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Promoting a Practitioner-Based Agenda in the Development, Dissemination, and Implementation of Empirically Supported Treatments

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ABSTRACT

In an effort to integrate scientific inquiry and clinical practice, Division 12 (Clinical Psychology) of the American Psychological Association has compiled and disseminated a list of Empirically Supported Treatments (ESTs). These are evidence-based interventions for diverse psychosocial problems that have been subjected to rigorous scientific trials and have been found to be efficacious for specific target populations. However, universal acceptance of the EST movement has not occurred. This paper will enumerate three barriers to the successful development, dissemination, and implementation of ESTs that practitioners cannot change and three barriers to each that practitioners can change. We suggest that successful EST implementation may best be facilitated through a thoughtful consideration of the limits of development and dissemination and by an active promotion of a practitioner-based agenda. The lack of a concerted effort on behalf of practicing clinicians to more fully participate in the EST movement lies at the core of the problem and the beginning of its solution.

INTRODUCTION

There is a growing trend to develop and disseminate efficacious psychotherapy interventions. The most visible evolution of this trend is the American Psychological Association (APA) Division 12 (Clinical Psychology) Taskforce, which has compiled and regularly updated a list of manualized Empirically Supported Treatments (ESTs). Most of these psychotherapies are cognitive/behavioral in orientation and focus on the treatment of identifiable DSM diagnoses. The methodology of study for ESTs is modeled after guidelines used to demonstrate the efficacy of medications. While multiple case studies may be sufficient to establish a treatment as empirically supported, the preferred methodology is a randomized clinical trial in which patients are randomly assigned to, at minimum, either a control group or a treatment group. Pre- and post-treatment assessment allows researchers to assess change to determine whether or not a specific psychotherapy is efficacious. According to the criteria adopted by the Taskforce, in order for a treatment to be considered empirically supported, it must demonstrate superiority to a placebo or an inert treatment, such as a control group (Chambless & Hollon, 1998). Another requirement is that ESTs be manualized, which allows them to be implemented consistently by various professionals and presumably reduces variability attributable to the therapist.

The EST movement has been largely motivated by the pressure to provide evidence to managed care companies that certain psychotherapies are efficacious and are therefore worthy of reimbursement. Since the inception of the Taskforce, psychotherapy research has increased significantly and the focus has been largely on identifying treatments that have specific active ingredients that can be demonstrated to be causal agents in effecting change. This has meant that the EST movement has assumed a strong medical model approach in which non-specific factors inherent in all psychotherapies are largely ignored in the same way that placebo effects are ignored in medical trials (Wampold, 2001). While the medical model is not shared by all psychologists, the motivation to demonstrate through research that psychotherapy is effective has been a focus of professional psychology for decades.

In response to the EST movement, Division 17 (Counseling Psychology) recently drafted seven principles for use in evaluating the efficacy of various treatments (Wampold, Lichtenberg, & Waehler, 2002). These address issues such as measuring success in psychotherapy, addressing the importance of clinically significant change (rather than only statistically significant change), and focusing on problems that are not captured in the DSM, such as vocational interventions, marital conflict, and anger management. While greater effort probably needs to be given to the collegial validation (Norcross, 1999) of the criteria proposed by Division 12, both clinical and counseling psychologists have been vocal advocates for a psychology that is rooted in science and informed by clinical practice. However, disagreement with regard to the objectives of the EST movement has limited their acceptance by practitioners.

This article will address these issues by (a) summarizing the EST debate, (b) offering a rationale for embracing the EST movement, and (c) exploring barriers to universal development, dissemination, and implementation. It will be argued that there are three barriers that

practitioners cannot change and three barriers that practitioners can change, the careful consideration of which will directly impact the success or failure of the EST movement. As an overarching theme, the importance of a practitioner-based agenda will be presented as a means of actively involving practitioners in this debate and as an ingredient that is essential to the successful development and utilization of ESTs. In exploring the steps necessary for the EST movement to develop to fruition, the divisions delineated by Gotham (2004) will be used. These include (a) technology development—devising and testing new treatments, (b) technology dissemination—transferring treatments to practitioners, and (c) technology implementation—using treatments in clinical practice. As Gotham indicates, differentiation among these stages helps to avoid confusion while informing intervention strategies specific to each.

