

Training in and Dissemination of Empirically-Validated Psychological Treatments: Report and Recommendations

**Task Force on Promotion and Dissemination of Psychological Procedures
Division of Clinical Psychology
American Psychological Association**

Report and Recommendations

At the request of David Barlow, President of Division 12, and under the aegis of Section III, this task force was constituted to consider methods for educating clinical psychologists, third party payors, and the public about effective psychotherapies. Lacking the enormous promotional budgets and sales staff of pharmaceutical companies, clinical psychologists labor at a disadvantage to disseminate important findings about innovations in psychological procedures. Despite the great strides in the development and validation of effective treatments, it is not clear that the benefit of our approaches is widely appreciated, even by other clinical psychologists.

We believe that, if the public is to benefit from the availability of effective psychotherapies, and if clinical psychology is to survive in this heyday of biological psychiatry, APA must act to emphasize the strength of what we have to offer -- a variety of psychotherapies of proven efficacy. We suggest that psychologists hold an advantage in being the primary scientists in the

psychotherapy field. Given the limited resources at APA's disposal, we should lead with our strength and spotlight our achievements in data-based psychological interventions.

Composed of clinical psychologists in psychology departments, medical schools, and private practice, along with experts in knowledge exchange, this task force considered the following issues: training for students at the predoctoral and internship level and for practitioners, and promotion of psychological interventions to third party payors and the public. Task force members included representatives from a number of theoretical perspectives -- psychodynamic, interpersonal, and cognitive-behavioral -- to emphasize our commitment to promotion of all psychotherapies of proven worth, rather than those from any one school. A preliminary version of this report was presented at the APA meeting in Toronto to obtain member feedback. The revised report and its recommendations were adopted by the Division 12 Board of Directors at its October 1993 meeting. Each section contains recommendations for APA action.

Defining Empirically-Validated Treatment

Although there is a vast literature on the efficacy of different psychotherapy approaches, not all of the literature bears on current conclusions about treatment efficacy. The well-known meta-analysis of Smith, Glass, and Miller (1980), for example, convinced many that substantial evidence demonstrated the efficacy of psychosocial treatments. However, despite the 475 studies reviewed in the meta-analysis, several factors weighed against changing training based upon the evidence. For one, the bulk of the

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studies reviewed by Smith et al. were conducted with subjects not seeking treatment for clinical problems (Andrews & Harvey, 1981). Although some of these studies did focus on clinical problems, the review predated the 1980 arrival of DSM-III (American Psychiatric Association, 1980), which represented a major advance in the reliable categorization of clinical disorders. Finally, and perhaps most important, the studies in the Smith et al. review predated the standardization of treatments in research studies through the use of treatment manuals.

With the exception of some highly specific behavioral treatments which were probably described in sufficient detail to permit replication of studies and to allow for adequate training of therapists, the Beck, Rush, Shaw, and Emery (1979) volume marked the beginning of the availability of a treatment manual for a major treatment approach with a specific patient problem. Since that time, treatment manuals have become a required element of psychosocial treatment research (Luborsky & DeRubeis, 1984). Evidence that treatment manuals successfully standardize treatment has been accumulating (Crits-Christoph et al., 1991). Such standardization and precise definition of treatment through treatment manuals and other procedures reduce the methodological problems caused by variable therapist outcomes and lead to more specific clinical recommendations (Crits-Christoph & Mintz, 1991). Although there have been relatively few efficacy studies of manual-guided treatments for specific patient problems or disorders, compared to the large number of studies reviewed by Smith et al. (1980), research over the past 15 years has substantiated the effectiveness of some psychosocial treatments.

The question of whether the research evidence is adequate to warrant a treatment's implementation is especially relevant to the current environment, in which professional groups and others are making clinical recommendations based upon the research literature (American Psychiatric Association, 1993). From a research perspective, no treatment is ever fully validated; there are always more questions to ask (e.g., about non-specific effects or the essential components, about client

characteristics that might make this treatment less effective than another). To a certain extent, then, the decision on whether a particular treatment has sufficient empirical validation to warrant its dissemination for widespread clinical training and implementation will rest on the use of criteria which are somewhat arbitrary.

Because of the arbitrariness of drawing the line at what constitutes sufficient evidence for treatment efficacy, we have proposed two categories: *well-established treatments*, and *probably efficacious treatments*. We suggest that treatments that have not been established as at least probably efficacious be considered *experimental treatments*. We want to emphasize that our intention is not to declare that treatment derived from a given theoretical orientation (e.g., interpersonal therapy) is effective in general. Rather, we suggest that psychotherapies may be established as effective for a particular problem (e.g., interpersonal therapy for depression). Although some psychologists reject diagnostic-group descriptions of client samples, we believe no treatment will work for all problems, and it is essential to verify which treatments work for which types of disorders. We note that we are not wed to the DSM system. Rather, we urge psychotherapy researchers to provide clear enough definitions of their samples that readers can determine the appropriate limits of generalization of their research results.

Our criteria are summarized in Tables 1 and 2. We recognize that our criteria are somewhat arbitrary, and that other criteria might be equally important. For example, the clinical significance (Jacobson & Revenstorf, 1988), as opposed to the statistical significance, of a treatment is important to consider. Additionally, in some cases a treatment for a disorder for which no other treatments have been shown to be successful may have been demonstrated to be extremely powerful by an open trial without a control condition. It could be argued that, even without evidence from controlled outcome studies, such a treatment should be disseminated, since the treatment appears very promising, and no other effective treatments have been identified. However, controlled outcome studies are likely to remain the source of most policy decisions and

clinical recommendations. Moreover, we believe establishing efficacy in contrast to a waiting list control group is not sufficient. Relying on such evidence would leave psychologists at a serious disadvantage vis à vis psychiatrists who can point to numerous double-blind placebo trials to support the validity of their interventions.

