APA GUIDELINES on Evidence-Based Psychological Practice in Health Care

WORKGROUP OF THE COMMITTEE ON PROFESSIONAL PRACTICE AND STANDARDS (COPPS) AND THE BOARD OF PROFESSIONAL AFFAIRS (BPA)

APPROVED BY APA COUNCIL OF REPRESENTATIVES
FEBRUARY 2021

AMERICAN PSYCHOLOGICAL ASSOCIATION

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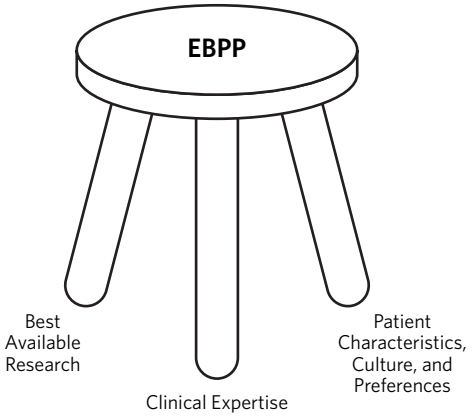
INTRODUCTION

Since its inception at the end of the 19th century, applied psychology has sought to harness science for practical purposes, including the provision of clinical services within health care. Over the course of the 20th and early 21st centuries, the field deepened its commitment to evidence-based practice through endorsement of training models that integrate science and practice and proliferation of research on psychological treatments. At the turn of the 21st century, the concept of "evidence-based medicine" began to take hold in public policy discussions, prompting the American Psychological Association (APA) to develop a policy statement on Evidence-Based Practice in Psychology (EBPP). APA policy calls for "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA, 2006a, p. 273). This tripartite model, illustrated in Figure 1, explicitly defines EBPP as the intersection of high-quality research, clinical expertise, and patients' characteristics, sociocultural backgrounds, and preferences.

Components of Evidence-Based Practice in Psychology (EBPP)

APA's EBPP policy clearly identifies each of the three components of the tripartite model. The current professional practice guidelines illustrate *how* psychologists can apply these components to professional practice in health care. They provide a framework for integrating research evidence with clinical skill and patient identities and preferences. These guidelines seek to clarify and extend APA's EBPP policy by articulating practical considerations and providing illustrative examples of evidence-based psychological practice in health care.

Figure 1. Components of Evidence-Based Practice in Psychology (EBPP)



Need for Guidelines

Professional practice guidelines offer psychologists guidance on roles, patient populations, or practice settings based on current research and professional consensus (APA, 2015c). They differ from clinical practice guidelines, which make recommendations for the treatment of specific disorders or conditions based primarily on systematic reviews that summarize research evidence of treatment efficacy. The current professional practice guidelines were developed in recognition that clinical practice guidelines emphasize research, particularly treatment efficacy, with relatively little guidance regarding either clinical expertise or patient characteristics, culture, and preferences. Thus, there is a need to discuss the roles of both of these factors in evidence-based psychological practice in health care.

Moreover, a more complete delineation of EBPP can provide a useful foundation from which to begin to explore questions related to the treatment of specific disorders or conditions (e.g., see Henriques, 2018). A foundational approach to psychological treatment makes sense because treatment extends beyond any particular theory, orientation, method, set of techniques, diagnosis, or health condition and takes place within a larger intervention process. Though the intervention process does not have to proceed in a particular sequence, it often includes some or all of the following elements: conducting a psychological assessment; developing a treatment plan; cultivating and maintaining an effective therapeutic relationship; tailoring psychological services to patient characteristics, culture, and preferences; assessing patient progress and outcomes over time; and modifying the clinical approach when it does not produce the desired outcomes.

It is important to define the scope of EBPP and to distinguish it from empirically supported treatments (ESTs). EBPP is more comprehensive and encompasses a broad range of clinical activities including psychological assessment, diagnosis, case formulation, prevention, treatment, psychotherapy, and consultation. It involves a decision-making process for integrating research, clinical expertise, and patient characteristics, culture, and preferences to achieve the best outcome for the patient. In contrast, ESTs are specific treatment methods found to be efficacious for certain conditions or problems under specified circumstances in controlled clinical trials. Given this distinction between EBPP and ESTs in addition to the differences between professional practice guidelines and clinical practice guidelines, endorsement of specific treatment methods is not the aim of the current professional practice guidelines. A wide range of treatment methods and principles of change are consistent with EBPP.

Purpose of Guidelines

The term *guideline* in this document refers to statements that suggest or recommend specific professional behaviors, activities, endeavors, approaches, or conduct for psychologists. Guidelines differ from standards in that the latter are mandatory and may be accompanied by an enforcement mechanism whereas the former are purely aspirational in intent and implementation. Guidelines aim to facilitate the systematic development of the profession and promote a high level of professional practice by psychologists. They are not intended to change, limit, or define the scope of practice for any group of psychologists. "Guidelines are not intended to be ... exhaustive and may not be applicable to every professional and clinical situation. They are not definitive and they are not intended to take precedence over the judgment of psychologists" (APA, 2002b, p. 1048). In other words, guidelines serve an educative function for psychologists and health care professionals, not a regulatory function (APA, 2015c). They are not intended to create a requirement for practice or to be used by third parties to limit coverage for reimbursement.

These guidelines are informed by APA standards and positions and are consistent with the Ethical Principles of Psychologists and Code of Conduct (APA, 2016), the Resolution on Psychotherapy Effectiveness (APA, 2012b), and the Guidance for Developers and Users of Professional Practice Guidelines (APA, 2015c). Existing guidelines about the provision of psychological services in particular settings such as health care delivery systems (APA, 2013) or for specific communities such as girls and women (APA, 2018b), boys and men (APA, 2018a), persons with diverse racial, ethnic, and other sociocultural backgrounds (APA, 2017; 2019b), people with low income and economic marginalization (APA, 2019a), individuals with disabilities (APA, 2011), lesbian, gay, and bisexual clients (APA, 2012a), transgender and gender nonconforming people (APA, 2015b), and older adults (APA, 2014b) are important resources for psychologists that complement and strengthen the current guidelines. When applicable, federal and state laws and regulations supersede this guidance.

Definitions

These guidelines encompass "all direct services rendered by health care psychologists, including assessment, diagnosis, prevention, treatment, psychotherapy, and consultation" (APA, 2006a, p. 273). Psychological intervention is broadly defined to include all of these services and should not be interpreted to imply any particular therapeutic technique, method, or orientation. This inclusive definition was originally set forth in APA's EBPP policy statement and is retained in the current guidelines. That said, APA's EBPP policy statement focuses primarily on treatment while acknowledging that the "same general principles apply to psychological assessment, which is essential to effective treatment" (APA, 2006a, p. 273). The current guidelines retain the same focus on psychological treatment within the context of health care.

Throughout these guidelines, the term 'patient' refers to the child, adolescent, adult, older adult, couple, family, or other individual or group receiving psychological services. The authors recognize that, in many instances, there are valid reasons for using alternative terms including client, consumer, individual, or person instead of 'patient' to describe the recipient of psychological services. 'Patient' was chosen in accordance with APA's 2018 resolution for the use of this term in policy and rules pertaining to health care services and settings (APA, 2018c). The authors also acknowledge the existence of community- and school-based intervention and prevention efforts with multi-tiered behavioral components that are evidence-based in design and to which aspects of these guidelines apply despite the fact that the term 'patient' is typically inappropriate in these settings.

Background

These guidelines were developed by an APA workgroup comprised of members from the Board of Professional Affairs (BPA) and the Committee on Professional Practice and Standards (COPPS). No group or individual contributed financial support for this project, and no member or sponsoring organization will derive financial benefit from the review, approval, or implementation of these guidelines. In an effort to be inclusive and comprehensive, the workgroup invited and incorporated feedback from a variety of subject matter experts. As is customary, the guidelines also underwent a 60-day public comment process, during which members of the public were invited to provide written comments. The workgroup made substantive changes to the guidelines to address this feedback.

The literature supporting these guidelines reflects a broad range of established psychological research, theory, and policy. References include primarily publications from the past 15 years, although older seminal studies are also referenced. The literature review, however, was not exhaustive nor was it the kind of systematic review that would be customary when developing clinical practice guidelines.