Criticism of the EST movement is of importance to its success, and consideration given to those who do not share this agenda is vital to its expansion. Imbedded in this discussion is the recognition that there are currently a large number of clinicians who may not be easily persuaded to conform to the Taskforce recommendations, and that choosing not to include them in the EST dialogue will ultimately impede its success.

Opponents argue that ESTs will divide academicians and clinicians, fragment clinical skills, retard research, and negatively impact education and training (Garfield, 1998; Henry, 1998; Norcross, 2002). Others argue that ESTs do not accurately reflect real-world practice because they emphasize internal consistency in research trials at the expense of the ecological validity of the practice environment (Seligman, 1995). Since ESTs, by definition, are manualized, some have criticized treatment manuals on the grounds of not allowing self-correction, undermining clinical artistry, and neglecting case information (Addis & Waltz, 2002; Norcross, 2002). Finally, it has been argued that ESTs are inconsistent with research indicating that successful psychotherapy occurs when several common factors are present, such as an emotionally-charged therapeutic relationship, the opportunity to practice new ways of relating, and a cogent theory to explain the onset of problems from which techniques that lead to behavioral and affective change can be logically derived (Frank, 1982; Norcross, 2002).

While many of the above criticisms have been answered to varying degrees (Addis & Waltz, 2002; Arnow, 1999), they remain relevant issues that impede endorsement of ESTs by many clinicians. We must continue to be self-reflective and critical of our research if we are to be a successful profession. Even still, there are several reasons that compel practitioners to embrace the EST movement. These include the arguments that ESTs are (a) a natural outgrowth of a science-based profession (unique to psychology and distinguished from other helping professions), (b) an ethical duty of psychologists (Arnow, 1999), and (c) a reasonable response to the challenge of managed-care (Beutler, 1998; Hunsley & Rumstein-McKean, 1999) and the non-empirical standard of effective treatment as defined by the legal justice system (Deegear & Lawson, 2003). Moreover, ESTs may lend themselves to practice guidelines, a task that could easily be assumed by another professional body with less expertise (Bologna, Barlow, Hollon, Mitchell, & Huppert, 1998) and hasten the dwindling professional autonomy of psychologists (Nathan, 2000).

As a science-based profession, controversy notwithstanding, psychology is obligated to embrace the EST movement. While this does not imply a blind endorsement of the Taskforce recommendations, it does suggest that greater involvement by clinicians is essential to any successful promotion or reshaping of the current EST agenda. It is important to the future of psychology that we work to mend the rift between those who conduct research on psychotherapy and those who translate this research into practice. Indeed, it may be argued that psychology has always promoted a scientific agenda as its founding philosophy in the same way that medicine has been rooted in empiricism and its promotion of Evidence-Based Medicine a reaffirmation of its origin (Gupta, 2003).

Division within psychology, however, may fragment the field and provide opportunities for the expansion of non-science-based professions to the sacrifice of psychology. For example, it has been argued that clinical social work, amid some controversy (see Thayer & Myers, 1998), should not endorse the EST movement because the underlying philosophy of social work is incompatible with (a) a disease model, (b) psychotherapy as a singular psychosocial intervention, and (c) the emphasis on empirical findings to the neglect of clinical judgment (Raw, 1998; Witkin, 1998). As such, psychology is the sole proprietor of a claim to science as the foundation of its practice. Embracing this claim may solidify psychology's future in an unstable market by providing opportunities to develop or evaluate ESTs and by increasing reimbursement potential for clinical services through the compilation of convincing research evidence (Cummings, 1995).

If the field of behavioral health parallels that of medicine, psychology may find itself in a unique position as a leader among other mental health professions in the dissemination and implementation of ESTs. There are, however, important issues that are likely to impact both the reasonableness of the extant EST agenda and the success of any modified agenda.

BARRIERS WE CANNOT CHANGE

Three barriers to the development, dissemination and implementation of ESTs over which we have little or no control as practitioners include (a) the heterogeneity of the profession (development barrier), (b) increased specialization (dissemination barrier), and (c) managed care (implementation barrier). In varying ways, these barriers strain the practice environment, and a thoughtful consideration of each may help clarify our expectations with regard to ESTs.

