

Barriers to Dissemination of Evidence-Based Practices: Addressing Practitioners' Concerns About Manual-Based Psychotherapies

Michael E. Addis, Clark University

Wendy A. Wade, Center for Behavioral Health

Christina Hatgis, Clark University

The last several years have seen much debate over the appropriateness and viability of empirically supported manual-based psychotherapies for clinical practice. While the majority of discussions have focused on the strengths or weaknesses of evidence-based treatments, and the differences between research and clinical practice, scant attention has been paid to addressing the actual concerns of practitioners in clinical settings. Based on the available research, and our experiences with training and supervision in manual-based treatments, we discuss practitioners' most common concerns, including (a) effects on the therapeutic relationship, (b) unmet client needs, (c) competence and job satisfaction, (d) treatment credibility, (e) restriction of clinical innovation, and (f) feasibility of manual-based treatments. Rather than arguing that these concerns are unwarranted, we suggest future directions the field must take if evidence-based treatments are to be viable and effective in clinical practice. Starting with the assumption that these treatments have much (but not everything) to offer practitioners in clinical settings leads to qualitative and quantitative research questions involving all parties with an interest in evidence-based practice.

Key words: dissemination, treatment manuals, clinical practice, managed care, effectiveness. [*Clin Psychol Sci Prac* 6:430-441, 1999]

Since the Boulder conference clinical psychologists have identified themselves as scientist-practitioners, but the

marriage of science and practice has always been troubled. It should not be surprising that such fierce controversy has emerged over the prospect of evidence-based treatments in clinical practice (e.g., Addis, 1997; Chambless & Hollon, 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995).¹ Dramatic changes in health care reimbursement have created an atmosphere of anxiety, fear, and anger in many practicing clinicians (McCabe, 1996; Miller, 1996; Silverman, 1996). The movement to establish clinical practice guidelines (e.g., Hayes, Follette, Dawes, & Grady, 1995; Nathan, 1998) will no doubt meet with similar reactions. Psychotherapy researchers have tried to align themselves with practicing clinicians by offering evidence-based treatments as demonstrated efficacious interventions, and as a hopeful response to managed care's demand for accountability, as well as the perceived hegemonic threat of pharmacological interventions. Yet these treatments continue to meet with much debate, controversy, and suspicion.

There have been extensive discussions about evidence-based treatments carried out, with few exceptions (e.g., Fensterheim & Raw, 1996; Silverman, 1996), by clinical researchers. A series of articles by Wilson (1996, 1998), and other renowned clinical researchers (Heimberg, 1998; Persons & Silberschatz, 1998; Strosahl, 1998; Strupp & Anderson, 1997), provide thorough and pointed discussions of the issues involved. Many of these arise as we discuss concerns expressed by practitioners. Yet our purpose in this article is not to further these debates, nor to propose solutions based on ideological grounds. Instead, we start with the assumption that evidence-based practice is a worthwhile goal. Although manual-based treatments are not synonymous with evidence-based practice, they do provide a potentially helpful means to utilize efficacious interventions in real-world clinical settings. Our question then is, what are the obstacles to using

Address correspondence to Michael E. Addis, Department of Psychology, Clark University, 950 Main St., Worcester, MA 01610. Electronic mail may be sent to maddis@clarku.edu.

these treatments, and why are they apparently so suspect by many practitioners? Put another way, what are the more immediate practical, psychological, and systemic variables that directly affect practitioners' ability to use manualized treatments?

PRACTITIONERS' PSYCHOLOGICAL REALITIES

Using a treatment manual is not a matter of theoretical or empirical debate for practitioners. It is a *psychological reality*. By psychological reality we mean to emphasize first that practitioners are the ones who must grapple with attitudes and feelings regarding autonomy, competence, and the perceived threat of manualized treatments. To take just one example, the fact that 80–90% of patients improve in cognitive behavioral treatment of panic disorder (Barlow, Craske, Cerny, & Klosko, 1989; Klosko, Barlow, Tassinari, & Cerny, 1990) can be both reassuring and extremely intimidating to a practitioner. What if *my* patients don't improve? It is also the individual practitioner who must reorient to a structured protocol when previous training and experience emphasized flexibility and eclecticism. Ideological arguments that practitioners *should* be motivated to utilize manualized treatments are insufficient and, at times, counterproductive. The fact is that most don't and there are reasons why.

Second, by referring to a psychological reality we want to highlight the context in which evidence-based practice is likely to occur for most practitioners. Over the last 20 years practitioners have begun to feel the direct effects of economic and accountability contingencies, and will continue to do so. More than ever, clinicians must answer questions about why they're treating particular clients, why they're choosing particular interventions, and whether such choices are justified economically in terms of outcomes. Again, there is a strong argument to be made that practitioners *should* ask themselves such questions (Nezu, 1996). But in the current economic and political context these questions are more likely to come from outside forces (e.g., case reviewers, insurance panels, HMO administrators) than from clinicians themselves. This means that clinicians' psychological reactions to the idea of manual-based treatments are as much or more a function of stressful and combative interactions with third-party payers than of the merits of these treatments as debated by academic researchers. In short, practitioners' concerns about, experiences with, and reactions to manualized treatments must be explored and understood if evidence-based practice is to become a reality.

