and decisions about clients* (2nd ed.). New York: Wiley.
841
- 842 Gamst, G., Dana, R. H., Der-Karaberian, A., & Kramer, T. (2000). Ethnic match and patient
843 ethnicity effects on global assessment and visitation. *Journal of Community Psychology*,
844 *28*, 547-564.
845
- 846 Garb, H. N. (1998). Clinical judgment. In H. N. Garb (Ed.), *Studying the Clinician: Judgment*
847 *Research and Psychological Assessment* (pp. 173-206). Washington, DC: American
848 Psychological Association.
849
- 850 Goodheart, C. D. (in press). Evidence, endeavor, and expertise in psychology practice. In C.D.
851 Goodheart, A. E. Kazdin, & R. J. Sternberg (Eds.), *Practice and research perspectives on*
852 *the evidence for psychotherapy*. Washington, DC: American Psychological Association.
853

- 854 Greenberg, L. S., & Newman, F. L. (1996). An approach to psychotherapy change process
855 research: Introduction to the special section. *Journal of Consulting and Clinical*
856 *Psychology, 64*, 435-438.
- 857
858 Groth-Marnat, G., Beutler, L. E., & Roberts, R. I. (2001). Client characteristics and
859 psychotherapy: Perspectives, support, interactions, and implications for training.
860 *Australian Psychologist, 36*, 115-121.
- 861
862 Grove, W. M., Zald, D. H., Lebow, B. S., Snitz, B. E., & Nelson, C. (2000). Clinical versus
863 mechanical prediction: A meta-analysis. *Psychological Assessment, 12*, 19-30.
- 864
865 Hall, G. C. N. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical, and
866 conceptual issues. *Journal of Consulting and Clinical Psychology, 69*, 502-510.
- 867
868 Haynes, R. B., Devereaux, P. J., & Guyatt, G. H. (2002). Clinical expertise in the era of
869 evidence-based medicine and patient choice. *Evidence-based medicine notebook, 7*, 1-3.
- 870
871 Henry, W. P., Schacht, T. E., Strupp, H. H., Butler, S. F., & Binder, J. L. (1993). Effects of
872 training in time-limited dynamic psychotherapy: Changes in therapist behavior. *Journal*
873 *of Consulting & Clinical Psychology, 61*, 434-440.
- 874
875 Hollon, S. D., DeRubeis, R. J., Shelton, R. C., Amsterdam, J. D., Salomon, R. M., O'Reardon, J.
876 P., et al. (in press). Prevention of relapse following cognitive therapy versus medications in
877 moderate to severe depression. *Archives of General Psychiatry*.
- 878
879 Hollon, S. D., Thase, M. E., & Markowitz, J. C. (2002). Treatment and prevention of depression.
880 *Psychological Science in the Public Interest, 3*, 39-77.
- 881
882 Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy*
883 *relationships that work: Therapist contributions and responsiveness to patients* (pp. 37-
884 70). New York: Oxford University.
- 885
886 Huppert, J. D., Bufka, L. F., Barlow, D. H., Gorman, J. M., Shear, M. K., & Woods, S. W.
887 (2001). Therapists, therapist variables, and cognitive-behavioral therapy outcome in a
888 multicenter trial for panic disorder. *Journal of Consulting and Clinical Psychology, 69*,
889 747-755.
- 890
891 Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st*
892 *century*. Washington, DC: National Academy Press.
- 893
894 Kessler, R. C., Stang, P., Wittchen, H. U., Stein, M., & Walters, E. E. (1999). Lifetime
895 comorbidities between social phobia and mood disorders in the US National Comorbidity
896 Survey. *Psychological Medicine, 29*, 555-567.
- 897
898 Kim, D., Wampold, B. E. & Bolt, D. M. (in press). Therapist effects in psychotherapy: A random
899 effects modeling of the NIMH TDCRP data. *Psychotherapy Research*.