The heterogeneity of the profession is a barrier to EST development. While the majority of psychological training programs adhere to a scientist-practitioner (Boulder model) approach both in philosophy and course requirements (O'Sullivan & Quevillon, 1992), there are a number of practitioners who, for various reasons, do not. There are professionals who view ESTs as theoretically narrow or discriminatory against schools of psychotherapy other than cognitive/behavioral. These practitioners are unlikely to recognize the need for EST development and to be antagonistic towards any such efforts. A reality of our profession is that there will always be practitioners who resist change, are minimally invested in their work, or intentionally

assume a polar stance in reaction to the modal values of the profession. Contrary to common belief, these practitioners are much needed in their opposition; their antagonistic position is necessary to monitor the progression of science and remind those who promote ESTs that the targets of their treatments are not "disembodied entities" (Elkin, 1999, p. 27). A thoughtful consideration of the role that non-scientific professionals play in the development of science is fundamental to the success of its goals. How this is to be accomplished while continuing to promote a scientist-practitioner model will be a challenge of immense proportion to the leaders of our field, yet one which seems essential to its expansion.

Increased specialization has exerted an influence on EST dissemination, particularly in its influence on clinical decision-making. Paralleling the medical profession, psychology has witnessed a burgeoning of specialties as research has increased with regard to specific patient populations and disorders. One unfortunate consequence of this advance is that professionals are more vulnerable to information processing errors, particularly the availability heuristic (Wierzbicki, 1993). This occurs when the probability of the presence of a disorder is overestimated because prototypes of that disorder are readily available in long-term memory. The effect this may exert on EST dissemination is that practitioners in specialty areas may be vulnerable to overestimating the prevalence of a particular clinical syndrome by virtue of their frequent exposure to the same.

Further, as non-empirical interventions are refined through experience and reinforced by illusory correlation (Hunsley & Rumstein-McKean, 1999) and over-estimated confidence (Dawes, 1994), they may evolve (or devolve) into recalcitrant philosophical approaches that are cloaked as professional prerogatives. As evidence, a recent survey of eating disorder specialists found that less than 40% adhered to cognitive behavioral therapy (a treatment of demonstrable efficacy for this population) (Mussell et al., 2000). Mussell et al. further noted that of the reasons psychologists gave for using empirically-based techniques, compatibility with their theoretical orientation was cited with nearly the same frequency as whether or not the technique was based on research evidence. That is, we evaluate data according to the theory we adopt and reject that which is inconsistent. As we become increasingly specialized we run the risk of developing a more narrow focus with regard to important decisions we make, which makes us increasingly vulnerable to errors in judgment while our commitment to non-empirical intervention expands.

Based on the current trajectory of the profession, it seems unreasonable to expect all practitioners to abandon their subjectively true interventions for manualized, albeit empirical, protocols. While there seems little that can be done to curb this development, it may help if the promoters of ESTs more effectively integrated the role of clinical decision-making into standardized protocols, creating for resistant practitioners a viable place for their clinical impressions. However, as this is not likely to be a panacea, the goal of EST dissemination may need to be reconsidered and adapted.

Managed care has slowed the delivery and implementation of efficacious psychotherapy, in a way counter to its intention. It is because of the increased accountability and cost-driven

orientation of HMO's and MCO's that many professionals are overworked and under-compensated. Lacking time and energy, they may neglect current psychotherapy research (Montgomery & Ayllon, 1995) or may be financially unable to devote premium clinical time to professional development. The unfortunate irony of this situation is that ESTs may be the only reasonable response to the demanding environment of managed care. As Cummings (1995) has argued, psychologists who are unable to demonstrate the clinical and cost-effectiveness of their services will die out and be replaced by those who can. Because of their analytical and integrative skills, psychologists are equipped to collect and evaluate data that demonstrates the financial benefits of the specific product(s) they market.

In spite of these hopeful alternatives for working within the managed care system, the reality of the contemporary practice environment is such that many practitioners will simply be unable to integrate ESTs into their practice. This barrier both decreases the likely success of universal implementation and challenges proponents of ESTs to take a more active role in packaging efficacious treatment in a way that is attractive to practitioners and consistent with a pressured work environment. The existing criteria may need to be modified by the Taskforce in an attempt to be responsive to the realities of the practice environment.

