

# Empirically Supported Treatments: 10 Years Later

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## Abstract

Division 12 of the American Psychological Association (APA) first established a Task Force to identify and promote empirically supported psychological treatments in 1993. This Task Force, headed by Dianne Chambless, conducted a survey of doctoral and internship training programs in clinical psychology, focused on training and supervision in empirically supported treatments (ESTs). The present article reports on a 10-year follow-up to that survey. APA-accredited programs in the U.S. and Canada indicated the degree to which they provide training in 26 treatments listed as empirically supported by the Task Force since the 1990s. Results indicated improvements in didactic dissemination, although supervised training in ESTs appears to be declining. Comments solicited from Training Directors point to several important obstacles to providing training in ESTs.

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The concept of evidence-based medicine rests on the premise that the quality of patient care is enhanced when practitioners use treatments with empirical support (Sackett, Richardson, Rosenberg, & Haynes, 2000). In an effort to identify and promote empirically supported psychological treatments, Division 12 of the American Psychological Association (APA) first established a Task Force to examine this issue in 1993. The aim was to define empirically supported psychological procedures, along with examples of interventions that met those criteria, and to explore issues of dissemination of this information to professionals, consumers, and policymakers. Dianne Chambless headed the first Division 12 efforts in this process

in the 1990s, chairing the Task Force on Promotion and Dissemination of Psychological Procedures, which has now evolved into the Committee on Science and Practice. This article describes a survey conducted when Drs. Woody and Weisz were members of this Committee.

In their initial report, which was adopted by the Division 12 Board of Directors in 1993, the Chambless Task Force provided a list of 25 examples of treatments that met their criteria for empirical support in treating children, adolescents, and adults. The group continued to review and evaluate treatments in subsequent years, providing an expanding set of examples of treatments with empirical support (Chambless, 1998; Chambless et al., 1996). As the Task Force documents have always emphasized, these lists provide examples rather than exhaustive accounts. Many widely used treatments have yet to be rigorously tested, and, due to limited resources, the Task Force undoubtedly failed to identify some treatments that in fact have empirical support.

Widespread use of an evidence-based approach to psychological practice is possible only when research results are disseminated to professionals and incorporated into training programs. The initial Task Force conducted a survey of APA-accredited doctoral and internship training programs in clinical psychology in the United States and Canada. The survey assessed the degree to which these programs were providing didactic instruction or supervised training in treatments identified by the Task Force as having empirical support. The survey listed all 25 treatments the Task Force had identified as examples of empirically supported interventions on the basis of the research literature. Directors of Clinical Training were asked to simply indicate each treatment for which their program provided didactic or supervised training (rated separately). Internship Directors were asked to indicate the degree to which "interns are trained to a level of competence or receive formal supervision during their year-long experience." Responses remained anonymous. The response rate was 83% for the 167 doctoral programs surveyed and 55% for the 428 internship programs.

As many readers are aware, the Task Force reports were successful in generating discussion and debate within the field of psychology about the value and definitions of empirically supported treatments (ESTs). Although the initial report was highly controversial, it served to motivate several other groups to identify and publicize more examples of ESTs (e.g., Chambless & Ollendick, 2001; Weisz, 2004). The publicity and professional debate surrounding ESTs has



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sparked other changes as well: APA now espouses the value of science as the empirical basis of practice in its accreditation guidelines, the Canadian Psychological Association (CPA) accreditation guidelines explicitly require that students learn skills in using research to inform practice, and both APA- and CPA-approved continuing education (CE) providers are asked to disclose the degree of empirical support for treatments they teach. Critical to the movement for evidence-based practice is the question of whether training programs have changed the degree to which they include empirically supported treatments in the curriculum. To answer this question, we undertook this survey under the aegis of the Division 12 Committee on Science and Practice.

