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Smoothing the Trail for Dissemination of Evidence-Based Practices for Youth: Flexibility Within Fidelity

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The role and implementation of evidence-based practice and empirically supported treatments has been hotly contested among researchers and practitioners. Using examples of and from various empirically supported treatments the authors offer suggestions for smoothing the pathway for dissemination of evidence-based practice with children and adolescents. The authors underscore that mediational analyses, treatment process studies, and the continued creation of flexible treatment manuals as important components of successful dissemination. Flexibility within fidelity is proposed as the preferred perspective that eases the transition and dissemination of empirically supported treatments from research clinics to service clinics.

Keywords: evidence-based practice, empirically supported treatments, children and adolescents, flexibility within fidelity, treatment manuals

Professional psychology has, at more than one point in its history, witnessed increased attention for the need to bridge the gap between science and practice. Often the arguments have been that practitioners were not practicing what researchers had found to be efficacious. It is also worth noting that rarely were practitioners actively informing researchers of the topics and themes to be investigated. Rather, the people involved had taken sides—either by job choice, preexisting predilections, or the merits of one set of arguments. Unfortunately, taking sides has contributed to building barriers more than bridging gaps. Whether or not our opinion is true, it is arguably true that the “bridging” process is best accomplished from two directions.

In this decade, the bridging the gap mantra pertains to evidence-based practice (EBP). Much has been written to advance the arguments supporting a central role for empirically based treatments (EBTs) and empirically supported treatments (ESTs) in clinical practice (e.g., Barlow, Levitt, & Bufka, 1999; Cukrowicz et al., 2005; McCabe, 2004; Ollendick & Davis, 2004). Complicating the matter further are the subtle distinctions between these terms, which have sometimes been used interchangeably and incorrectly. All of the opinions have not appeared in print: With greater candor and some malice, much more has been said than written. Indeed, we have witnessed and have been participants in both cooperative and collegial conversations as well as controversial and contentious commentaries on the merits and demerits of EBTs, ESTs, manual-based therapy, and related topics. The American Psychological Association issued a statement in support of EBP in psychological practice (Levant, 2005), underscoring the importance of bridging the gap between research and practice. However, the evidence indicates that in the majority of clinical settings, this has not occurred (Addis & Krasnow, 2000); thus, the American Psychological Association mandate has made it necessary now more than ever to cross the chasm.

Before entering into discussion and proffering ideas meant to smooth the trail, it is essential that we define our terms (see Beutler, 1998; Kendall, 1998; Kettlewell, Morford, & Hoover, 2005). The several terms can be viewed on a continuum of increasing scientific control, with EBP being the least controlled (including both scientific principles and clinical judgment), and studies of EST being the most controlled (such as in randomized clinical trials). This differing level of scientific control does not pass value judgments on the relative importance of the different criteria, but merely reflects a distinction between the terms. Given such a continuum (i.e., inherent flexibility in the criteria) there is room for various kinds of research designs for outcome research (e.g., a single-case design may be appropriate at one point, whereas a random clinical trial would be more appropriate at another).

What is meant by the term EBP? The definition offered by American Psychological Association suggests that to effectively practice EBP, clinicians must apply empirically supported principles toward treatment. However, there is also room for clinical expertise to synthesize scientific findings with individual client characteristics. Another oft-used term is EBTs. What is meant by this term? Empirically based indicates that there is research support for the ingredients of the treatment. A basic feature of an
intervention that is said to be empirically based is that the determination of what should be included in the treatment has been based on the disorder and what is known about it as identified in basic research (examples to follow). What is intended by the term ESTs? Although there are some disagreements, a basic feature of any intervention said to be included within this category is that the intervention has been evaluated scientifically with sound methodology (e.g., a randomized clinical trial) and when judged against a set of outcome standards has been found to meet the criteria. Regarding ESTs, one can further ask “What are the criteria to be applied when identifying an EST?” For the specifics we refer you to Chambless and Hollon (1998) and to the special issue of the Journal of Consulting and Clinical Psychology (Kendall & Chambless, 1998) and the Journal of Clinical Child Psychology (Lonigan & Elbert, 1998). In short, the criteria include that the intervention be tested using methodologically sound evaluations with real patients, that there be consistent findings across studies, and that supportive outcomes are provided by more than one research setting or proponent of the treatment. We suggest that all three practices are important. In the effort to cross the chasm between research and practice, EBP is a great place to start, and randomized clinical trials offer valuable information.