In the interest of time, we did not attempt an exhaustive review of the literature to find every treatment that would meet the above criteria. Rather, task force members quickly generated a list of treatments they believed to be empirically verified, and we searched for research to document these impressions. This list became the basis for two surveys which will be summarized in subsequent sections. Although our list is incomplete, it provides documentation at a glance of how much scientific clinical psychology has to offer. We recommend that a complete list of treatments of documented efficacy be established and up-dated as new evidence is provided (Recommendation 1). We want to emphasize that one should not conclude that a treatment absent from our list has not been shown to be effective; we may simply have overlooked it in our review of the literature or new literature may have already emerged since the time of our review.

The treatments are listed in Table 3, along with the citations for the demonstration of their efficacy. The citations listed are for either specific efficacy studies or for review articles that summarize a body of literature on a treatment. Typically evidence for efficacy was based on measures of the presenting problem (e.g., self-report or interview measures for depression), although sometimes investigators also provided evidence of change on measures of generalized adjustment. We found the psychodynamic treatments were especially difficult to categorize using our designations. We want to comment on this point particularly because we realize our conclusions might be controversial. In a recent review of studies of brief dynamic therapy Crits-Christoph (1992) concluded that there is evidence that these treatments are superior to wait-list and equal to other standard treatments. However, although the seven studies of brief dynamic therapy reviewed by Crits-Christoph used treatment guides or

manuals, no two studies applied the same treatment model to the same population of patients. These treatment models, taken individually, therefore, do not qualify as having adequate efficacy evidence for our category of well-established treatments. Several studies, however, suggest that brief dynamic therapy treatments are, using our criteria, probably efficacious treatments. These include the study by Thompson, Gallagher, and Breckenridge (1987) showing brief dynamic therapy to be equally effective to cognitive and behavioral therapies in the treatment of geriatric depression, and the study by Woody, Luborsky, McLellan, and O'Brien (1990) showing that brief dynamic therapy adds somewhat to the benefits derived from drug counseling with opiate addicts. However, our survey did not ask about these particular treatments with these populations. In addition, three studies (Piper, Azim, McCallum, & Joyce, 1990; Shefler & Dasberg, 1989; Winston et al., 1991) found brief dynamic therapy of varying forms to be better than wait-list for heterogeneous patient groups. Although each brief dynamic therapy should be evaluated in its own right, given the state of the research literature on these treatments we decided to consider them as a class and with the designation of probably efficacious.

It should also be noted that there are many other studies of dynamic therapy that do not qualify as providing efficacy evidence based upon the criteria that we have applied. These studies were mostly conducted before the advent of treatment manuals. With dynamic therapy in particular, the use of treatment manuals is crucial to accomplish some degree of treatment specification. This is because the dynamic rubric encompasses a wide range of treatments and because therapists of various styles and levels of training characterize themselves as dynamically oriented. Thus, for studies of dynamic therapy in which no treatment manual was used there is a real question about what therapy was actually delivered by each of the participating therapists. In light of the large number of APA members who practice psychodynamic psychotherapy, in the interest of the profession and the public, we conclude that it is critical that more efficacy

evidence on the outcome of psychodynamic therapies for specific disorders be obtained (Recommendation 2) if this widely used treatment is to survive in today's market.

Predoxloral Training in Empirically-Validated Psychological Treatments

The application of research to clinical practice exemplifies the scientist-practitioner model of clinical psychology. Indeed, clinical psychologists have been in the forefront of psychotherapy research and have developed a body of data documenting the efficacy of psychological procedures derived from a variety of theoretical perspectives. Yet it is unclear whether clinical psychology educators train their doctoral students to be aware of and competent in delivering these treatments. In this section we (a) summarize the results of the task force's survey assessing current predoxloral training in empirically-validated treatments (a full report will be published elsewhere), (b) describe our recommendations for training procedures, and (c) make recommendations for a facilitative role for APA in promoting predoxloral training in such treatments.

We constructed a survey of treatments in which clinical doctoral students receive didactic instruction or practicum training (reported in detail by Crits-Christoph et al., 1994). The list of treatments in the survey included, among others, those in Table 3. Directors of clinical training were asked to check off those treatments in which their students received at least some training. Of 167 directors of APA-approved clinical programs, 81% provided useable data in response to our request. Programs were highly variable in their coverage of the validated treatments. The average treatment was included in didactic courses in 46% (range 0-96%) of programs and in practica in 44% (range 0-92%). We were most concerned with how many programs might be doing an inadequate job of introducing students to empirically-documented treatments. To examine this question, we roughly defined minimal coverage of validated treatments to be teaching 25% of the treatments in didactic courses and at least two in practica. We set our standard low

because efficacy data on a number of the treatments in Table 3 are recent and because we no doubt missed some validated treatments in our list. According to the clinical directors' report, 22% of the programs provided didactic coverage of less than 25% of validated treatments, whereas 4 programs did not provide clinical training in any of the empirical treatments, and 1 provided training in only one treatment. These findings are worrisome in that they suggest that, in one APA-approved program in five, empirically-validated treatments may be under-emphasized.

Our results indicate that APA doctoral programs in clinical psychology are teaching many of the empirically-validated psychosocial treatments. This is a positive statement about our training programs, as it appears that there is strong interest in attending to the evolving research literature. Despite this trend, however, there are reasons to believe that APA programs could improve in this area. For one, it seems possible that programs be able to provide some coverage of most, if not all, of the empirically-validated treatments in courses. By making students aware of the relevant research literature, together with brief discussions of the nature of the treatment per se, students can seek out clinical training in specific treatments of interest during their internships or post-doctoral training years. If, however, students receive no exposure to a treatment and its empirical support during their courses, they may be more likely to restrict their clinical interests to the fewer number of treatments to which they are exposed in their practica or internship training. That over 20% of programs do not teach anything about 75% or more of the empirically-validated treatments is of particular concern in this regard.