COMMON PRACTITIONER CONCERNS

Practitioner's concerns can be divided into six broad categories: the therapeutic relationship, patient/client needs, competence and job satisfaction, credibility of manual-based treatments, restriction of clinical innovation, and feasibility issues. For each category we begin with examples that typify clinician concerns. We then address each concern considering both relevant empirical studies and our own experiences training and supervising clinicians in manual-based treatments. For each concern we also consider future directions that will help facilitate implementation of these treatments in clinical settings. In some instances, our suggestions involve empirical research. In other situations they require dialogue between researchers and practitioners. In all cases, the overarching theme is the need to consider the attitudes, concerns, experiences, and working contexts of practitioners attempting to implement manual-based treatments.

The Therapeutic Relationship Will Be Compromised or Ineffective

A common concern voiced by practicing clinicians is that it is not possible to develop an effective therapeutic relationship while using a treatment manual. There are a number of variations on this theme. One is the widely held assumption that implementation of manualized treatments requires clinicians to abandon their rapport building skills and the less well defined factors that together comprise the notion of therapeutic style. In a recent national survey of practicing psychologists' attitudes toward treatment manuals, Addis and Krasnow (in press) found that 45% of clinicians agreed with the statement, "Treatment manuals overemphasize therapeutic techniques." Forty-seven percent agreed with the statement, "Treatment manuals ignore the unique contributions of individual therapists," and 33% agreed that "using treatment manuals detracts from the authenticity of the therapeutic interaction."

What We Know. Practitioners are wise to consider the quality of the therapeutic relationship when using manualized treatments. A meta-analysis by Horvath and Symonds (1991) suggests an effect size of .26 for the relationship between measures of the therapeutic alliance and outcome across a range of psychotherapies. At a process level, Raue, Goldfried, and Barkham (1997) found that higher ratings of the therapeutic alliance were associated with higher impact sessions of psychodynamic and cogni-

tive behavioral therapies. Moreover, rigid adherence to a protocol under conditions of a strain in the therapeutic alliance is associated with poorer outcomes in cognitive behavioral therapy (CBT) for depression (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996). Although the therapeutic relationship is clearly important in manualized interventions, it may not be the primary change mechanism. In the context of a manualized treatment for cocaine dependence, Carroll, Nich, and Rounsaville (1997) found higher alliance ratings in an active coping skills treatment than in a control condition. However, level of the alliance was associated with outcome in the control but not the active treatment. In manualized treatments a strong alliance may facilitate client involvement and investment in the treatment and enhance the likelihood that specific techniques or interventions are effective.

Although these studies support the importance of the therapeutic relationship, they do not specifically address the issue of whether clinicians in service clinic settings can establish effective therapeutic alliances while using manualized treatments. At the Center for Behavioral Health (CBH), a community mental health center (CMHC) in Bloomington, Indiana, client ratings of the therapeutic relationship for programs utilizing only manualized treatments were superior compared to ratings of CBH programs providing treatment as usual (i.e., not manualized treatments). In comparison to a national sample of CMHCs, ratings of the therapeutic relationship were superior for CBH programs utilizing manualized treatments. Taken together, these data suggest that clients and therapists engaged in manualized treatments in clinical practice can form strong alliances.

Future Directions. The common perception that manual-based treatments turn therapists into technicians rather than genuine human beings suggests that training programs and psychotherapy researchers have not succeeded in conveying the importance of the therapeutic relationship in these treatments. It is a mistake to assume that clinicians inexperienced in the use of manualized protocols know how to establish an effective therapeutic alliance using these protocols. Indeed, there are alliance-building strategies used in manualized treatments that many clinicians are unfamiliar with. Examples include (1) clarifying the role of the therapist as a coach and collaborator, (2) identifying client and therapist expectations for treatment, (3) eliciting and addressing client concerns about specific

interventions, homework, and treatment outcome, and (3) debriefing at the end of each session and eliciting client feedback.

Although it would be helpful for all media of dissemination (workshops, books, clinical articles) to focus more on the therapeutic relationship, it will not be enough to suggest simply that "the therapeutic relationship is important in manual-based treatments." A rationale and range of strategies need to be articulated. There are numerous ways to approach this. One that we have found useful is to incorporate alliance-building strategies into workshops and training experiences. At the beginning of a workshop we ask clinicians to generate concerns about using manual-based treatments. We then address their concerns throughout, incorporating them into relevant topics and clinical examples. Videotape vignettes and role-plays can also be used for demonstration purposes. For example, some clinicians learning a CBT treatment for the first time may have difficulty with the degree of directiveness required of the therapist and perceive it as a threat to the therapeutic alliance. Role-playing ways of being both warm and directive is a helpful strategy here. Discussion could focus on the fact that (a) different types of relationships are required for different treatments, (b) being directive and warm are not mutually exclusive, and (c) there are varying degrees of directiveness possible as long as one adheres to the structure of the treatment. This is only one example of a process of discussing in detail practitioners' concerns about the quality of the therapeutic relationship in manual-based treatments.

Treatment manuals themselves need to devote more space to the therapeutic relationship and other nonspecific factors (Addis, 1997). To take one example, generating hope is a key process of combating demoralization in many CBT treatments (Addis & Jacobson, in press; Ilardi & Craighead, 1994). As a nonspecific factor, generating hope is not isolated from specific therapeutic techniques. Instead, it is often embedded in interventions such as presenting the treatment rationale, assigning homework, and examining the evidence for specific cognitions (Schaeffer, 1983). Making explicit the mutual dependence of specific and nonspecific factors can help practitioners bring already developed skills to the context of training in a manualized treatment. It also avoids an unnecessary dichotomy between technical and relational aspects of a treatment (Addis, Hatgis, Soysa, Zaslavsky, & Bourne, 1999).

Patient/Client Needs May Not Be Met

There are several common concerns related to the idea that manual-based treatments may not meet clients' needs. We consider each separately along with the available evidence and future directions.