Before we engage in discussion, we ask that you the reader to put aside all of your preexisting positions, be they practice oriented or research focused. We ask that you temporarily table your tendencies to support or discourage EBTs or ESTs, and that you further separate from your other biases. Having done these challenging requests, we now ask that you take a moment and ask yourself the following question: “What should we, as professional psychologists, use to select and justify a treatment approach?” Although this question shall be put aside for now, keep it in mind for reconsideration at a later point.

Illustrations of EBTs for Youth

Illustrations can help to define a category. To delineate what is meant by EBTs, we describe examples from treatments for youth who are depressed, anxious, and who have aggressive and conduct problems. These examples are illustrative, and the list is therefore not meant to be exhaustive. With regard to depression, for instance, studies have identified that depressed youth hold negative views of themselves that are not accurate (Kendall, Stark, & Adam, 1990). That is, a young girl with depression may think she is unattractive, not liked by peers, unathletic, or lacking intelligence. What is important to know about these beliefs is that, according to findings from research, they are often inaccurate. The youth is not significantly more or less attractive, popular, athletic, or smart than the bulk of the youth in the classroom.

Examine the findings of a study of just this matter (Kendall et al., 1990). It was found that, in terms of self-perceptions of academics, social status, physical appearance, and the like, children with depression saw themselves as below their classmates, whereas teachers of these same youth rated the youth with and without depression as indistinguishable on these factors. The teachers, informed by having many children in class and rating each member of the class on the same dimensions, did not rate youth with depression (as defined by self-report and for some, youth diagnostic evaluations) as meaningfully different from youth who do not have depression. Thus, research has found that the self-deprecating beliefs of youth with depression are not veridical but are misperceptions of their relative status on several dimensions. An empirically based intervention would, logically and with good clinical intention, target such inaccuracies in self-perceptions as an appropriate focus for treatment (e.g., Stark & Kendall, 1996; Stark et al., 1996). Clinical research and practical wisdom combine to inform the therapist not to argue with the youth nor try to convince them that their beliefs are inaccurate. Indeed, data suggest that testing the accuracy of the beliefs can be helpful. For example, holding the belief that “no one likes me” can be tested via a survey in which individuals are asked to list the names of people who like them. Such a survey (data gathering) can also test (serve as a behavioral experiment) to challenge (without conflict) the inaccurate belief. Such an intervention is empirically based.

Regarding youths with conduct and aggression problems, basic research indicates that these youth display a misattribution of intentionality. That is, aggressive youth see negative outcomes from ambiguous situations involving others as having been intentional and provocative, and thereby justifying their retaliation (Dodge, 1985). An event occurs, the event is interpersonal and has an unwanted outcome, but the cause of the outcome is unclear. An aggressive youth is prone to bypass the lack of clarity and assume, with some conviction, that the unwanted outcome was purposeful—the other person did it on purpose and, with that initial belief, it is not far to then conclude that the situation requires retaliation (e.g., “I’m not gonna let him get away with that”). Interventions that include role-play exercises (see Lochman, Powell, Whidby, & Fitzgerald, 2006; Nelson, Finch, & Ghee, 2006), in which different youth play different roles in a revolving fashion, permit participants to experience the same incident from multiple points of view. Such a perspective-taking exercise facilitates the youth with conduct disorders to challenge the attribution of intentionality. Consider the following question that can be attached to the exercise: “If it wasn’t on purpose when I bumped him, how can I be sure it was on purpose when he bumped me?” Such a research-based social cognitive processing error (misattribution) is a proper target for intervention; the role-play challenges the inaccurate attribution, and such an intervention is empirically based.