In regard to supervised practicum training, it is understandable that programs cannot train students in a large number of different treatment approaches. This might be due to the lack of access to certain populations (e.g., sex offenders), lack of access to supervisors who are experienced in the approach, or simply time constraints in students' schedules. We believe students should receive initial training in at least two empirically-documented therapies and recommend that APA

programs make stronger efforts to provide supervised clinical experience for such treatments.

What can APA do to facilitate more training in empirically-validated treatments at the predoctoral level? A number of recommendations can be made. First, we urge APA site visitors for accreditation of doctoral programs to make training in empirically-validated treatments a high priority issue (Recommendation 3). Amount of coverage of certain treatments in courses could be examined through review of assigned readings. In regard to practica, site visitors could record the amount of training in different modalities that is provided, and in particular investigate the extent to which training to competence in empirically-validated treatments is a part of students' experiences. This information could be collected through interviews with supervisors and students.

Once graduate programs understand that the provision of training in empirically-validated treatments is one criterion for accreditation, programs would be more likely to look for supervisors with specific skills in these treatments when enlisting new supervisors for their program. In addition to outside supervisors, clinical training provided by the faculty could also be shaped in this direction. When hiring new faculty, a program could be attentive to an applicant's ability to bring high level training in an empirically-validated treatment not currently represented in the program. Further, APA could set guidelines for continuing education of existing faculty so that they become more proficient at certain treatment methods.

Dissemination of empirically-validated treatments could also be aided through making treatment manuals more easily obtainable. Moras (1993) has cogently argued for the utility of such manuals in training psychotherapists. She suggests that these manuals facilitate therapists' developing competence through enhancing their conceptual understanding of the treatment and its basis, their acquisition of specific and general skills necessary to carry out the treatment, and their awareness of potential iatrogenic effects. Investigators receiving federal support for psychotherapy develop detailed and clinically-useful treatment manuals that are excellent resources for training students. However, many

treatment manuals are as yet unpublished documents available only through the authors, and their very existence is not widely known. Many investigators are willing to share photocopied versions of their manuals with those knowledgeable enough to ask for them, whereas it often takes years (if ever) for a manual to be available in book form from a publisher. These investigators might well be willing for APA to disseminate photocopies of their manuals until such time as they are published. (We will call this informal publication.) A list of such manuals and directions for how to obtain them could then be provided to directors of clinical training. We recommend that the Education and Practice Directorates facilitate training by working with the various National Institutes to seek investigators' permission for informal publication of treatment manuals once efficacy data have accrued (Recommendation 4).

Although the Task Force has made a variety of recommendations for the dissemination of empirically-validated treatments, it is important to also indicate that we are not suggesting that all clinical training be restricted to these treatments at this point in time. It is clear that much more research on treatment efficacy is needed. There are certainly treatments that have won relatively wide clinical acceptance because of clinical observations that they are effective for many patients, but for which little or no systematic, controlled outcome data exist. Training programs may elect to continue to teach these treatments in addition to treatments with stronger empirical foundations. In the long term, however, programs should increasingly move towards a concentration of effort in training students in those methods which rest on firm empirical support.

Internship Training in Empirically-Validated Psychological Treatments

We mailed a similar survey to the 428 APA-approved internship program directors (reported in detail by Crits-Christoph et al., 1994). In this case we asked directors to check those treatments in which interns were trained to competence or in which they received formal supervision during the internships. Internship

directors were asked to identify their program as exclusively adult, exclusively child, or a combination of adult and child. We received responses from directors of 91 adult, 28 child, and 118 combination programs (55% response rate).

We found that the concept of required competencies for completion was rare in the adult-only and combined programs (0-24% for any one treatment), although less so in the child-only programs (0-68%). In terms of the kinds of interventions for which formal supervision is provided, the picture looks a bit brighter. For example, in the adult-only programs, at least half of the programs responding were providing supervision in the cognitive-behavioral treatments for mood and anxiety disorders. On the other hand, almost none (8%) provided training in another well-validated psychological approach to depression -- interpersonal therapy. The intervention most likely to be required for completion (20% of programs) and for which supervision was most likely to be available (74%) was "other short-term dynamic therapy," one of a number of treatments we included on the survey for which there are no efficacy data meeting our criteria.

In the child-only programs supervision was offered in a number of behavioral interventions. Most likely to be required for completion were two interventions for which adequate research evidence of efficacy is still lacking -- strategic family therapy (50% of programs required) and structural family therapy (50%). The emphasis given these popular treatments in clinical training highlights the importance of more controlled research on these interventions. Like the adult-only programs, the combined programs responding required few skills but offered supervision in many treatments with established efficacy.

The internship is the last major APA-approved training experience most doctoral level clinical psychologists will receive. We believe that it is APA's responsibility to see that we send clinicians out into the practice world who are not only competent but also competitive. In the future, competent and competitive may be one and the same. It seems possible that, rightly or wrongly, reimbursement may soon be limited to

those interventions with demonstrated efficacy, being provided by clinicians with demonstrated competence in those interventions. We believe there is an important opportunity for clinical psychology in these developments. Not only have clinical psychologists been leaders in the development of standardized, manual-based interventions, they have also been major innovators in formulating specific procedures for training and for assessment of competence. We need to capitalize on these strengths by using them to ensure that our students emerge from internship prepared to deliver competently valid, effective psychotherapies.

We recommend that APA-site visit teams make training in empirically-validated treatments a criterion for APA accreditation (Recommendation 5). Specifically, we suggest that every student completing training should be competent in at least one intervention with demonstrated efficacy. We further suggest that site visit teams consider the adequacy of training methods and the use of empirical methods for assessment of competence.