Manualized Treatments Ignore Individual Client Differences:

What We Know. There are no data to suggest that individual clients' needs are unmet in manual-based treatments. In fact, tailoring manualized treatments to individual clients' needs is critically important. In CBT for panic disorder (Craske, Meadows, & Barlow, 1994), instructions in diaphragmatic breathing, cognitive restructuring, and exposure phases of treatment are individualized to address salient physical, cognitive, and behavioral manifestations of each individual's panic disorder. Similarly, the CBT and interpersonal therapy (IPT) protocols for treatment of depression are individually tailored. CBT for depression takes into account the relative importance of behavioral activation for each individual depending on client functioning in this area. Cognitive interventions are tailored to address the individual's thoughts, perceptions, and beliefs.

Future Directions. Dispelling the myth that manualized protocols are cookie-cutter approaches will require researchers and trainers to specify ways in which protocols are personalized to take individual client symptoms and problems into account (see Kendall, Chu, Gifford, Hayes, & Nauta, 1998, for some excellent examples). Manual-based treatments require a delicate balance between clinician flexibility and maintaining fidelity to treatment protocols (Addis et al., 1999). Achieving a balance between flexibility and fidelity may be routine for seasoned therapists, trainers, and researchers, but many clinicians need guidance in this area. Training experiences and treatment manuals need to provide common examples of when and when not to adhere to a protocol, as well as examples of flexibility. For example, adherence to CBT for depression includes addressing the client's complaint of the day (e.g., an argument with their spouse). That event is incorporated into the model by examining related emotions, cognitions, and behaviors, with interventions targeting these components. On the other hand, should the client mention domestic violence the protocol would be temporarily abandoned; assessment and interventions around safety issues are indicated. Thus, manuals

could include a list of situations (e.g., bereavement, abuse, trauma, divorce) that may take precedence over adherence to a protocol.

Manual-Based Treatments Cannot Meet the Needs of Multi-problem Clients: What We Know.

There is a paucity of data addressing the issue of manualized treatment effectiveness with multiproblem clients. Two studies of CBT for panic disorder did not find comorbidity predictive of treatment outcome (Brown, Antony, & Barlow, 1995; Wade, Treat, & Stuart, 1998). Notably, the Wade et al. sample consisted of CMHC clients presenting with primary diagnoses of panic disorder with or without agoraphobia. Exclusionary criteria included only active symptoms of alcohol or drug dependency, psychosis, or mental disorders caused by a medication condition. Despite the inclusion of clients with comorbid diagnoses, treatment outcome results were comparable to those of efficacy studies employing more stringent exclusionary criteria. Persons, Bostrom, and Bertagnolli (in press) found that CBT for depression conducted in a clinical practice context demonstrated comparable outcomes to those found in controlled clinical trials. Comorbidity did not predict treatment response, although individuals with a range of additional diagnoses were included in the study. Thus, manualized treatments have been found to be equally efficacious for clients with either single or multiple problems when outcomes are measured in terms of the targeted problem.

There is accumulating evidence that the positive effects of manualized treatment for specific disorders generalize to other problem areas. For example, Wade et al. (1998) found significant improvement in symptoms of depression, social phobia, blood-injury phobia, and generalized anxiety in patients treated specifically for panic disorder in a community mental health setting. Lehman, Brown, and Barlow (1998) reported a series of case studies in which CBT for panic disorder was used to treat three patients with both panic disorder and alcohol abuse. All patients failed to meet criteria for alcohol abuse at post-treatment, and two out of three reported a remission of panic disorder. Borkovec, Abel, and Newman (1995) found that successful treatment of generalized anxiety disorder led to the reduction in concurrent anxiety and mood diagnoses. The benefits of cognitive behavioral treatment for bulimia nervosa also appear to generalize to other areas such as depression, self-esteem, and social

functioning (Fairburn, Kirk, O'Connor, & Cooper, 1986).

Future Directions. A first step is to disseminate the existing research. Specific discussions of co-morbidity issues can be incorporated into treatment manuals, workshops, and clinical training. Second, more effectiveness research is needed in which manual-based treatments are evaluated in populations with comorbid and multiproblem symptom pictures. It is also essential to understand why practitioners are sometimes concerned that manualized treatments will not be effective for clients with comorbid diagnoses. In our anecdotal experience, therapists often appear to raise this issue when feeling overwhelmed by the range of a client's problems. Trainers and supervisors need to understand the difficulties involved in maintaining a therapeutic focus with multiproblem clients, particularly for therapists trained in more client-centered approaches. The key point here is that discussion of these issues is far preferable to simply asserting that a treatment is appropriate for multiproblem clients. Such discussions can occur in a formal research context (e.g., focus groups), but should also occur locally wherever an organization or group of practitioners is attempting to follow a manualized treatment.

Manual-Based Treatments Ignore Clients' Emotions: What We Know. The identification and experiencing of emotions are critically important components of many manualized treatments. Examples include identification of fearful states and accompanying cognitions that occur in anxiety disorders. CBT for depression also relies heavily upon awareness of emotions in the form of mood shifts that serve as cues to engage in activities or cognitive restructuring. Phenomenologically, all treatments involve getting to know a client and his or her unique life experiences. Manualized treatments are no exception.

Future Directions. Given the central role of emotion in many manualized treatments, it is surprising that many clinicians are concerned that structured protocols do not devote enough time to exploring and validating a client's feelings. Practitioners might be less concerned if they were provided with explicit information about the importance of emotion and how it is addressed within a particular manual-based treatment. For example, it would be instructive to contrast the conceptualization of emotion in CBT versus other approaches. Treatment manuals, work-

shops, and other training experiences could easily incorporate such information into their presentations.

