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Artículo de Revisión

Current overview of evidence-based clinical psychology in alcoholism and other drug addictions

Panorámica actual de la psicología clínica basada en evidencias en alcoholismo y otras drogodependencias

Humberto García Penedo [1*]
Alexis Lorenzo Ruiz [1]

[1] University of Havana, Faculty of Psychology. Havana, Cuba.

Email: humberto@psico.uh.cu

Abstract

This article presents, for generalization to clinical practice, the criteria used in the evaluation of psychotherapeutic procedures as outlined by the American Psychological Association, along with the considerations of various authors on this topic and the controversies it has generated. Attention is drawn to the effectiveness levels of the various available intervention modalities, thus facilitating the appropriate selection of the treatment procedure according to the type of addiction. The search method employed narrowed the review to the area of alcoholism and other addictions, selecting articles such as systematic reviews, protocols, and reports from the American Psychological Association related to

Evidence-Based Psychological Practices, as well as those from the *National Institute for Health and Care Excellence (NICE*) in the United Kingdom and Cochrane, all classified with the international keyword " *evidence-based psychology addiction* ." The selected sources were publications directly or indirectly associated with the aforementioned organizations.
Keywords: Psychological practices; evidence; alcoholism; drug addiction.

Resumen

Se exponen, para su generalización a la práctica asistencial, los criterios empleados en la evaluación de los procedimientos psicoterapéuticos pautados por la Asociación Americana de Psicología, las consideraciones de varios autores sobre ello y las polémicas generadas. Se llama la atención acerca de los niveles de eficacia de las diversas modalidades de intervención disponibles, de modo que facilite la elección adecuada del procedimiento asistencial según el tipo de adicciones. El método de búsqueda que se ha seguido es el de estrechar la revisión al área del alcoholismo u otras adicciones eligiendo artículos del tipo revisiones sistemáticas, protocolos e informes de la Asociación Americana de Psicología referentes a las Prácticas Psicológicas Basadas en la Evidencia, las del *National Institute for Clinical Excellence*, del Reino Unido y de Cochrane, y clasificados con el descriptor básico internacional " *based evidence psychology addiction"*. Las fuentes de elección han sido las publicaciones asociadas directa o indirectamente a los sitios antes mencionados.

INTRODUCTION

This work takes as its starting point the existence of a situation that arose at the end of the last century, in which clinical psychologists, despite scientific findings, frequently failed to apply them in practice. Instead, they relied on personal experience, opinion, and what is known as "clinical judgment" (practices not supported by prior scientific studies demonstrating any degree of effectiveness). Adding to this situation was the fact that those who contributed financially to scientific studies, paid healthcare services, and other factors, demanded that the treatments administered to clients be empirically validated. These issues allow us to clarify the potential existence of medical negligence in lawsuits, as well as the scope of medical insurance coverage in relation to treatment costs.

The aforementioned factors triggered pressure that ultimately led, in 1995, to the issuance of an official document by Division 12 of the *American Psychological Association* (APA), dedicated to clinical psychology, [(1)] which established the new requirements and specified the conditions that studies with the corresponding certificate of procedure endorsed by

psychological science would have to meet (Appendix). Six years earlier (1989), the U.S. Congress had created the *Agency for Health Care Policy and Research* , whose purpose was to determine the effectiveness of psychological treatments for mental disorders and establish a directory of therapies with proven efficacy, with the ultimate goal of improving the quality of the health care system. (2)

Evidence-based clinical psychology has been defined as: "that which is applied in the understanding, diagnosis and treatment of the various disorders, using methods that have been scientifically validated." (3)

The guidelines constitute a set of recommendations on how to approach the diagnosis, prevention or treatment of addictions in their many forms, which are based on reviews of works with varying degrees of scientific evidence and are updated with a certain degree of systematicity according to the scientific production of the field.

Periodic updates on *Evidence-Based Psychological Practices* (EBPPs) are published on sites such as the Cochrane Collaboration, the Ibero-American Cochrane Centre, *PsycINFO, Psychological Abstracts, Dissertation Abstracts International, and the APA Thesaurus of Psychological Index Terms* , forming what is known as *the PsycINFO Database.* The Spanish website Infocopse presents proven effective psychological treatments.