Advanced Training for the Private Practitioner: Issues in Continuing Education

Each of the 50 states and the District of Columbia now has some form of licensure for professional psychologists. These various licensure laws vary widely but in most cases require that psychologists participate in some form of continuing education in order to maintain their license. The American Psychological Association has in place a system by which approval of sponsors of continuing education for psychologists is granted. We find that this system pays inadequate attention to the importance of adequate training in empirically-validated treatments in two ways: We are concerned by *what* clinical psychologists learn to meet continuing education requirement and by *how well* they learn it.

It is not our intention to advocate censorship of continuing education requirements, but we do find the absence of any emphasis on the empirical validation of treatments presented in workshops carrying APA approval to be

distressing. The APA Continuing Education 1993 Criteria and Procedures Manual covers such things as facilities, co-sponsorship, adequate financial resources for support of continuing education programming, instructional personnel, ethics, and advertising in very specific language. However, the sections on "Curriculum Content" and "Program Selection and Development" are, at best, sketches. Although there is a paragraph that refers to the need for empirical data in the support of "new, innovative, and/or breakthrough types of findings," even the most cursory review of the CE offerings which carry APA sponsor approval reveals that this requirement is often violated. For example, the ethics of widespread training in Eye Movement Desensitization/Reprocessing are currently a topic of hot debate. Even this procedure's supporters have agreed that, to date, there is little, if any, empirical support for this technique. Yet advertisements for these workshops frequently indicate that the sponsor is approved by APA for continuing credit but omit any mention of the dearth of efficacy data.

At minimum, we urge APA to enforce its current guidelines requiring documentation of the efficacy of new treatment procedures to be taught in workshops that are APA-approved for continuing education credit (Recommendation 6). Moreover, we believe that, regardless of how well-established a treatment procedure is, if APA is to sponsor a continuing education program, the organizers and presenters should be required to state in all promotional materials whether their techniques are empirically validated (Recommendation 7). This addition to workshop promotional material would allow psychologists to make more informed choices concerning continuing education selections and would encourage research on procedures that currently lack data-based validity. An additional solution considered by the task force was to advocate weighing continuing education hours by the amount of empirical support for treatment procedures to be learned. Such a plan would clearly reinforce psychologists for keeping up to date with demonstrably effective approaches while not closing out training in procedures for which there is a wealth of clinical, if not empirical, support.

Beyond the question of providing information on the proven efficacy of a given technique lies the question of how to develop adequate skill in a new area of practice. Clinical continuing education is designed either to acquaint practitioners with new developments in a field in which they already have expertise or to introduce them to new areas of practice or new skills. The typical workshop format may well be sufficient for adding to a current area of competence. However, if the professional is interested in developing new areas of expertise for use with clients, we believe the current common format of 3-hour to 3-day workshops constitutes inadequate training for ethical practice. We consider supervised clinical work to be requisite for ethical practice of new procedures and urge APA to adopt this position as its standard (Recommendation 8). When we scanned 6 months of advertising in The APA Monitor, we found very few (<10%) continuing education programs required supervised clinical application prior to awarding continuing education credits or certification in the new area.

Any clinical continuing education program should include a component of required supervision. Models for such training programs do exist. Historically, psychoanalytic training programs have emphasized the necessity for close clinical supervision of independent professionals when developing new areas of expertise. Such programs have typically required extensive weekly supervision of the analyst in training by a senior analyst. Training often includes extensive review of transcripts or videotaped sessions by a panel of analysts responsible for determining the level of proficiency of the analyst in training. Other programs, such as those developed by cognitive therapists and rational-emotive therapists, have integrated ongoing clinical supervision as a necessary component of training in order to receive certification within their form of therapy. Current initiatives in developing specialized training in clinical health psychology (e.g., The Institute for Clinical Health Psychology at the Massachusetts School of Professional Psychology) have also attempted to integrate didactic and applied training. While these statements are not intended to be either exhaustive or an

endorsement of the specific content of any training program, certain structural aspects of these programs are taken as illustrative of what might be added to all forms of continuing education on therapeutic techniques.

The Atlanta Center for Cognitive Therapy (ACCT), taken as an example with which we are most familiar, has a certification and training program that has been providing training to clinicians since 1986. The program's structure was adapted from one originally developed by Dr. Arthur Freeman. One of the things that makes this training program different from many other long-term training programs is that it is based in a private practice which is not subsidized by a university or professional school. While the training offered is often cosponsored by different professional organizations, ACCT maintains control over the content and form of all programs offered. The cosponsorship process with other business concerns, such as for-profit hospitals and managed care organizations, distributes the financial burden of developing and conducting such training. This allows professionals to participate at a lower direct cost than would otherwise be possible. This type of relationship between sponsors may serve as a model of how to promote psychotherapy to business concerns whose support is becoming increasingly essential for psychotherapy to thrive. Training is directed primarily at independent health care professionals (psychologists, social workers, nurses, etc.) and graduate students. The content of the course work centers on the theory and application of cognitive therapy in a variety of contexts.

The program has several essential components, including course work, readings, written exams, research papers, role playing, and case consultation on the participant's current clinical work. Topics covered focus primarily on current articles and texts on empirically-supported treatment methods broadly defined as cognitive. There are four courses in the primary certification process. The first, Fundamentals of Cognitive Therapy, is taught by senior psychologists at ACCT. The second course, Applications of Cognitive Therapy, is taught by visiting professionals from all over the world (recently

including Aaron Beck, David Barlow, David Burns, David Clark, and Arthur Freeman) focusing on areas of special interest to the visiting lecturer. The third course involves case consultation on a weekly basis at ACCT on current clinical cases from the participants' own practice or setting. The final course involves both an oral and a written case conceptualization and presentation. To receive clinical certification the participant must have received direct experience and case consultation under a senior cognitive therapist.

