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The CPA Presidential Task Force on Evidence-Based Practice of Psychological Treatments

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In 2011, the Board of Directors of the Canadian Psychological Association (CPA) launched the Task Force on Evidence-Based Practice of Psychological Treatments to support and guide practice as well as to inform stakeholders. This article describes the work of this task force, outlining its *raison d'être*, providing a comprehensive definition of evidence-based practice (EBP), and advancing a hierarchy of evidence that is respectful of diverse research methodologies, palatable to different groups, and yet comprehensive and compelling. The primary objective was to present an overarching methodology or approach to thinking about EBP so that psychologists can provide and implement the best possible psychological treatments. To this end, our intention for this document was to provide a set of guidelines and standards that will foster interest, encourage development, and promote effectiveness in EBP.

Keywords: evidence-based practice, evidence-based treatment, empirically supported treatment, psychotherapy, psychological treatment

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As part of the 2011–2012 Canadian Psychological Association (CPA) President's mandate (see Dozois, 2012, 2013), the Board of Directors voted in favor of a motion (March 2011) that the CPA establish a task force on the evidence-based practice (EBP) of psychological treatments that would generate a set of criteria and develop a position statement regarding the optimal integration of research evidence into practice. The board members believed that it was important for the CPA to develop a position on EBP in psychology to support and guide practice as well as to inform stakeholders. Psychological health and psychological disorders are clearly a priority for many of Canada's stakeholder groups (e.g., the Mental Health Commission of Canada, Treasury Board, Public Health Agency of Canada), and effective psychological treatment is also an important priority for CPA.

Background

Important objectives in professional psychology include the generation of treatment-relevant scientific knowledge and the application of this knowledge to the development of efficacious and effective interventions for mental and behavioral health problems (Baker, McFall, & Shoham, 2009; Kazdin, 2008; Lilienfeld, 2010; Treat, Bootzin, & Baker, 2012). Such objectives arise from a growing recognition in the field that the practice of psychological treatments should be based on valid evidence regarding which approaches to intervention are most likely to be successful. Although there is controversy regarding what constitutes "evidence," most psychologists believe in the utility of research for informing clinical practice and view EBP positively (Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2013).

In 1995, the American Psychological Association's (APA) Society of Clinical Psychology Task Force on Promotion and Dissemination of Psychological Procedures published its initial report, which listed treatments considered to be well-established or probably efficacious according to a standard set of criteria (e.g., Chambless & Ollendick, 2001; Chambless et al., 1996). These criteria were subsequently adopted by the CPA Section on Clinical Psychology in their task force report, *Empirically Supported Treatments in Psychology: Implications for Canadian Professional Psychology* (Hunsley, Dobson, Johnston, & Mikail, 1999a, 1999b).

Although many researchers and practitioners were enthusiastic about these efforts to promote empirically supported treatments, the criteria used to designate such treatments elicited considerable controversy. Concerns with the focus on empirically supported treatments have done little to narrow the gap between research and practice and to alter many clinicians' utilization of scientific literature (see Hunsley, 2007a; Kazdin, 2008; Lilienfeld et al., 2013, for reviews of some of the challenges and solutions). For example, some psychologists have argued that the type of research deemed necessary to produce supportive evidence for a treatment is incompatible with schools of psychotherapy outside of the cognitive behavioral therapy (CBT) framework (e.g., Bryceland & Stam, 2005; see Stuart & Lilienfeld, 2007). Although randomized clinical trials (RCTs) are considered the "gold standard" for psychotherapy outcome research, there are widespread concerns that the generalizability of their findings to actual clinical practice is limited. However, there is growing evidence that these concerns are exaggerated or overstated (Hunsley, 2007a; Hunsley & Lee, 2007; Lee, Horvath, & Hunsley, 2013; Teachman et al., 2012). Others have criticized the preponderance of CBT treatments that, for lack of a better term, "made the list" of empirically supported treatments (e.g., Westen & Morrison, 2001). Still others contended that manualized treatments fail to address the complexities of clinical practice (see Duncan & Reese, 2013, for review). Treatment manuals are often unfortunately misrepresented as step-by-step, mechanistic protocols for the delivery of therapy. However, treatment manuals are usually written in such a way that the spirit of the therapeutic approach and the specific treatment procedures are outlined. As such, treatment manuals help therapists to deliver EBP in a consistent and reliable way while also adjusting to the complexity of the individual patient.