For youth with internalizing problems linked to anxiety, research findings indicate that anxious youth (a) cognitively misperceive threat (e.g., Vasey, El-Hag, & Daleiden, 1996) and anticipate catastrophes, (b) do not recognize the modifiability of emotions (Southam-Gerow & Kendall, 2000), and (c) engage in behavioral avoidance (e.g., Barrett, Rapee, Dadds, & Ryan, 1996) that is maintained by negative reinforcement. An empirically based intervention targets these cognitive, emotion management, and behavioral features by addressing the probabilities of events and the manner with which emotions are modifiable and by not permitting avoidance (as in exposure tasks). For example, in the second half of the Coping Cat program (after the child has learned coping strategies; Kendall & Hedtke, 2006a, 2006b), opportunities are provided for the child to practice his or her newly acquired skills in challenging anxiety-provoking situations (the child does not engage in behavioral avoidance). A child who is distressed about speaking in front of others would first discuss the matter with his or her therapist and the two would collaboratively brainstorm the coping strategies to use in the actual situation. The child then speaks in front of others (exposure task). After the exposure, the child and therapist think about the experience, and the child is...
rewarded for effort. Following the exposure task, the child is more prone to engage and face other anxiety-provoking situations, as well as be more willing to again speak in front of others (Kendall & Suveg, 2006).

Psychological disorders in youth are diverse: There are problems associated with each, but the cognitive, emotional, behavioral, and familial features vary. No one intervention is appropriate for all disorders (Kiesler, 1966, 1971) or for youth of all ages (Kendall, Lerner, & Craighead, 1984). The bottom line is that the components and targets of an EBT are based on the nature of the disorder as identified in basic research. Theory and experience are important in the provision of an intervention (i.e., therapy, prevention), but EBTs rely on more than theory and more than clinical experience to inform the intervention.

Examples of ESTs for Youth

The main difference between the EBTs illustrated above and ESTs are that ESTs comprise those that have passed the test of treatment-outcome evaluation (see Ollendick, King, & Chorpita, 2006). These outcome evaluations are typically randomized clinical trials with real patients who have met criteria for the disorder who are then randomly assigned to a treatment condition with independent and blind evaluators of the outcome providing data on the degree of change resulting from the treatment. The methodological niceties (e.g., random assignment, comparison treatments, independent evaluators, proper statistical comparisons) that are a part of modern randomized clinical trials (see also Kendall, Holmbeck, & Verduin, 2004) allow one to have reasonable confidence in both the findings and the clinical applicability of the findings. Examples of probably efficacious treatments for children and adolescents can be found in (a) books and chapters (e.g., Chamberlain & Ollendick, 2001; Christophersen & Mortweet, 2001; Hibbs & Jensen, 2005; Kazdin & Weisz, 2003; Kendall, 2006; Ollendick et al., 2006; Weisz, 2004), (b) the results of reviews available on Web-based resources (Substance Abuse and Mental Health Services Administration–sponsored contract run by MANILA Consulting Group, available at http://www.nationalregistry.samhsa.gov), (c) lists generated by professional associations (e.g., Herschell, McNeil, & McNeil, 2004; Burns, Hoagwood & Mrazek, 1999; special issues of the Journal of Consulting and Clinical Psychology, Kendall & Chamberlain, 1998, and the Journal of Clinical Child Psychology, Lonigan & Ebert, 1998).