Updates are also published on the *National Institute for Health and Care Excellence (NICE) website* . NICE is an independent body whose primary objective is to ensure that the English National Health Service uses treatments supported by the best available empirical evidence. There you can find *the Guideline Scope* , a guide that lists the main articles on the site, such as: the main guidelines for the treatment of alcoholism in adults, statistics on alcoholism in the UK, guidelines for alcoholism intervention in schools, and other relevant documents. It is recommended to review the *Local Alcohol Profiles for England* (LAPE), which contains statistics on alcohol consumption and abuse by age, age at first use, and sex. Since 2004, it has been based on frequent surveys and numerous rigorously analyzed and categorized data sources, which are updated relatively often. You can also consult other guides and manuals from previous years for comparison and explanations of their development processes. All of this contributes to the improvement of professional practice in the preventive, investigative, and care lines from the paradigm of evidence-based psychology, which obeys the dream of standardizing, as far as possible, all professional activity in the problem of addictions.

It is recommended to review the latest *Clinical Guide* , which, although it was prepared in 2011, has been updated and corrected to the present with indications on the diagnosis, evaluations and general management of harmful alcohol consumption.

Other highly professional sites on PPBE include the *National Guideline Clearinghouse* , which has more than 160 specific guides on effective treatments published by professional organizations in the U.S., and the National *Registry* of Evidence Based Programs and Practices, which compiles best practice guides in substance abuse prevention and mental health.

The Spanish society SOCIDROGALCOHOL has been working on the topic of addictions for more than 40 years, and for some time now has compiled reviews of scientific work to develop comprehensive intervention guides that include psychotherapeutic treatments.

This study aimed to highlight the need to update the effectiveness of treatments used in the care of alcoholism and other drug dependencies, contributing to excellence in psychological services in that area.

METHOD

Thematic review on alcoholism and other drug addictions. Published articles that responded to the descriptor "Based evidence psychology addiction " and that were documented in the National Institute for Clinical Excellence (NICE) of the United Kingdom and Cochrane, mainly, were consulted .

Characterization of studies to assess their empirical validation

The original APA document [(1)] established two broad categories for grouping psychotherapeutic treatments based on efficacy: well -*established* treatments and *probably efficacious treatments* . They suggested that treatments be declared effective with respect to specific clinical problems, for example, interpersonal therapy for the treatment of depression. Thus, it is essential to verify which treatments work for certain types of disorders so that readers can identify the appropriate limits of study results.

The difference between well-established treatments and those that are probably effective lies in: "the quality of the empirical evidence that supports them, that is, the type of methodological design through which the empirical evidence has been obtained, with the highest evidence being that provided by the randomized experimental design." [(4)]

According to the requirements of the APA's Division 12, for treatments to be empirically validated with the highest degree of validity, they would have to have been carried out using experimental methodology, such as randomized clinical trials or efficacy studies with at least two groups: the experimental or treatment group and a comparison group, whether the pharmacological treatment, the placebo, or another type of intervention. [(5)]

Empirical evidence could be supported by meta-analytic studies that allow us to know the average effect size produced by the psychological intervention. [6] This procedure, in general, consists of reviewing large numbers of scientific studies, considering the rigor followed by their authors, and determining whether the results obtained offer any evidence of the effectiveness of certain practices.

Among the requirements that experimental methods must follow are the terms efficiency and effectiveness, which refer to the methodological concepts of internal and external validity, respectively. [4] Efficacy studies compare a therapeutic group against a control group under conditions of maximum experimental control. The following criteria must be met: [7]

1. Patients are randomly assigned to treatment and control conditions.
2. Controls are rigorous. Not only are there patients who do not receive treatment, but there are also placebo groups that receive the therapeutic ingredients in a way that is credible to both the patient and the therapist.
3. Treatments are manualized with detailed descriptions of the therapy. Adherence to the manual is measured using video sessions.
4. Patients receive a fixed number of sessions.
5. The objectives are adequately operationalized.
6. Blinded designs are used where the patient's group assignment is unknown.
7. Patients meet the criterion of having only one diagnosed disorder, and those with multiple disorders are typically excluded.
8. Patients are followed for a fixed period after treatment.

