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COMMENTARY

Translating Evidence-Based Assessment Principles and Components Into Clinical Practice Settings

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In this comment I describe the common elements of evidence-based assessment (EBA) emphasized in the articles comprising this special series: the use of science to inform assessment activities; the use of nomothetic and idiographic assessment measures; the development of case conceptualizations that include, but are not limited to, diagnoses; and a reliance on treatment monitoring strategies to inform the ongoing provision of treatment. Focusing on treatment monitoring as an exemplar of EBA, I examine clinicians' objections to these procedures as a way of understanding broader concerns about the possible downside of incorporating EBA practices into clinical settings. In this context, the use of a social validity framework to understand and address these concerns has the potential to enhance the translation of EBA principles and components into clinical practice and, ultimately, improve our clinical services.

Consider the following two scenarios:

Scenario 1 *At the end of the first session of cognitive therapy for depression, the therapist summarized what was discussed in the session, described the direction that treatment was likely to take, and asked if the client had any questions. The client, who had read a great deal online about cognitive therapy for depression prior to booking this initial session, asked whether there were any symptom or "negative thinking" questionnaires that needed to be completed before treatment went much further. The therapist reassured the client that such measures were not necessary, as it was already clear what course needed to be followed in the treatment. The therapist also said that, even though some therapists had clients complete such measures during therapy, there was really no need to this. After all, the therapist stated, an experienced therapist can always tell how treatment is going.*

Scenario 2 *After working with a cognitive-behavioral clinical supervisor for 3 weeks, a psychology intern expressed surprise to the supervisor that none of their cases thus far had involved a diagnostic evaluation prior to the development of a treatment plan. The supervisor replied that such evaluations were not a good use of clinical time, as they could be very time-consuming and thus reduce the amount of time available to provide therapy. The puzzled intern then asked whether this ever had a negative impact on treatment, as the intern's prior training had stressed the need for a thorough evaluation that included diagnosis as part of the case conceptualization process. The supervisor informed the intern that there was no reason to be concerned, as diagnoses weren't really all that critical in determining a treatment plan.*

For most readers of this journal, it was presumably difficult to imagine these situations. This is unlikely a reflection of their creative abilities, but, rather, of the challenge in imagining these scenarios as depicting cognitive-behavioral therapy (CBT) practices. Even if one is able to imagine such clinical scenarios unfolding, it is highly unlikely that one would describe the services as CBT, or at least not as good quality, ethical CBT. The reason for this is simple: little or no formal, systematic assessment activities appear to be involved in either of the scenarios. The central role of assessment in interventions for all client age groups has long been a hallmark of the cognitive-behavioral family of treatment approaches (Kendall & Korgeski, 1979; Mash & Hunsley, 1990). Since their initial development decades ago, behavior therapies, cognitive therapies, and cognitive-behavioral therapies

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have all emphasized the importance of assessing clients' presenting problems prior to commencing treatment, closely monitoring the impact of treatment, and evaluating treatment outcome.

That is not to say that all clinicians providing CBT services are necessarily proficient or up-to-date in their use of assessment tools and strategies. Surveys often find that clinicians delivering evidence-based treatments do not have extensive training in the provision of these services. For example, in their survey of psychologists who provided interventions for clients with eating disorders, Mussell et al. (2000) found that, although 70% of respondents reported using evidence-based treatments (primarily CBT), three-quarters of these respondents had not been trained in the provision of the treatments. Likewise, Becker, Zayfert and Anderson (2004) surveyed psychologists who provided treatments for clients with posttraumatic stress disorder and found that only one in four had received training in the use of exposure. Without appropriate training, it is highly unlikely that the key components of evidence-based services will be adequately implemented, including the use of thorough initial and ongoing assessments. In other words, "doing CBT" is not necessarily the same as "doing CBT properly." Beyond this, even those with solid CBT training are likely to benefit from ongoing learning about state-of-the-science assessment information, such as is provided by the articles that form this special section of *Cognitive and Behavioral Practice*.

As Jensen-Doss (2015–in this issue) described in her introduction, the special section was designed to provide readers with information on evidence-based assessment (EBA) strategies that are directly relevant to clinical practice. Collectively, the articles in this special section do a truly admirable job of providing practice-relevant guidance for using and implementing assessment tools, methods, and systems. The range of topics covered in these articles is impressive: options for free assessment measures that can be used in mental health settings (Beidas et al., 2015–in this issue), scientifically sound strategies for combining assessment data and using the resulting case conceptualization to guide treatment (Christon, McLeod, & Jensen-Doss, 2015–in this issue; Youngstrom, Choukas-Bradley, Calhoun, & Jensen-Doss, 2015–in this issue), avenues available for incorporating EBA into school-based mental health services (Borntrager & Lyon, 2015–in this issue; Connors, Arora, Curtis, & Stephan, 2015–in this issue), ways to use data from ongoing treatment monitoring of both client psychosocial functioning and critical therapy process variables to enhance any form of mental health service (Scott & Lewis, 2015–in this issue), and strategies to address the challenges of developing and implementing treatment monitoring systems to inform and guide practice (Borntrager & Lyon, 2015–in this issue; Landes et al., 2015–in this issue). Taken together, these articles provide a very informative and valuable set of resources for professionals looking to introduce EBA into a clinical setting or to fine-tune the ways in which EBA is already incorporated into their clinical services.

In this comment, I begin by describing the common elements of EBA as illustrated in the articles comprising the special section. Although statements about the general principles of EBA are available in the literature (e.g., Hunsley & Mash, 2007; Mash & Hunsley, 2005; McLeod, Jensen-Doss, & Ollendick, 2013), it is important to examine how EBA is actually implemented in clinical settings. This allows for a determination of the principles and components of EBA that appear to be most germane to practice, providing an opportunity to highlight aspects of assessment that cut across clinical services offered in a range of settings and for a range of client populations. Based on the articles in the special section, the most critical elements appear to be relying on science to inform assessment, using both nomothetic and idiographic assessment measures, developing case conceptualizations that include but are not limited to diagnoses, and relying on treatment monitoring strategies to inform the ongoing provision of therapy for a client.

Next, I focus on the use of treatment monitoring (or progress monitoring, as it is being increasingly called) as an exemplar of EBA practices. Long an integral component of CBT practices, the explicit monitoring of client progress is now included in many clinical services derived from other theoretical orientations. Such diffusion of behavioral assessment procedures is not at all uncommon, as many prototypic features of behavioral assessment have been adopted as part of general psychological assessment practices (cf. Mash & Hunsley, 2004). Although the clinical utility of treatment monitoring is well-established in the research literature, the uptake of these assessment procedures has been relatively slow and limited. By examining some of the commonly expressed objections clinicians have to treatment monitoring, concerns about EBA more broadly may become apparent. In the final part of this comment, I suggest that a renewed focus on the social validity of interventions designed to yield behavior change, when applied to the implementation of treatment monitoring tools and systems, has the potential to enhance both the rate and extent to which EBA is adopted into clinical practices. The resulting efforts to engage clinicians and other stakeholders in discussions about the value of treatment monitoring (and EBA more generally) are likely to pay impressive dividends with respect to the translation of EBA principles and components into everyday practice.

Common Elements of EBA in the Special Series

The first common element apparent in all of the articles is the use of science, both as a "product" and as a way of thinking, in determining the constructs to assess,