- 900
901 Kleinman, A. M. (1977). Depression, somatization and the new cross-cultural psychiatry. *Social*
902 *Science and Medicine, 11*, 3-10.
903
- 904 Krueger, R. F. (2002). Psychometric perspectives on comorbidity. In J. E. Helzer, J. J. Hudziak,
905 & J. James (Eds.), *Defining psychopathology in the 21st century: DSM-V and beyond*.
906 (pp. 41-54). Washington, DC: American Psychiatric Publishing, Inc.
907
- 908 Kunda, Z. (1990). The case for motivated reasoning. *Psychological Bulletin, 108*, 480-498.
909
- 910 Lambert, M. J., Bergin, A. E., & Garfield, S. L. (2004). Introduction and historical overview. In
911 M.J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior*
912 *Change* (5th ed., pp. 3-15). New York: Wiley.
913
- 914 Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J.
915 Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change*
916 (pp. 139-193). New York: Wiley.
917
- 918 LeVine, R. A. (1983). Fertility and child development: An anthropological approach. *New*
919 *Directions for Child Development, 20*, 45-55.
920
- 921 Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with
922 outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical*
923 *Psychology, 68*, 438-450.
924
- 925 McReynolds, P. (1997). *Lightner Witmer: His life and times*. Washington, DC: American
926 Psychological Association.
927
- 928 Meehl, P. E. (1954). *Clinical vs. statistical prediction*. Minneapolis, MN: University of
929 Minnesota Press.
930
- 931 Moore, C. C., & Mathews, H. F. (2003). The psychology of cultural experience: Book review.
932 *International Journal of Social Psychiatry, 49*, 77.
933
- 934 Muñoz, R. F., Hollon, S. D., McGrath, E., Rehm, L. P., & VandenBos, G. R. (1994). On the
935 AHCPR Depression in Primary Care guidelines: Further considerations for practitioners.
936 *American Psychologist, 49*, 42-61.
937
- 938 Nathan, P. E. (1998). Practice guidelines: Not yet ideal. *American Psychologist, 53*, 290-299.
939
- 940 Nathan, P. E., & Gorman, J. M. (2002). *A guide to treatments that work*. London: Oxford
941 University Press.
942
- 943 National Institutes of Health (2004). *State implementation of evidence-based practices: Bridging*
944 *science and service*. (NIMH and SAMHSA RFA MH-03-007). Retrieved November 19,
945 2004, from <http://grants1.nih.gov/grants/guide/rfa-files/RFA-MH-03-007.html>.

- 946
947 Newman, D. L., Moffitt, T. E., Caspi, A., & Silva, P. A. (1998). Comorbid mental disorders:
948 Implications for treatment and sample selection. *Journal of Abnormal Psychology*, *107*,
949 305-311.
950
951 Norcross, J. C. (2001). Purposes, processes, and products of the task force on empirically
952 supported therapy relationships. *Journal of the Division of Psychotherapy, American*
953 *Psychological Association*, *38*, 345-356.
954
955 Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work: Therapist contributions*
956 *and responsiveness to patient needs*. New York: Oxford University Press.
957
958 Norcross, J. C., Beutler, L. E., & Levant, R. F. (Eds.). (2005). *Evidence-based practices in*
959 *mental health: Debate and dialogue on the fundamental questions*. Washington, DC:
960 American Psychological Association.
961
962 Olfson, M., Marcus, S. C., Druss, B., Elinson, L., Tanielian, T., & Pincus, H. A. (2002). National
963 trends in the outpatient treatment of depression. *Journal of the American Medical*
964 *Association*, *287*, 203-209.
965
966 Persons, J. B. (1991). Psychotherapy outcome studies do not accurately represent current models
967 of psychotherapy: A proposed remedy. *American Psychologist*, *46*, 99-106.
968
969 Reed, G. M., & Eisman, E. (in press). Uses and misuses of evidence: Managed care, treatment
970 guidelines, and outcomes measurement in professional practice. In C. D. Goodheart, A. E.
971 Kazdin, & R. J. Sternberg (Eds.), *Practice and research perspectives on the evidence for*
972 *psychotherapy*. Washington, DC: American Psychological Association.
973
974 Roth, A., & Fonagy, P. (2004). *What works for whom? A critical review of psychotherapy*
975 *research* (2nd ed.). New York: Guilford Press.
976
977 Sackett, D. L., Straus, S. E., Richardson, W. S., Rosenberg, W., & Haynes, R. B. (2000).
978 *Evidence based medicine: How to practice and teach EBM* (2nd ed.). London: Churchill
979 Livingstone.
980
981 Sameroff, A. J., Lewis, M., & Miller, S. M., (Eds.). (2000). *Handbook of developmental*
982 *psychopathology* (2nd ed.). Dordrecht, Netherlands: Kluwer Academic Publishers.
983
984 Shakow, D., Hilgard, E. R., Kelly, E. L., Luckey, B., Sanford, R. N., & Shaffer, L. F. (1947).
985 Recommended graduate training program in clinical psychology. *American Psychologist*,
986 *2*, 539-558.
987
988 Shirk, S. R., & Karver, M. (2003). Prediction of treatment outcome from relationship variables in
989 child and adolescent therapy: A meta-analytic review. *Journal of Consulting & Clinical*
990 *Psychology*, *71*, 452-464.
991

