Dissemination of effective methods: Behavior therapy's next challenge

Jacqueline B. Persons, Ph.D.
Center for Cognitive Therapy
Oakland, CA

Abstract

Dissemination of the effective interventions developed by behavior therapists is one of behavior therapy's most important tasks now and in the coming years. I argue that dissemination is timely when a treatment is supported by data from randomized controlled trials (RCTs) or from a large series of single case studies, even if effectiveness data are not yet available. I offer recommendations for improving dissemination of empirically-supported behavioral interventions and methods.

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Behavior therapy[1] has done a remarkable job of developing effective interventions for numerous clinically important disorders and problems. A special issue of Journal of Consulting and Clinical Psychology (in press) titled "Empirically Supported Psychological Treatments" provides comprehensive reviews of the currently-available empirically supported treatments for disorders and problems of adults, youth, couples, and medical patients. The number of disorders and problems for which effective treatments are available is quite impressive. Many--but certainly not all--of these treatments, are behavioral.

Practitioners have been disappointingly slow to adopt these new treatments, however. As a result, large numbers of patients do not receive effective treatment. One of behavior therapy's most important tasks in the coming years is to disseminate our innovations. If we can accomplish this goal as successfully as we have developed the treatments, we will have truly made a significant contribution to alleviating suffering.

To convey the scope and importance of the dissemination problem, I provide several examples of diffusion failure. I discuss the issue of when dissemination is appropriate, and I conclude with some recommendations for enhancing dissemination efforts.

Dissemination failures

Many effective interventions developed by behavior therapists are rarely used in clinical practice. Miller et al. (1995) note that the interventions demonstrated effective in randomized controlled trials (RCTs) are not the ones routinely used in clinical practice to treat alcohol abuse. In fact, they write, "The negative correlation between scientific evidence and application in standard practice remains striking, and could hardly be larger if one intentionally constructed treatment programs from those approaches with the least evidence of efficacy." (p. 33).

Similarly, Barlow (1994a) reports that most patients with panic and phobias do not receive empirically-validated treatments for those disorders. Boudewyns and Fry (1986) surveyed all VA Medical Centers who had Psychology Services in 1983 and found that only 10 of 152 facilities (6.6%) used a behavior modification/token economy unit of the sort shown in controlled studies to be effective in the treatment of chronic mental patients.

And despite impressive evidence from randomized controlled trials that it is effective in 70% of cases (a higher success rate than any other therapy), less than 5% of American primary care physicians prescribe conditioning therapy for treatment of childhood enuresis (Rushton, 1989). And 75% of a sample of 196 members of the American Association for Marriage and Family Therapy chose family therapy, individual psychotherapy, or play therapy as the first line treatment approach for enuresis; only 25% chose conditioning therapy (Wagner & Hicks-Jimenez, 1986).

Thus, clinicians are slow to adopt interventions shown effective in RCTs. A related problem is that clinicians do not routinely utilize empirical methods in their work. For example, they do not routinely use objective measures to monitor their patients' progress. A recent survey of licensed mental health professionals who are members of the American Psychological Association showed that, of a sample of 15,918 clinicians

who responded to the survey, fewer than 40% utilized outcome measures in his/her practice (American Psychological Association, 1996). Related, Kendall, Kipnis, and Otto-Salaj (1992) found that 41% of of a sample of 315 therapists who were surveyed about how they handled treatment nonresponders indicated that they planned to continue using the same interventions; these therapists had not developed an alternative treatment plan or made a plan to refer the patient to another clinician.

Behavior therapists place a high value on using both empirically-supported treatment protocols and an empirical approach to clinical practice. These modes of working are increasingly popular, as the notion of evidence-based practice takes hold (cf. Evidence-based Medicine Working Group, 1992). Unfortunately, neither is widely used by mental health professionals.

When is dissemination appropriate?

What level of empirical support is needed to justify dissemination of a therapy? Ideally, we would like both efficacy evidence from RCTs and effectiveness evidence that examines whether results of treatments studied i RCTs generalize to naturalistic settings. Certainly we know from Weisz, Weiss, and Donenberg (1992), for example, that interventions found effective in carefully controlled research settings are not always equally effective when used in clinical settings. We would also like good empirical data showing which patients respond to which interventions, to assist clinicians in choosing interventions and in tailoring standardized protocols to the particular needs of individual patients.

Unfortunately, the bulk of evidence currently available is from RCTs. We have little information about whether protocols shown effective in RCTs are also effective in clinical practice, and we know even less about individual factors that are related to treatment responsiveness. Does this mean that dissemination is premature?

I believe not. I believe that it is appropriate to disseminate findings based on RCTs alone, even when data from effectiveness studies are not available. I recommend that behavior therapists define effective treatments using criteria of the sort set by Chambless and Hollon (in press), which are similar to those set by the Task Force on Promotion and Dissemination of Psychological Procedures of the Division of Clinical Psychology of the American Psychological Association, chaired by Dianne Chambless (Chambless et al., 1996; Task Force, 1995). Chambless and Hollon (in press) define an efficacious treatment as one that has been shown effective in more than one RCT conducted by more than one group of investigators, or one that has been shown effective in multiple replications of single case designs conducted by more than one research group.

Certainly the question of whether these criteria are sufficient to justify dissemination is a controversial one. A common argument given to support the view that these criteria are inadequate is the generalizability argument. This argument claims that RCTs of empirically-validated protocols study patients who meet such rigorous selection criteria, in protocols that are so far from routine clinical practice, that results simply cannot be generalized to clinical practice (Seligman, 1996; Silberschatz' arguments in Persons & Silberschatz, in press). In fact, Fensterheim and Raw (1996) suggest that it may be unethical to utilize treatment protocols studied in RCTs to clinical practice!