## Method

### Participants

Directors of all APA-accredited clinical psychology doctoral (Ph.D. and Psy.D.) programs ( $n = 333$ ) and predoctoral internships ( $n = 468$ ) in the United States and Canada were invited to participate. Respondents included 136 directors of clinical training (doctoral programs) and 184 internship directors, for a response rate of 40.8% and 39.3%, respectively. We were unable to determine the degree to which respondent programs are the same as those who responded to the 1993 survey.

### Measure

The survey was designed to be as brief as possible and to adhere rather closely to the questions that were asked in the 1993 survey. Respondents reviewed a list of treatments and indicated the degree to which their program teaches each psychotherapy modality. Response options included “taught in course briefly,” “taught in course thoroughly,” “supervised clinical training,” and “formal clinical training or certifica-

Table 1

Treatment	Taught in Course			Supervised Training	
	2003 Briefly	2003 Thoroughly	1993	2003	1993
<b>Anxiety and Stress</b>					
Cognitive therapy for panic	88.5	65.2	64.4	60.5	69.6
Applied relaxation for panic disorder	79.1	56.6	65.9	48.8	61.5
Exposure treatment for agoraphobia*	75.2	50.4	64.4	44.2	59.3
CBT for generalized anxiety disorder	89.2	72.1	69.6	66.7	77.0
Exposure for social phobia*	78.3	47.3	64.4	41.9	59.3
Stress inoculation training for coping with stressors†	31.8	11.6		6.2	
Exposure and response prevention for obsessive-compulsive disorder	71.4	55.9	58.5	48.1	48.1
Exposure / guided mastery for specific phobia*	79.9	56.6	64.4	48.8	59.3
Systematic desensitization for specific phobia	35.7	13.2	68.9	11.6	62.2
<b>Depression</b>					
Behavior therapy for depression	71.3	46.5	36.3	42.6	16.3
CBT for depression	92.3	78.3	89.6	72.1	80.0
Interpersonal therapy for depression	72.9	56.6	25.9	53.5	16.3
<b>Health</b>					
CBT for bulimia†	72.2	36.5		35.7	
Interpersonal therapy for bulimia	59.7	31.0	20.7	25.6	31.9
CBT for chronic lower-back pain	46.5	22.5	47.4	21.7	46.7
Behavior therapy for headaches	49.7	26.4	38.5	25.6	27.4
Multi-component CBT for pain associated with rheumatic disease†	31.1	11.7		0.8	
Multi-component CBT with relapse prevention for smoking cessation†		19.4		17.8	
<b>Problems of Childhood</b>					
Behavior modification for enuresis	58.2	25.6	45.2	24.0	40.0
Parent training for children with oppositional behavior	35.7	14.0	57.8	10.9	60.0
<b>Marital Discord</b>					
Behavioral marital therapy	57.4	35.7	57.0	31.0	60.7
Emotionally focused couple therapy for moderately distressed couples	74.3	69.4	39.3	68.9	46.7
<b>Other Problems</b>					
Family education for schizophrenia	45.7	20.9	24.4	18.6	22.2
Dialectical behavior therapy for borderline personality disorder	69.8	41.9	17.0	35.7	16.3
Habit reversal and control techniques	51.2	24.8	41.5	21.7	35.6
Behavior modification for sex offenders	36.5	18.7	23.7	17.1	27.4

### Right: Table 1

Percentage of Doctoral Programs Offering Training in Empirically Supported Treatments in 2003 and 1993

Note: † denotes treatments not surveyed in 1993. \* denotes target problems that were grouped together as one item (i.e., phobias) in the 1993 survey. “Cognitive therapy” for panic was described as cognitive behavior therapy (CBT) in 1993. CBT for depression was described as “cognitive therapy” in 1993, although both surveys explicitly mentioned Beck’s approach. “Chronic lower back pain” was described simply as “chronic pain” in 1993.