APA Guidelines on Evidence-Based Psychological Practice in Health Care

THE GUIDELINE STATEMENTS

Overview of the Guidelines

THE INTERVENTION PROCESS

- **Guideline 1:** Psychologists are mindful of the principles and importance of evidence-based practice.
- **Guideline 2:** Psychologists strive to maintain and enhance their knowledge of the research and scholarly literature applicable to their practice.
- **Guideline 3:** Psychologists endeavor to conduct assessments that are appropriate for the setting, purpose, and population.
- **Guideline 4:** Psychologists seek to participate in collaborative treatment planning with patients and others when appropriate.
- **Guideline 5:** Psychologists aim to cultivate and maintain effective therapeutic relationships, therapist characteristics, and change principles.
- **Guideline 6:** Psychologists endeavor to adapt their clinical approach to patient characteristics, culture, and preferences in ways that increase effectiveness.
- **Guideline 7:** Psychologists aim to monitor the treatment process and clinical outcomes routinely.
- **Guideline 8:** Psychologists seek to modify their clinical approach when appropriate and terminate treatment when the patient is no longer benefitting or when treatment goals have been met.

COLLABORATION AND WHOLE HEALTH

- **Guideline 9:** Psychologists endeavor to collaborate with other professionals when appropriate to facilitate effective care.
- **Guideline 10:** Psychologists strive to promote overall patient health, functioning, and well-being.

THE INTERVENTION PROCESS

GUIDELINE 1

Psychologists are mindful of the principles and importance of evidence-based practice.

Rationale

Professional psychology is deeply committed to EBPP in health care for several reasons. First, EBPP is grounded in reliable research evidence. This research evidence is not limited to therapeutic methods but extends to the entire treatment process including the therapeutic relationship, different facets of clinical expertise, and the patient's biopsychosocial characteristics, intersecting identities, and circumstances. Second, EBPP involves the development of effective therapist interpersonal skills that facilitate strong therapeutic relationships. Third, EBPP entails flexibly tailoring services to patient characteristics, culture, and preferences, which minimizes dropout and improves outcomes (Swift, Callahan, Cooper, & Parkin, 2018). Fourth, by virtue of training in both research and clinical practice, psychologists are among those uniquely qualified to delineate evidence-based practice. They have the necessary expertise to lead the expansion of evidence-based health care into the future. Fifth, psychologists' commitment to EBPP ensures that practice and training do not stagnate over time but rather continue to advance in accordance with the best available research, development of clinical expertise, and the field's growing understanding of how to adapt treatment to each patient. Sixth, EBPP has the potential to enhance public health by increasing societal access to effective care.

As psychologists strive to provide the most effective care, they have an important opportunity to identify and disseminate all of the active ingredients in evidence-based practice, enhance public health, influence mental health policies, and drive the field toward offering the best possible psychological services.

Application

APA policy on EBPP (2006a) calls for the integration of three factors in the delivery of psychological care: the best available research evidence, the expertise of the clinician, and patient characteristics, culture, and preferences.

Psychologists seek to consult research evidence of relevance to their practice. Relevant research evidence includes but is not limited to the literature on human development and functioning; personality; psychopathology; therapeutic treatments, relationships, and processes; preventive strategies; assessment; outcomes monitoring; ethical, legal, and cultural considerations; as well as professional practice guidelines and clinical practice guidelines. Understanding human development, functioning, and behavior change involves broad knowledge of a full range of biological, psychological, sociocultural, and developmental factors. Guideline 2 offers psychologists guidance about staying abreast of the research literature relevant to their practice areas, distinguishing between different types of evidence, and critically evaluating research findings.

Clinical expertise is defined as "competence attained by psychologists through education, training, and experience that results in effective practice" (APA, 2006a, p. 275). It entails a wide range of competencies including but not limited to interpretation and applica-tion of relevant research evidence; knowledge about theories, models, and effective practice in psychotherapy; critical thinking and integration of multiple streams of information; assess-ment; case formulation; clinical decision-making; treatment planning; development and maintenance of a therapeutic relationship; delivery of treatment and other clinical services; adaptation of psychological services to patients' characteristics, culture, and preferences; mon-itoring of patient progress and outcomes; modification of the clinical approach when needed; and consultation (Health Service Psychology Education Collaborative, 2013). Additionally, clinical expertise encompasses therapist characteristics such as empathy, positive regard, congruence, and attendance to one's own reactions to patients (Elliott, Bohart, Watson, & Murphy, 2018; Farber, Suzuki, & Lynch, 2018; Hayes, Gelso, Goldberg, & Kivlighan, 2018; Kolden, Wang, Austin, Chang, & Klein, 2018). These traits predict better patient outcomes in routine clinical practice. All human beings, including psychologists, are prone to errors stemming from various biases (e.g., confirmation bias, a tendency to favor information that confirms one's preexisting beliefs) and inappropriate use of heuristics (e.g., availability heuristic, a mental shortcut that favors information recalled most quickly). Clinical expertise therefore also requires attention to biases and heuristics that can adversely affect judgment, awareness of the bounds of one's knowledge, as well as openness to external sources of feedback. Regular consultation with colleagues and systematic collection of patient feedback can offer protection from the adverse effects of biases and heuristic shortcuts and contribute to improved patient outcomes. The different facets of clinical expertise are described in greater detail throughout many of the following guidelines.

Research suggests patients attain better outcomes when treatment is adapted to patients' preferences, sociocultural backgrounds, and other dimensions of individual differences (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009). Specifically, research supports adapting psychotherapy to patient race, ethnicity, religion, spirituality, preferences, reactance level, stage of change, and coping style (Norcross & Wampold, 2019). Guideline 6 provides guidance for adapting treatment to these patient characteristics. It also presents a clinical vignette to illustrate how treatment can be tailored to patient preferences.

GUIDELINE 2

Psychologists strive to maintain and enhance their knowledge of the research and scholarly literature applicable to their practice.

Rationale

Scientific progress is an ongoing process. As new research findings emerge, the depth and breadth of the scientific evidence base grow. To provide the best available care, psychologists endeavor to monitor the evolving research literature and achieve and

maintain familiarity with scientific sources of professional guidance. Psychologists also strive to evaluate the quality of research and relevance of findings to their particular practices and settings.

Application

Psychologists attempt to stay abreast of the research literature relevant to their practice areas. This literature includes a variety of topics related to the scientific understanding of human psychology, assessment procedures, therapeutic approaches, processes, and relationships, as well as analyses of ethical, legal, and cultural factors important in clinical practice. Psychologists develop professional knowledge, for example, by participating in continuing educational opportunities, attending state, regional, or national conferences, completing in-person, video-, or audio-based training, participating in peer consultation groups or journal clubs, researching online databases, engaging in independent reading, and delivering presentations and trainings. When developing professional knowledge, psychologists strive to deepen existing skill sets while also broadening exposure to other relevant topics. Participation in these types of learning and educational opportunities is consistent with the expectation that psychologists make ongoing efforts to maintain competence (2.03 Maintaining Competence; APA, 2016) and base practice on established scientific and professional knowledge (2.04 Bases for Scientific and Professional Judgments; see also 2.01e Boundaries of Competence; APA, 2016).

Psychologists also seek to familiarize themselves with current standards of practice by reviewing professional practice guidelines and clinical practice guidelines. As stated previously, professional practice guidelines provide psychologists guidance on roles, patient populations, or practice settings, whereas clinical practice guidelines systematically summarize the evidence base on the efficacy of treatments for specific health conditions. Though very useful for evaluating treatment efficacy, clinical practice guidelines do not address the entire range of symptoms, co-occurring conditions, populations, settings, and roles that psychologists are likely to encounter in practice. Thus, psychologists use clinical practice guidelines in conjunction with professional practice guidelines and other sources of relevant research to tailor services to the individual patient. For example, when initiating psychotherapy with a 68-year-old African-American male patient with depressive symptoms, the psychologist might consult clinical practice guidelines for recommendations about specific efficacious treatment methods for depression across age groups and may additionally refer to professional practice guidelines for information about psychological practice with men, older adults, and individuals from racial and ethnic minority groups to tailor treatment to the patient's intersecting identities.