More recently, the APA established a task-force on EBP in psychology that attempted to acknowledge multiple types of research evidence in evaluating treatment effects. The report of this task force was adopted as APA policy with the explicit statement that, "Evidence-based practice in psychology is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273; also see Spring, 2007). This policy moves beyond a simple listing of treatments with empirical support to consider other important variables that have been shown to influence clinical outcomes. The APA task force unfortunately did not operationalize what constitutes "evidence" in this policy; rather, it "identified a continuum of data sources available to clinicians, from uncorroborated clinical observations through meta-analyses of the results of RCTs" (Stuart & Lilienfeld, 2007, p. 615; also see Gaudiano & Miller, 2013). The task force report also said little about the need for ongoing idiographic evaluation of clinical services to guide treatment decisions after the initiation of services.

Although there are various definitions of "evidence" and understandable reactance to certain types of research designs being elevated above others, rigorous controlled research is necessary to evaluate the effect of our interventions (Dozois, 2013; Kazdin, 2008; Lilienfeld, 2010). As such, current debate in the literature focuses not so much on whether it is necessary to use research findings but on how research findings should be incorporated into clinical interventions.

It is also important to point out that EBP is a process by which the best evidence available is used to make optimal clinical decisions (see Hunsley, 2007a). Although some psychologists mistakenly equate EBP with empirically supported therapies, the two are not synonymous. In fact, there are many ways to provide evidence-based treatment (e.g., by focusing on effectiveness trials and naturalistic studies or by emphasizing evidence-based procedures and principles of practice). Clinical practice should be evidence-informed, but it does not need to be narrowly evidence-driven (Bohart, 2005). Likewise, research should be informed by practice to ensure that the discipline and profession are providing evidence for treatments that respond to the kinds of problems that clients bring to psychology practitioners.

The Work of the CPA Task Force

The CPA Task Force on Evidence-Based Practice of Psychological Treatments was co-chaired by Drs. David J. A. Dozois and Sam Mikail. The task force was populated during the summer and began its work in September 2011. Task force members (11 in

total) were chosen by the co-chairs of the task force and approved by the CPA Board of Directors. The intention was to choose individuals who would represent various research, practice, knowledge-translation, consumer, and community perspectives. There was also good representation from different theoretical orientations, including behavioral, cognitive-behavioral, emotion-focused, interpersonal, and psychodynamic perspectives. The task force members met a total of 12 times from September 2011 to November 2012 (11 teleconferences and 1 face-to-face meeting). Considerable work was also conducted via e-mail correspondence, the use of Dropbox™ (to download documents and articles pertaining to EBP), and in various subcommittees.

The task force produced an initial draft document that operationalized what constitutes EBP of psychological treatment (a definition of evidence and a hierarchy of available evidence). In terms of defining what is meant by "evidence," the members of the task force were interested in a definition that was comprehensive enough to incorporate the following ideas: (a) research evidence is central; (b) psychologists should be evidence-based not only in their general fund of knowledge but also in session-by-session work; and (c) the process of evidence-based treatments is one of collaboration with a client/patient (rather than a top-down process). The next step involved establishing a hierarchy of evidence that was sound, unbiased (e.g., respectful of diverse research methodologies), and based on the best available knowledge.

At this point, the task force was interested in obtaining feedback on these core elements before completing its next steps. The consultation process involved an online survey that was open to all CPA members and was advertised through listserves (e.g., CPA News) and in *Psynopsis* (Canada's psychology magazine). The online survey was open for a period of 2 months and was completed on April 15, 2012. Input on the initial document was sought specifically from CPA members who practiced or had an interest in psychological treatments. Various organizations (e.g., Association of Canadian Psychology Regulatory Organisation [ACPRO], Canadian Council of Professional Psychology Programs [CCPPP], and Canadian Register of Health Service Psychologists [CRHSP]) were also contacted for their feedback. The chairs of the following CPA sections were also asked to respond to the consultation document: Aboriginal, Addictions, Clinical, Clinical Neuropsychology, Counseling, Criminal Justice, Family, Health, Psychoanalytic, Psychologists in Education, Rural and Northern, Sport and Exercise, and Traumatic Stress. In general, the task force's statements were very well received by respondents: Most respondents were enthusiastic and positive about the definition and levels of evidence. The task force members considered the feedback carefully during subsequent teleconferences, and a revised version of the evidence statement and hierarchy was then generated.