- 992 Skovholt, T. M., & Jennings, L. (2004). *Master therapist: Exploring expertise in therapy and*
993 *counseling*. Needham Heights, MA: Allyn & Bacon.
994
- 995 Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American*
996 *Psychologist, 32*, 752-760.
997
- 998 Smith, M. L., Glass, G. V., & Miller, T. L. (1980). *Benefits of psychotherapy*. Baltimore: Johns
999 Hopkins University Press.
1000
- 1001 Strauss C., & Quinn, N. (1992). Preliminaries to a theory of culture acquisition. In H. L. Pick, Jr.,
1002 P. W. van den Broek, & D. C. Knill (Eds.), *Cognition: Conceptual and methodological*
1003 *issues* (pp. 267-294). Washington, DC: American Psychological Association.
1004
- 1005 Stricker, G., Abrahamson, D. J., Bologna, N. C., Hollon, S. D., Robinson, E. A., & Reed, G. M.
1006 (1999). Treatment guidelines: The good, the bad, and the ugly. *Psychotherapy, 36*, 69-79.
1007
- 1008 Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American*
1009 *Psychologist, 53*, 440-448.
1010
- 1011 Sue, S., Fujino, D. C., Hu, L. T., Takeuchi, D. T., & Zane, N. W. S. (1991). Community mental
1012 health services for ethnic minority groups: A test of the cultural responsiveness hypothesis.
1013 *Journal of Counseling Psychology, 59*, 533-540.
1014
- 1015 Sue, S., & Lam, A. G. (2002). Cultural and demographic diversity. In J. C. Norcross (Ed.),
1016 *Psychotherapy relationships that work: Therapist contributions and responsiveness to*
1017 *patients* (pp. 401-421). New York: Oxford University.
1018
- 1019 Sue, S., Zane, N., & Young, K. (1994). Research on psychotherapy with culturally diverse
1020 populations. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and*
1021 *behavior change* (4th ed., pp. 783-817). New York: John Wiley & Sons.
1022
- 1023 Tanenbaum, S. J. (2005). Evidence-based practice as mental health policy: three controversies
1024 and a caveat. *Health Affairs, 24*, 163-173.
1025
- 1026 Thorne, F. C. (1947). The clinical method in science. *American Psychologist, 2*, 161-166.
1027
- 1028 Toth, S. L., & Cicchetti, D. (1999). Developmental psychopathology and child psychotherapy. In
1029 S. W. Russ & T. H. Ollendick (Eds.), *Handbook of psychotherapies with children and*
1030 *families: Issues in clinical child psychology* (pp. 15-44). Dordrecht, Netherlands: Kluwer
1031 Academic Publishers.
1032
- 1033 Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*.
1034 Mahwah, NJ: Lawrence Erlbaum.
1035
- 1036 Wampold, B. E., & Brown, G. S. (2005). Estimating therapist variability: A naturalistic study of
1037 outcomes in managed care. *Unpublished manuscript*.