We also suspect that there are language barriers between proponents of manualized treatments and many practicing clinicians. The technical vocabulary of many CBT treatments (e.g., automatic thoughts, interoceptive exposure) may seem inconsistent with a more phenomenological exploration of a client's feelings and thoughts. This discrepancy may disappear with time. The terms transference, repression, and sublimation may have felt technical initially but have since become infused with subtle meaning. In the meantime, those disseminating manualized treatments need to be sensitive to language issues and concerns that such treatments are more "technical" than "emotional." In fact, the very term "manual" may do disservice to the goal of empirically based practice (Addis & Krasnow, in press). "Evidence based," "structured," "goal directed," or other terms may prove more palatable.

Concerns About Competence and Job Satisfaction Using Manual-Based Treatments

Some practicing clinicians are concerned about their ability to learn and successfully implement manual-based treatments. These fears may be reasonable given current political and economic pressures; their livelihoods may depend upon adopting empirically based practices. An extension of this concern is that political forces (e.g., practice guidelines) will take on a big brother presence, dictating treatment interventions while monitoring outcomes. Another set of worries involves issues of job satisfaction. Manual-based treatments can be viewed as uncreative, constraining, boring, and unfulfilling.

What We Know. Data on clinician satisfaction, confidence, and skill level with regard to manualized treatments are extremely limited. Yet there are some success stories of training practicing clinicians from diverse backgrounds in the application of manualized treatments. One comes out of the Center for Behavioral Health in Bloomington, Indiana, where two clinics were developed under a mandate from the Board of Directors to provide empirically supported treatments for anxiety and major depressive disorders (Wade et al., 1998). Existing clinical staff with diverse training backgrounds (Ph.D., PsyD, EdD, MSW, and MA clinicians), and equally diverse orientations were trained and supervised in manualized treatment protocols. This effort required cohesive admin-

istrative support in addition to allocation of resources, not the least of which were time and money. The clinicians report anecdotally that their work using manualized treatments is the most satisfying clinical work they have done. Boredom is uncommon among these clinicians; every case is unique and provides new challenges. As their experience with manualized treatments accumulates, clinicians observe measurable client improvement (e.g., clients make gains on standardized outcome measures, resume working, discontinue medications, etc.), and they derive satisfaction from facilitating this improvement. Implementation of manualized treatments has become a part of the CBH culture. In recent years a number of clinicians untrained in these protocols have requested manualized training and have applied for transfers into departments that provide exclusively empirically supported interventions.

At Clark University we are currently in the beginning phases of collaborating with a large HMO to examine training and treatment processes and outcomes as master's level clinicians (primarily social workers) learn a manualized treatment for panic disorder. We are also interested in whether the manualized treatment enhances outcomes compared to treatment as usual. Although the outcome data are only beginning to accumulate, the participating clinicians report high levels of satisfaction with the training. In fact, many of them have said spontaneously that it is one of the high points of their week because they feel that they are receiving high-quality training in the treatment of a difficult population. The majority of these clinicians are also anxious about their ability to learn the treatment, and somewhat fearful of having their sessions audio-taped and evaluated by an expert. At the same time, they are grateful for the chance to be educated in a state-of-the-art treatment.

Future Directions. There is clearly a need for more extensive research on practitioner satisfaction and comfort using manualized treatments. It would be helpful to view manualized treatments as pieces of technology that, while they may be helpful to clients, will only be used by therapists if they are perceived as helpful, satisfying to use, and manageable to learn. As payment for mental health services has become more restricted and funding sources have dried up, there is a tremendous amount of pressure on practicing clinicians to meet productivity and revenue requirements dictated by organizational policies. As a result, clinicians have very little time to devote to non-

revenue-generating activities such as training. The situation suggests a number of important research areas. How do various training models impact clinician satisfaction and comfort using manualized treatments and practice guidelines? Does practitioner input into the adoption and implementation of empirically based practices lead to better adherence and greater job satisfaction? Are there cost-effectiveness benefits to devoting a portion of practitioner time to training and supervision in manualized treatments? These sorts of questions place an emphasis on what might be called *process* dissemination research, as opposed to limiting effectiveness solely to the realm of clinical outcomes.

Broad-reaching efforts to elicit practitioner input regarding difficulties, challenges, and successes utilizing empirically supported treatments might mitigate clinician suspiciousness, bridge the schism between science and practice, and improve treatment outcomes. Of course, the idea of eliciting practitioner input into psychotherapy research is not a new one. Previous calls for collaboration between researchers and practitioners have largely been motivated by the assumption that practitioners can generate useful questions for psychotherapy researchers to address. The issue here is different. Practitioners are the end users of manualized treatments. Their input is thus not in service of researchers' goals, but in service of enhancing their own outcomes in clinical practice. One possibility is to systematically build clinician feedback into the development and dissemination of treatment manuals. What areas are difficult to understand? What aspects seem too technical? Which parts are less likely to "come alive" during treatment? Ideally, this type of feedback should be gathered from clinicians of varying skill levels and work settings. An experienced CBT therapist working in an academically oriented research clinic may have very different experiences with a treatment than a front-line master's level clinician seeing 30 clients weekly in a capitated managed care clinic. To incorporate this sort of feedback underscores the idea that manuals are not designed to put an end to clinical judgment and practitioner input into treatment development. Rather, they should be considered current working guidelines to effective interventions.

