Why Empirically Supported Psychological Treatments Are Important

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The emergence of managed care and similar reimbursement systems that require greater accountability and the development of clinical practice guidelines have increased the importance of evidence-based clinical practice. As a result of these two trends, it appears as though the future of psychotherapy will require clinicians to deliver a psychological intervention that is supported by research. Such treatments exist for a variety of the most common presenting problems (e.g., anxiety disorders, depression) but to date have frequently gone unrecognized and underutilized. The current article will discuss the importance of identifying, promoting, and disseminating empirically supported therapies with an emphasis on the efforts of the American Psychological Association Society of Clinical Psychology's Committee on Science and Practice.

Keywords: *evidence-based psychotherapy; empirically validated treatments; psychotherapy; efficacy.*

The continuing evolution of the U.S. health care system will ultimately have a profound impact on the way that psychotherapy is practiced. The increasing penetration of managed care and the development and proliferation of clinical practice guidelines and treatment consensus statements have raised the stakes for accountability. Essentially, managed care companies and developers of treatment guidelines are concerned with the same basic question: Does a treatment work for a particular disorder? (Managed care companies have an additional concern: whether a treatment is cost-effective). Although

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these forces are influencing every area of health care, this article will focus on their impact on the practice of psychotherapy.

MANAGED CARE

More than any previous event, managed care organizations (or any other system monitoring the utilization and cost of service such as HMOs, capitated contracts with providers, etc.) are reshaping the practice of psychotherapy. In the traditional fee-for-service model, decisions about the cost and length of treatment were primarily functions of choices made by the doctor and patient, with the allocation of resources (i.e., cost of psychotherapy) being of little concern to the clinician. In fact, the fee-for-service model encouraged the provision of service, as more service created more income. However, in response to the increased costs of psychotherapy and, in particular, to the perceived "endless" nature of psychotherapy, managed care organizations are pressuring clinicians to allocate decreasing amounts of service.

To date, the focus of managed care organizations' cost cutting has been almost entirely on limiting the number of sessions a patient receives. However, to compete, managed care organizations will also have to focus on the quality (effectiveness) of the psychotherapeutic interventions, as they strive to satisfy both the consumer (i.e., patient) and payor (e.g., employer providing health benefits). Thus, in essence, managed care organizations must balance their motivation to cut costs with effective clinical outcomes. Simply reducing the length of care will not accomplish this goal, as it would likely result in ineffective outcomes, leading in turn to both consumer dissatisfaction and increased costs down the road (as the severity of the disorder may increase and become less responsive to treatment). Thus, concern for the effectiveness of an intervention will eventually temper the managed care organizations' focus on economics. Ultimately, managed care organizations will be interested in clinicians providing the "optimal intervention: . . . the least extensive, intensive, intrusive, and costly intervention capable of successfully addressing the presenting problem" (Bennett, 1992).

CLINICAL PRACTICE GUIDELINES

A second force having a significant impact on the practice of psychotherapy is the establishment of clinical practice guidelines and treatment consensus statements. As noted by Smith and Hamilton (1994), "Guidelines are now being developed because there is a perception that inappropriate medical care is sometimes provided and that such inappropriate care has both health and economic consequences" (p. 42). It is well known that in all medical fields, there is significant variability in treatments delivered to patients with various illnesses and that patients are not necessarily always receiving the most effective treatment. Consequently, to ensure that patients uniformly receive the optimal intervention (whether it is a type of medication, surgical procedure, or psychotherapeutic intervention), clinical practice guidelines are being developed.

The Agency for Health Care Policy and Research (AHCPR) with the Public Health Service is a federal agency involved in clinical guideline development. To create impeccable guidelines, only treatments with documented efficacy from randomized controlled trials are considered. Therefore, for an intervention to be included as a first-line treatment, research evidence attesting to its efficacy must be available. As a result, the recommendations of the clinical practice guidelines are quite clear. For example, consider the wording from the AHCPR (1993) guidelines for depression, which states that when psychotherapy is to be selected as the sole treatment,

> the psychotherapy should generally be time limited, focused on current problems, and aimed at symptom resolution rather than personality change as the initial target. Since it has not been established that all forms of psychotherapy are equally effective in major depressive disorder, if one is chosen as the sole treatment, it should have been studied in randomized controlled trials. (p. 84)

In addition to endorsing specific treatments for depression that have sufficient empirical evidence (e.g., cognitive behavioral therapy [CBT] and interpersonal psychotherapy [IPT]), the report goes on to state, "Long-term therapies are not currently indicated as first-line acute phase treatments" (p. 84).