Several professional groups offer evidence-based clinical practice guidelines and similar reviews of research evidence on treatment efficacy relevant to psychological practice within health care. These groups include the Emergency Care Research Institute (generally known as ECRI Institute), the National Institute for Health and Care Excellence, the Cochrane Collaboration, the Campbell Collaboration, the World Health Organization, the American Psychological Association, the American Psychiatric Association, and the International Society for Traumatic Stress Studies, among others. In addition, both the Society of Clinical Psychology (APA Division 12) and the Society of Clinical Child and Adolescent Psychology (APA Division 53) maintain resources that provide information about effective treatments for various psychological diagnoses.[1] Of note, some health care systems, third-party payers, professional associations, and other entities produce guidelines that may not align with current standards for developing practice guidelines. Psychologists endeavor to gauge the quality of the guideline development process before following guideline recommendations. Gauging the quality of practice guidelines facilitates clinical decision-making about whether, when, and how to follow the recommendations. When evaluating guideline quality, psychologists are encouraged to consult APA's "Criteria for Evaluating Treatment Guidelines" (APA, 2002a) and the Institute of Medicine's (2011) "Finding What Works in Health Care: Standards for Systematic Reviews." Important factors to consider are the type and amount of research evidence on which guidelines are based and the extent to which the evidence answers the questions posed and supports the conclusions reached.

When evaluating the research evidence, psychologists endeavor to pay attention to both efficacy (i.e., the strength of evidence for a causal effect) and clinical utility (i.e., generalizability, feasibility, and cost-benefit analysis; APA, 2002a). As such, psychologists recognize the value of various study designs including but not limited to systematic reviews and meta-analyses, randomized controlled trials (RCTs), cohort studies, case control studies, case series, single-case experimental designs, process-outcome studies, effectiveness research, ethnographic research, clinical observation, qualitative research, and mixed-methods research (APA, 2006a; Murad, Asi, Alsawas, & Alahdab, 2016). They appreciate that different designs are best suited to answering different questions.

Research designs vary in the specific practical implications they can offer. For example, RCTs control most effectively for threats to internal validity and are thus best suited for drawing causal inferences about treatment effects. However, RCTs often have specific selection criteria that may not generalize to patients typically seen in practice. Moreover, they generally study changes in diagnostic symptoms or status, even though patients frequently have additional idiographic symptoms and personal goals. Additionally, RCTs typically do not test the mechanisms hypothesized to underlie the treatment, meaning that the causal pathway for patient change remains unknown. Finally, RCTs generally examine treatments as a whole. As a result, RCT findings for multicomponent treatment methods do not identify the necessary and sufficient subcomponents. To provide additional examples of the utility of different research designs, effectiveness studies are well positioned to establish the ecological validity and portability of treatments in real-world practice settings, and qualitative

[1] https://www.div12.org/psychological-treatments
https://effectivechildtherapy.org

research lends itself to understanding the richness and complexities of lived experiences, personal goals and values, the meanings of psychological constructs, and the processes of therapy, but neither research design is capable of distinguishing causal effects.

Though treatments recommended by high-quality clinical practice guidelines warrant strong consideration in treatment planning, psychologists maintain awareness of the limitations of such guidelines. Specifically, clinical practice guidelines primarily include treatment methods that have been systematically studied with RCTs and generally do not include treatments that either do not lend themselves to this type of study or have not yet been evaluated in the literature. As a result, the absence of guideline endorsement does not imply the absence of efficacy. Therefore, treatments that do not appear in clinical practice guidelines but enjoy other research support may be reasonably considered in treatment planning. Moreover, research has identified not only efficacious treatment methods but also effective therapeutic relationships, therapist characteristics, change principles, and therapy adaptations to patient characteristics. Psychologists endeavor to familiarize themselves with this literature in addition to the research on evidence-based treatments so that they can offer a more holistic approach to therapy.

GUIDELINE 3

Psychologists endeavor to conduct assessments that are appropriate for the setting, purpose, and population.

Rationale

The overarching purposes of psychological assessment are to clarify patients' presenting concerns, gather information that contributes to case conceptualization and informs treatment planning, and identify patient characteristics, goals, and preferences that are relevant to the treatment process. Effective assessments also engage patients in their care.

Application

Assessment is often an ongoing process that occurs throughout treatment, from the initial intake through periodic progress monitoring to evaluation of final therapy outcomes. The specific sequence and components of assessment vary depending on the clinical setting, patient presentation, and assessment purposes. The initial assessment typically includes diagnosis of presenting problems and disorders, case conceptualization, and identification of patient strengths, characteristics, sociocultural contexts, and preferences. Before beginning the assessment, the psychologist informs the patient of confidentiality requirements, limits to confidentiality, as well as the purpose, format, and possible outcomes of the assessment. The psychologist endeavors to answer the patient's questions and, as appropriate, obtains informed consent before proceeding. When applicable, the psychologist also inquires about the patient's goals for the assessment (i.e., what the patient hopes to learn from the assessment) and takes steps to ensure that the assessment is responsive to those goals. Because assessment is often the first step in the psychological intervention process, it provides psychologists with an early opportunity to set the tone for a successful therapeutic relationship. Therefore, psychologists strive to adopt a collaborative approach to assessment and develop an effective working relationship with the patient. Psychological assessments that include collaborative and personalized feedback are associated with more positive treatment processes and better clinical outcomes (Poston & Hanson, 2010).

Psychologists endeavor to ground assessment practices in the best available research on psychological assessment, psychometrics, measurement, clinical judgment, psychopathology, personality, development, and patient biopsychosocial circumstances and characteristics that can influence assessment results. Structured clinical interviews and adherence to diagnostic criteria are associated with higher diagnostic reliability (Garb, 1998; Garb, Lilienfeld, & Fowler, 2016). Tests of personality and psychopathology can permit inferences about response consistency and validity, clarify complex diagnostic pictures, and aid with differential diagnosis. When assessments include tests, psychologists seek to select measures that are reliable, valid for the intended use, and appropriate for the assessment purpose, population, setting, and context in accordance with the ethical mandate for the appropriate use of assessment (9.02 Use of Assessments; APA, 2016). They strive to demonstrate knowledge of the psychometric properties, valid applications, and appropriate interpretations of the tests that they employ. When interpreting test findings, psychologists account for a range of possible sources of variability related to context, setting, purpose, and population (e.g., depression in children is often misconstrued as a lack of motivation whereas depression in older adults is sometimes mistaken for early-stage dementia; see 9.06 Interpreting Assessment Results; APA, 2016).

Psychologists endeavor to ask about patients' sociocultural backgrounds and preferences and how patients would like to incorporate those aspects of their lives into treatment. This information allows psychologists to tailor treatment to patient preferences, which can result in higher treatment retention and better outcomes (Swift, Callahan, Cooper, & Parkin, 2018; Swift, Callahan, & Vollmer, 2011). Psychologists are mindful of demographic and cultural biases that may affect assessment and diagnosis (e.g., the tendency to diagnose certain mental health conditions more readily in one gender). They strive to mitigate the adverse effects of these biases through careful attention to diagnostic criteria, use of semi-structured interviews and evidence-based personality tests as appropriate, and consideration of disconfirming as well as confirming evidence. Psychologists also seek to reduce vulnerability to demographic and cultural biases by interpreting assessment results within the context of the patient's developmental history and sociocultural background. They refrain from pathologizing behaviors that are normative for the patient's culture (e.g., distinguishing appropriate spiritual and religious expressions from psychopathological hallucinations and delusions) or developmental stage (e.g., distinguishing normative adolescent risk-taking from an externalizing disorder).

Psychologists aim to assess and account for comorbid conditions. Co-occurrence of two or more mental health conditions is very common (Hamdi & Iacono, 2014). Individuals with mental health disorders also experience higher rates of medical

disease and premature death from medical causes (Druss, Zhao, Von Esenwein, Morrato, & Marcus, 2011; Parks, Radke, & Mazade, 2008). Given the prevalence of co-morbid disorders, psychologists seek to assess for co-occurring conditions, develop familiarity with common comorbid presentations in the population they treat (including common physical health conditions), consult the relevant literature on comorbid conditions, and create treatment plans that account for these conditions. For example, a psychologist working with a patient who experiences depression and chronic pain would attempt to formulate a treatment plan that addresses the interrelations between the patient's pain, mood, and functioning. Thus, the treatment plan might include exploration of how pain fits into and influences the patient's self-perception, interpersonal dynamics, and sociocultural context, suggestions for pacing during efforts to activate behaviorally, discussion of realistic and relevant goals, and management of pain flares.