Certainly we cannot assume that results of RCTs generalize to clinical practice, as Weisz et al. (1992) demonstrated. Why, then, do I argue that data from RCTs is sufficient to support dissemination?

Imagine you have just received a diagnosis of, say, carpal tunnel syndrome. Would you like your physician to proceed with treatment on the basis of her trial-and-error clinical experience, or would you like her to treat you by adapting a treatment shown effective in RCTs to the specifics of your case? I would prefer the latter method, and I assume most readers of this article would as well. For this reason, we must begin to disseminate the treatments that have been shown in RCTs to be effective. I argue that treatments shown effective in RCTs are superior to treatments not studied in RCTs, even if effectiveness data are not available.

Therefore, I recommend that behavior therapists begin working to disseminate the behavioral therapies that meet the criteria of the APA Task Force Report and Chambless and Hollon (in press). I also recommend disssemination of empirical modes of practice. If clinicians begin routinely collecting data to monitor outcomes of their patients, sorely-needed effectiveness data can be collected.

Improving dissemination: Recommendations

To do a good job of dissemination, we need to view it as something we need to work at. Behavior therapists sometimes seem to have the attitude that "the efficacy data should carry the day." Yet, as Barlow (1994b) points out: "A drug company spends hundreds of millions of dollars in promotion when a new drug is developed; when we develop a new approach, it just sits there." (p. 7).

To do a good job of dissemination, we also need to learn much more about it. Surprisingly little research has examined diffusion failure of behavioral interventions (for an exception, see Backer, Liberman, & Kuehnel, 1986). We do know that several factors influence dissemination (Backer et al., 1986), and I discuss several here.

Weaknesses in training play an important role in clinicians' failure to use empirically-validated protocols. Many clinicians do not use these protocols because they were never trained to use them, as the surveys of predoctoral training programs and internships by the APA Task Force showed (Task Force, 1995). Similarly, many students are not taught to value an empirical approach to clinical work (Date, 1996). Changes in training programs for both young and established clinicians are needed.

We know that personal contact with the developer or a champion of the innovation is a key factor in the dissemination process (Backer et al., 1986). This factor may help us understand the rapid adoption by clinicians nationwide of Eye Movement Desensitization and Reprocessing (EMDR); Francine Shapiro, who developed EMDR, is a charismatic, articulate, and peripatetic personality. The rapid diffusion of EMDR is a phenomenon that merits careful study.

Innovations are more readily adopted if they are consistent with the methods clinicians are already using (Backer et al., 1986). This notion suggests that even if individualized formulation-driven treatment methods are not superior to standardized therapies (as they have not been shown to be), there may be some advantage to disseminating them if they are more likely to be adopted by clinicians.

Dissemination can be aided by increasing clinicians' access to information about innovations, as many (see Beutler, Williams, & Wakefield, 1993) have pointed out.

Simply presenting new interventions in professional journals is not sufficient. AABT's new journal, Cognitive and Behavioral Practice, addresses this need, as does the publication in book form of numerous empirically-supported treatment protocols, and of videotape and other clinically-oriented materials describing these interventions. More of these types of materials are needed.

As teachers, mentors, models and examples, we need to be certain that all of us are modelling and teaching good clinical behaviors. How many of readers of this article collect data to monitor your patients' progress? How many of us answer clinical questions by reviewing the available scientific evidence? Are we appropriately assertive with clinicians who are using non-evidence-based modes of practice?

We know that dissemination efforts are particularly well-received if they reach individuals with a felt need for a solution to a particular problem that the innovation addresses. This fact suggests that a powerful route to enhancing dissemination is to inform consumers about innovations. Consumers include individuals, insurance companies, and other professionals, particularly physicians. I believe that consumers hold the key to clinicians' adoption of innovations, because consumers hold the reinforcements clinicians are seeking; if consumers begin insisting upon certain treatments, clinicians will learn to provide them.

To get across our message to consumers, behavior therapists need to begin taking speech lessons to improve their public speaking abilities, making arrangements to appear on Oprah!, writing query letters to magazines to sell articles, supporting consumer groups like the Obsessive Compulsive Foundation and the Anxiety Disorders Association of America, writing letters to the editor and to Dear Abby, and writing books for the lay public. These types of contributions have the potential to alleviate human suffering far more than most articles published in academic journals. For example, Feeling Good, a self-help book that describes cognitive therapy for depression, has sold millions of copies (Burns, 1980). A RCT recently showed that depressed individuals randomly assigned to bibliotherapy, in which, over the course of one month they read the book and completed any of the exercises they chose to do, reported fewer depressive symptoms than individuals assigned to a wait-list control condition (Jamison & Scogin, 1995). Additional dissemination suggestions are offered by Persons (1995), Beutler, Williams, Wakefield, and Entwistle, (1995), and Sobell (1994).

In summary, I argue that in recent years behavior therapy has developed a wealth of effective new methods. Certainly we need to strengthen our methods and produce more data showing that results of RCTs generalize to clinical practice. But we cannot wait for these things to happen before we begin working aggressively to disseminate the important findings we already have.

Author Notes

Correspondence concerning this article may be sent to Jacqueline B. Persons, Center for Cognitive Therapy, 5435 College Avenue, Oakland, CA 94618. E-mail address: personsj@aol.com.

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Note

1. I use the term "behavior therapy" to encompass the full range of behavioral, cognitive, and cognitive-behavioral therapies.