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Table 2

Treatment	2003	1993
<b>Anxiety and Stress</b>		
Cognitive therapy for panic	68.9	66.0
Applied relaxation for panic disorder	61.7	70.0
Exposure treatment for agoraphobia*	36.6	38.0
CBT for generalized anxiety disorder	74.3	78.0
Exposure for social phobia*	44.8	38.0
Stress inoculation training for coping with stressors†	43.7	
Exposure and response prevention for obsessive-compulsive disorder	49.7	36.0
Exposure/guided mastery for specific phobia*	41.5	38.0
Systematic desensitization for specific phobia	49.2	53.0
<b>Depression</b>		
Behavior therapy for depression	31.6	16.0
CBT for depression	82.5	66.0
Interpersonal therapy for depression	42.6	14.0
<b>Health</b>		
CBT for bulimia†	24.6	
Interpersonal therapy for bulimia	12.0	28.0
CBT for chronic lower-back pain	31.7	54.0
Behavior therapy for headaches	26.2	32.0
Multi-component CBT for pain associated with rheumatic disease†	16.4	
Multi-component CBT with relapse prevention for smoking cessation†	23.5	
<b>Problems of Childhood</b>		
Behavior modification for enuresis	22.4	43.0
Parent training for children with oppositional behaviour	37.2	64.0
<b>Marital Discord</b>		
Behavioral marital therapy	16.4	41.0
Emotionally focused couple therapy for moderately distressed couples	14.8	42.0
<b>Other Problems</b>		
Family education for schizophrenia	24.6	50.0
Dialectical behavior therapy for borderline personality disorder	38.3	15.0
Habit reversal and control techniques	17.0	31.0
Behavior modification for sex offenders	14.8	26.0

### Above: Table 2

#### Percentage of Internship Programs Offering Formal Supervision in Empirically Supported Treatments in 2003 and 1993

Note: † denotes treatments not surveyed in 1993. \* denotes target problems that were grouped together as one item in the 1993 survey. "Cognitive therapy" for panic was described as cognitive behavior therapy (CBT) in 1993. CBT for depression was described as "cognitive therapy" in 1993, although both surveys explicitly mentioned Beck's approach. "Chronic lower back pain" was described simply as "chronic pain" in 1993.

tion." "Briefly" was arbitrarily defined as course instruction for one week or less.

Survey items are listed in Tables 1 and 2. The 1993 survey included all treatments listed as "well established" or "probably efficacious" in that initial report. Although most of these treatments were also included in the 2003 survey, several treatments that did not have a specific target of intervention (i.e., behavior modification for developmentally disabled individuals, token economy programs, brief dynamic therapies) were not included in this survey. Two other treatments from the 1993 survey were also left off the 2003 survey because of a significant evolution in the way the treatment was described over the various Task Force reports. These treatments were group cognitive behavioral therapy (CBT) for social phobia (not specifically identified as a group treatment in the 1998 report) and behavior therapy for female orgasmic and male erectile dysfunctions. (No treatments were judged to be empirically supported for erectile dysfunction in the 1998 report; the probably efficacious treatment for female orgasmic dysfunction was "Masters and Johnson's sex therapy.")

In addition to most of the treatments from the 1993 survey, the present survey included all of the well-established treatments from the 1998 Task Force report (Chambless et al., 1998) even if those treatments had not been identified as empirically supported at the time of the 1993 survey. In cases for which the exact name of the treatment might be confusing or a matter of scholarly debate (e.g., cognitive or cognitive behavioral?), the surnames of researchers known for testing that treatment were included as a prompt. Because including all treatments judged to be probably efficacious in the 1998 report ( $n = 56$  treatments) would have been impractical, only the four treatments that were listed as "well established" were added. These included CBT for bulimia (erroneously left off the 1993 list), stress inoculation training for coping with stressors, and multi-component CBT for both rheumatic disease pain and smoking cessation.

#### Procedure

The survey, including a brief explanatory cover letter and a stamped addressed return envelope, was mailed to all members of the APA mailing lists for Directors of accredited doctoral and internship programs in clinical psychology in early 2003. The cover



letter explained that the survey was a repeat of the 1993 survey and that responses would remain anonymous. Directors who did not respond by the deadline (approximately 4 weeks following receipt) received a second mailing with the same materials.