Along the same line as treatment guidelines, consensus statements are also likely to carry a great deal of weight in determining which treatments should be delivered. For example, in 1991 a Consensus Development Conference on the Treatment of Panic Disorder was held, sponsored by the National Institute of Mental Health and the Office of Medical Applications of Research, National Institutes of Health. As was true in the process of developing the AHCPR treatment guidelines, the available scientific evidence determined the merit of various treatments. The format of the conference was to let "each camp put its best data forward," and the panelists would evaluate and weigh the evidence to formulate a consensus statement (Wolfe & Maser, 1994).

As in the case of treatment guidelines, a number of specific treatments were judged to be effective for panic disorder, including several pharmacological compounds and CBT (cf. Panic Consensus Statement published in Wolfe & Maser, 1994). In addition, similar to treatment guidelines, the Panic Consensus Statement is clear on its position regarding the use of treatments not supported by empirical evidence: "One risk of maintaining individuals in nonvalidated treatments of panic disorder is that misplaced confidence in the therapy's potential effectiveness may preclude application of more effective treatment" (p. 244). The statement also spells out a specific concern about the use of psychotherapies without demonstrated effectiveness for panic disorder: "The nature of the therapeutic relationship makes it difficult for the patient to seek additional or alternate treatment" (p. 244).

As one can imagine, as clinical guidelines and treatment consensus statements continue to emerge for a wide array of emotional disorders, they will have a significant impact on the way clinicians practice psychotherapy. In effect, these documents set standards of care, which if ignored, leave the clinician both ethically and legally vulnerable. Health insurance companies and managed care plans are now providing their practitioners with copies of guidelines and asking that they be followed. For example, Merit Behavioral Care Corporation, in a letter to their providers (July 14, 1997), stated the following: "Consistent with national standards, the Medical Affairs Committee of MBC endorses clinical practice guidelines." They then provided references

to specific treatment guidelines for schizophrenia, major depression, substance abuse, and bipolar disorder. The implications are clear: Failure to provide an empirically supported treatment from these guidelines, when one exists, may constitute malpractice in the eyes of the payor. Indeed, as noted by Barlow and Barlow (1995), a number of states have passed or are in the process of passing legislation that gives guidelines the "force of law" by protecting clinicians who follow the guidelines from malpractice litigation.

IDENTIFYING, PROMOTING, AND DISSEMINATING EMPIRICALLY SUPPORTED TREATMENTS

Since the early 1990s, the Society of Clinical Psychology (Division 12) has focused attention on the two potent trends noted above. In 1993, David H. Barlow, then president of the society, created a Task Force (TF) on the Promotion and Dissemination of Psychological Procedures. A primary goal of the TF was to inform various constituencies about the state of the science regarding clinical interventions: "this task force was constituted to consider methods for educating clinical psychologists, third-party payors, and the public about effective psychotherapies" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 3).

The Task Force on Promotion and Dissemination of Psychological Procedures, later renamed the Task Force on Psychological Interventions and now the standing Committee on Science and Practice (CSP) completed groundbreaking work. "First-generation" accomplishments include (a) the development of criteria for levels of empirical support (Task Force on Promotion and Dissemination of Psychological Procedures, 1995), (b) the identification of relevant treatment outcome studies and weighing the evidence in those studies according to the TF criteria, (c) publication of lists of treatments meeting criteria for different levels of empirical support (Chambless et al., 1996, 1998), (d) the development of resource lists of treatment manuals and training opportunities for ESTs (Sanderson & Woody, 1995; Woody & Sanderson, 1998). These materials, as well as forthcoming updates, are available on the Society of Clinical Psychology Web site (www.apa.org/divisions/div12/journals.shtml).

The above products, although not perfect, have drawn attention and facilitated ongoing exchanges of ideas—both pro and con—to weighty issues in clinical psychology and prompted close examination in both the practice and research communities. As a result of this feedback, the work of the CSP continues with the goal of improving and extending the work completed to date as well as identifying new areas to focus attention. Specifically, the following areas are currently being addressed: (a) standardizing review procedures and establishing reliability by using a detailed coding manual to determine evidence-based treatments (this term will replace EST); (b) developing a classification scheme for empirical support (i.e., strength of evidence ratings); (c) broadening the range of treatments addressed and outcomes assessed; (d) educating consumers, practitioners, and policy makers about ESTs (for a thorough description of current and future directions of the CSP, see Weisz et al., 2000).

IDENTIFYING EMPIRICALLY SUPPORTED TREATMENTS

The first mission of the original TF was to define criteria to determine which treatments qualified as ESTs. For a treatment to be judged as empirically supported, (a) the treatment must have been shown to be superior to a pill or psychological placebo or be equivalent to an already established treatment, (b) a treatment manual must have been used in the studies, and (c) the characteristics of the client sample must have been clearly delineated. Both group and single case designs were considered as evidence (for a full description of the criteria used, see Chambless et al., 1998). Based on the strength of evidence, the TF then distinguished between two levels of EST: “well established” and “probably efficacious” (the latest list of ESTs is published in Chambless et al., 1998 and can be viewed at www.apa.org/divisions/div12/est/97report.ss.html).