Credibility of Empirically Supported Treatments

Some practitioners are convinced that they already offer effective treatment to their clients and are unmotivated to learn manualized treatments. The "overly confident and

anti-empirical" clinician has, in fact, added fuel to the fire for proponents of empirically based practice. Yet, if we assume that therapeutic efficacy depends in part on a practitioner's belief in the efficacy of a treatment, an important question for proponents of manualized treatments is how to enhance treatment credibility in the eyes of front-line clinicians.

What We Know. There have been no published studies to our knowledge on the credibility of manualized treatments to practicing clinicians. In a recent study, Addis and Krasnow (in press) found that a national sample of practicing psychologists were as likely to endorse attitudes emphasizing a treatment manual's positive effects on outcomes, as attitudes emphasizing a manual's negative effects on the therapeutic process. Their results also indicate that attitudes toward treatment manuals are reliably associated with what a practitioner thinks a manual is. Practitioners who think a manual is a treatment protocol imposed by a third-party payer are more likely to think that manuals have deleterious effects on treatment process and outcome. Those who think manuals emphasize individual case conceptualization endorse the exact opposite attitudes.

Anecdotally, our experience in training clinicians suggests that pervasively negative attitudes are less common than critics of treatment manuals might think. It may be that the ideas of published critics are taken as representative of practitioners when in fact they are not. There may also be a selection factor operating in those clinicians who attend workshops on manualized treatments and participate in research. Nonetheless, given a supportive context, we often find clinicians willing to discuss their insecurities regarding client outcomes and eager to learn treatments with demonstrated efficacy. There are still those practitioners who, for a number of reasons, find no value in empirically based practice. Some may think that the results of research studies can't possibly shed any light on clinical practice because the two contexts differ so dramatically. Others contend that psychotherapy is more of an art than a science and therefore dismiss the value of research results on epistemological grounds. Finally, some practitioners reject manual-based treatment because it threatens to reveal real or imagined deficits in therapeutic skill.

Future Directions. The primary hurdle here is the same one that has plagued our field since its inception: How

do we train and maintain scientist-practitioners? We have found it useful to "think globally and act locally," by taking the issue out of the realm of ideological debate, bringing it down to concrete clinical practice, and following the old adage that you catch more flies with honey than with vinegar. Whether disinterest in empirical data is a function of excessive pride, fear, or a strong commitment to alternative epistemologies, heavy-handed polemics are not likely to be effective. At a local level, those people involved in dissemination of manualized treatments need to generate dialogue focused on practitioner concerns. For example, a clinical director in a managed care setting can foster a discussion on the pros and cons of introducing manualized treatment. Rather than touting the superiority of manual-based psychotherapy, discussions should focus on practitioners' perspectives on the utility of these treatments. What does this treatment have to offer to your clinical work? What about it seems likely to help your clients? What aspects of the treatment cause you concern?

Parloff (1998) has suggested that proponents of manual-based treatments use such discussions "as a useful ploy to 'co-opt' the critics or, failing that, possibly to educate them" (p. 379). This is not our goal in recommending strategies to engage practitioners. We assume that manual-based treatments have something (not everything) to offer clinical practitioners. The next question is what can we do to maximize what they have to offer? For example, we assume that most practitioners would like to know with greater confidence that they are offering effective treatment. Yet it may take time and a context of professional support, rather than threat, to engage practitioners who don't already see value in empirically based practice. Some may never see the value. But it will always be more productive to approach practitioners at a level of helpful interest, rather than setting them up as straw-people in a debate over the value of science versus art.

Restriction of Clinical Innovation

Two concerns fall under this heading. First are fears that practitioners will become obsolete as they are replaced by technicians or computers. Second is the concern that widespread practice of manual-based treatment will retard development of new theories and alternative interventions.

What We Know. There are no studies on whether dissemination of manualized treatments to clinical practice reduces clinical innovation and leads to the obsolescence

of skilled practitioners. Fears of becoming obsolete are valid if one assumes, as many clinicians do, that a treatment manual's function is to replace the therapist. In this scenario, clinical skill and innovation are supplanted by rigid adherence to a protocol. As we've argued above, rigidity is not a defining characteristic of manualized practice. However, there may be a legitimate role for paraprofessionals trained in the administration of manualized treatments (Strosahl, 1998). If effectiveness can be demonstrated and costs reduced, then paraprofessionals and computers deserve a place in behavioral health care. Which, if any, disorders can be effectively treated using paraprofessionals is an important empirical question. Heimberg (1998) argues that advanced training will be necessary for effective implementation of manualized treatments: "[T]he therapist will frequently find himself or herself with a failed intervention and asking the ever-present question 'What do I do now?', and it is this grounding (in theory and advanced training) that increases the chance of an answer that is both productive and within the limits of the protocol" (p. 389). The future of integrated models that may include practitioners, technicians, and computer-based treatments remains uncertain. What is clear, however, is that while some of the simpler aspects of a manual-based treatment may require minimal training, other aspects such as case conceptualization and individually tailoring treatments will probably require the clinical sophistication of practitioners with advanced training.

Adoption of manualized treatments may actually *facilitate clinical innovation* by specifying what are currently the most effective interventions. Wilson (1998) notes that existing manualized treatments are not always successful and we are far from having all the answers. For example, we haven't solved problems of treatment resistance and attrition. Movement toward standardization will allow for a more systematic study of treatment "failures" and necessary treatment modifications. This would improve upon the current situation where innovation is highly idiosyncratic depending on the individual clinician.