However, the strongest evidence lies in the therapy studied through a randomized experimental design. [4] Other criteria are argued to support the efficacy of a treatment when:

- Rigorous studies were conducted by different researchers demonstrating superiority over pharmacological treatment, placebo, or other treatments;
- in experimental designs with $N = 30$ per group, at a minimum, or in single-case studies (no less than 9);
- a treatment manual was available and patients were identified according to a manual such as the DSM-IV. [7]

In previous reviews on the subject at hand, a group of authors made other clarifications regarding the effectiveness of the treatments: [2]

a) A treatment is considered effective and specific when it is better than an alternative treatment or a placebo;

b) It is considered an effective treatment if it is better than no therapy, at least, as assessed in two independent studies;
c) A treatment is considered probably effective if it obtains positive results but has not yet been replicated.

Another element that is used when assessing the efficiency of psychotherapeutic treatments, beyond monetary costs, is to consider the achievement of therapeutic objectives and the shortening of the time of suffering of the patients.

In another study, he shares the following criteria on the basic qualities of the treatments: [8]

1. Effective, if they have achieved positive results for health users in properly controlled studies, so that they are also useful, viable, and can be generalized in other contexts;
2. Effective, that is, useful in care;
3. Efficient, when their use achieves greater benefits with less cost than other alternatives for dealing with the problem in question.

According to *Martínez* [9], PPBE has three conceptual pillars: the empirical foundation; the integration of the population's preferences, values, and idiosyncrasies into the intervention; and the professional's expertise and experience. Therefore, since cultural aspects are important in validating treatments, some authors introduce the term "cultural competence" as a complement to the validity of PPBE, [10] a term that essentially refers to the therapist's mastery of the sociopsychological and cultural characteristics of the groups they work with.

According to *Caycho* [11], evidence-based practice (EBPP) seeks to answer three fundamental questions: Are the procedures used by psychologists the best for achieving effective treatments? Can these procedures be applied to diverse situations and settings? Which procedures produce the greatest benefits at the lowest cost?
Similarly, *García* [12] states: "Evidence-based practice, therefore, is opposed to approaches based on tradition, intuition, beliefs or personal opinions, the unsystematic, conventional, anecdotal, unfounded, or fortuitous." The same author describes a measure of the internal validity (effectiveness) of interventions (a ratio of 8 to 1 increases confidence in effectiveness):

1. Better than an alternative therapy (randomized controlled trials, RCTs)*
2. Better than a non-specific therapy (RCTs)
3. Better than no therapy (RCTs)
4. Quantified clinical observations
5. Strong positive clinical consensus regarding its efficacy
6. Mixed clinical consensus

7. Strong negative clinical consensus regarding its efficacy
8. Conflicting evidence

Echeburúa et al. [2] have published a list of conditions that are directly linked to the levels of evidence of studies to evaluate efficacy, effectiveness and efficiency of psychotherapeutic treatments, which are presented in the table .

One of the issues that PPBE provides is the emphasis on the importance of informing the patient about the best available therapeutic evidence, both for continuous assessment, prevention or care. [13]

Controversies surrounding the positions of the American Psychological Association

There are positions that clash, to some degree, with some of the requirements imposed by the APA's 12th Division, as can be seen in the considerations of *Llobell* and others:

The question arises as to whether the (laboratory) findings can be generalized to the real-world intervention setting. The fact that an intervention is effective is not a sufficient guarantee of its usefulness or practical importance. Randomized clinical trials or efficacy studies are necessary, but not sufficient, to guarantee the efficiency or effectiveness of the treatment . [4]

Other authors also acknowledge these limitations in generalizing research findings to clinical practice, as well as their application to other clinical cases. [3] Similarly, these authors cite another difficulty encountered: the fact that treatments that proved effective in a clinical trial may not be so later in clinical practice. Perhaps the stringency of such conditions may be influencing the low number of studies dedicated to seeking empirical evidence regarding therapeutic intervention techniques or programs, reflected in 5.9% of Chilean research and 2.29% of Argentine research for these purposes. [7]