For present purposes, examples of ESTs can be mentioned for conduct and aggression problems in youth (e.g., multisystemic family therapy, Henggeler & Borduin, 1990; parent–child interaction therapy, Brinkmeyer & Eyberg, 2003; coping power, Lohman et al., 2006; parent management training, see Kazdin, 2005). There are examples for youth with depression (Brent, Holder, & Kolko, 1997; Stark et al., 2006; Mufson, Dorta, & Wickaramatne, 2004; see also Weisz, McCarty, & Valeri, 2006) and for youth with anxiety disorders (e.g., Kendall et al., 1997; Pediatric OCD Treatment Study Team, 2004; see also Albano & Kendall, 2002; Piacentini, March, & Franklin, 2006). The interested reader can also consult summary chapters and articles that consider ESTs for the full range of childhood disorders (e.g., Herschell et al., 2004; Ollendick et al., 2006).

Treatment Fidelity and Manual-Based Treatments

Fidelity has to do with the degree to which the treatment as written (described and prescribed in the written treatment manual) was indeed the treatment that was actually provided to (received by) the patient (see also Perepletchikova & Kazdin, 2005). Although professional psychologists read treatment manuals, they are typically not fully trained or supervised (or certified) in providing ESTs. Our experience is that competent and reasonable practicing professionals pick and choose features of ESTs that they see as holding promise or being of merit. Entire EST programs are not as readily adopted as are the personally selected strategies or ideas that are a part of the larger program. Implementation of selected parts of an EST would not likely meet the rigorous research and clinical standards needed for treatment fidelity.

Treatment fidelity is not the same as treatment quality: Treatment quality refers to an expert judgment. When one is concerned with quality assurance, it takes an expert to review audio/video tapes of sessions to make quality judgments. When striving to smooth the path toward dissemination of ESTs, we are not yet so much concerned with measuring treatment quality as we are very much concerned with the fidelity of the intervention. Fidelity is typically determined by checking tapes of actual treatment sessions for adherence to the written treatment manual.

The mere mention of a treatment manual can, in some professional circles, contribute to distress and expressions of outrage. Treatment manuals have their critics (e.g., Bohart, O’Hara, & Leitner, 1998; Addis, Cardemil, Duncan, & Miller, 2006; Lambert, 1998; Westen, Novotny, & Thompson-Brenner, 2004), and these critics have pointed out that using a manual to deliver clinical services is too steadfast and linear, too much like a cookbook, likely to prevent creativity, likely to create technicians rather than clinicians, lacking in individuality, and that using a targeted manual does not match real complex client presentations. We do not disagree with all of these comments and criticisms. In fact, some treatment manuals do appear cookbookish, and several lack attention to the necessary clinical sensitivities needed for proper individualization and implementation. An EST may not be at fault, but a less than optimally prepared and presented manual may be culpable. However, although critics state that therapists might be offended by treatment manuals because of the criticisms noted earlier, one study found that over 75% of cognitive–behavioral therapists surveyed from the community indicated that they liked manuals either “a lot” or “a great deal” and found value in using them (Najavits, Weiss, Shaw, & Dierberger, 2000). Unfortunately, reported attitudes and actual implementation of manuals in a more diverse group of practitioners was not as positive, with 47% of clinicians reporting never having used a manual for their patients (Addis & Krasnow, 2000).

Advocates of treatment manuals, to varying degrees, have advanced that application of a treatment following a manual nevertheless requires clinical skill (Abramowitz, 2006). The therapist manual describes strategies for implementation, not exact or specific words to say. Advocates have also pointed out that therapist manuals facilitate training, are necessary for treatment evaluation, and are applicable to complex cases. In addition, and we believe this to be most important, treatment manuals can be implemented flexibly (see Kendall, Chu, Gifford, Hayes, & Nauta, 1998; Nock, Goldman, Wang, & Albano, 2004). When striving to smooth the
trail toward the implementation of ESTs, we can achieve flexibility within fidelity.