Future Directions. It is incumbent on those of us who develop and disseminate manualized treatments to emphasize the role of the individual clinician as one who balances a dialectic between adhering to an empirically supported treatment and bringing that treatment to life (Kendall et al., 1998). For example, we have observed considerable clinical innovation in the way therapists

trained in manual-based treatments adapt the interventions to meet the needs of individual clients. Therapists are encouraged to implement the interventions detailed in the manual, but are free to use their personal style, intuition, and creativity in bringing the interventions to life.

A higher priority should also be placed on research examining cases where manualized treatments are not effective. Panels, conferences, research symposia, and published articles addressing treatment "failures" should reveal certain types of clients, presenting problems, or therapeutic impasses that require innovation to maximize the effectiveness of a manualized treatment.

Feasibility Concerns

A common set of concerns about manualized treatments in clinical settings cluster around questions of feasibility. These include issues related to training, implementation, and client acceptance of manualized treatments. A typical training concern is the perception that manual-based treatments require expensive and time-consuming instruction and supervision that are not readily accessible. Furthermore, manualized treatments are often regarded as highly technical and disorder specific. How many different manualized treatments must the working clinician learn in order to best serve a diverse group of clients? Other implementation issues concern external constraints. For example, how does a service clinic address managed care session limits that fall short of the number required for the most effective manualized treatment? Finally, client acceptability concerns are crucial because, like any psychological intervention, manualized treatments require a client's ability and willingness to participate actively in treatment. How can a therapist know if a manual-based treatment is appropriate for a particular client? Should client preference play a role in clinical decision making? If so, how? What if a client does not possess the reading and writing skills necessary for particular treatments? All of these questions bear on client issues related to feasibility.

What We Know. As with other concerns, very little research has been conducted on the feasibility of manualized treatments in clinical settings. In terms of systemic parameters, there are examples where dissemination has been feasible. The CBH study mentioned above demonstrated that a manualized treatment for panic disorder could be successfully incorporated into the structure of a community mental health setting. In this setting there was

considerable administrative support for introducing empirically supported treatments. This translated directly into time allotted to practitioners for training and supervision, collection of outcome data, and other costs incurred by implementing and maintaining a manualized treatment program. The Clark University study is being conducted in collaboration with Boston Road Clinic (BRC), a private mental health clinic with over 100 clinicians, and contracts with 25 different managed care companies, resulting in roughly 275,000 enrollees. BRC has made a commitment to empirically based practice and makes provisions for study therapists to see clients for 12–15 weekly sessions and to attend biweekly training meetings. Warren (1995) describes using a manual-based treatment for panic disorder in a private practice setting, and Persons et al. (in press) provide evidence of the feasibility of a manualized treatment for major depression in a group practice. Strosahl, Hayes, Bergan, and Romano (1998) also demonstrate the feasibility of using a less structured and more broad-based treatment protocol in a large managed care setting. These studies provide a handful of examples of the feasibility of manualized treatments in a range of clinical practice settings.

Future Directions. Strosahl (1998) points out that there are considerable costs associated with training in most manualized treatments. Administrators cannot be sure that a financial investment in training will be offset not only in terms of immediate patient outcomes, but in terms of therapist and contract retention. Thus, variations in training and supervision models become important research topics. Are two-day intensive workshops in manualized treatments sufficient to train front-line practitioners? What is the comparative cost-effectiveness of training in diagnosis-specific versus broad-based treatment protocols? These questions assume, of course, that training opportunities will be readily accessible to clinicians which, at present, is often not the case.²

Since collegial consultation has been found to be a highly valued source of clinical information for practitioners (Cohen, Sargent, & Sechrest, 1986), a group training model may capitalize on this by optimizing the context for consultation and reducing costs. Another option would be to provide intensive training for one or two practitioners (depending on the size of the organization) who commit to staying with an organization for at least a fixed amount of time and dedicating a portion of

their clinical hours to training and supervising colleagues.

How many different manual-based treatments should a practitioner have in his or her therapeutic repertoire? Anecdotally, our impression is that an initial solid grounding in the common elements of manual-based intervention (e.g., how to create structure without sacrificing rapport, how to tailor and “sell” an intervention to individual clients, how to set goals and monitor progress) would make subsequent learning of different treatments much easier. From that point, the research on generalizability of treatment effects suggests that principal diagnoses can be seen as a point of entry for therapeutic interventions that alleviate secondary sources of distress as well (Fairburn et al., 1986; Lehman et al., 1998; Wade et al., 1998). Common treatment elements within diagnostic subgroups also suggest the value of a broad-based approach to training. For example, a therapist might strive for proficiency in one manualized treatment for each broad classification of problems (i.e., the anxiety disorders, affective disorders, addictive behaviors, personality disorders, and social skills needs), or a subset of these as appropriate. From there, further specialization would be driven by the interests and needs of particular clinicians, clients, and service settings.

Many manualized treatments require a greater frequency and regularity of sessions than is common in many practice settings. While it is true that managed care companies can limit the number of services provided to their subscribers, this is not unique to manualized treatments. These treatments may, in fact, be more adaptable to session limits since they typically spell out effective interventions that can be combined in a goal-oriented approach. For example, a manualized treatment might be tailored to fit insurance limits by combining session topics and incorporating bibliotherapy in between sessions to supplement the in-session work. Finally, empirical evidence of the efficacy of each component of a manualized treatment can be used to buttress arguments for the extension of insurance benefits.