Psychologists attempt to adapt assessments to the patient, purpose, and setting. For example, psychologists who work with children and families often solicit parent and teacher perspectives, especially when information from collateral informants is necessary for accurate assessment and diagnosis. Moreover, crisis assessments that aim to ascertain imminent risk of harm will likely have a narrower scope and may focus more specifically on major risk factors compared to more extensive mental health assessments. Psychologists accepting same-day referrals in a fast-paced primary care setting may opt to conduct briefer and more goal-oriented assessments compared to psychologists taking psychotherapy referrals in an outpatient mental health setting. Likewise, psychologists working in schools, long-term care facilities, other residential places, organizations, correctional institutions, and other settings tailor assessments in ways that are appropriate for these specific settings.

At the end of the assessment process, psychologists strive to communicate impressions, findings, and recommendations to the patient using accessible and sensitive language, and they attempt to provide thoughtful answers to any questions the patient raises.

GUIDELINE 4

Psychologists seek to participate in collaborative treatment planning with patients and others when appropriate.

Rationale

Shared decision-making is the process through which the psychologist, the patient, and, when appropriate, others (such as family caregivers, health care team members, and teachers) jointly discuss treatment options to develop a treatment plan consistent with the patient's goals and needs. This process is also known as collaborative treatment planning. Treatment planning typically includes consideration of the relative benefits and risks of each treatment option as well as the possibility of no treatment, and it is documented as part of the informed consent process. Shared decision-making has the potential to lead to better decisions, increased patient engagement, reduced premature discontinuation, more coordinated care, and improved outcomes (Barry & Edgman-Levitan, 2012; Stacey et al. 2017; Tryon, Birch, & Verkuilen, 2018).

Application

Psychologists strive to engage patients and appropriate others in collaborative discussions about treatment. They typically begin treatment planning by ensuring that patients understand their rights and responsibilities related to treatment in accordance with the ethical mandate for informed consent (10.01 Informed Consent to Therapy; APA, 2016). At times, crisis stabilization or patient safety may compel psychologists to provide services in the absence of patient consent (e.g., older adults diagnosed with failure to thrive may be unresponsive to efforts to obtain consent; individuals with acute psychotic or manic symptoms may refuse medications required for stabilization). In these instances, psychologists attempt to involve relevant others in treatment decisions as appropriate and share important information and decisions with the patient to the extent possible. When stabilization and safety are attained, more collaborative discussions can occur.

Psychologists seek to share information about different treatment options with patients and appropriate others and, together, they agree on the process through which they will work together. For example, psychologists may describe available treatment methods, the efficacy of each method, and the associated risks and side effects. They also acknowledge when the efficacy of a particular treatment has not been adequately evaluated. When recommending a treatment, they strive to rely on the best available research, their clinical expertise, applicability of the treatment to the setting and patient characteristics, as well as patient values and preferences. They aim to avoid treatments that have been discredited or found harmful. Psychologists actively seek patients' input during treatment planning and listen to their perspectives. They frequently inquire about patients' goals for treatment and work towards agreement on how they will collaborate to achieve these goals. Psychologists aspire to respect their patients' autonomy and do not coerce them to participate in an unwanted or aversive treatment. In most cases, the patient makes the final treatment decision. Exceptions include situations involving potential harm to the patient or others, crises and threats to safety or stability, or lack of decisional capacity.

When research evidence is limited, psychologists attempt to proceed cautiously based on the best available research relevant to the clinical situation (e.g., evidence on similar clinical presentations, settings, contexts, cultural factors, patient preferences), their clinical expertise (e.g., including a careful assessment of the sources underlying the patient's presenting problems and integration of multiple streams of information about the clinical situation), consultation with knowledgeable colleagues, and patient input. Psychologists appreciate that no treatment is universally efficacious and that different patients may respond differently to any given treatment (Cohen & DeRubeis, 2018; DeRubeis et al., 2014). If a patient has a history of non-response to a given treatment, the psychologist attempts to understand why the prior treatment was not successful, tries to assess any current treatment barriers, and recommends the most suitable treatment course based on the information learned.

Apart from the treatment method, psychologists also seek to discuss the treat-

ment format, the therapeutic relationship, and therapy processes with patients during treatment planning. For example, they may discuss the advantages and disadvantages of involving the patient's support persons in treatment or consider the possibility of group psychotherapy. Psychologists are also encouraged to ask patients about the type of therapeutic relationship (e.g., empathic, collaborative) and therapist (e.g., directive, warm) they desire, as well as the activities they would like therapy to entail (e.g., psychoeducation, skill-building, insight development, emotional release).

Given that multiple factors inform clinical decision-making, psychologists document treatment discussions with patients and appropriate others including the rationale for why care proceeded in a given direction. Psychologists revisit the treatment plan periodically and document treatment plan updates. Documentation serves as a historical record for the psychologist and is informative for others if questions arise about the care provided.

GUIDELINE 5

Psychologists aim to cultivate and maintain effective therapeutic relationships, therapist characteristics, and change principles.

Rationale

Psychological treatment is provided in the context of a collaborative professional relationship. Compelling evidence shows that the quality of the therapeutic relationship is associated with treatment outcome (Norcross & Lambert, 2019). A large body of literature suggests that "nonspecific" factors, including the therapeutic relationship, therapist skills and traits, change principles, and patient characteristics, affect treatment outcome, independently of the specific therapeutic technique (e.g., transference interpretation, empty chair technique, cognitive restructuring, prolonged exposure; Cuijpers et al., 2012; Wampold & Imel, 2015). Also known as "common factors" because they are shared between different therapeutic orientations (e.g., psychodynamic, humanistic, cognitive-behavioral, interpersonal), these factors likely account for as much, if not more, outcome variance as the technique itself. For example, in the depression literature, a meta-analytic decomposition of overall patient improvement found that about half could be attributed to "common factors," a third to extra-therapeutic factors (e.g., factors associated with waiting-list and care-as-usual controls such as spontaneous remission, self-directed change, social support, and fortuitous occurrences), and only a sixth to specific factors associated with the therapeutic orientation such as the particular technique (Cuijpers et al., 2012). Psychologists are mindful that this is not a question of therapeutic relationship OR technique, but relationship AND technique, and that appropriate attention to each maximizes positive change. Thus, applying specific evidence-based techniques in the context of the therapeutic relationship appears to produce incremental benefits for the patient beyond the positive change attributed to "nonspecific factors" such as the therapeutic relationship.

Application

The therapeutic relationship powerfully predicts patient outcomes across treatment modalities (i.e., individual, couple, and family therapy), therapeutic orientations, treatment delivery mechanisms (i.e., Internet-based psychotherapy versus face-to-face psychotherapy), and patient age groups (Flückiger, Del Re, Wampold, & Horvath, 2018; Friedlander, Escudero, Welmers-van de Poll, & Heatherington, 2018; Karver, De Nadai, Monahan, & Shirk, 2018). This relationship is characterized by several interrelated facets including empathy (Elliott, Bohart, Watson, & Murphy, 2018), congruence (Kolden, Wang, Austin, Chang, & Klein, 2018), goal consensus and collaboration (Tryon, Birch, & Verkuilen, 2018), and rupture repairs (Eubanks, Muran, & Safran, 2018). Each of these facets is discussed in greater detail below.

Empathy has been conceptualized both as an intrapersonal therapist trait and an interpersonal and interactional relationship quality (Elliot, Bohart, Watson, & Murphy, 2018). Neuroscientific research points to three functional components of empathy: automatic affective sharing between the self and an other, self-other awareness including the ability to distinguish between self and other, and conscious perspective-taking and self-regulation including the capacity to inhibit one's own perspective while attending to someone else's (Eisenberg & Eggum, 2009). Therapy researchers differentiate among three modes of therapeutic empathy, including establishment of rapport, moment-to-moment attunement to the patient's communication, and understanding of the patient's current experiencing within the context of their personal history (Elliot, Bohart, Watson, & Murphy, 2018). In therapy, psychologists strive to develop empathic relationships by attuning to the impact of the patient's emerging feelings and impressions and continually adjusting their own understandings and assumptions. Empathic responses go beyond simple reflections of patient statements and include exploratory empathy (i.e., efforts to capture the patient's unspoken feelings, such as "This experience left you feeling hurt"), evocative empathy (i.e., bringing the patient's experience to life in session through rich, evocative language and imagery, such as "I can picture you running around frantically trying to put out fires everywhere"), and process empathy (i.e., attending to the patient's inner experience in the moment, such as "Your face lit up when you started talking about your new interest").