- 1038
1039 Wampold, B. E., Lichtengberg, J. W., & Waehler, C. A. (2002). Principles of empirically
1040 supported interventions in counseling psychology. *The Counseling Psychologist, 30*, 197-
1041 217.
1042
1043 Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-
1044 analysis of outcome studies comparing bona fide psychotherapies: Empirically, "all must
1045 have prizes." *Psychological Bulletin, 122*, 203-215.
1046
1047 Weisz, J. R., & Hawley, K. M. (2002). Developmental factors in the treatment of adolescents.
1048 *Journal of Consulting and Clinical Psychology, 70*, 21-43.
1049
1050 Westen, D., Novotny, C. M., & Thompson-Brenner, H. (2004). Empirical status of empirically
1051 supported psychotherapies: Assumptions, findings, and reporting in controlled clinical
1052 trials. *Psychological Bulletin, 130*, 631-663.
1053
1054 Westen, D., & Weinberger, J. (2004). When clinical description becomes statistical prediction.
1055 *American Psychologist, 59*, 595-613.
1056
1057 Witmer, L. (1907/1996). Clinical psychology. *American Psychologist, 248-251*. [Original article
1058 from the *Psychological Clinic, 1907, 1, 1-9*.]
1059
1060 Yates, B. F. (1994). Toward the incorporation of costs, cost-effectiveness analysis, and cost-
1061 benefit analysis into clinical research. *Journal of Consulting and Clinical Psychology, 62*,
1062 729-736.
1063
1064 Zane, N., Sue, S., Young, K., Nunez, J., & Hall, G. N. (2004). Research on psychotherapy with
1065 culturally diverse populations. In M. J. Lambert (Ed.), *Handbook of psychotherapy and*
1066 *behavior change* (5th ed., pp. 767-804). New York: John Wiley & Sons.
1067
1068 Zarit, S. H., & Knight, B. G. (Eds.). (1996). *A guide to psychotherapy and aging: Effective*
1069 *clinical interventions in a life-stage context*. Washington, DC: American Psychological
1070 Association.

APPENDIX A

2005 Presidential Task Force on Evidence-Based Practice American Psychological Association

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APPENDIX B

2005 Presidential Task Force on Evidence-Based Practice American Psychological Association

Background Materials Reviewed

- Adams, C. & Gilbody, S. (2001). Nobody ever expects the Spanish Inquisition. *Psychiatric Bulletin*, 25, 291-292.
- Anthony, W., Rogers, E.S., & Farkas, M. (2003). Research on evidence-based practices: Future directions in an era of recovery. *Community Mental Health Journal*, 39(2), 101-114.
- Arkes, H.R. (1981). Impediments to accurate clinical judgment and possible ways to minimize their impact. *Journal of Consulting and Clinical Psychology*, 49, 323-330.
- Atkins, D., & DiGuseppi, C. (1998). Broadening the evidence base for evidence-based guidelines: A Research Agenda based on the work of the U.S. Preventive Services Task Force. *American Journal of Preventive Medicine*, 14, 335-344.
- Barlow, D.H. (2004). Psychological treatments. *American Psychologist*, 59(9), 869-878.
- Beutler, L.E. (2000). Empirically based decision making in clinical practice. *Prevention & Treatment*, 3(27). <http://journals.apa.org/prevention/volume3/pre0030027a.html>
- REPLIES:
- Garb, H.N. (2000). On empirically based decision making in clinical practice. *Prevention & Treatment*, 3(29). <http://journals.apa.org/prevention/volume3/pre0030029c.html>
 - Norcross, J.C. (2000). Toward the delineation of empirically based principles on psychotherapy: commentary on Beutler (2000). *Prevention & Treatment*, 3(28). <http://journals.apa.org/prevention/volume3/pre0030028c.html>
 - Woody, S. (2000). On babies and bathwater: Commentary on Beutler (2000). *Prevention & Treatment*, 3(30). <http://journals.apa.org/prevention/volume3/pre0030030c.html>
 - Beutler, L.E. (2000). Empirically based decisions: A comment. (Response to Commentaries on Empirically based decision making in clinical practice. *Prevention & Treatment*, 3(31). <http://journals.apa.org/prevention/volume3/pre0030031r.html>
- Bohart, A.C. (2000). Paradigm clash: Empirically supported treatments versus empirically supported psychotherapy practice. *Psychotherapy Research*, 10(4), 488-493.
- Bohart, A.C. (2003, August). *Evidence-based psychotherapy means evidence-informed, not evidence-driven*. Paper presented at the American Psychological Association convention, Toronto, Ontario, Canada.
- Borkovec, T.D., Echemendia, R.J., Ragusea, S.A., & Ruiz, M. (2001). The Pennsylvania practice research network and future possibilities for clinically meaningful and scientifically rigorous psychotherapy effectiveness research. *Clinical Psychology: Science and Practice*, 8(2), 155-167.