An interesting question raised by some authors concerns the supposed rigorous control of therapy sessions in experimental studies. It arises from the fact that patients' lives are much broader and not limited to these sessions. Relevant situations occur in their lives, such as acquiring wealth, recovering from a failed marriage, and other events that, while not controlled by therapists, influence the results of interventions, even without the researchers' knowledge. Therefore, it is essential that researchers report all external details to the patients being studied. [14]

Some authors have defended the idea that the therapeutic results obtained are strongly related to the doctor-patient relationship, [15-16] a matter supported by long clinical

experience, which makes the measurement and control of the changes that are intended to be measured in the application of procedures whose effectiveness is to be supported more complex.

It is important to clarify that the perspective on PPBE is positivism taken to its extreme. However, the reasons that led to its emergence are valid, as are the practical guidelines that include considerations on how to provide care to patients and how to tailor treatments to their specific situations.

The fact that the evidence has been presented in terms of strength levels makes the rule somewhat more flexible, allowing for research designs that contribute some degree of the expected evidence for the procedures. Achieving experimental purity is difficult, as other variables influence the results obtained, and even if some control over these variables, such as the doctor-patient relationship, could be achieved, the degree of real significance for each patient remains to be determined, given the wide range of subjective experiences.

Supporting evidence-based practices (EBPPs) means defending the scientific foundation of psychological practices and valuing researchers' findings. At the same time, it means considering and evaluating the intervening factors from a qualitative perspective, a procedure that allows for multiple interpretations of the same intervention, further clarifying the results obtained and the specific contributions of the components involved. A mixed-methods approach can help resolve the differences in positions that currently seem irreconcilable, but science must be preserved, and patients must receive care supported by the research and clinical efforts of thousands of therapists who have made their modest contributions to psychotherapy.

The PPBE constitutes a valuable reference point to be taken into account and its requirements closely followed; however, there is a fairly widespread consensus that consists of applying several therapeutic modalities at the same time, knowing that qualitatively they enhance each other to generate a better effect on the clients of the therapies, the so-called multimodal treatments, [17] even their combination with pharmacological treatments.

A systems-oriented perspective makes it clear that diverse psychotherapeutic approaches, when combined, offer more promise than single-type therapies. Similarly, the complex relationships between healthcare teams and patients, which significantly impact clinical outcomes, cannot be ignored. These issues pose challenges to research seeking to reconcile different perspectives without succumbing to an extreme positivism that, in its attempt to practice psychology, oversteps the boundaries of the discipline. Nor should it fall into a position that, by emphasizing qualitative aspects at best, neglects the methodological procedures and theoretical frameworks that facilitate the control of variables and lead to a

clearer understanding of the relationships between clinical practice and its expected multiple psychological effects.

About PPBE in the field of substance addictions

The most important psychotherapeutic approaches that have been studied in substance addicts are behavioral, cognitive-behavioral, motivational, and psychodynamic/interpersonal therapies. The effectiveness of group therapies, family/marital therapy, and attendance at self-help groups has also been evaluated. [18]

Several scholars on the subject outline the therapies proven for addiction, the most prevalent being cognitive-behavioral therapies. [2,7,19]

1. Multicomponent cognitive-behavioral therapy for smoking cessation;
2. Cognitive-behavioral therapy for cocaine and opiate dependence;
3. Brief dynamic therapy for opiate dependence; and
4. Multicomponent behavioral therapy in the treatment of alcoholism.

The *National Institute for Clinical Excellence's Guide to Alcoholism* recommends the following therapeutic modalities for the care of addicts, based on their proven effectiveness:

1. Cognitive-behavioral therapies focused on alcohol-related problems (one 60-minute session per week for 12 weeks);
2. Behavioral therapies focused on alcohol-related problems (one 60-minute session per week for 12 weeks);
3. Social and environmental network-based therapies focused on alcohol-related problems (eight 50-minute sessions for 12 weeks); and
4. Couples therapy focused on alcohol-related problems and their impact on relationships, to achieve abstinence or to maintain alcohol consumption levels agreed with the service and the therapist (one 60-minute session per week for 12 weeks).