Brief vignettes that illustrated the process of EBP were then solicited from members of the task force and chairs of relevant CPA sections. Individual experts were also invited to contribute an extended vignette that outlined the process of being evidence-based in one's practice within a particular therapeutic approach. Task force members also developed a brochure oriented toward the public, highlighting the importance of EBP and the value of psychological interventions. A list of resources to help professional psychologists locate reliable and up-to-date information regarding EBP was also compiled. Finally, a set of recommendations was created to further advance the EBP of psychological treatments.

The full task force report is available on the CPA website (see www.cpa.ca/aboutcpa/committees/cpataskforces). Below, we briefly describe each of the aforementioned components. Although an important contribution in and of itself, the task force report is also intended to serve as a springboard for further development and dissemination. We hope that this will be a "living" document that will continue to be used, updated, resourced, and promoted by the CPA Board and Head Office staff, CPA sections, practitioners, and scientists.

EBP of Psychological Treatments: A Definition

EBP of psychological treatments involves the conscientious, explicit, and judicious use of the best available research evidence to inform each stage of clinical decision-making and service delivery. This requires that psychologists apply their knowledge of the best available research in the context of specific client characteristics, cultural backgrounds, and treatment preferences.

Consistent with ethical codes and professional standards, EBP entails the monitoring and evaluation of services provided to clients throughout treatment (from initial intake to treatment termination and maintenance of gains). Evidence-based psychological practice also pertains to one's own professional development. This requires a commitment to continually inform and/or be informed by research evidence so as to identify and select interventions and treatment strategies that maximize the chance of benefit, minimize the risk of harm, and deliver the most cost-effective treatment.

EBP relies, first and foremost, on research findings published in the peer-reviewed scientific literature including, at a minimum, treatment process and treatment outcome research.[1] All research methodologies have the potential to provide relevant evidence, but in examining the scientific literature preference should always be given to studies that are based on research methodologies that, as much as possible, control threats to the validity of the research findings. Consistent with their academic training, psychologists are expected to thoughtfully evaluate the peer-reviewed scientific literature, recognizing the applied value and the limitations of current knowledge. Several avenues are available for psychologists to maintain their knowledge of the relevant scientific literature, including reliance on methodologically sound primary studies, systematic reviews, and clinical practice guidelines.

Respect for the dignity of persons is imperative in EBP. Psychologists work in collaboration with their clients in developing and implementing their services. Psychologists have knowledge of the research literature, which forms the basis for developing treatment options that may be indicated for a client with particular characteristics. Clients have valued lived experiences, including previous symptoms or treatment experiences, preferences, and

[1] To improve psychotherapy outcome, it is important to gain a clearer understanding of how therapy works or what may account for its failure to work (Castonguay, 2013; Kazdin, 2008). Treatment process research moves beyond the question of whether psychotherapy leads to meaningful change and focuses on identifying the dimensions and mechanisms of treatment most strongly associated with positive and negative outcome. A sampling of this literature can be found in the 2013, 50th anniversary issue of the journal *Psychotherapy* (Vol. 50).

motivation. Communication and collaboration between the psychologist and the client is crucial to the process of achieving informed consent and reflects best practice that is based on current evidence.

Sources and Levels of Evidence

EBP relies on diverse sources and levels of evidence. First and foremost, this evidence includes research findings published in the peer-reviewed scientific literature. For psychological practice, the evidence to be considered in recommending or providing a treatment should be derived from sources such as treatment outcome research, treatment process research, and basic and applied psychological research that can inform clinical practice (see Figure 1). After the initiation of treatment, data should be obtained from the ongoing monitoring of clients' reactions, symptoms, and functioning, and these data should inform decisions about treatment planning, modification, completion, and discontinuation.