PROMOTION AND DISSEMINATION

Deciding on criteria and identifying ESTs is merely the first step in the process of increasing their use. The second step is to call attention to ESTs so that practitioners, health insurers, and the general public

are all aware of their efficacy (promotion) and to be sure that practitioners are able to use these treatments (dissemination).

Promotion. As noted by Barlow (1994), despite the considerable data that exist demonstrating the efficacy of psychological interventions, they seem to be taking a back seat to pharmacological approaches in clinical practice guidelines. One possible explanation for this may be that, unlike the pharmaceutical companies who spend a significant amount of money promoting the use of their treatments to both consumers and providers, no such profit-motivated organization exists for psychotherapeutic interventions. As a result, many patients are unaware that effective psychological treatments exist and thus do not seek them out. Clearly, more effort needs to be focused on educating the public about ESTs. As a first step toward this goal, the CSP has launched a Web site listing a description of ESTs for a range of disorders so that "consumers" of mental health services can find out what types of treatments have been shown to be effective for the problem/disorder for which they are seeking treatment (cf. A Guide to Beneficial Psychotherapy: www.apa.org/divisions/div12/rev_est/index.shtml).

Dissemination. Identifying and promoting ESTs will not solve all of the problems noted above. The next step is to ensure that the treatments are available. Unfortunately, as suspected by the CSP, a survey of clinical psychology doctoral programs and internship programs revealed that there is insufficient training in ESTs (Crits-Christoph, Frank, Chambless, Brody, & Karp, 1995). For example, two of the first-line treatments for depression listed by the AHCPR depression treatment guideline, CBT and IPT, are not always taught in graduate and internship training. Specifically, among clinical psychology internship programs—the place where clinical psychologists receive the bulk of supervised clinical experience—only 59% of programs provided supervision in CBT for depression, and a mere 8% of programs provided supervision in IPT. University doctoral programs were slightly better, with 80% offering supervision in CBT and 16% in IPT.

It is important to note that having supervision available does not mean that students are required to receive it. As a result, these numbers do not indicate that 80% of students are in fact receiving training in CBT, and thus the percentages are likely an overestimation of the total number of clinical psychology students receiving training in these approaches. For example, only 14% of internship programs required training in CBT for depression and only 3% in IPT. Although we are unaware of data from other mental health training programs (e.g., psychiatry residency programs, social work departments), our colleagues from these departments have suggested the data would be no better—and, more likely, are worse.

Unfortunately, if one examines the training in ESTs for disorders other than depression, the numbers are even lower (Crits-Christoph et al., 1995). For example, the survey revealed that only 7% of internship sites provide supervision in IPT for bulimia, 5% in CBT for social phobia, 3% in IPT for depression, and 22% in CBT for depression. The numbers for doctoral programs, although higher, are still not all that promising: 21% offer supervision in IPT for bulimia, 24% in CBT for social phobia, 26% in IPT for depression, and 90% in CBT for depression. Each of these treatments represents a first-line intervention for the respective disorder (with some of the treatments being the only empirically supported psychotherapeutic intervention), so it is not as though training in some other EST approach is occurring.

If training at both graduate and internship levels is lacking, then one can imagine how difficult it will be to disseminate these treatments to practitioners already in the field. To date, no formal process exists to disseminate and train practitioners in the use of ESTs. As noted by Calhoun, Moras, Pilkonis, and Rehm (1998) in a recent article on training in ESTs, reaching professionals is the most problematic area. With a rapidly changing database, clinicians trained 10 years ago are unlikely to be up-to-date with the newer, evidence-based psychotherapies. Indeed, the majority of references supporting ESTs have appeared in the past 10 years. How can we motivate clinicians to learn ESTs? Even if they are motivated, how can we disseminate the treatments and provide high-integrity supervision to insure they are properly trained? These questions are being considered by the CSP and must be considered by educators and clinicians to insure that the

practice of psychotherapy is able to meet the demands of the evolving health care system.

SUMMARY

If the health care system continues to move in the same direction, evidence-based clinical practice will become essential. As noted above, in attempting to contain costs while still maintaining effective patient care, managed care organizations will become increasingly interested in clinicians who are trained in brief psychotherapies with documented efficacy. In addition, several managed care companies have begun to review the treatment outcome literature and are endorsing intervention "treatment guidelines" for various disorders (e.g., depression, panic disorder) and are in the process of developing methodology to track practitioner adherence to recommended treatment procedures.

Recognizing the importance of the evidence-based treatment movement in health care, especially as it pertains to psychotherapy, the Society of Clinical Psychology established a task force to identify, promote, and assist in the dissemination of ESTs. In addition to continuing to develop ESTs, the next challenge for clinical psychology appears to be in training clinicians in these approaches to ensure that the treatments are available to the public so that psychotherapy remains a viable treatment in the new health care environment.

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