Like empathy, congruence has intrapersonal and interpersonal facets. The intrapersonal facet is characterized by genuineness, personal awareness, and authenticity, whereas the interpersonal facet includes the capacity to articulate one's experience to another person transparently (Kolden, Wang, Austin, Chang, & Klein, 2018). Psychologists aspire to build congruent therapeutic relationships by being open to joint experiencing with patients, owning their emotions and reactions, and being willing to reflect on their experiences aloud in therapy. Congruent responses may include targeted self-disclosure or articulation of one's own thoughts and feelings. Such responses are sincere and not intellectualized to the point of avoiding emotional realness. To maintain congruence over time, psychologists attempt to recognize moments of incongruence and then engage in self-reflection to facilitate a return to greater authenticity.

Psychologists encourage congruence in others by striving to create an environment in which patients are able to express themselves transparently (Kolden, Wang, Austin, Chang, & Klein, 2018).

Goal consensus refers to agreement between the therapist and patient on treatment directions and objectives. Psychologists seek to achieve goal consensus by identifying treatment goals in collaboration with patients and agreeing on the process through which they will work together to achieve these goals (Tryon, Birch, & Verkuilen, 2018; see Guideline 4 for a discussion of shared decision-making in treatment planning).

A rupture is a breach in the therapeutic relationship or alliance, which may involve a confrontation between the therapist and patient or the patient's withdrawal from therapy. Rupture repairs are associated with improved patient outcomes (Eubanks, Muran, & Safran, 2018). Psychologists seek to repair ruptures by attending to potential signs of a breach in the therapeutic alliance (e.g., patient expressions of annoyance or dissatisfaction with the therapist or the treatment; patient disengagement or withdrawal; therapist misstep or error) and endeavoring to address these issues in a non-defensive manner, as is discussed in greater detail in Guideline 8.

Apart from these components of the therapeutic relationship, therapists vary in certain traits and skills that are associated with patient outcomes in routine clinical practice. These therapist characteristics include empathy and congruence, as well as positive regard (Farber, Suzuki, & Lynch, 2018) and attunement to "countertransference" reactions, defined as therapist affective, cognitive, behavioral, and somatic reactions to their patients (Hayes, Gelso, Goldberg, & Kivlighan, 2018). Positive regard encompasses affirmation, non-possessive warmth, respect, support, acceptance, validation, and prizing. Therapists can convey positive regard for patients both verbally through choice of words and nonverbally through tone of voice, body language, and eye contact. Psychologists may attend to their own affective, cognitive, behavioral, and somatic reactions to patients in several ways. At times, a psychologist's reactions to a patient provide valuable information about the patient's personality and interpersonal dynamics. The psychologist can utilize this information to guide case conceptualization and the treatment plan. Alternatively, or additionally, psychologists' reactions can serve as an indicator of their own interpersonal processes and emotional well-being. In this case, attunement to their reactions can help psychologists cultivate self-awareness and recognize when to attend to their own health and well-being or seek consultation. When psychologists recognize that their reactions to a patient are based on their own personal dynamics, they may consider the potential value of sharing this realization with the patient (Hayes, Gelso, Goldberg, & Kivlighan, 2018).

Beyond the therapeutic relationship and therapist characteristics, several change principles cutting across different treatment methods are associated with better outcomes. They include promoting treatment credibility, cultivating patients' positive expectancies (i.e., their beliefs in the benefit of treatment) and self-efficacy (i.e., their beliefs in their own ability to make meaningful and lasting changes), and offering patients the opportunity to release emotion and have new, corrective experiences (Goldfried, 1980; Grencavage & Norcross, 1990; Weinberger, 2014). Translating these principles into practice involves providing patients with an informed, compelling, and individualized rationale for the proposed treatment and thoughtfully addressing questions and concerns to build their trust in the treatment approach (Constantino et al., 2018). Further, when working with patients who have low expectancies, therapists strive to adopt an affiliative and supportive attitude, as this stance is associated with better outcomes among these patients (Constantino et al., 2007). Psychologists also endeavor to display appropriate emotion in therapy and create a safe space for patients to express, process, and explore their own emotions (Peluso & Freund, 2018). Therapists thus strive to avoid criticism and inflexibility, both of which can inhibit patient emotional expression. Finally, psychologists seek to provide patients with opportunities for new learning and acquisition and practice of new behaviors.

Last, but certainly not least important, among the "common factors" are patient characteristics. These include positive expectancies, motivation for treatment, greater self-efficacy, and higher levels of functioning (Norcross & Lambert, 2019; Weinberger, 2014), all of which are associated with better treatment outcomes. Treatment outcomes also improve when psychologists adapt psychotherapy to patient race, ethnicity, religion, spirituality, reactance level, stage of change, coping style, and preferences (Norcross & Wampold, 2019). Guideline 6 offers guidance about how psychologists can effectively individualize treatment to these patient characteristics and preferences.

A rich literature has addressed how best to integrate these "common factors" with specific therapeutic techniques (Hofmann & Weinberger, 2007; Wampold & Imel, 2015; Wampold & Ulvenes, 2019; Weinberger, 2014). Based on this research, an effective approach to therapy cultivates patients' positive expectancies, fosters their self-efficacy, and provides them with opportunities to confront their problems and build mastery by applying the insights they gleaned or developing new skills, all within the context of a strong therapeutic relationship. Moreover, research on psychodynamic psychotherapy has found that certain dynamic techniques—namely, connecting current feelings to the past, identifying recurrent patterns in patients' experiences, and attending to similarities among patients' relationships over time, settings, or people—are most effective when the therapeutic relationship is strong (Owen & Hilsenroth, 2011).

Although attention to the therapeutic relationship, therapist skills and traits, change principles, and patient characteristics is always important, some of these factors may warrant special consideration with certain patient populations. For example, investment in the therapeutic relationship may be particularly critical in psychotherapy with individuals who have PTSD, other trauma-related disorders, attachment disorders, or personality disorders. These individuals often have difficulty trusting others (Zurbriggen, Gobin, & Kaehler, 2012), may have a history of invalidating interpersonal experiences, and might lack a foundation for secure attach-

ments (Wallin, 2007). As a result, psychologists strive to pay special attention to relationship dynamics when working with these populations and foster and maintain trusting therapeutic relationships. As another example, patients who are depressed are sometimes unduly pessimistic about the likelihood that they will respond to treatment. For this reason, the instillation of hope and cultivation of positive expectancies may be particularly important in work with individuals who experience depression (van Grieken et al., 2016).

GUIDELINE 6

Psychologists endeavor to adapt their clinical approach to patient characteristics, culture, and preferences in ways that increase effectiveness.

Rationale

APA policy on EBPP (2006a) affords special consideration to patient characteristics, culture, and preferences. APA's (2017) multicultural guidelines encourage psychologists to recognize that identity and self-definition are fluid and complex, interact dynamically, and are shaped by the individual's multiple social contexts. Engaging these aspects of a person's culture and identity in psychological practice improves patient engagement and treatment outcome and reduces premature termination (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Harris, Kelley, & Shepard, 2015). Research supports adapting psychotherapy to aspects of patients' culture including their race, ethnicity, religion, and spirituality (Norcross & Wampold, 2019). Meta-analyses have found that culturally informed practice addresses simultaneously the ethical mandate for cultural sensitivity and the clinical pursuit of effective treatment (Smith & Trimble, 2016; van Loon, van Schaik, Dekker, & Beekman, 2013). In addition to cultural adaptations, tailoring treatment to patients' stage of change, reactance level, and coping style is likely also effective. Beyond these patient characteristics, research supports adapting treatment to patients' preferences (Norcross & Wampold, 2019). Failure to heed patient preferences may result in premature dropout and worse outcomes among those who remain in treatment (Swift, Callahan, Cooper, & Parkin, 2018; Swift, Callahan, & Vollmer, 2011).