To determine the strength and relevance of research findings to their practice, psychologists should consider the hierarchy of evidence available for the treatment options under consideration (see Figure 2). Although all research methodologies have some potential to provide relevant evidence, psychologists should first consider findings that are replicated across studies and that have used methodologies that address threats to the validity of obtained results (e.g., internal validity, external validity, generalizability, transferability). Thus, psychologists should consider the best available evidence highest on the hierarchy of research evidence. Evidence lower on the hierarchy should be considered only to the extent that better research evidence does not exist or if there are clear factors that mitigate against using the best evidence.

Properly designed systematic knowledge syntheses are at the top of the hierarchy because these are based on the results of multiple investigations. Systematic knowledge syntheses can include a range of methodologies, including systematic reviews, meta-analyses, metasyntheses, realist syntheses, and practice guidelines that systematically synthesize evidence. When systematic knowledge syntheses are not available, psychologists should refer to primary research studies that are based on methodologies that address threats to the value of the research findings. For example, in quantitative research, RCTs can provide evidence with strong internal validity; in treatment research, these studies are typically known as efficacy studies. However, it is also important for psychologists to consider the external validity of research findings and to consider the results of studies designed to have high external validity (i.e., generalizability); in treatment research, these studies are often referred to as effectiveness studies. Ideally, psychologists should consider studies that have high internal validity and studies that have high external validity.

Figure 1. Sources of evidence that inform clinical practice.

There is likely to be process and outcome research relevant for many of the treatments provided by psychologists, and psychologists are expected to keep current with respect to new developments in the field. In those cases in which there may be little or no relevant treatment research, practice guidelines may be available that are based on a consensus among experts and have been determined by formalized methods. In addition, other options may be considered, although none of them are truly evidence-based. Such options are at the lowest level of the evidence hierarchy and include unpublished practice-based data, prior clinical experience, and professional opinions not based on published research.

Regardless of the nature or strength of the evidence used to inform treatment selection and planning, psychologists should be prepared to alter the treatment being provided on the basis of data from ongoing treatment monitoring (including in-session and between-session client reactions and changes in symptoms and functioning). This will frequently involve adjusting the content, sequencing, timing, or pacing of treatment elements. In some instances, this might lead to a decision, made in collaboration with the client, to discontinue the treatment and make a referral to another treatment provider. In such situations, psychologists should reconsider the relevant hierarchy of evidence to determine alternative options that might be appropriate for the client.

Vignette Examples

The task force believed that the relevance and usability of the report would be enhanced considerably by the inclusion of clinical vignettes that illustrate the use of the hierarchy in actual clinical practice. Vignettes are commonly used in clinical and academic materials; they are effective teaching tools because they provide relevant, accessible, and interesting examples to consider and reflect upon (Pettifor, McCarron, Schoepp, Stark, & Stewart, 2010).

Task force members, chairs of relevant CPA sections, and other psychologists were invited to submit brief vignettes of composite cases describing various aspects of the use of EBP and the application of the hierarchy. The primary objective of the brief vignettes was to illustrate the process of evidence-based decision-making and practice. Our intention was not to be exhaustive but rather to provide several short examples that reflect actual clinical decision-making and the process of applying EBP in psychological treatment.

We also solicited more extended vignettes from various experts in the field. As noted earlier, clinicians are expected to practice in an evidence-based manner and have an ethical and professional responsibility to provide the best treatment for a particular client on the basis of the research evidence available. As such, clinicians should use the hierarchy of research evidence to determine which approach to treatment is optimal (and to revisit this hierarchy when necessary). These extended vignettes were intended to demonstrate evidence-based thinking once the initial treatment decision-