Psychotherapeutic interventions for addiction are characterized by their wide variety, reflecting clinical heterogeneity. Self-deception, for example, is common in drug addicts, [20] and therefore interventions have been designed to address it, primarily using motivational interviewing, [21] which is highly specific due to its objectives and methodology, but while necessary, it is not sufficient. Because addiction often involves avoidance of experiences, symptoms, and/or memories, *Acceptance and Commitment Therapy* (*ACT*) has also been used, [22-23] while relapse prevention training and its variations have been employed to prolong abstinence. [24] Similarly, other

psychotherapeutic modalities could be cited that aim to achieve different objectives than those mentioned above and which cannot be met by the methods discussed.

Addictions are complex and varied, a condition that requires the application of multimodal treatments. Even at the level of group psychotherapy, more than one type is needed to achieve diverse psychotherapeutic goals that complement the expected effects. [25] Likewise, the second principle characterizing drug addiction treatment, established by the U.S. National Institute on Drug Abuse (NIDA), posits that there is no single treatment appropriate for all patients. [26] This means personalizing treatments and expanding the range of individual intervention modalities in response to the clinical heterogeneity of drug addicts, thus necessitating the development of specialized treatments for subgroups of patients with different needs. [17]

Inspired by the complexity of addictions, *Sánchez* stated: "The use of treatments that have demonstrated effectiveness is an obligation for professionals, although it must be considered that in the field of addictive behaviors, many cases cannot be treated on the basis of them, since the needs of patients often require flexible and personalized methods." [18]

It is even suggested that in the same patient there are different moments to be addressed clinically, which implies formulating dissimilar therapeutic objectives in each patient, with different approaches and therapeutic resources as well.

Knowing this reality in addiction and considering the guidelines established by the APA, while taking into account the characteristics of our context, we start from the principle of multimodal treatments. From this, researchers will have to deal with the challenge of conducting research in circumstances where the patient must, for obvious reasons, be under a comprehensive system of therapeutic influences. This explains, to some extent, why quasi-experimental studies on PPBE have been carried out, comparing the influence received by two experimental groups. Both groups received the same treatment, and only one received an additional treatment, to see if there were significant differences regarding abstinence or other appropriately chosen variables. [28]

It is suggested that as many favorable and unfavorable influences as possible surrounding a patient under study be identified, along with their perspectives on these influences, to improve the accuracy of future outcomes. Social work and interviews are extremely useful for this purpose.

Mixed-methods designs that allow for the evaluation of non-quantifiable components, such as the doctor-patient relationship or the therapeutic community system for hospitalized patients, among others that significantly strengthen healthcare management, should be

considered. Focusing research efforts on more specific problems for subgroups of patients who share common issues is also a current need in this field.

For general knowledge, I would like to highlight that a review is currently being prepared by a team from the *National Institute for Clinical Excellence* (Protocol) to define the effectiveness of *Mindfulness* in the treatment of drug addicts. Based on its conclusions, it may or may not be included in the list of therapies we have previously presented as having proven effectiveness. [27] Furthermore, it is very useful to point out that the *National Institute for Clinical Excellence 's Guide to Alcoholism*, which we have referenced, includes a section outlining topics that require further investigation and the importance of each one in particular for the purpose of improving the treatment and prevention of these problems, so that it can serve as a guide for researchers in their work plans.

In summary, evidence-based psychological practices, on the one hand, are not new ideas, and on the other hand, they encourage reflection on the true technical challenges and ethical commitments inherent in those who dedicate themselves to psychology as a science and profession. These are issues already present in clinical practice and require professionals to constantly refine their theoretical and methodological precepts, while also distinguishing themselves from other approaches, such as empirically supported treatments.