- Bullock, M. (2004.) What is evidence and what is the problem? *Psychological Science Agenda*, March 2004, 3-4.
- Carpinello, S.E., Rosenberg, L., Stone, J., Schwager, M., & Felton, C.J. (2002). New York State's campaign to implement evidence-based practices for people with serious mental disorders. *Psychiatric Services*, 53(2), 153-155.
- Carter J.A. (2002). Integrating science and practice: Reclaiming the science in practice. *Journal of Clinical Psychology*, 58(10), 1285-1290.
- Castro F.G., Barrera M., & Martinez C. (2004). The Cultural adaptation of prevention interventions: Resolving tensions between fidelity and fit. *Prevention Science* 5(1), 41-45.
- Chorpita, B.F., Yim, L.M., Donkervoet, J.C., Arensdorf, A., Amundsen, M.J., McGee, C., et al. (2002). Toward large-scale implementation of empirically supported treatments for children: A review and observations by the Hawaii empirical basis to services task force. *Clinical Psychology: Science and Practice*, 9(2), 165-190.
- Davidson K.W., Goldstein, M., Kaplan, R.M., Kaufman, P.G., Knatterud, G.L., Orleans, C.T., et al. (2003). Evidence-based Behavioral Medicine: What is it, and how do we achieve it? *Annals of Behavioral Medicine*; 26, 161-171.
- Dawes, R.M., Faust, D., & Meehl, P.E. (2002). Clinical versus actuarial judgment. In T. Gilovich & D. Griffin (Eds.), *Heuristics and biases: The psychology of intuitive judgment* (pp. 716-729). New York, NY: Cambridge University Press.
- Drake, R. E., Goldman, H.H., Leff, S.H., Lehman, A.F., Dixon, L., Mueser, K.T., et al. (2001). Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services*, 52(2), 179-182.
- Drugs vs. talk therapy: 3,079 readers rate their care for depression and anxiety. (2004, October). *Consumer Reports*, 22-29.
- Elstein, A.S., & Schwartz, A. (2002). Clinical problem solving and diagnostic decision making: a selective review of the cognitive research literature. In J.A. Knottenerus (Ed.) *The evidence base of clinical diagnosis* (pp. 179-195). London, England: BMJ Publishing.
- Gambrill, E. (1990). The need to refine clinical reasoning skills: problems and prospects. In E. Gambrill (Ed.), *Critical thinking in clinical practice-improving the accuracy of judgments and decisions about clients* (pp. 1-25). Somerset, NJ: Jossey-Bass.
- Garb, H. N. (1998). Clinical judgment. In H.N. Garb (Ed.), *Studying the Clinician: Judgment Research and Psychological Assessment* (pp. 173-206). Washington, DC: American Psychological Association.