### Results and Discussion

The results from the 2003 survey are shown in Table 1 for doctoral programs and Table 2 for internships. For convenience of comparison, the 1993 survey results are reproduced in these tables as well. Note that the responses were considered on a Guttman scale, meaning that the responses are hierarchical, with items lower than the item endorsed by the respondent are also considered to be true. For example, if a respondent indicated that a given treatment was covered thoroughly in a course, then that program was also counted in the frequency for brief instruction but

**“...there seems to be little agreement among doctoral and internship programs about the appropriate training curriculum for clinical psychologists.”**

not for supervised training.

The most popular empirically supported treatment in both 1993 and 2003 was cognitive therapy for depression. The vast majority of doctoral and

internship programs provide supervised training in this treatment. Most programs also provide supervised training in empirically supported treatments for anxiety disorders, including cognitive therapy for panic and CBT for generalized anxiety disorder (GAD), and most doctoral programs provide supervised training in emotionally focused couple therapy.

*How have things changed during these 10 years of debate about ESTs in our profession?*

Of 22 treatments that were included in both the 1993 and 2003 surveys, 18 are covered (at least briefly) by a higher percentage of doctoral programs in 2003 than in 1993. Within accredited doctoral programs, supervised training for ESTs has increased for only four treatments since 1993: behavior therapy for depression, stress inoculation training for coping with stressors, interpersonal therapy for depression, and emotionally focused couple therapy. In contrast, supervised training is less frequently offered for 16 ESTs than was true in 1993. At the internship level, supervised training has become more widely available

for eight (of 22) treatments in the last 10 years and less widely available for 14 treatments.

In 1993, most doctoral programs provided supervised training for 11 out of 22 ESTs. This figure has dropped since that time, with the results of the 2003 survey indicating that only 5 out of 26 ESTs were included as part of supervised training in the majority of programs. Recall, however, that the same respondents may not be represented in both surveys.

*To What Degree do Programs Provide Training in any EST?*

On average, doctoral programs reported that they provide supervised training to graduate students in an average of 9.5 ( $sd = 5.4$ ) interventions out of the 26 surveyed. This compares with a mean of 11.5 in the 1993 survey. The distribution had two modes, 9 and 13 interventions ( $n = 18$  each), with a range from 0 ( $n = 8$  programs) to 26 ( $n = 1$  program). Internship programs reported similar figures, providing supervised training in an average of 9.3 ( $sd = 7.1$ ) interventions out of 26 surveyed. This average, however, represents a distribution for which the *mode was zero*, meaning no supervised training in any of the ESTs we surveyed. The range extended from zero ( $n = 21$  programs) to 26 ( $n = 1$  program). Comparable data for internship programs were not provided in the report of the 1993 survey.

*How Consistent is Training in ESTs Across Programs in Canada and the USA?*

One (admittedly liberal) definition of consistency is whether more than half of responding programs provide training in a given topic. By this definition, graduate programs responding to the survey show consistency in teaching about some ESTs. Most doctoral programs at least touch on 17 (out of 26 surveyed) treatments in didactic instruction, but only nine treatments are covered *thoroughly* in didactic graduate school instruction. (The 1993 survey did not distinguish between brief and thorough instruction.) Internships show less consistency; only four treatments are taught by more than 50% of internship programs responding to the survey. These four treatments include strategies for treating some of the most commonly encountered problems in clinical practice (depression, generalized anxiety, and panic). In 1993, eight treatments were taught by at least half of the internships.