Application

Psychologists strive to respect patient characteristics, culture, and preferences by partnering with the patient and appropriate others in clinical decision-making (Barry & Edgman-Levitan, 2012). They endeavor to attend to these patient attributes throughout the treatment course, from assessment through treatment planning and delivery to termination of services.

Psychologists seek to adapt their clinical approach to patients' presenting concerns because different presentations often require different approaches. For example, patients with a trauma history often avoid thinking and talking about their trauma, and this avoidance impedes emotional processing and delays symptom resolution. For some of these patients, development of trust in the therapeutic relationship may be necessary before they are able to discuss their trauma in greater detail. With this consideration in mind, a set of competencies has been developed for therapists who treat traumatized patients and for those who train and supervise these therapists (Cook, Newman, & The New Haven Trauma Competency Group, 2014). As another example, patients who are depressed typically have difficulty initiating responses; it is not that they cannot engage in activities, they have trouble getting started (Koval, Kuppens, Allen, & Sheeber, 2012; Miller, 1975). Psychologists' efforts to help their patients break a large task down into its component parts and to overcome inherent inertia increase the likelihood of treatment success (Dimidjian, Barrera, Martell, Muñoz, & Lewinsohn, 2011).

Psychologists also attempt to tailor treatment to patient characteristics such as stage of change. Patients may share a diagnosis but differ notably in their readiness for change, meaning that the same treatment may not be appropriate for all individuals with the same diagnosis. Patients expressing ambivalence about initiating a change in substance use (i.e., patients in the contemplation stage) may need a therapy stance quite different from patients actively working to change their substance use (i.e., patients in the action stage; Krebs, Norcross, Nicholson, & Prochaska, 2018). Specifically, therapeutic approaches that increase patient insight, awareness, and emotional salience may be more useful during earlier stages, whereas approaches fostering behavioral change may be more effective for patients in later stages.

Given the effectiveness of tailoring treatment to patients' sociocultural backgrounds including race, ethnicity, religion, spirituality, and their intersection, psychologists attempt to develop familiarity with culturally informed approaches (Zane, Bernal, & Leong, 2016). Meta-analytic results indicate that individuals from racial and ethnic minority groups tend to have better therapy outcomes when they participate in culturally adapted mental health interventions compared to traditional or unadapted interventions (Griner & Smith, 2006; Hall, Ibaraki, Huang, Marti, & Stice, 2016). Moreover, mental health interventions which have been adapted for a particular cultural group are more effective than interventions delivered to individuals from a variety of cultural backgrounds (Griner & Smith, 2006). Effective cultural adaptations include delivery of treatment in patients' preferred language if it is other than English (Griner & Smith, 2006) and incorporation of culturally relevant explanations of mental illness into treatment (Benish, Quintana, & Wampold, 2011). In general, when deciding whether and how to adapt treatment, psychologists seek to balance fidelity to evidence-based methods with sensitivity to patient culture and preferences (Sanetti, Collier-Meek, & Fallon, 2016). For more specific guidance in this area, they can avail themselves of several heuristic frameworks for culturally adapting treatment (e.g., Barrera & Castro, 2006; Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Hwang, 2006; Lau, 2006; Leong, 1996; Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999).

Several conceptual models provide frameworks for the provision of culturally competent care by situating psychological services within a sociocultural context. For example, the ADDRESSING model encourages specific consideration of age, developmental disabilities, acquired disabilities, religion, ethnicity, sexual orientation, socioeconomic status, indigenous group membership, nationality, and gender for a more complete understanding of

cultural identity (Hays, 2016). Additional characteristics such as rural residence and language use may also be important, as may be their intersectionality. As another example, the Layered Ecological Model of the Multicultural Guidelines (APA, 2017) posits dynamic, nested social systems that interact over time. This model encourages psychologists to seek to understand the role of these social systems in patients' lives.

Individuals from racial and ethnic minority groups are less likely to receive psychological services, face more barriers to accessing care, and are more likely to terminate treatment early (Wang et al., 2005a; Snowden, 2001). Psychologists recognize that socioeconomic disadvantage, injustice, and discrimination pose barriers to accessing mental health care and contribute to mental health difficulties. They refrain from unduly attributing underlying causes of mental illness to the individual. Rather, psychologists try to understand the influence of personal history and societal forces on the individual's experience, perspective, and functioning. They strive to practice with cultural humility, which involves a continuous process of deliberate self-reflection and self-evaluation, an attitude marked by genuine curiosity and openness toward learning about another's experience, awareness of and willingness to explore power dynamics, and development of mutually respectful relationships with patients (Gallardo, 2014). Because people vary in how they think about and experience psychological distress and what they expect from treatment, psychologists aim to incorporate these diverse understandings into their practice to provide the most evidence-based care. They attempt to anchor psychological explanations in references, examples, anecdotes, and metaphors relevant to an individual's cultural background. For example, when working with a population that embraces non-Western healing traditions, psychologists seek to adapt their language and conceptual models accordingly and show openness to collaborating with community partners when appropriate (Gone, 2010).

Aside from adapting treatment to patient characteristics and culture, psychologists strive to offer treatments that meet the preferences of each particular patient. Patient preferences include activity preferences (also known as role preferences), therapist preferences, and treatment preferences. Activity preferences consist of the types of activities in which patients want to engage during treatment (e.g., joint completion of worksheets, no homework assignment outside of sessions), as well as preferences about treatment setting and format (e.g., individual versus group psychotherapy, involvement of parents or teachers). Therapist preferences include the demographic characteristics (e.g., sex, race, ethnicity, religion) and personality traits (e.g., directiveness, warmth) that patients desire in a therapist. Finally, treatment preferences refer to patients' preferred intervention type (e.g., pharmacotherapy alone, psychotherapy alone, different types of psychotherapy, a combination of pharmacotherapy and psychotherapy; Cabral & Smith, 2011; Swift, Callahan, Cooper, & Parkin, 2018). Incorporation of these patient preferences into the treatment plan is associated with better outcomes. For example, a randomized preference trial found that patients with PTSD who received their preferred treatment between prolonged exposure therapy and sertraline were more likely to be adherent and experienced greater symptom reduction compared to patients who did not receive their preferred treatment (Zoellner, Roy-Byrne, Mavissakalian, & Feeny, 2019).

The following brief vignette illustrates how patient preferences can be incorporated into the initial treatment plan and throughout the treatment process. A female psychologist initiated treatment with a 30-year-old male combat veteran experiencing PTSD symptoms. She began the treatment planning process by inquiring about the patient's treatment goals and preferences. The psychologist actively elicited what types of treatment appealed to the patient, how he wanted to work with his therapist, what qualities he desired in a therapist, and what outcomes he hoped to achieve. Within the context of this discussion, the psychologist offered information about a variety of treatment options including the rationale for the proposed approaches and a description of what these treatments might entail. She recommended a trauma-focused therapy. She also invited further feedback from the patient, who indicated a preference for working with a therapist who is warm, validating, and willing to listen. While the patient was assigned to this particular therapist and they were of the same racial background, he did not indicate any preferences regarding other therapist characteristics. He added that he needed to build trust in the therapeutic relationship before he felt comfortable engaging in a trauma-focused therapy. To accommodate these preferences, the psychologist invested in developing a supportive therapeutic relationship; she offered frequent expressions of validation and adopted a non-judgmental and empathic stance. She also continued to seek periodic feedback from the patient about his experience in therapy and his preferences for the remaining treatment course. As the patient's preferences changed over time (e.g., he expressed interest in more therapist directiveness, more structured treatment, and increased readiness to address the trauma), the psychologist accommodated those preferences through a collaborative discussion with the patient about potential next steps in treatment.