While there are elements within each aforementioned barrier for which we can, with effort, assume limited responsibility, the realities of heterogeneity within the profession, increased specialization, and managed care are, for the most part, unalterable by simply promoting rational argument. These barriers constrain the extant EST agenda. Yet, in order to work successfully within these barriers, those who promote ESTs are encouraged to package treatment protocols in a more user-friendly manner, provide information to practitioners on the limits of clinical judgment, and develop a set of expectations for practitioners within which is clearly articulated a role for those who choose not to practice ESTs. By necessity, the goals of the EST movement may need to be reconsidered and changed, inclusive of a place for all professional psychologists. To do otherwise would only ostracize members of our own profession and promote the elitism that has plagued psychology with regard to other important topics, such as subdoctoral training and prescription privileges.

BARRIERS WE CAN CHANGE

There are three barriers to the successful development, dissemination, and implementation of ESTs that practitioners can remedy. These include (a) the inflexibility of research methods in EST innovation (development barrier), (b) the limited amount of research that has been conducted on supervision (dissemination barrier), and (c) the lack of established criteria for judging competence in EST delivery (implementation barrier). As barriers that can be controlled, or changed, these will be discussed from the perspective of viable recommendations for promoting a practitioner-based agenda.

One barrier to the development of ESTs is the lack of flexibility in selecting a research methodology to assess treatment efficacy. The majority of ESTs have been established through

internally valid experiments, or randomized clinical trials. While methodologically sound, these designs have limited external validity, and as such limited applicability to practitioners. Consistent with a practitioner-based agenda, “unorthodox” experimental procedures should be encouraged and utilized, the results of which should be integrated with those of extant randomized clinical trials to further demonstrate the validity of ESTs or expand the number of treatments that meet the criteria established by the Taskforce. Indeed, the Taskforce has indicated that treatment efficacy can be demonstrated through multiple case studies of sufficient sample size, a research methodology arguably appealing to and viable for practitioners. While it has been generally suggested that internal and external validity are inversely related (Gelso, 1979), this may be a false dichotomy, as Howard (1993) suggests. That is, it may not be true that as more variables in an experiment are controlled, the applicability of that experiment to the “real world” decreases. If so, this opens the way for methodologies as divergent as narrative reports and case studies. Such approaches may substitute for randomized clinical trials in replication studies or in the context of a restricted research budget. Because we do not all worship “at the alter of the randomized clinical trial” (Norcross, 1999, p. 475), alternative research designs may also increase collegiality. Psychology may benefit from establishing a research method hierarchy as has been promoted by the field of medicine (Gupta, 2003) as one means of guiding researchers who may be able to conduct research other than tightly controlled experiments and thereby contribute more meaningfully to the development of new ESTs.

Collaborating with providers in an effort to expand the research that supports the efficacy of extant treatments may be an important means of furthering the goal of EST development and insuring that interventions are quickly and effectively distilled beyond the walls of academia. Case studies, for example, may have a distinct advantage over randomized clinical trials in identifying critical activities or therapeutic "events," which could complement and extend common factors research. For example, techniques designed to heighten awareness (a common factor reported by Prochaska and Norcross, 1994) could be pooled over several manuals and its outcome variance compared across different treatments. This may lead to different recommendations regarding the timing of or extent to which this technique should be used across different treatments with different diagnostic groups. A similar concept has been promoted by Drozd and Goldfried (1996).

In unison with the expansion of a practitioner-based agenda, there is a need to broaden the definition of those disorders for which ESTs are developed. Most ESTs target specific DSM-IV-TR diagnoses. However, because these criteria reflect narrow clinical entities (Wilson, 1993) of questionable distinction (Barone, Maddux, & Snyder, 1997), broadening the criteria for which ESTs are developed may increase their ecological validity. Indeed, the majority of EST researchers surveyed by O’Donohue, Buchanan, and Fisher (2000) indicated that a DSM diagnosis does not solely inform their treatment recommendations. There is a need for ideographic assessment (Davison, 2000), theory-driven intervention (Persons, 1991), and treatment guidelines based on problems not reflected in the current diagnostic nomenclature (Iwamasa & Orsillo, 1997). Forming diagnostic groups on the basis of an assessment of interpersonal relationship patterns (Kiesler, 1991) may be one alternative. The principles

proposed by Division 17 in review of ESTs for anger management (Deffenbacher, Oetting, & DiGiuseppe, 2002), career counseling (Whiston, 2002), and family therapy (Sexton & Alexander, 2002) exemplify this approach. As Norcross (1999) has noted, "it is frequently more important to know what kind of patient has the disorder than what kind of disorder the person has" (p. 474).