An important aspect of this certification program is its flexibility. The academic components are offered both live and via videotaped self-study thereby allowing a participant flexibility in balancing work schedules and training requirements. This option is also valuable for those participants not living near a large city in which such training opportunities routinely exist. Of central importance to note is that even in the self-study format clinical consultation is required for certification. In some cases the case consultation section of the program is done by telephone and fax. Additional audio and videotaped therapy samples are requested, when appropriate. An additional level of flexibility is offered by advanced training in cognitive therapy. The major focus of this 6-month program, taught by well-known cognitive therapists, is clinical case consultation. The professional is encouraged to work on difficult cases and use advanced techniques. Continued academic readings and written assignments are an integral component of these programs as well as the essential clinical contact and consultation.

Clinical Health Psychology is fast becoming another area of specialization for which graduate programs may not have adequately prepared the practicing professional. Another example of a continuing education program whose form might serve as an exemplar for such advanced training programs is the Intensive Program in Clinical Health Psychology offered by the Massachusetts School of Professional Psychology. This program serves as an example of formal continuing education through a free standing professional school. The program offers 30 three-hour seminars weekly from September

through May, plus 15 small group supervision sessions through the same period. This seems a close parallel to the program offered by the Atlanta Center for Cognitive Therapy but in this case is sponsored by an educational institution. The rationale for this formal training, as stated by the Institute, is that "postgraduate training in Clinical Health Psychology has not been readily available" and that the Institute offers "training in a comprehensive, sequential manner." Emphasis is placed on both fundamentals of academic knowledge and supervised clinical experiences in order to develop and deepen the knowledge and ability of the participants.

Many universities are now heavily involved in training for business and government. APA could encourage psychology departments and professional schools to design structured curricula for continuing education for psychologists as well. Alternatively, our recommendations for organized training and supervised clinical work for continuing education could be readily incorporated into the proposal for the National College of Professional Psychology currently under consideration by the APA Council. We urge APA to encourage the development of innovative programs combining structured didactic learning with supervised clinical work (Recommendation 9).

Informing Clinicians About Empirically-Validated Treatments

Psychotherapy researchers generally assume that nonacademic clinicians should be ready and eager to read the literature about developments in effective treatments and then to go forth and learn to administer these therapies. This presumes that clinicians find psychotherapy research relevant, which may not always be the case. Research trials are not necessarily designed to address the questions clinicians want to have answered (Backer, Liberman, & Kuehnelt, 1986). Clinicians' questions may be less about theoretical issues of importance to academicians and more about practical issues that affect how one treats a particular kind of client. The rift between practitioner and researcher can best be mended by discarding the notion of dissemination and

thinking instead in terms of knowledge exchange. Clinicians are, in fact, the experts on what they do and what they want to know, and they need to be treated as partners in the research enterprise if they are to value the ultimate findings.

How can these problems be rectified? First, researchers need assistance in learning to frame their findings to make them useful and digestible for the practicing psychologist. We suggest that a regular column on data-based treatment approaches be published regularly in the Monitor (Recommendation 10). Second, researchers and clinicians need to have a dialogue about what information would have a significant impact on the clinician's practice. Division 12 is well-positioned to bridge this unfortunate gap. We suggest that the division sponsor roundtable discussions about treatment issues at APA and midyear conferences where clinicians and researchers come together on equal footing to identify important questions for psychotherapy research (Recommendation 11).

Third, we suggest that the development of health maintenance organizations, along with the continuation of community mental health centers and other privately funded mental health centers, provides an opportunity for educating practitioners about empirically-validated treatments. In such a setting the administrators can foster attainment of new treatment skills by making time available for the type of structured training program we have advocated in the previous section, thus reaching practitioners who might otherwise remain uninformed about these treatments. We propose that APA assist state psychological associations in developing training curricula for empirically-validated treatments and offering these through HMOs and other mental health centers (Recommendation 12). These organizations need to be approached with the goal of convincing them that it is in their best interest to help their clinicians be more effective. Because information is more likely to be used if it comes from trusted sources, at the national organization level APA should work with national HMO trade organizations to educate their leadership about the benefits of upgrading the training of therapists employed by their member organizations (Recommendation 13).

In recognition of the need to inform practitioners and the public about developments in psychopathology and treatment research, the National Institute of Mental Health has established the Office of Knowledge Exchange and also funds the Office for Scientific Inquiry. We suggest that APA work with these offices to foster dissemination of findings about the benefits of empirically-validated psychotherapies (Recommendation 14).

Informing the Public about Empirically-Validated Treatments

Researchers often make the erroneous assumption that, if their findings are sound and important, they will be used eagerly by the potential consumers. In fact, research on dissemination shows that, even if we are successful in informing the public about the advances in psychotherapy, this does not insure that people will use our services when they need them (Rich, 1991). What affects people's utilization of information? Important factors include whether the source of the information is viewed as trustworthy and how the information is formatted (e.g., avoiding jargon, using question and answer format, using easy to read graphs and charts). Information has to be targeted to particular segments of the population if it is to be formatted effectively for that group. For example, we know that African-Americans with anxiety disorders are unlikely to see psychologists who specialize in anxiety, rather they often seek help from their ministers (Neal & Turner, 1991). To reach this community, the message should be delivered by figures they trust, perhaps those in the ministry or other well-known people. We propose that the APA Practice and Public Interest Directorate develop targeted public service announcements and media campaigns for well-defined population segments (Recommendation 15).

The continued work of APA's media office to spotlight the work of psychotherapy researchers is also important. We suggest that the media office hold regular briefing for science writers about developments in empirically-validated psychotherapies, along with other

findings in psychological research (Recommendation 16).