Although the relevance of patient characteristics to treatment outcome is widely recognized, studies of treatment efficacy often do not examine specific patient characteristics other than patient diagnoses or, rarely, patient preferences. When such characteristics are studied, they frequently do not occur in a large enough proportion of the sample to meet criteria for statistical significance as moderators of differential response to treatment. Patient-by-treatment interactions (the basis for identifying differential patient response to treatment) can be difficult to detect, and the scientific literature sets a fairly high bar for establishing the existence of such interactions (Pocock, Assmann, Enos, & Kasten, 2002). Moreover, existing research is based primarily on individuals from dominant cultural groups, which limits the applicability of findings to underrepresented and marginalized populations. Continuous efforts should be made to include culturally and economically diverse communities in research and to create culturally competent evidence-based practices. Of note, the recent development of treatment selection algorithms (Cohen & DeRubeis, 2018; DeRubeis et al., 2014) based on "big data"

(Kessler, 2018) suggests that we are approaching an era in which the identification of the optimal treatment for a given patient may become possible.

GUIDELINE 7

Psychologists aim to monitor the treatment process and clinical outcomes routinely.

Rationale

Psychologists recognize that routine monitoring of patient progress is a tenet of evidence-based practice (APA, 2006a) and consistent with Ethical Principle A to benefit patients and do no harm (Beneficence and Nonmaleficence, APA, 2016). Routine monitoring may include regular assessment of patient psychological symptoms, interpersonal functioning, and social support, as well as the quality of the therapeutic relationship. Such monitoring allows the clinician to take note of and respond to the needs of the patient. Patient progress monitoring can be used to identify patients at risk for problematic treatment response and, when used, is associated with lower deterioration rates and increased clinically significant change rates in those patients (Lambert, Whipple, & Kleinstäuber, 2018). Although the effects of progress monitoring appear to be negligible when averaged across all patients, they are larger and statistically significant among patients predicted to respond poorly to treatment (Kendrick et al., 2016) and when feedback is frequent and timely (Fortney et al., 2017).

Application

Several existing patient progress monitoring instruments have been found effective with different populations and in various settings (Barkham, Mellor-Clark, & Stiles, 2015; Boswell, Kraus, Castonguay, & Youn, 2015; Brown, Simon, Cameron, & Minami, 2015; Duncan & Reese, 2015; Kopta, Owen, & Budge, 2015; Lambert, 2015; Youn et al., 2015). Psychologists make efforts to use patient progress monitoring instruments that are appropriate for the population and setting at hand. They strive for cultural and contextual sensitivity. Psychologists attempt to implement monitoring processes that are reliable, valid, sensitive to change, and relevant (APA, 2009). They appreciate the value of progress monitoring for integrated case conceptualization, and they endeavor to link initial and ongoing assessments to treatments that achieve desired outcomes for their patients, including outcomes such as symptom reduction and improved quality of life and role functioning. When monitoring patient progress, psychologists seek to solicit real-time patient feedback about treatment response and satisfaction with the therapeutic relationship. With the resultant data, psychologists can identify patients at risk for a poor treatment outcome (e.g., patients who do not demonstrate expected treatment gains, show symptom deterioration, experience a perceived loss of social support, or report an alliance rupture). Psychologists then attempt to acknowledge any areas of concern via open and collaborative discussion with patients. These discussions may involve consideration of changes to the treatment approach, as is described in greater detail in Guideline 8.

Although there is evidence that monitoring patient progress can contribute to beneficial outcomes (Lambert & Shimokawa, 2011; Shimokawa, Lambert, & Smart, 2010), currently, most psychologists do not engage in routine patient progress monitoring (Ionita, Fitzpatrick, Tomaro, Chen, & Overington, 2016). This gap between evidence and practice is somewhat disconcerting in light of research showing that clinicians have difficulty identifying warning signs of patient deterioration and treatment failure (Hatfield, McCullough, Frantz, & Krieger, 2010). Given the research evidence supporting routine patient progress monitoring, psychologists are encouraged to seek guidance about effective implementation of the most suitable instruments for their setting.

GUIDELINE 8

Psychologists seek to modify their clinical approach when appropriate and terminate treatment when the patient is no longer benefitting or when treatment goals have been met.

Rationale

Psychologists intend to provide high-quality care and are sensitive to the possibility that the current clinical approach might not be appropriate or effective for a given patient. The emergence of additional presenting problems (e.g., revelation of trauma or substance misuse) or compelling research evidence may suggest that a change to the clinical approach is indicated. Additionally, routine patient progress monitoring might reveal lack of progress, patient deterioration, loss of support, or dissatisfaction with the therapeutic relationship (Lambert, Whipple, & Kleinstäuber, 2018). Psychologists are open to patient feedback suggesting a need to change the clinical approach or repair an identified rupture. Meta-analyses indicate that rupture resolution is associated with better patient outcomes such as higher treatment completion rates and greater symptom reduction (Eubanks, Muran, & Safran, 2018).

Application

Psychologists are open to information that indicates a need to modify the clinical approach. When psychologists become aware that their clinical approach is not appropriate or effective, they attempt to initiate changes to increase the likelihood of a favorable patient response. A psychologist may solicit the patient's perceptions of the clinical approach, treatment progress, and any possible barriers. The therapist might then seek additional feedback about the patient's needs and preferences including consideration of whether and how engagement of the patient's culture and values might be helpful. When indicated, the psychologist may conduct additional assessment of the patient's presenting concerns and diagnoses, consult the relevant research literature, or obtain consultation or supervision to determine how best to proceed in an evidence-based manner. The psychologist could use all of this information to engage in collaborative decision-making with the patient and appropriate others (Tryon, Birch, & Verkuilen, 2018). Within the context of this conversation, the therapist might discuss the possibility of referring the patient to another provider who can offer an alternate approach such as a different kind of psychotherapy, pharmacotherapy, or other intervention either as an adjunctive treatment or in lieu of the current treatment. In the end, the psychologist tries to help the patient consider different options for moving forward, which may include accommodating

new information within the existing treatment approach, modifying the treatment approach, adopting a new approach, or discontinuing care.

Psychologists endeavor to attend to potential signs of alliance ruptures including confrontation ruptures (e.g., patient expresses annoyance with the therapist or discontent with the therapy) and withdrawal ruptures (e.g., patient disengages from the therapy; Safran & Muran, 2000). They strive to address these issues in a non-defensive manner. For example, the clinician might validate the patient's statements, reflect the patient's emotions and perspective, invite the patient to share their experience of the rupture, and emphasize the patient's right to make their own choices. Psychologists aim to accept and communicate responsibility for their own behavior. At times, it may be therapeutic for a psychologist to help a patient recognize potential parallels between in-session ruptures and interpersonal dynamics in the patient's life (Eubanks, Muran, & Safran, 2018). If direct exploration of the rupture is not clinically indicated (e.g., patient experiencing significant emotional dysregulation in the moment), the psychologist might acknowledge the rupture indirectly (e.g., helping the patient regulate their emotions). Psychologists also strive to recognize and work through their own emotions that may be triggered by an alliance rupture. At times, psychologists' emotional reactions to their patients may provide valuable information about their patients' personalities and interpersonal processes. In these cases, psychologists allow this information to inform the treatment approach. At other times, psychologists' affective reactions may serve as an indicator of their own emotional state. In these situations, psychologists seek to cultivate self-awareness and self-insight, practice self-care, and avail themselves of consultation or supervision as needed.

Psychologists terminate treatment if patients have not benefitted sufficiently or when patients' goals have been met and there is no ongoing need for treatment. In the former case, the psychologist would generally consider alternative treatment options with the patient and arrange referral as appropriate. In either case, the psychologist would typically review treatment progress with the patient prior to termination, process the patient's thoughts and feelings about termination, identify the conditions that would warrant a return to working together, discuss how to reinitiate treatment when needed, and say goodbye. If the therapist and patient agree to terminate treatment because of apparent patient improvement, they might choose to extend the intervals between sessions before termination to monitor patient functioning during periods of reduced therapeutic contact and to identify and address any challenges that arise. When appropriate, the psychologist and patient may also formulate a relapse prevention plan to help the patient maintain treatment gains after the conclusion of therapy.

COLLABORATION AND WHOLE HEALTH

GUIDELINE 9

Psychologists endeavor to collaborate with other professionals when appropriate to facilitate effective care.