Empirically supported treatments represent another approach to psychological practice, one that places excessive emphasis on controlled empirical evidence, disregarding the psychologist's expertise, the client's cultural background, and other types of evidence. [29] In contrast, evidence-based practice (EBPP) is based on best available evidence, where the client's idiosyncrasies and values are paramount, clinical expertise provides the conceptual framework, and intervention is embedded within ethical parameters. It is EBPP, then, that lends credibility and rigor to our discipline. [29]

Therefore, we believe that PPBE will, over time, distinguish between professional practice and practice that may be questioned at a clinical, forensic, and social level. [30]

Finally, biopsychosocial-spiritual-environmental approaches are rarely discussed in periodicals in Cuba and Latin America. Therefore, this could also serve as a call for attention to the professional practice of psychology in the clinical field in general, and in the understanding and treatment of addictions in particular. The professional practice we aspire to—the use of biopsychosocial-spiritual-environmental approaches and the biopsychosocial-spiritual-environmental support needed by each of the populations that request them—requires taking these considerations into account in order to minimize ineffective or pseudoscientific procedures and actions that are not supported by sound methodologies.

CONCLUSIONS

One of the biggest challenges in studying the effectiveness of interventions for drug addiction is the fact that addictions require multimodal treatments, which demands greater rigor in properly attributing the effectiveness provided by each of the care management practices used.

It is obvious that a look at the intervention modalities recognized as effective in addictions reveals quite few in relation to the many intervention variants we apply in Cuba. Among these, we recognize the effectiveness of the therapeutic community and autonomous groups functioning within the inpatient institution, to cite a few examples. [25] There is a need for national scientific production that highlights the true value of what we do in these terms.

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Appendix Recommendations from Section 12 of the APA (1995)

1. We recommend that a list of proven effective treatments be established and updated as evidence becomes available.

2. It is critical that more evidence of the effectiveness of psychodynamic therapies for specific disorders be obtained.

3. We urge visitors to the APA website who are pursuing doctoral accreditation to prioritize training in empirically validated treatments. This will be one of the criteria used for their accreditation.

4. That the Education and Practice Boards facilitate training by working with various national institutes to seek researchers' permission for the informal publication of treatment manuals once efficacy data have been increased.

5. That the APA site visitor team undergo training in empirically validated treatments as a criterion for their accreditation. Specifically, we suggest that each student completing the training be proficient in at least one intervention with proven efficacy.

6. We urge the APA to strengthen common guidelines by requiring documentation on the effectiveness of new therapeutic procedures to be discussed in APA-approved workshops as educational credits.

7. Even without considering how well established a therapeutic procedure is, if the APA subsidizes a continuing education program, the organizers and presenters must be listed on all promotional material if their techniques are empirically validated.

8. We consider supervised clinical work a requirement for the ethical practice of new procedures and urge the APA to adopt this position in its standards.

9. We urge the APA to encourage the development of innovative programs combining structured didactic learning with supervised clinical practice.

10. We suggest that a regular column of databases on upcoming treatments be published regularly in the Monitor.

11. We suggest establishing APA treatment funding roundtables and semiannual conferences where clinicians and researchers come together to identify important research issues in psychotherapy.

12. That the APA assist the state of the psychological association in curriculum development and training for empirically validated trainings and offer this through the HMO and other mental health centers.

13. That at the national APA organization level, work be done with the national HMO organization guild to educate its leaders about the benefits of updating the training of therapists employed by the members of their organizations.

14. That the APA work with these offices (*Office of Knowledge Exchange, Office for Scientific Inquiry*) to encourage the dissemination of findings on the benefits of empirically validated treatments.

15. That the APA Board of Directors, in the public and practical interest, develop advertised fixed public services and media campaigns for well-defined popular segments.

16. That the communications office maintain a regular exchange with science writers about the development of empirically validated treatments as well as other findings in psychological research.

17. In the practical and public interest, the Board of Directors should conduct research to identify negative attitudes about psychotherapy and design campaigns to address them.

18. APA works to make financiers aware of the empirically documented benefits of psychotherapy for emotional disorders.

19. The APA should encourage institutes to fund research into long-term treatments for populations that require them.

20. The APA needs to continue its efforts to educate funders on the health benefits and cost-effectiveness of psychotherapy.

Conflict of interest

The author declares that there is no conflict of interest.