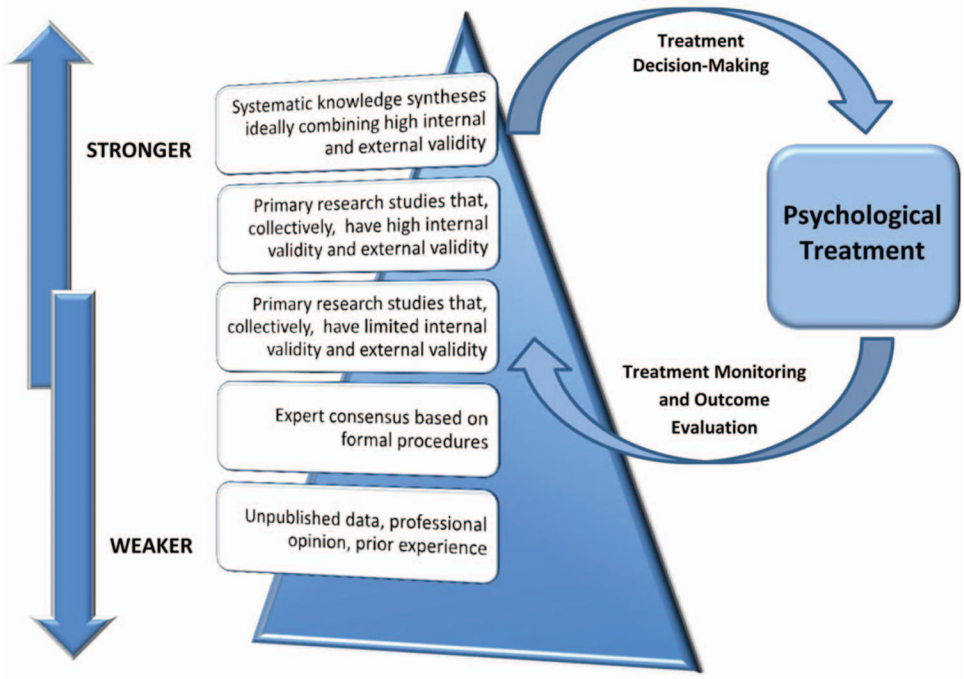

Figure 2. The hierarchy of research evidence related to clinical practice.

making process had taken place. Their purpose was to illustrate the process of being evidence-based in one's assessment, conceptualization, therapeutic planning, and treatment implementation.

Various therapeutic approaches are efficacious for unipolar depression and dysthymia (Australian Psychological Society, 2010; Beck & Dozois, 2011; Goldman, Greenberg, & Angus, 2006; Hollon, Thase, & Markowitz, 2002; Hunsley, Elliott, & Therrien, 2013; Leichsenring & Leibing, 2007). Using the same basic case example of depression, three extended vignettes focused on evidence-based assessment; case formulation; treatment planning; and implementation from cognitive therapy, emotion-focused therapy, and brief psychodynamic psychotherapy approaches. A separate case was used to illustrate evidence-based reasoning from an interpersonal psychotherapy perspective. Research findings published in the peer-reviewed scientific literature, including treatment outcome research, therapy process research, and basic research that can be applied to clinical practice, were highlighted to demonstrate the process of EBP and the thoughtful evaluation of the peer-reviewed scientific literature. The inclusion of different treatment protocols in response to the same basic clinical presentation was meant to underscore the reality that in some instances, the literature supports the efficacy of several treatment approaches. In such cases, what is important is that the best available evidence guides clinicians' decisions along with their existing skill base and consideration of the treatment approach that best matches a given client's preferences and/or disposition.

Recommendations to the CPA Board of Directors

The final component of the task force report involved a series of specific recommendations for the CPA Board of Directors to help ensure that this document exhibited clinical utility and demonstrated longevity. The task force members discussed the implications and scope of the report and made specific recommendations to the CPA Board of Directors relating to ethical principles, accreditation standards, dissemination, and continuing education. These recommendations are reviewed briefly below.

Canadian Code of Ethics

The Values Statement accompanying Principle I of the Canadian Code of Ethics (Respect for the Dignity of Persons) states

> Rights to privacy, self-determination, personal liberty, and natural justice are of particular importance to psychologists, and they have a responsibility to protect and promote these rights in all of their activities. As such, psychologists have a responsibility to develop and follow procedures for informed consent, confidentiality, fair treatment, and due process that are consistent with those rights (Canadian Psychological Association, 2000, p. 8).