Flexibility Within Fidelity

To illustrate flexibility within fidelity, we use examples from a 16-session program for treating children and adolescents who meet diagnostic criteria for an anxiety disorder using a treatment manual (Kendall & Hedtke, 2006a) and a youth workbook (Kendall & Hedtke, 2006b). Eight of the sessions can be described as psycho-educational, and 8 involve exposure tasks (Kendall & Hedtke, 2006b; see also the separate versions for adolescents, www .workbookpublishing.com; www.childanxiety.org). Although the program includes, and participant youth experience, more than the following, the following components suffice for illustrative purposes: exposure tasks, rewards, parental participation, and celebrating success (e.g., certificate, commercial). In each component, although an umbrella concept is used, children have an individualized experience. It is also of interest to note that this particular EST was reported to have been implemented with flexibility (Kendall & Chu, 2000).

All participant youth complete exposure tasks, but the exposure tasks are entirely individualized for each client. Treatment for social rejection in the school cafeteria or for general worried distress about a parent’s health would include and require exposure tasks—but they would be done flexibly and specifically for the presenting problem (see Kendall et al., 2005). A potential exposure task for social anxiety might involve the teen doing a survey and asking other teens about cafeteria behavior. An exposure task for general distress about parental health might focus on open discussions about health issues and a call to an expert to ask questions.

Rewards, although consistent in value and in being contingent for effort, vary considerably across clients. Some are objects or toys, some are privileges, and some are social activities. The young girl who chooses a colored pencil set receives an individualized reward, as does the young girl who chooses a Frisbee. The walk outside with the therapist may be the selected reward for one child, whereas time playing a computer game may be the preferred reward for another child. All of these children receive rewards for their efforts in overcoming avoidance (fidelity), but the rewards are selected individually (flexibility).

Parents may contribute as collaborators or as consultants, and they may do each of these to varying degrees, but all parents are somehow involved. For example, treating a child with separation anxiety requires that the parent(s) be more involved than for a youth whose anxiety disorder is social phobia. When planning and conducting role-play activities for the child with separation anxiety, it is wise to have the parents role-play how they will act and react as the child displays greater autonomy. In contrast, role-plays for a child with social phobia would likely not include the parents.

As a last example, each of the events that come at the end of the Coping Cat program (e.g., the “commercial”) is orchestrated and crafted by the child. The act of creating a commercial (children put their treatment experience into their own words and tell someone else about what they have accomplished) and filming it has fidelity with the treatment protocol, but the actual event is entirely individualized. There have been displays of bowling down “fear” pins, singing songs of courage, and cartoon illustrations of mastery experiences.

For an example of flexibility within fidelity from outside of the Coping Cat program, consider the work of Nock et al. (2004), who discussed a young boy with panic disorder. Nock et al. illustrated how an adult treatment for panic disorder was modified into a developmentally appropriate treatment for a child. Although the authors deviated from the traditional treatment package, the modifications were necessary developmentally and were implemented flexibly (but with fidelity). The authors used continuous monitoring of the boy’s panic attacks and thus demonstrated an important point: When it is necessary to deviate from a manual a good deal, it is valuable to monitor and assess effectiveness at multiple points. Research is needed to examine the notion of flexibility within fidelity in an empirical manner to determine the boundaries of an EST (i.e., when flexibility turns into nonadherence).

Smoothing the Trail for Dissemination to Service Clinics

We believe that the whole of professional psychology is interested in providing optimal services for their clients. We recognize, however, that not everyone would agree that an EBT or EST is automatically preferred—that present arguments aside, flexibility within fidelity may be considered too difficult, and that approaches to treatment other than EBTs or ESTs may be chosen and implemented. Even when an optimist may be accurate and practitioners in service clinics are willing to accept that an EBT/EST can be applied flexibly and that there are client-driven individualizations that are proper and preferred, one might ask: “Can a smooth path be made for the dissemination of an EST from a research clinic to a service clinic?”