- Gonzales, J.J., Ringeisen, H.L., & Chambers, D.A. (2002). The tangled and thorny path of science to practice: Tensions in interpreting and applying "evidence." *Clinical Psychology: Science & Practice*, 9(2), 204-209.
- Griffin, D., Gonzalez, R., & Varey, C. (2001). The heuristics and biases approach to judgment under uncertainty. In A. Tesser & N. Schwartz (Eds.), *Blackwell handbook of social psychology : intraindividual processes* (pp. 207-235). Malden, MA: Blackwell.
- Haynes, B.P., Devereaux, P.J., & Gordon, H.G. (2002). Clinical expertise in the era of evidence-based medicine and patient choice. *Evidence-based Medicine Notebook*, 7, 1-3.
- Henry, W.P. (1998). Science, politics, and the politics of science: The use and misuse of empirically validated treatment research. *Psychotherapy Research*, 8(2), 126-140.
- Hoagwood, K. (2002). Making the translation from research to its application: The *je ne sais pas* of evidence-based practices. *Clinical Psychology: Science and Practice*, 9(2), 210-213.
- Hollon, S. D. (1996). The efficacy and effectiveness of psychotherapy relative to medications. *American Psychologist*, 51, 1025-1030.
- Hollon, S. D., Thase, M. E., & Markowitz, J. C. (2002). Treatment and prevention of depression. *Psychological Science in the Public Interest*, 3(2), 39-77.
- Humphreys, K. & Tucker, J.A. (2002). Toward more responsive and effective intervention systems for alcohol-related problems. *Addiction*, 97, 126-132.
- COMMENTARIES:
- Ösejö, L. (2002). Responsive interventions need responsible funding. *Addiction*, 97, 133.
 - Moskalewicz, J. (2002). Treatment services for drinking problems: Hidden questions. *Addiction*, 97, 133-134.
 - Perl, H.I., & Hilton, M.E. (2002). Ask the right questions and make good use of the answers: A response to Humphreys & Tucker. *Addiction*, 97, 134-136.
 - Blomqvist, J. (2002). Striking the balance between science and common sense. *Addiction*, 97, 136-137.
 - Babor, T.F. (2002). Scribbling in the margins: Comments on Humphreys & Tucker. *Addiction*, 97, 137-138.
 - Humphreys, K. & Tucker, J.A. (2002). Romance, realism, and the future of alcohol intervention systems. *Addiction*, 97, 138-140.
- Kanapaux, W. (2003). 'We are the evidence' – Consumers seek shift in research focus. *Behavioral Healthcare Tomorrow*, 12(1), SR25-SR27.
- Kazdin, A.E. (2001). Progression of therapy research and clinical application of treatment require better understanding of the change process. *Clinical Psychology: Science and Practice*, 8(2), 143-151.
- REPLY:

- Rounsaville, B.J., Carroll, K.M., & Onken, L.S. (2001). Methodological diversity and theory in the stage model: reply to Kazdin. *Clinical Psychology: Science and Practice*, 8(2), 152-154.

- Keckley, P.H. (2003). *Evidence-based medicine and managed care: Applications, challenges, opportunities – Results of a national program to assess emerging applications of evidence-based medicine to medical management strategies in managed care*. Nashville, TN: Vanderbilt University, Center for Evidence-based Medicine.

- Lambert, M.J. (2004). The effectiveness of psychotherapy: What has a century of research taught us about the effects of treatment. Retrieved May 19, 2004 from Psychotherapeutically speaking – Updates from the Division of Psychotherapy (29). <http://www.divisionofpsychotherapy.org/lambert.pdf>

- McGlynn, E.A., Asch, S.M., Adams, J., Keesey, J., Hicks, J., DeCristofaro, A., et al. (2003). The quality of health care delivery to adults in the United States. *New England Journal of Medicine*, 348, 2635-2645.

- Norcross, J.C. (2001). Purposes, processes, and products of the task force on empirically supported therapy relationships. *Journal of the Division of Psychotherapy, American Psychological Association*, 38(4), 345-356. [Steering Committee article from the same journal is included.]

- Norcross, J.C. & Hill, C.E. (2004). Empirically supported therapy relationships. *The Clinical Psychologist*, 57(3), 19-24.

- Office of Management and Budget. (2004). *What Constitutes Strong Evidence of a Program's Effectiveness?* Retrieved February 23, 2005 from http://www.whitehouse.gov/omb/part/2004_program_eval.pdf

- Ollendick, T.H. (2003, August). *Evidence-based practice with children and adolescents: Promises and pitfalls*. Paper presented as Presidential Address for American Psychological Association, Division 53, Child Study Center, Virginia Polytechnic Institute and State University.

- Ollendick, T.H., & King, N.J. (2004). Empirically supported treatments for children and adolescents: advances towards science-based practice. In P. Barrett and T. H. Ollendick (Eds.), *Handbook of interventions that work with children and adolescents: From prevention to treatment*. London: John Wiley & Sons, Ltd.

- Orlinsky, D.E., Ronnestad, M.H., & Willutski, U. (2004). Fifty years of psychotherapy process outcome research: Continuity and change. In M.J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (pp. 307-311). New York: Wiley.

- Pingitore, D., Scheffler, R., Haley, M., Sentell, T., & Schwalm, D. (2001). Professional psychology in a new era: Practice-based evidence from California. *Professional Psychology: Research & Practice*, 32(6), 585-596.