Contained within Value I are several standards addressing the issue of informed consent. The EBP task force recommended that Standard I.17 be expanded to read

> I.17 Recognise that informed consent is the result of a process of reaching an agreement to work collaboratively, rather than of simply having a consent form signed. *This includes ensuring those receiving services from psychologists are apprised of available evidence-based treatment options and the psychologists' ability to provide those services effectively and efficiently"* (Canadian Psychological Association, 2000, p. 10).

The Values Statement accompanying Principle II of the Canadian Code of Ethics (i.e., Responsible Caring) states "A basic ethical expectation of any discipline is that its activities will

benefit members of society . . . Therefore, psychologists demonstrate an active concern for the welfare of any individual, family, group, or community with whom they relate in their role as psychologists" (Canadian Psychological Association, 2000, p. 15). The statement underscores the importance of developing and using methods that will maximize benefit while minimizing potential harm to recipients of psychological services. Implied in this statement is the centrality of relying on empirical evidence to guide case formulation, treatment planning, and clinical intervention.

The EBP task force concluded that this section of the Canadian Code of Ethics would be strengthened by the addition of a direct statement recommending that ethical psychological practice is guided by empirical evidence and use of the evidence hierarchy:

> II.21 Strive to provide and/or obtain the best possible service for those needing and seeking psychological service. This may include, but is not limited to, selecting interventions that are relevant to the needs and characteristics of the client *that are evidence-based and guided by the evidence hierarchy*, and that have reasonable theoretical or empirically supported efficacy in light of those needs and characteristics (Canadian Psychological Association, 2000, pp. 17–18; proposed changes presented in italics).

Accreditation Standards

The Accreditation Standards for Doctoral and Internship Programs in Professional Psychology (Canadian Psychological Association, 2011) stipulate that "Training in the practice of psychology includes a range of assessment and intervention procedures and is not restricted to a single type. Although programmes may emphasise different theoretical models and skills, students need to become familiar with the diversity of major assessment and intervention techniques in common use and their theoretical bases. Programmes must include training in evidence-based interventions as well as training in more than one therapeutic modality" (p. 21). This standard serves as an essential foundation for EBP for developing professional psychologists. The EBP task force recommended that the accreditation panel consider expanding this standard to include instruction and training in evidence-based decision-making that is guided by use of the evidence hierarchy.

Dissemination of EBP Methods

The EBP task force recommended that the Education Directorate, Practice Directorate, and Science Directorate of CPA take steps to disseminate the findings and conclusions of the EBP task force and look for opportunities to sponsor or provide continuing education workshops, seminars, and symposia to psychologists in EBP and EBP decision-making. The annual convention of the CPA and annual meetings of provincial and territorial psychological associations and societies can serve as vehicles for these sessions. For example, in June 2013, a workshop was presented that highlighted the task force's recommendations, outlined the application of the hierarchy to everyday practice, and reviewed some online search strategies (Dozois, Mikail, Hunsley, & Bieling, 2013; cf., Falzon, Davidson, & Bruns, 2010). Unfortunately, most psychologists are familiar with only a couple of search tools (typically PsycINFO® and Medline®). For instance, Berke, Rozell, Hogan, Norcross, and Karpiak (2011) surveyed 549 psychologists about their knowledge of various online resources. Although most respondents were familiar with PsycINFO and Medline (67% and 62%, respectively), other databases were less well known (e.g., only 25% knew about the Cochrane Database of Systematic Reviews and merely 18% were familiar with the National Institute for Health Care Excellence). These findings underscore the importance of working toward providing opportunities for training in search strategies relevant to the EBP hierarchy.