In an effort to smooth a path, potential speed bumps and pot holes will be identified and discussed. For example, ESTs are a very targeted effort—treatments are directed toward an identified primary problem, and for a time, practitioners implementing an EST would need to put aside other lesser matters. For example, an obese youth with depression who is receiving an EST for depressed mood might not receive a specific treatment for obesity. Will the inherent focus of ESTs be well-received in service clinics? A second example has to do with training. Those whose graduate training included ESTs will not have to relearn, but experienced practitioners without such training or education would have to gain needed training. Will they, and at whose expense? A last example, the supervision that is provided within the implementation and evaluation of ESTs is often a meeting point that spotlights encouragement and offers a supportive environment. The supervision in an evaluated treatment may be greater than the supervision provided when it is transported. In one EST, there was 2 hr of weekly supervision for 4–5 cases (Southam-Gerow & Kendall, 2006). Is such supervision available in service clinics, and if not, does the change in supervision affect the transportability of an EST to a service clinic (Kendall & Southam-Gerow, 1995)? In addition, there are more complex issues that face the implementation of ESTs. For example, the reality of managed care and reimbursement is that it is not always guaranteed that insurance will cover the number of sessions necessary for an EST. This dilemma in turn would affect clinical practice. Consequently, it is important to be aware of these problems, and research addressing these concerns is vital.

To foster transportability and achieve dissemination of ESTs, we need to provide the smoothest pathway possible. One method
is the deployment-focused model of intervention proposed by Weisz, Jensen, and McLeod (2005). However, discussions regarding models of dissemination are beyond the scope of this article. Note that the transportation of ESTs does not take place on a one-way street. There are efforts needed on the practitioners’ side, but much of the work falls on those who are promoting EBTs and ESTs. How can we smooth the trail? Two suggestions are offered—and both are directed toward those promoting dissemination: Conduct research evaluations of the active processes involved in an EST (mediational studies), and prepare treatment manuals that accurately reflect, within fidelity, flexible applications.

**Dissemination Via Mediational Analyses**

Practitioners and outcome researchers are both intrigued, for good reason, with the process of psychotherapy (e.g., Shirk & Karver, 2006; Weersing & Weisz, 2002). Within an EST, what are the mediational variables that help to explain the changes that take place? What are the moment-to-moment features of the interpersonal interaction that are important for documented positive change? By conducting mediational analyses (e.g., Treadwell & Kendall, 1996) and studying the therapy process (e.g., Kiesler, 1973; Weersing & Weisz, 2002) within an EST, those who wish to advocate for and advance ESTs make the effort to travel with practitioners on a route of mutual interest.

As an illustration, consider the process variable “child involvement,” operationalized as a child’s active participation in treatment activities (e.g., Braswell, Kendall, Braith, Carey, & Vye, 1985; Chu & Kendall, 2004). Child involvement, coded from taped sessions of manualized treatment, has been found to predict both improvement and maintenance of gains.

Relationship factors and the therapeutic alliance are important to practitioners and researchers alike (Shirk & Karver, 2003; Wolfe, 2006). Studies can be done to address questions such as “What are some empirically supported ‘therapist relationship-building’ strategies?” That is, “What is it that therapists do, as determined and documented by research, that leads to a positive child rating of the therapeutic relationship?” (see Norcross, 2002). The trail may be smoothed when one refers to recent findings that a “collaborative” therapist style (during the first 3 sessions) and an absence of “pushing the child to talk” about distressing themes were significant and meaningful predictors of a good child-rated therapeutic relationship (Creed & Kendall, 2005). Within an EST, there are empirically supported therapist behaviors that contribute to a strong child-rated alliance.