- Reed, G.M., McLaughlin, C.J., & Newman, R. (2002). American Psychological Association policy in context: The development and evaluation of guidelines for professional practice. *American Psychologist, 57*(12), 1041-1047.
- American Psychological Association. (2002). Criteria for evaluating treatment guidelines. *American Psychologist, 57*(12), 1052-1059.
 - American Psychological Association (1995). *Template for developing guidelines: Interventions for mental disorders and psychosocial aspects of physical disorders.* Washington, DC: American Psychological Association.
- Rounsaville, B.J., Carroll, K.M., & Onken, L.S. (2001). A stage model of behavioral therapies research: Getting started and moving on from stage I. *Clinical Psychology: Science and Practice, 8*(2), 133-142.
- Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist, 32*, 752-760.
- Stricker, G., & Trierweiler, S.J. (1995). The local scientist: A bridge between science and practice. *American Psychologist, 50*(12), 995-1002.
- Sturm, R. (1999). What type of information is needed to inform mental health policy? *The Journal of Mental Health Policy and Economics, 2*, 141-144.
- Tanenbaum, S.J. (1999). Evidence and expertise: The challenge of the outcomes movement to medical professionalism. *Academic Medicine, 74*(7), 757-763.
- Tanenbaum, S.J. (2003). Evidence-based practice in mental health: practical weaknesses meet political strengths. *Journal of Evaluation in Clinical Practice, 9*(2), 287-301.
- Torrey, W.C., et al. (2001). Implementing evidence-based practices for persons with severe mental illnesses. *Psychiatric Services, 52*(1), 45-50.
- Tucker, J.A. (2004, April). *Crossing the Quality Chasm: Adaptation to Mental Health and Substance Use Disorders.* Testimony for the Board on Health Care Services, Institute of Medicine, Washington, DC.
- Upshur, R.E.G., VanDenKerkhof, E.G., & Goel, V. (2001). Meaning and measurement: and inclusive model of evidence in health care. *Journal of Evaluation in Clinical Practice, 7*(2), 91-96.
- Wampold, B.E. & Bhati, K.S. (2004). Attending to the omissions: A historical examination of evidence-based practice movements. *Professional Psychology: Research & Practice, 35*, 563-570.
- Wampold, B.E., Lichtengberg, J.W., Waehler, & C.A. (2002). Principles of empirically supported interventions in counseling psychology. *The Counseling Psychologist, 30*(2), 197-217.

- Quintana, S.M., & Atkinson, D.R. (2002). A multicultural perspective on principles of empirically supported interventions. *The Counseling Psychologist, 30*(2), 281-291.
- Weisz, J. R., Weiss, B., & Donenberg, G. R. (1992). The lab versus the clinic: Effects of child and adolescent psychotherapy. *American Psychologist, 47*, 1578-1585.
- Wells, K.B. (1999). Treatment research at the crossroads: The scientific interface of clinical trials and effectiveness research. *American Journal of Psychiatry, 156*, 5-10.
- Westen, D., Novotny, C., & Thompson-Brenner, H. (2004). The empirical status of empirically supported therapies: Assumptions, methods, and findings. *Psychological Bulletin, 130*, 631-663.
- Westen, D., & Weinberger, J. (2004). When clinical description becomes statistical prediction. *American Psychologist, 59*(7), 595-613.
- Wolff, N. (2002). Using randomized controlled trials to evaluate socially complex services: Problems, challenges, and recommendations. *The Journal of Mental Health Policy and Economics, 3*, 97-109.
- Yates, B. T. (1994). Toward the incorporation of costs, cost-effectiveness analysis, and cost-benefit analysis into clinical research. *Journal of Consulting and Clinical Psychology, 62*, 729-736.
- Yates, B. T. (1995). Cost-effectiveness analysis, cost-benefit analysis, and beyond: Evolving models for the scientist-manager-practitioner. *Clinical Psychology: Science and Practice, 2*, 385-398.
- Yates, B. T. (2000). Cost-benefit analysis and cost-effectiveness analysis. In A. Kazdin (Ed.), *Encyclopedia of Psychology*. Washington, DC: American Psychological Association.