An important and relatively neglected barrier to the dissemination of ESTs is research on the use and effectiveness of supervision. While supervision has been touted as a vehicle to lessen resistance to manualized intervention (Luborsky, 1993), increase protocol adherence (Lambert & Arnold, 1987), and bridge the training gap between academia and clinical practice (Hayes, 1996), data on supervisor knowledge of and receptivity to ESTs is lacking. A perusal of the data published in the Directory of Clinical Psychology Internships (Blanchard, 1998) that provides a list of the ESTs for which predoctoral internships offer either (a) formal training, or (b) supervision only, suggests that the majority of available ESTs are not taught during internship and that supervision is provided for only a portion of all ESTs. By randomly selecting three internship sites from the east, west, and midwest, the mean number of ESTs for which supervision only is provided is 42 out of 72, whereas the mean number for which formal training is offered is only 19 out of 72 (clearly this is an informal estimate with limited validity, but hopefully emphasizes the importance and relative dearth of research on supervision and EST dissemination).

This informal finding suggests two things. First, the majority of students interested in ESTs must receive such training from their academic institution, not their internship site, if they are to receive training at all. Second, most internships may be unable to provide supervision for even a majority of those ESTs currently available. Consistent with this observation, a more formal survey of the training opportunities for ESTs in APA-accredited internship sites revealed that only 25% of sites provide 15 or more hours of training in ESTs (Hays et al., 2002). The issue of whether or not this is sufficient training for competence has yet to be decided.

Supervision is essential to the dissemination of ESTs because most therapists are unlikely to obtain the continuing education they need to reach competence in ESTs (Parloff, 1998) after internship. However, as discussed above, it is clear that such supervision is not being provided. As such, there are no data that address the issue of non-EST trained supervisors monitoring the practice of therapists trained in ESTs. Moreover, for those with some EST training, there is no consensus as to the amount, type, or length of supervision needed for proficient implementation of ESTs after formal academic coursework (Hunsley & Rumstein-McKean, 1999). As with clinical experience, there is a need to define the role that supervision should play in any effort to achieve proficiency in ESTs. Without a concerted effort directed at defining the role of supervision, dissemination of ESTs may be restricted only to certain practitioners, or may be a short-lived endeavor that does not persist beyond the first generation of those from select academic training programs.

There are several researchable issues with regard to supervision that have yet to be addressed. These include the fact that many supervisors have not been trained in ESTs, the power differential inherent in supervising beyond one's level of competence, openness to training supervisees intent on empirically-grounded intervention in settings where supervisors promote and practice non-empirical psychotherapy, and others. The need for more research in this area is consonant with the need to promote a practitioner-based agenda for EST dissemination. Full-time practitioners are in an ideal position to investigate the role of supervision, and in so doing provide details regarding difficulties with and problems in the area of supervision that are likely to impede the dissemination of ESTs. Without an empirical understanding of supervision issues, dissemination is likely to fail, and the EST movement archived as an erudite fade.

Finally, a barrier to the implementation of ESTs is the lack of established criteria for judging competence in EST delivery. There has been no agreement on the amount of time, type, or quality of training necessary to reach an acceptable level of competence in ESTs (Calhoun, Moras, Pilkonis, & Rehm, 1998). Without such guidelines, there may be a tendency to emphasize quantity over quality of clinical experience (Davison, 1998). The current emphasis on amassing clinical hours to compete for pre-doctoral internships reflects this trend. While quality and quantity of training are not necessarily mutually exclusive, without agreement on training expectations, competence is likely to be subject to the reductionism of numbers. It may behoove training directors in academic and internship programs to strive for a consensus on the relative importance of empirical vs. non-empirical skill acquisition. Recent practice guidelines and accreditation principles published by the APA and joint meetings among doctoral training councils (Thorn, 2000) seem to be a step in the right direction. However, more needs to be accomplished. Promoters of ESTs could specify necessary training criteria for each EST, including the recommended number of direct contact hours, type and duration of supervision, and any essential or recommended readings. These guidelines could be used to determine acceptable levels of training in each respective treatment. Arguably, such information should be packaged as a matter of consumer information to potential practitioners such that decisions could be made with regard to whether or not to integrate any given EST into one's practice. This would maximize the control that practitioners exercise over the scope of their practice and their efforts to infuse state-of-the-art treatments into their treatment repertoire.