Overall, there seems to be little agreement among doctoral and internship programs about the appropriate training curriculum for clinical psychologists. This is likely due to the APA accreditation

standards that encourage programs to establish their own model and follow it. Although there is undoubtedly good agreement about the general topics that programs should cover (e.g., assessment, breadth courses), there is apparently little general agreement about content or supervised training experiences that should be provided in each program. Other than relatively good agreement that cognitive therapy for depression and panic or GAD are important, most of the treatments that have robust empirical support are not taught (in a supervised way) by the majority of training programs. While the EPPP licensing exam provides some standardization of the knowledge about psychology that licensed psychologists have, it would appear that there is little overlap in supervised practical skills and knowledge obtained in various training programs, particularly at the internship level.

***“...most of the treatments that have robust empirical support are not taught (in a supervised way) by the majority of training programs.”***

*How Valid are the Results of this Survey?*

Several decisions related to the design of the survey place limitations on its interpretation. A major consideration was the ability to compare the 2003 results with the 1993

results. Another consideration was keeping the survey as brief as possible to increase the probability of response. (Directors of training programs receive many surveys each year.) Maximizing these aims meant that we did not include most treatments that have been identified as empirically supported by other groups after 1993 (see Chambless & Ollendick, 2001). As described above, we were unable to completely achieve the aim of comparing with the 1993 results because we cannot identify which programs responded to that survey.

The nature of the survey presents some issues related to validity. For example, most of the treatments listed in the survey are targeted toward individual therapy with mid-life adults. Programs that focus on preparing students for working with individuals at either end of the lifespan would not check many treatments on this survey. As another example, Directors of programs may have used their “best guess” about the level of training provided for each treatment for several reasons. Although Directors of Clinical Training programs have access to syllabi

for all clinical courses (because of accreditation reviews), it is doubtful that they took the time to study these syllabi before responding to the survey. Accordingly, they likely responded on the basis of recall, which is subject to many biases with which researchers are familiar.

Furthermore, many (or most?) clinical programs do not provide training based on diagnoses or treatment types, which is how the survey was organized. Rather, many programs provide training based on a coherent theoretical rationale (e.g., evidence-based, cognitive-behavioral, psychodynamic, family systems) as it is applied to whichever clients are admitted to the training clinic. These programs undoubtedly vary in the degree to which they find the results of randomized controlled trials to be valuable sources of information for treatment planning. The point is that even Directors of programs dedicated to clinical science would have to guess about the degree to which their students or interns receive training in each of the treatments on the survey. In some programs, students’ training is almost entirely contingent on their supervisors, so it would be difficult to make blanket judgments about which ESTs are covered in the program.

*What are Some of the Obstacles to Providing Training in ESTs?*

After conducting this survey, we posted listserv questions asking for feedback from our colleagues in the Council of University Directors of Clinical Psychology (CUDCP) and the Association of Psychology Postdoctoral and Internship Centers (APPIC). Many Directors of Clinical Training ( $n = 28$ ) and Internship Directors ( $n = 12$ ) provided thoughtful responses articulating perceived obstacles to providing training in ESTs. The main obstacles indicated were uncertainty about how to conceptualize training in ESTs, lack of time, shortage of trained supervisors, inappropriateness of established ESTs for a given population, and philosophical opposition.

*Nature of training in ESTs.*

Some Training Directors expressed uncertainty about what it means to train students in evidence-based practice. They questioned the implied training structure of the survey, which was that students learn to conduct manualized treatments one-by-one. They called for a wider discussion on how to train students in principles of behavior or principles of evidence based practice. Without such a higher level approach, respondents argued that students may become technicians, able to articulate a client’s diagnostic



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label and to point to a tested treatment manual for that diagnosis, but unable to propose a conceptualization about what various behaviors mean for the individual or how the individual came to have the presenting problem.

*Lack of time.* Training directors indicated that there is insufficient time in the curriculum to provide training in specific manualized treatments, particularly among programs that emphasize research training. Others noted that proper training in a treatment protocol involves repeated experiences under close supervision, and the rapid pace of graduate and internship training rarely permit this, particularly for generalist training. This problem is compounded in training centers that focus on research because faculty members are often too busy with research to become

heavily involved in supervision.