A second factor to be considered in encouraging the public to make use of empirically-validated psychotherapies is not the absence of information but the presence of negative beliefs about psychotherapy. Dissemination research shows that simply repeating information about psychotherapy is not enough without identifying concerns that may provide a disincentive for psychological treatment, for example, the idea that all psychotherapy involves years of lying on a couch for any benefit, or that behavior therapists are controlling and manipulative. The Practice and Public Interest Directorates should conduct research to identify negative attitudes about psychotherapy, and design a campaign to address these (Recommendation 17).

Educating Third Party Payors

In our comments thus far, we have considered how to inform psychologists and those in training about empirically-validated treatments and how to deliver them. However, there is another constituency we need to convince -- insurance and managed care companies and government agencies whose decisions affect the availability of psychotherapy to the public. Obviously APA needs to continue to work to make the empirically-documented benefits of psychotherapy for emotional disorders known to third party payors (Recommendation 18). Since many of the decisions about mental health care are made at the state or local level, APA might be most effective by assisting the state psychological associations to inform carriers and agencies in their areas.

That many of our effective treatments are short-term should prove attractive to those who foot the bills, and this point should be made salient. Nevertheless, treatment cannot always be short-term. Many of us believe there are clients who require and benefit from long-term treatment, but to sell this point, we need research on this question. The National Institutes have been generally reluctant to fund research on treatments that require longer than 6 months. APA should

encourage the Institutes to fund research on long-term treatments for populations that may require such approaches (Recommendation 19), else these treatments be legislated out of existence for lack of documentation.

Not only are there data on the effectiveness of psychotherapy for emotional disorders, but there is also a wealth of findings emerging on the benefits of psychotherapy for physical disorders which should be of considerable interest to third-party payors who tend to dismiss psychological treatment as a needless and discretionary expense. We review some of these findings below.

The Influence of Psychological Processes on Physiological Systems

Psychoimmunologists have gathered impressive evidence showing that the state of the mind affects the state of the body through the mediation of the neuroendocrine system (Blalock, Harbour, McMenamin, & Smith, 1985; Brier, Albus, Picker, Zahn, Wolkowitz, & Paul, 1987; Gazzaniga, 1992; Guyton, 1987; McClelland, 1989). Much of this research has focused on stress. Glaser et al. (1987) collected blood samples of medical students during high stress (final exams) and low stress (after summer vacation) periods. They found a general suppression of immune functioning in the high stress, relative to the low stress, blood samples. Additionally, the students reported a higher incidence of infectious disease during the high stress period. Cohen, Tyrrell, and Smith (1991) examined the effects of stress on susceptibility to the common cold. Their subjects completed psychological stress measures and were then exposed to common cold viruses under controlled laboratory conditions. High stress subjects were approximately twice as likely to succumb to the cold virus as low stress subjects.

McClelland (1989) reviewed a series of studies conducted by himself and his associates showing that motive strength, as measured through content analysis of associative thought, is related to health outcomes. Some of these studies showed that these effects could be long-term. Peterson and Seligman (1987) also reviewed a

series of studies showing that another chronic psychological condition, pessimism, can affect long-term health outcomes, including longevity. Moving closer to the types of things clinical psychologists see, Luborsky (1992) found that more depressed outpatients had poorer immune functioning than did less depressed patients. Finally, Shedler, Mayman, and Manis (1993) found that denial of psychological distress (conceptualized as defensiveness) was associated with physiological changes that could compromise the body's resistance to illness.

Thus, there is a compelling case for the hypothesis that psychological states can affect physical health. Moreover, these psychological conditions are often the very ones psychologists are asked to treat. But if we stop at this point, medical interventions could be justified as easily as could psychological methods. Perhaps all we need do is directly manipulate hormonal systems and dispense with lengthier and more costly psychological interventions. Indeed, this is the thrust of biological approaches to stress (e.g., management with tranquilizers). Accordingly, it is important to examine the evidence that the kinds of things psychologists do are effective. Fortunately, this evidence is quite strong.

Pennebaker and his colleagues (Francis & Pennebaker, 1992; Pennebaker, 1990; Pennebaker & Beall, 1986; Pennebaker & Heeron, 1984; Pennebaker, Kiecolt-Glaser, & Glaser, 1988) conducted a series of studies that were analogues of psychotherapy in the sense that subjects were asked to disclose private and distressing thoughts as freely as possible. The premise of their work is that avoiding or inhibiting expression of emotions has physiological costs which then have deleterious health consequences. Research by Shedler et al. (1993) on defensive denial supports this notion. Pennebaker further posits that lifting this inhibition, in the form of either writing or talking about a traumatic event, can reverse these effects and thereby positively influence health. He has provided a great deal of support for this. His studies, taken together, provide powerful evidence that disclosure of private and distressing thoughts can result in improved immune functioning and decreases in health service utilization.

Psychotherapy and Medical Costs

The Pennebaker studies are compelling but they do not address real psychotherapy and its effects on actual health care utilization costs. In an early study Duehrssen and Jorswick (1965) found that hospitalization of patients who received psychodynamic psychotherapy was less frequent over the 5 years studied than for a control group. Numerous authors have reported similar results, but some failed to show such effects. To provide more definitive conclusions about this line of research Mumford, Schlesinger, Glass, Patrick, and Cuerdon (1984) conducted an important meta-analytic summary of these data. Their analysis of 58 studies indicated that medical utilization decreased following psychotherapy. Since the Mumford et al. analyses, there have been several further studies showing that psychological treatment can reduce medical utilization, medical costs, or both (e.g., Holder & Blose, 1992), but no systematic review or meta-analysis of these more recent studies has yet been completed.