There is a strong need for research on clients' perceptions of and reactions to manualized treatments. What are clients' concerns about different manualized treatments? How are they best addressed? Our experience in training practitioners to use these treatments suggests that therapists' clarity about the treatment rationale for different interventions, and their ability to articulate it clearly to clients are two of the key factors affecting treatment

acceptance. Other factors may include previous treatment experiences, pre-existing ideas about the causes of particular problems, and pre-existing preferences or ideas about the therapeutic process.

Clients' intellectual capabilities and education levels have an impact on treatment planning, but not necessarily on treatment outcomes. Again, there are logical ways to proceed. At CBH we have made audio taped versions of psychoeducational materials and manuals for illiterate or barely literate clients. Particular treatment components may be more important than others and more feasible to provide despite education and intellectual level (e.g., exposure in treatments of anxiety). Difficulty with any component of treatment could occur for a multitude of reasons, including but not limited to a client's intellectual or educational level. Slowing down the treatment process or assigning extra homework as needed can facilitate a client's ability to benefit from each component of the therapy. Again, diversity in clients' educational backgrounds and levels of intellectual functioning are not challenges unique to manualized treatments.

CONCLUSION

Few developments in clinical psychology have generated such a volume or intensity of debate as the role of manualized treatments in clinical practice. There is no doubt that the context of research differs from the context of clinical practice. Whether manualized treatments can make the transition from one to the other is ultimately an empirical question. What is clear is that clinical practitioners, researchers, clinic administrators, clients, and third-party payers are the ones who will shape the answer. Consideration of some of the more immediate psychological and practical concerns has been, with few exceptions (Strosahl, 1995, 1998), largely absent from the research and clinical literature. Instead, debates over the superiority of clinical judgement versus protocol-driven treatment, and considerations of the different agendas of researchers and practitioners have taken center stage. These heated debates, along with the fear and anger associated with the myriad of changes in mental health service delivery, have tended to polarize discussions of manualized treatments. If, on the other hand, one starts with the assumption that evidence-based treatments have something useful to offer clinical practice, the questions become (1) under what conditions are they useful? (clearly not all visits to a psychotherapist require adherence to a structured protocol),

and (2) how can we maximize their positive effects on treatment outcomes? This stance forces us to consider the psychological and economic realities of practitioners, administrators, and third-party payers.

There is an urgent need for research focused on concerns and concrete obstacles related to dissemination of manual-based treatments. Methodological dogmatism would be a serious mistake. There is much that can be learned from focus groups and detailed qualitative impressions from pilot projects assessing the feasibility of various dissemination models. Yet there is no substitute for controlled quantitative research when it comes to assessing the size of treatment or training effects. Collaborations between clinical researchers and industrial organizational psychologists should also be fruitful. Ready or not, we have reached a stage where demonstrating treatment effects in controlled research is no longer sufficient. Whether manualized treatments will retain their effectiveness in the "real world" is only partially under the control of clinical researchers. The process of dissemination and implementation will be jointly shaped by all parties including researchers, practitioners, administrators, and clients. The first step toward success is asking the right questions of the right people and paying close attention to their answers.

NOTES

1. Throughout the article, our concern is with treatments that are relatively structured, and have been shown to be efficacious in controlled clinical trials. Treatments falling under this general category have also been referred to as "manual based," "empirically validated," and "empirically supported." We choose the terms "evidence based" and "manual based" because they are the most inclusive, because they avoid technical debates over the criteria for "validation" or "support," and because the former parallels recent developments in medicine.

2. Whether cost issues should be given priority is a difficult ethical issue and depends on the particular context and research question. Moreover, many psychotherapy researchers are *not* trained in evaluating cost-effectiveness. We would suggest that treatment researchers not automatically include cost issues in grant proposals and research studies, but that they determine whether and in what way cost is an issue in clinical and administrative decisions that affect feasibility, and make decisions accordingly.

ACKNOWLEDGMENT

Preparation of this article was supported in part by Grant R29 MH57778-01 from the National Institute of Mental Health.