*Shortage of trained supervisors.* Many clinicians who serve as supervisors are generalists who cannot justify the time and expense of learning specialized treatments. One needs to be quite proficient in a given treatment to be sufficiently flexible to provide supervision, and it may be hard for generalists to see the payoff of the expense of continuing education and supervision in a new, highly specific, approach if their practice involves clients with a wide variety of problems. Some Training Directors also noted that many supervisors say they use certain ESTs, but they lack specific training in those approaches. Several Directors of Clinical Training argued that a training clinic controlled by clinical faculty is required to provide all students with a good foundation in evi-

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and/or,
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APF provides nomination forms. Nominations should include the form, a statement that illustrates how the nominee fulfills the guidelines of the award, and the nominee's current vita and bibliography. Letters in support of the nomination are welcome. All materials should be coordinated and collected by the chief nominator and forwarded to APF at the same time.

The deadline for receipt of materials is **December 1, 2005**. Requests for nomination forms and completed nomination packets should be mailed to the APF Charles L. Brewer Teaching Award Coordinator, 750 First Street, NE, Washington, DC, 20002-4242. Requests for nomination forms may also be sent to [foundation@apa.org](mailto:foundation@apa.org).



dence-based practice. Numerous Training Directors lamented their options for practicum placements, pointing to a disconnect between the values of the training program and the values of training clinics.

*Narrowness of established ESTs.* Although the lists of examples of ESTs have grown quite long, they are still rather narrow compared to the diversity of practice settings and the clientele of those settings. Sadly, segments of the population that are underserved due to issues such as poverty, age, language barriers, or rural settings are also underrepresented in research. Generally speaking, few ESTs have been developed or tested with these factors in mind (although children and the elderly are receiving increased attention). Furthermore, while some studies have addressed simple issues of comorbidity, the scientific method underlying randomized controlled trials requires manipulation of one variable (i.e., intervention) at a time. Manualized treatments tested in this way may not always be so easily applied in a straightforward way to complex cases; therapists often find themselves adapting the treatment extensively because they see a pure EST as inadequate to address the client's complicated set of problems.

*Philosophical opposition.* Some Training Directors indicated principled opposition to the notion of ESTs. Some of this opposition was based on the idea that lists of ESTs reflect a political or theoretical bias more than they reflect treatments that work. Others opposed what they see as an erosion of their autonomy as professionals due to pressure to conduct ESTs. In this view, the manualized approach is seen as too rigid and objectifying rather than humanizing clients. Some Training Directors also expressed a lack of trust in researchers, pointing to stories of misleading reporting of clinical trials from the drug industry in support of this view.

### Conclusion

Whether doctoral and internship programs provide more or less training in ESTs than they did in 1993 depends on how one asks the question. On one hand, training programs teach (to some degree) a greater number of ESTs than they did 10 years ago. Only two treatments are taught less frequently than they were in 1993 (parent training for children with oppositional behavior and systematic desensitization for specific phobia). On average, doctoral and internship programs reported that they provide graduate students

with supervised training in an average of 9.5 ( $sd = 5.4$ ) interventions out of the 26 surveyed.

On the other hand, supervised training in most ESTs is less widely available, at both the doctoral and internship levels, than it was in 1993, although some increases in supervision were observed. Aside from relatively good agreement that cognitive therapy for depression, panic and GAD are important, most of the treatments with robust empirical support are taught (in a supervised way) by fewer than half of the training programs. Further, the consistency with which students can expect to receive training in ESTs is declining. Although 11 of 22 treatments with well-established empirical support were included in most predoctoral supervised training curricula in 1993, the figure was down to a handful out of 26 in 2003. While most programs responding to this survey indicated that they provide supervision in a variety of ESTs, many accredited programs still provide no training in ESTs. If the results of this survey are any indication, graduate training in clinical psychology has a long way to go before it reflects the scientific basis of the discipline. □

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