Direct studies of the mediators of EST response offer great promise. To date, only a few published studies (e.g., Kaufman, Rohde, Seeley, Clarke, & Stice, 2005; Treadwell & Kendall, 1996) have examined the mediators of treatment response in youth (see also Prins & Ollendick, 2003). Within the anxiety area, change in negative self-talk (not positive self-talk) was found to partially mediate change in diagnostic status from pre- to posttreatment. That is, for those youth whose treatment was successful, as defined by the absence at posttreatment of the primary diagnosis at pretreatment, the relationship between treatment status and outcome was partially accounted for by changes in negative self-talk (Albano, Marten, Holt, Heimberg, & Barlow, 1995). Additional mediational analyses will not only address the underlying explanations for improvements found in ESTs but also smooth the acceptance of ESTs among practitioners.

**Dissemination Via Manuals That Are Alive**

One feature of an EST treatment manual that will ensure that the manual is dismissed is if it is dictatorial and rigid. Treatment manuals should not be simple outlines, with no meat on the bones, nor should they be specific transcripts of exactly how the treatment is to be provided for every case. A service provider would be justifiably insulted if presented with either type of a therapy manual.

It is the responsibility of those who encourage ESTs, and especially those who develop and evaluate treatments using manuals, to produce manuals that have life. There can and should be an overarching structure, but the service provider is also permitted flexibility in the fulfilling of the main goals of the treatment program. Accordingly, preferred transportable manuals provide the structure, organization, sequence, and duration of the program and note the goals of each session. The general preferred strategies to optimize the implementation of the intervention are provided as well, and some sample transcripts (as illustrations) can be offered. To directly encourage and facilitate flexible application (within fidelity) manuals can provide call outs (e.g., “flex” call outs) in places where a flexible application should be considered. In other words, places where flexibility can be identified and suggested can be included within the manual (see, e.g., Kendall & Hedtke, 2006a).

When implemented, a living treatment manual permits therapist creativity and is not rule bound—there is room for flexibility and individualization. But, the treatment is nevertheless provided within the prescribed strategic approach. The manual permits and even illustrates how the intervention strategies are to be tailored to the presenting problem, within the target goal, while also endorsing sensitivity to child and parent factors (Kendall et al., 1998). Ideal manuals are capable of being evaluated scientifically and implemented clinically.

**Conclusion**

Although not as widespread as would be favored, the present generation of treatment manuals are more in line with the recommendations discussed herein. Clearly, more would be better. Kiesler (1966, 1971) was correct in noting that there is no one treatment that is effective for everyone, and we need to continue to research the question “What therapeutic approaches are effective with which types of clients in producing which kinds of change?” The research designs needed for randomized clinical trials are cumbersome and complex, but they are necessary. Manuals are needed to operationalize the treatment, but they need not be inflexible.

In addition, we need to add to the agenda, “What can researchers, and practitioners, do to facilitate the dissemination of the findings?” This matter is especially important in light of the fact that scientific advances in treatment are usually not implemented in the health care system for 20–25 years (Hogan, 2003). Facilitating dissemination efficiently along with maintaining treatment integrity is an especially important goal both practically and ethically.
In part because of the absence of a viable economic engine to promote EBPs and ESTs, there can sometimes be a nonbenefit neglect of even the most impressive treatment outcome data. It is the case, though unfortunate, that some mental health professionals are not impressed by and do not change their practice as a result of reading an outcome study. The data are essential for ESTs, but researchers also need to interact with and listen to those whose efforts are in daily clinical service (e.g., Weisz, Thruber, Sweeney, Proffitt, & LeGagnoux, 1997). We need to hear their issues and attend to them.

Sensitivity to practitioners’ issues makes for informed research, but the research remains essential. Flexibility within fidelity. The data give us footing, buttressing one treatment approach over those that are dataless. Recall the opening question: If we do not choose to be guided by the data, “What else would we do?” Outcome data provide valuable treatment information, but practicing clinicians have valuable insight and knowledge that can be very useful when attempting to implement ESTs. Encouraging a collaborative and collegial exchange between the two perspectives is paramount, and once realized, the trail for dissemination of EBPs will be less rough and prohibitive.

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