REFERENCES

- Addis, M. E. (1997). Evaluating the treatment manual as a means of disseminating empirically validated psychotherapies. *Clinical Psychology: Science and Practice*, 4, 1-11.
- Addis, M. E., Hatgis, C., Soysa, C. K., Zaslavsky, I., & Bourne, L. S. (1999). The dialectics of manual-based treatment. *The Behavior Therapist*, 22, 130-132.
- Addis, M. E., & Jacobson, N. S. (in press). A closer look at the treatment rationale and homework compliance in cognitive therapy for depression. *Cognitive Therapy and Research*.
- Addis, M. E., & Krasnow, A. D. (in press). A national survey of practicing psychologists' attitudes towards psychotherapy treatment manuals. *Journal of Consulting and Clinical Psychology*.
- Barlow, D. H., Craske, M. G., Cerny, J. A., & Klosko, J. S. (1989). Behavioral treatment of panic disorder. *Behavior Therapy*, 20, 261-282.
- Borkovec, T. D., Abel, J. L., & Newman, H. (1995). Effects of psychotherapy on comorbid conditions in generalized anxiety disorder. *Journal of Consulting and Clinical Psychology*, 63, 479-483.
- Brown, T. A., Antony, M. M., & Barlow, D. H. (1995). Diagnostic co-morbidity in panic disorder: Effect on treatment outcome and course of comorbid diagnoses following treatment. *Journal of Consulting and Clinical Psychology*, 63, 408-418.
- Carroll, K. M., Nich, C., and Rounsaville, B. J. (1997). Contribution of the therapeutic alliance to outcome in active versus control psychotherapies. *Journal of Consulting and Clinical Psychology*, 65, 510-514.
- Castonguay, L. G., Goldfried, M. R., Wiser, S., Raue, P. J., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology*, 64, 497-504.
- Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 66, 7-18.
- Cohen, L. H., Sargent, M. M., & Sechrest, L. B. (1986). Use of psychotherapy research by professional psychologists. *American Psychologist*, 41, 198-206.
- Craske, M. G., Meadows, E., & Barlow, D. H. (1994). *Therapist's guide for the Mastery of Your Anxiety and Panic II & agoraphobia supplement*. New York: Graywind.
- Fairburn, C. G., Kirk, J., O'Connor, M., & Cooper, P. J. (1986). A comparison of two psychological treatment for bulimia nervosa. *Behaviour Research and Therapy*, 24, 629-643.
- Fensterheim, H., & Raw, S. D. (1996). Psychotherapy research is not psychotherapy practice. *Clinical Psychology: Science and Practice*, 3, 168-171.
- Hayes, S. C., Follette, V. M., Dawes, R. B., & Grady, K. E. (1995). *Scientific standards of psychological practice: Issues and recommendations*. Reno: Context Press.
- Heimberg, R. G. (1998). Manual based treatment: An essential ingredient of clinical practice in the 21st century. *Clinical Psychology: Science and Practice*, 5, 387-390.
- Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, 38, 139-149.
- Ilardi, S. S., & Craighead, W. E. (1994). The Role of nonspecific factors in cognitive-behavior therapy for depression. *Clinical Psychology: Science and Practice*, 1, 138-156.
- Kendall, P. C., Chu, B., Gifford, A., Hayes, C., & Nauta, M. (1998). Breathing life into a manual: Flexibility and creativity with manual-based treatments. *Cognitive and Behavioral Practice*, 5, 177-198.
- Klosko, J. S., Barlow, D. H., Tassinari, R., & Cerny, J. A. (1990). A comparison of alprazolam and behavior therapy in treatment of panic disorder. *Journal of Consulting and Clinical Psychology*, 58, 77-84.
- Lehman, C. L., Brown, T. A., & Barlow, D. H. (1998). Effects of cognitive-behavioral treatment for panic disorder with agoraphobia on concurrent alcohol abuse. *Behavior Therapy*, 29, 423-434.
- McCabe, R. B. (1996, November). *Impact of rationed care on the health care provider*. Paper presented at the 1996 Kurt Almer Research Symposium, Albany, NY.
- Miller, I. J. (1996). Managed care is harmful to outpatient mental health services: A call for accountability. *Professional Psychology: Research and Practice*, 27, 349-363.
- Nathan, P. E. (1998). Practice guidelines: Not yet ideal. *American Psychologist*, 53, 290-299.
- Nezu, A. M. (1996). What are we doing to our patients and should we care if anyone else knows? *Clinical Psychology: Science and Practice*, 3, 160-163.
- Parloff, M. B. (1998). Is psychotherapy more than manual labor? *Clinical Psychology: Science and Practice*, 5, 376-381.
- Persons, J. B., Bostrom, A., & Bertagnolli, A. (in press). Results of randomized controlled trials of cognitive therapy for depression generalize to private practice. *Cognitive Therapy and Research*.
- Persons, J. B., & Silberschatz, G. (1998). Are results of randomized controlled trials useful to psychotherapists? *Journal of Consulting and Clinical Psychology*, 66, 126-135.
- Raue, P. J., Goldfried, M. R., & Barkham, M. (1997). The therapeutic alliance in psychodynamic-interpersonal and cognitive-behavioral therapy. *Journal of Consulting and Clinical Psychology*, 65, 582-587.
- Schaeffer, N. D. (1983). The context of therapist behavior and outcome prediction. *Professional Psychology: Research and Practice*, 14, 656-669.

- Silverman, W. H. (1996). Cookbooks, manuals, and paint-by-numbers: Psychotherapy in the 90's. *Psychotherapy, 33*, 207-215.
- Strosahl, K. D. (1995). Behavior therapy 2000: A perilous journey. *The Behavior Therapist, 18*, 130-133.
- Strosahl, K. D. (1998). The dissemination of manual based psychotherapies in managed care: Promises, problems, and prospects. *Clinical Psychology Science and Practice, 5*, 382-386.
- Strosahl, K. D., Hayes, S. C., Bergan, J., & Romano, P. (1998). Assessing the field effectiveness of acceptance and commitment therapy: An example of the manipulated training research method. *Behavior Therapy, 29*, 35-64.
- Strupp, H. H., & Anderson, T. (1997). On the limitations of therapy manuals. *Clinical Psychology: Science and Practice, 4*, 76-82.
- Task Force on Promotion and Dissemination of Psychological Procedures. (1995). Training in and dissemination of empirically validated psychological treatments. *The Clinical Psychologist, 48*, 3-23.
- Wade, W. A., Treat, T. A., & Stuart, G. L. (1998). Transporting an empirically supported treatment for panic disorder to a service clinic setting: A benchmarking strategy. *Journal of Consulting and Clinical Psychology, 66*, 231-239.
- Warren, R. (1995). Panic control treatment of panic disorder with agoraphobia and comorbid major depression: A private practice case. *Journal of Cognitive Psychotherapy: An International Quarterly, 9*, 123-134.
- Wilson, G. T. (1996). Manual-based treatments: Clinical application of research findings. *Behavior Research and Therapy, 34*, 295-314.
- Wilson, G. T. (1998). Manual-based treatment and clinical practice. *Clinical Psychology: Science and Practice, 5*, 363-375.

Received October 27, 1998; revised February 8, 1999; accepted February 22, 1999.