Serious Illness

There are also data suggesting that psychotherapy can retard the progression of disease in patients with life-threatening illness. Grossarth-Maticek and Eysenck (1989) reported that cancer patients who had psychotherapy lived longer than those who did not. Friedman et al. (1984) randomly assigned patients who had survived a heart attack (and so were at high risk for another) to either standard medical care or care plus group psychotherapy. The rate of second heart attacks was reduced by about 50% in the psychotherapy group. Similarly, Spiegel, Bloom, Kraemer, and Hotteil (1989) examined survival among women with metastatic breast cancer. Women who received psychotherapy survived about 1.5 years longer than women who received only standard medical care.

Recommendations

The evidence reviewed above provides an impressive amount of support for the argument that psychological procedures can have an important impact on physical health and are cost-effective as they do so. These studies may well underestimate the potential savings. What might we save if individuals received psychological help before they manifested physical problems?

APA needs to continue its efforts to educate third party payors and the public about the health benefits and cost effectiveness of psychotherapy (Recommendation 20). Additional research on the cost-effectiveness of psychotherapy is required, as is a more recent meta-analysis than that conducted by Mumford et al but on a grander scale and with more fine-grained sub-analyses. Their work was published in 1984 and based on data older than that (circa 1978). The Practice Directorate might wish to commission such a study, make it available to all psychologists through the American Psychologist, but also provide a readable summary for laypeople. We need current data to present to insurance companies and government officials.

Conclusion

In our recommendations we have outlined an ambitious program for Division 12 and APA to follow. We believe that clinical psychology has a great deal to offer consumers if we can position practitioners to be ready to provide the effective psychotherapies that have been developed and can convince the public and third party payors of what we already know. This is the time that we must blow our own horn and blow it loudly. We recognize that some of our recommendations will cost money, and that APA's resources are not infinite. We argue that pursuit of this agenda is a good use for our dues. However, we also want to emphasize that many of our recommendations can be implemented without financial cost and in very little time.

The task force welcomes comments on its report and recommendations. These should be sent to Dianne L. Chambless, Dept. of

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Epilogue

The task force report has been circulated widely in the months since adoption of its recommendations by the Division 12 board. We are pleased that many people agree with our suggestions and are working to implement our recommendation, and we are not surprised that many disagree with us. Although there are legitimate grounds for reasonable people to disagree concerning our recommendations, we find that a number of recurring objections we have heard are based on misreading or misunderstanding what we have said. We will address some common misperceptions here:

1. The recommendations of the report should be rejected because one or more treatments were left off the list of examples of empirically-validated treatments. We recognize that, working under time constraints, we did not construct an exhaustive list of treatments that meet our criteria and sincerely apologize if

creators or adherents of a particular approach feel slighted by our oversight. However, we urge readers to look beyond this to the recommendations themselves. These are the point of the report, and they do not rest on the list of treatments. Rather, the list was constructed to guide our survey and was not a major focus of the report. Instigated by current Division 12 president Martin Seligman and chaired by Peter Nathan, a new task force is charged with constructing a catalogue of effective treatments.

2. Don't tell us what to do with our students. We recognize the desire of individual programs to shape their training curriculum according to their own vision. However, those of us who teach in APA-approved clinical programs have chosen to seek APA accreditation, and the accreditation guidelines do direct instruction to a substantial degree. We believe it is appropriate to add to those guidelines, and that attention to psychotherapy's research base should be an inherent part of becoming a clinical psychologist.
3. The task force report reflects the intention of a group of cognitive-behavior therapists to gain advantage over adherents of other approaches. This concern really distresses us because we went to considerable lengths to get a balance of practitioners of various theoretical perspectives on the task force. The report is based on our commitment to empiricism which is decidedly not the same as cognitive-behaviorism. We did not say that only cognitive-behavioral treatments work (see Table 3) and do not believe this. We do recognize that there is a larger literature supporting empirically-validated cognitive-behavioral approaches according to our criteria (drafted by a psychodynamic researcher) and think the answer to that is simple (See Recommendation 2) -- researchers from noncognitive-behavioral perspectives need to get going on outcome studies. This is already happening.

4. The report says that treatments not on our list are no good and should not be used or taught. Decidedly not. We might have overlooked a treatment, or there may not be sufficient evidence to evaluate that treatment yet. This is quite different from knowing that a treatment is ineffective.
5. The task force should not have used treatment manuals as a criterion for efficacy research because manuals can only be developed for cognitive-behavioral treatments. We suspect that this belief is based on a misunderstanding about what psychotherapy researchers mean by manuals. It is true that cognitive-behavioral treatments more easily lend themselves to session-by-session outlines. However, manuals for other therapeutic approaches exist and look different. At base, a treatment manual is a clear description of a treatment, and this should be possible for adherents of all psychotherapy approaches to provide, else how can the treatment be taught? Note that manuals on psychodynamic and interpersonal psychotherapy were published a decade ago (Klerman, Weissman, Rounsaville, & Chevron, 1984; Luborsky, 1984; Strupp & Binder, 1984) and that disorder-specific manuals for psychodynamic treatment are being developed for on-going research projects. Examples in Rogerian and experiential psychotherapy include the manual Katherine Shear has developed for treatment of panic disorder and those authored by Leslie Greenberg and Laura Rice for depression.
6. All psychotherapies are equally effective, so there is no need to focus on those with empirical efficacy data in particular. We believe this conclusion is based on meta-analytic findings that have been superseded by more recent evidence. Earlier studies were based on treatments and subject samples that were poorly defined. Advances in psychotherapy research have led to more clearly interpretable findings, with some treatments being superior to others, depending on the disorder. For example, supportive therapy and relaxation have proved less effective than exposure-based approaches or cognitive therapy for agoraphobia (Chambless, Foa, Goldstein, & Groves, 1978), panic disorder (Beck, Sokol, Clark, Berchick, & Wright, 1992), and obsessive-compulsive disorder (Rachman, Hodgson, & Marks, 1971). The list of effective treatments for a given disorder may well be shorter or longer depending on what that disorder is, but without the evidence we cannot conclude that any type of psychotherapy would work equally well as one proved effective in controlled research.
7. It is meaningless to say that a treatment works, because there is always more research that needs to be done. For example, how must treatments be altered or selected based on personality characteristics of the client? We completely agree that additional research refining our current state of knowledge is vital. Yet to ignore what we do know in the meanwhile is to deprive people of treatments that have a decent probability of helping them and to put psychologists in a disadvantageous position vis à vis psychiatry.
8. It is dangerous to publicize that some treatments have an empirical basis of support. The list might get set in stone, or psychologists using treatments not yet validated might find it hard to get reimbursement from third party payors. Once a complete list has been developed and publicized (as, based on the charge of Peter Nathan's task force, it seems will be the case), we agree there is some risk the list might be ossified. A mechanism needs to be developed to see that this does not happen, and Division 12 has already set one in motion. We also recognize the concerns about third party payors. We think it is quite possible that they may begin to limit the type as well as the duration of treatments, and that such a move might hurt practitioners of unvalidated approaches. However, we think the real and more pressing question is whether psychotherapy will be included at all in health care plans. We believe that downplaying the