Rationale

Many people with mental health concerns first come to the attention of non-mental health professionals. In fact, individuals who receive treatment for mental health problems often rely on general medical providers for these services (Wang et al., 2005b), and approximately 20% of all primary care visits include care for a mental health concern (Olfson, Kroenke, Wang, & Blanco, 2014). In recognition of this reality, psychologists frequently partner with other professionals to deliver integrated care to patients.

There is growing recognition of the need for integrated care given that many individuals with mental illness die prematurely from medical causes; their average lifespan is more than eight years shorter than that of the rest of the population (Druss, Zhao, Von Esenwein, Morrato, & Marcus, 2011). Individuals with serious mental illness (e.g., severe psychotic disorders) experience even higher rates of chronic disease and early death, and they die 25 years earlier, on average, than the general population (Parks, Radke, & Mazade, 2008). For the population as a whole, behavioral factors contribute significantly to the onset and exacerbation of medical disease. The Institute of Medicine (2004) concluded that roughly half of the causes of morbidity and mortality in the United States (U.S.) are related to behavioral and lifestyle factors—factors that psychologists are well-positioned to address. These factors are linked to the leading causes of death including cardiovascular disease, cancer, chronic respiratory illness, and diabetes.

Apart from the comorbidity between mental illness and medical disease, other co-occurring problems across the biopsychosocial domains of human health and functioning often require collaboration between psychologists and professionals from various disciplines as well as patients' family members and support communities.

Application

Given the biopsychosocial nature of human development and functioning, the high rates of co-occurring biopsychosocial problems, and the fact that individuals commonly seek help for mental health problems from their primary care providers, psychologists recognize the need to work collaboratively with professionals from other disciplines. These collaborative efforts can result in several benefits to the patient including improved detection of mental health problems and increased access to effective behavioral health treatment. This is particularly important since it is estimated that only one-third of U.S. adults with mental

health disorders receive adequate treatment for these conditions (Kessler et al., 2005). Currently, the majority of individuals receiving treatment for their mental health conditions take psychotropic medications, though patients with non-psychotic disorders respond at least as well to psychotherapy and often with more enduring effects (APA, 2012b). Moreover, the large majority of individuals (75%) actually prefer psychotherapy to medications (McHugh, Whitton, Peckham, Welge, & Otto, 2013). Through collaboration with other providers and development of seamless referral mechanisms, psychologists can increase patient access to psychotherapy.

Psychologists can also help patients make positive health behavior changes such as improved chronic disease management, better adherence to treatment recommendations, increased exercise, reduced substance use, improved stress management, and stronger coping tools. Health psychologists, child psychologists, geropsychologists, and neuropsychologists have long worked collaboratively with medical professionals in the diagnosis and treatment of a wide range of health issues (e.g., O'Shea Carney, Gum, & Zeiss, 2015). Delivery of an integrated, biopsychosocial approach in the context of collaborative primary care is associated with improvements in health status, chronic disease management, preventive services, as well as cost savings (Jabbarpour et al., 2018).

Outside of traditional health care systems, many psychologists collaborate with educators in schools to address students' emotional, behavioral, and academic difficulties. Psychologists also engage in integreated care in correctional, occupational, and other settings. In addition, psychologists recognize the potential benefits of partnering with important social systems including families, cultural communities, and mental health advocacy and support groups to facilitate patient health care engagement and informed decision-making about health, wellness, and treatment.

The benefits of integrated care are increasingly being recognized. This approach has been heralded as an important step for improving health care in the U.S. (e.g., Institute of Medicine, 2001) and throughout the world (World Health Organization, 2010). It has become a priority for psychologists as well (APA, 2015a).

GUIDELINE 10

Psychologists strive to promote overall patient health, functioning, and well-being.

Rationale

More and more, psychologists are focusing on preventing the development of mental health problems and promoting health and well-being in addition to treating distress and dysfunction. Over four decades ago, George Engel (1977) popularized the biopsychosocial approach that emphasized the full range of biological, psychological, and social factors in health and human development as an alternative to the traditional biomedical focus on disease. The biopsychosocial perspective steadily gained ground across health care fields and was endorsed by APA and a wide variety of other health professions in the early 2000s (APA, 2006b). Around the same time, positive psychology with its focus on human strengths and flourishing also became more widely accepted (Seligman, Rashid, & Parks, 2006; Snyder & Lopez, 2002). Positive psychology built on a longstanding humanistic tradition to leverage patients' strengths in psychotherapy (Maslow, 1943; Rogers, 1951). Today, psychologists are increasingly practicing in accordance with these broader and more integrated approaches to health care.

Beyond these changes in psychological practice, effective implementation of a population health approach to physical and emotional well-being includes partnership between multiple systems including patients' social communities, health care providers and delivery systems, social service and criminal justice agencies, policymakers, and researchers.

Application

For most of the 20th century, psychologists and medical professionals focused heavily on treating disease, disability, and dysfunction. In recent decades, they are increasingly turning attention to preventing problems and disorders from developing as well as promoting health and wellness (APA, 2014a; Melchert, 2015).

There has been growing recognition that improving the health and well-being of the general population will require more attention to prevention in addition to the traditional emphasis on treating existing problems (National Research Council & Institute of Medicine, 2009). In the case of children, for example, prevention strategies could include reducing the prevalence and severity of risk factors (e.g., child maltreatment, parental substance abuse) while enhancing the impact of protective factors (e.g., resilience, presence of supportive parents and adults in the lives of children). On the other end of the age continuum, older adults could benefit from prevention initiatives that reduce risk factors for mental health disorders (e.g., social isolation, caregiver stress) while increasing protective factors (e.g., resilience, connection to community resources such as peer support groups). Similarly, administering routine screens for problematic substance use, depression, suicidal ideation, anxiety, and other issues to all patients during primary care visits is becoming more commonplace, permits early detection of emerging behavioral health difficulties, and can facilitate intervention before the development of more significant problems. Because negative consequences can result from either overpathologizing or underpathologizing, psychologists seek to interpret behavioral health screening data within the context of each patient's background and history to ensure that they are providing appropriate and respectful care that meets the patient's needs. Collaboration among health care professionals increases the health care system's ability to implement these preventive and early detection strategies universally with the population as a whole and respond appropriately with the best available care (Kazak, Nash, Hiroto, & Kaslow, 2017).

Alongside such preventive and early detection efforts, psychologists have been focusing on the promotion of health and well-being across the biopsychosocial domains. For example, behavioral treatments for obesity illustrate the unique value that psychologists add to traditional medical practice in promoting health and well-being. Indeed, recommended interventions for children who are overweight or obese are multicomponent and include psychological tools such as goal-setting

around physical activity and diet, problem-solving barriers, initiating and maintaining behavior change, and engaging the broader family system in healthy lifestyle choices (APA, 2018d).

Despite the emergence of broader population health initiatives that encompass prevention, early detection, treatment, and health promotion, several barriers challenge the effective implementation and dissemination of these evidence-based integrated approaches. These barriers include acceptability of this approach to health care providers, third-party payers, administrators, policymakers, and affected communities; potential administrative and workload burdens; incompatible organizational structures; insufficient provider reimbursement; training costs; and cultural concerns (Kazak et al., 2010). Effective implementation and dissemination therefore require engagement of multiple systems, including patients' social communities, health care providers, health care delivery systems, policymakers, and researchers (Hoagwood & Johnson, 2003; Kazak et al., 2010). There is a need for partnership between researchers and health care providers to ensure that researchers conduct the most useful dissemination and implementation studies and providers influence research questions and engage in the most evidence-based practices. Collaboration among different types of health care providers permits a truly interdisciplinary and integrated approach to health care that addresses patients' concerns across all biopsychosocial domains. Engagement of health care administrators can allow proper alignment of health care delivery systems around evidence-based, integrated principles of care. Outreach to policymakers and state and federal agencies increases the likelihood that funding and policies favor evidence-based, integrated approaches to improving health and health care. Partnerships with at-risk or affected communities including underrepresented or marginalized groups, peer support groups, and advocacy groups have the potential to increase the reach of mental health intervention efforts and to ensure their cultural acceptability and responsiveness. Finally, some of the most important strategies to promote mental health involve social change such as addressing homelessness, social inequities, and systemic racism. Psychological interventions and prevention strategies will only be as successful as the broader social context permits. Thus, psychologists strive to build coalitions to address these underlying societal challenges to promote population well-being.

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