Criteria for competence should also be applied to continuing education. While continuing education seems to be the ideal medium to disseminate psychotherapy to practitioners, there is little evidence it substantially alters therapist behavior (Calhoun et al., 1998). Perhaps more problematic is the lack of control over the content and quality of continuing education, and the fact that most workshops and seminars are too brief to adequately train clinicians (Davison, 1998). Viable alternatives may include workshops extended over several days, or multiple workshops with built-in supervision follow-up in the form of audio- or video-tapes (Calhoun et al., 1998). Mussell et al. (2000) found that 83% of respondents indicated a desire to learn ESTs, which suggests that the demand for education exists. The issue at hand is a clear definition of what is expected for practitioners to achieve a level of satisfactory competence. We suggest that

the implementation of ESTs would be more successful if agreement were reached with regard to competency expectations and if these expectations were provided to practitioners to accompany specific ESTs. A system of levels akin to professional credentialing may be one method of establishing criteria for competence; certification based on clearly-defined criteria would provide practitioners attainable goals and built-in rewards for their effort.

Amid controversy and criticism, there are three controllable barriers that present both a challenge to the EST movement and an opportunity to promote a practitioner-based agenda. These barriers include (a) the inflexibility of research methods used to establish the efficacy of ESTs, (b) engaging in supervision research, and (c) establishing criteria for competence in the practice of ESTs. Just as an initial impetus of the EST movement was to define efficacious interventions before managed care organizations, this is a timely opportunity for practitioners to redefine the parameters, methods, and goals of ESTs before these are so firmly established in our professional culture that change is impossible. This is the time for practitioners to be vocal with regard to establishing criteria for competence, to propose and carry out research on the impact of ESTs on supervision, and to argue for and conduct case studies and other "unorthodox" research methodologies that extend the efficacy of ESTs and contribute to extant findings with regard to critical therapy "events," the role of which may improve treatment efficacy and promote respect for patient differences and autonomy. If we fail to promote a practitioner-based agenda, the EST movement is likely to be restricted to a minority of psychologists, limiting its potential to affect lasting and significant change on the mental health field and its recipients.

CONCLUSION

The successful development, dissemination, and implementation of efficacious psychotherapies must include a rational acknowledgement of its limits. Thoughtful consideration of the qualities of the practice environment, such as managed care, increased specialization, and diversity among psychologists necessarily tempers any aspiration of universal implementation. While these issues challenge the leaders of this movement to be more responsive to clinical demands, they also encourage practitioners to be more active in their articulation and promotion of a practitioner-based agenda. Ubiquitous dissemination and implementation of ESTs is unlikely. As such, we suggest that promoters of ESTs clearly delimit the expectations, scope of practice, and role of all psychologists in this movement, inclusive of those who refuse to practice evidenced-based interventions. If only a portion of practitioners are persuaded, to what benefit is this to the greater profession, much less to the majority of our clients? It is the responsibility of all practitioners to be more active members of the EST movement and contribute to its structure, objectives, and methods.

Promoting a practitioner-based agenda has been offered as a means to decrease the polarization of the EST debate and improve the likelihood of its success based on thoughtful and reasonable professional objectives. What is required is a flexible, collaborative attitude with respect to the interface between those who promote ESTs and those who practice them. If we continue to ostracize members of our profession, our efforts to develop, disseminate, and

implement ESTs will likely fail; if we continue to be silent in our opposition of the extant research agenda, we will likely have no voice in its evolution. In a general sense, what is needed by all practitioners is a recommitment to the foundation of our profession, which is a bold call not only to mouth the words of a scientist-practitioner philosophy, but to live them as well.

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