data base for some of our treatments may result in psychotherapy's exclusion. This would not only hurt our practitioners but, more

important, the public who in that event would only receive medication for emotional problems.

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Table 1

Criteria for Empirically-Validated Treatments: Well-Established Treatments

-
- I. At least two good group design studies, conducted by different investigators, demonstrating efficacy in one or more of the following ways:
- A. Superior to pill or psychological placebo or to another treatment.
 - B. Equivalent to an already established treatment in studies with adequate statistical power (about 30 per group; cf. Kazdin & Bass, 1989).
- OR
- II. A large series of single case design studies demonstrating efficacy. These studies must have:
- A. Used good experimental designs and
 - B. Compared the intervention to another treatment as in I.A.
- FURTHER CRITERIA FOR BOTH I AND II:
- III. Studies must be conducted with treatment manuals.
 - IV. Characteristics of the client samples must be clearly specified.
-

Table 2

Criteria for Empirically-Validated Treatments: Probably Efficacious Treatments

-
- I. Two studies showing the treatment is more effective than a waiting-list control group.
- OR
- II. Two studies otherwise meeting the well-established treatment criteria I, III, and IV, but both are conducted by the same investigator.
Or one good study demonstrating effectiveness by these same criteria.
- OR
- III. At least two good studies demonstrating effectiveness but flawed by heterogeneity of the client samples.
- OR
- IV. A small series of single case design studies otherwise meeting the well-established treatment criteria II, III, and IV.
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Table 3

Examples of Empirically-Validated Treatments

Well-Established Treatments	Citation for Efficacy Evidence
Beck's cognitive therapy for depression	Dobson (1989)
Behavior modification for developmentally disabled individuals	Scotti et al. (1991)
Behavior modification for enuresis and encopresis	Kupfersmid (1989)
Behavior therapy for headache and for irritable bowel syndrome	Wright & Walker (1978)
Behavior therapy for female orgasmic dysfunction and male erectile dysfunction	Blanchard et al. (1987)
Behavioral marital therapy	Blanchard et al. (1980)
Cognitive behavior therapy for chronic pain	LoPiccolo & Stock (1986)
Cognitive behavior therapy for panic disorder with and without agoraphobia	Auerbach & Kilmann (1977)
Cognitive behavior therapy for generalized anxiety disorder	Azrin, Bersalel et al. (1980)
	Jacobson & Follette (1985)
	Keefe et al. (1992)
	Barlow et al. (1989)
	Clark et al. (1994)
	Butler et al. (1991)
	Borkovec et al. (1987)
	Chambless & Gillis (1993)

Table 3 (con't)
Examples of Empirically-Validated Treatments

Well-Established Treatments	Citation for Efficacy Evidence
Exposure treatment for phobias (agoraphobia, social phobia, simple phobia) and PTSD	Mattick et al. (1990) Trull et al. (1988) Foa et al. (1991)
Exposure and response prevention for obsessive-compulsive disorder	Marks & O'Sullivan (1988) Steketee et al. (1982)
Family education programs for schizophrenia	Hogarty et al. (1986) Falloon et al. (1985)
Group cognitive behavioral therapy for social phobia	Heimberg et al. (1990) Mattick & Peters (1988)
Interpersonal therapy for bulimia	Fairburn et al. (1993) Wilfley et al. (1993)
Klerman and Weissman's interpersonal therapy for depression	DiMascio et al. (1979) Elkin et al. (1989)
Parent training programs for children with oppositional behavior	Wells & Egan (1988) Walter & Gilmore (1973)
Systematic desensitization for simple phobia	Kazdin & Wilcoxin (1976)
Token economy programs	Lieberman (1972)
Probably Efficacious Treatments	Citation for Efficacy Evidence
Applied relaxation for panic disorder	Öst (1988) Öst & Westling (1991)
Brief psychodynamic therapies	Piper et al. (1990) Shefler & Dasberg (1989) Thompson et al. (1987) Winston et al. (1991) Woody et al. (1990)
Behavior modification for sex offenders	Marshall et al. (1991)
Dialectical behavior therapy for borderline personality disorder	Linehan et al. (1991)
Emotionally focused couples therapy	Johnson & Greenberg (1985)
Habit reversal and control techniques	Azrin, Nunn & Frantz (1980) Azrin, Nunn & Frantz-Renshaw (1980)
Lewinsohn's psychoeducational treatment for depression	Lewinsohn et al. (1989)