Dissemination to the general public and other professional audiences should also be considered. The task force recommended that the "Getting the Best Psychological Help" guide (embedded in the task force report) be distributed widely for display in offices of other health-care providers (e.g., general practitioners and specialists, chiropractors, hospital waiting areas, and various consumer-based groups such as the Canadian Cancer Association). The task force also recommended that this guide for individuals with lived experience be posted on the CPA Psychology Works web page. Developing different iterations of this guide to target specific segments of the community (youth, various ethnic and cultural groups) would also be a valuable service to the public. The guide that is presented in the task force report is intended to help individuals to seek out treatment that is based on the best available research and clinical evidence (see http://www.cpa.ca/aboutcpa/committees/cpataskforces). Information is provided on what effective psychological treatment entails, why EBP is important, how to determine if a psychologist practices in an evidence-based manner, and why the monitoring of treatment outcome is important.

Graduate Training and Continuing Education

Standard II.9 of the Canadian Code of Ethics states that psychologists "[k]eep themselves up-to-date with a broad range of relevant knowledge, research methods, and techniques, and their impact on persons and society, through the reading of relevant literature, peer consultation, and continuing education activities, in order that their services or research activities and conclusions will benefit and not harm others" (Canadian Psychological Association, 2000, p. 16).

The EBP task force recommended that the CPA Sections offering or sponsoring continuing education activities at the annual convention, or as stand-alone workshops, ensure that these offerings reflect EBP and EBP decision-making. Although not explicitly recommended in the task force report, we hope that graduate programs in clinical psychology will also use this document to engage students in discussion of EBP. Although students will benefit from training in specific empirically supported treatments, limiting the curriculum to this alone is insufficient. We also need to train psychologists in EBP (Babione, 2010; Bauer, 2007; Hershenberg, Drabick & Vivian, 2012; Hunsley, 2007b; Lee, 2007; Leffler, Jackson, West, McCarty, & Atkins, 2013). Students need to learn how to think critically, respect and understand scientific knowledge and empirical methodologies, and integrate this information to make scientifically informed clinical decisions within the context of a patient's needs and background. In this way, our students will be better positioned to think in an evidence-based manner and fully integrate new research into their practices.

Conclusion

The overriding objective of the CPA Task Force on Evidence-Based Practice of Psychological Treatments was to produce a report and a set of recommendations that would respond to the needs of professional psychologists and individuals who are in need of psychological treatment. Below we list, in bulleted form, the executive summary of the task force report. We hope that readers will take time to go through the full task force report and consider the spirit of EBP, the necessity of rigorous scientific data, and the importance of keeping up to date.

Summary Points

- Evidence for recommending or providing treatment should stem from treatment outcome research, treatment process research, and basic psychological research.
- Before providing treatment, psychologists should first consider the hierarchy of evidence available for the treatment options under consideration.
- Psychologists should use the best available evidence (evidence which is highest on the hierarchy) that includes findings that are replicated across studies and that have used methodologies that address threats to validity (e.g., RCTs to address threats to internal validity, naturalistic studies to address threats to external validity).
- Psychologists should frequently and systematically monitor clients' reactions, symptoms, and functioning during treatment.
- Psychologists should be prepared to alter the treatment on the basis of data from ongoing treatment monitoring, discussions with the client, and reconsideration of the relevant hierarchy of evidence.

Résumé

En 2011, le conseil d'administration de la Société canadienne de psychologie (SCP) a créé un groupe de travail ayant pour tâche de préciser les traitements psychologiques basés sur des données probantes dans le but à la fois d'appuyer et de guider les praticiens et d'informer les parties prenantes. Cet article décrit les travaux de ce groupe, présente sa raison d'être, fournit une définition complète de « pratique fondée sur des données probantes » ou « factuelle », et propose une hiérarchie des preuves qui est respectueuse des diverses méthodologies de recherche et acceptable pour différents groupes, tout en étant exhaustive et convaincante. L'objectif primaire était de présenter une méthodologie ou une démarche globale pour la réflexion sur la pratique fondée sur des données probantes de façon que les psychologues puissent offrir et mettre en application les meilleurs traitements possibles. À cette fin, notre intention, par ce document, était de fournir un ensemble de lignes directrices et de normes qui favoriseront à la fois l'intérêt à l'égard de la pratique fondée sur des données probantes, son efficacité et son développement.

Mots-clés : pratique basée sur des données probantes, traitement basé sur des données probantes, traitement fondé sur des données empiriques, psychothérapie, traitement psychologique.

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