Comparative Impact of Professional Mental Health Background on Ratings of Consumer Outcome and Fidelity in an Illness Management and Recovery Program

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Objective: Illness Management and Recovery (IMR) is a widely used evidence-based standardized psychosocial intervention. Little is known, however, about the impact of practitioner professional background on the consumer outcome. The current study aims to examine the delivery impact of practitioners who were mental health professionals, peer providers, or paraprofessionals on fidelity and consumer outcome in IMR. Method: Study participants were 252 persons with serious mental illness receiving psychiatric rehabilitation services in the community who received IMR (n = 210) or treatment as usual (TAU; n = 42). Study participants completed IMR groups that were delivered by either mental health professionals (n = 126), peer providers (n = 43), or paraprofessionals (n = 41). Study participants in the treatment group completed the Illness Management and Recovery scale before starting and after completing the IMR program; participants in the control group completed the same scale twice in similar time intervals. Fidelity ratings were made. Results: Regardless of practitioner background, consumers who received the IMR intervention demonstrated significant improvement compared to the control group. Post hoc analyses showed no statistically significant difference on consumer outcome regardless of whether the practitioner was a professional, paraprofessional, or a peer provider. All three IMR groups had good fidelity scores. Conclusions and Implications for Practice: The results demonstrate that IMR can be implemented with good fidelity and generate positive outcomes when delivered by practitioners who receive sufficient training and supervision regardless of their professional background.

Keywords: serious mental illness, rehabilitation, Illness Management and Recovery (IMR), fidelity

Illness Management and Recovery (IMR) is an evidence-based standardized psychosocial intervention. It was developed to help people with serious mental illnesses acquire knowledge and skills to manage their illness better and to identify and work toward achieving personal goals (Mueser, Corrigan et al., 2002; Mueser et al., 2006). IMR is based on five empirically supported self-management strategies: acquiring psychoeducation about mental illness and its treatment; taking cognitive–behavioral approaches to medication adherence; developing a relapse prevention plan; strengthening social support by social skills training; and acquiring coping skills training for the management of persistent symptoms. These self-management strategies are incorporated into 11 modules that cover these key areas (Gingerich & Mueser, 2005).

Research conducted around the world has supported the positive impact of IMR on several outcome domains. For example, results of a pilot study on 24 IMR completers in Australia and the United States revealed a significant improvement between baseline and postintervention assessment in illness management and recovery domains such as hope and goal orientation and improvement in coping strategies (Mueser et al., 2006). No improvement was found in social support and help from others.

In Israel, Hasson-Ohayon, Roe, and Kravetz (2007) studied a sample of 210 individuals with serious mental illnesses who were randomly assigned to either IMR (n = 119) or treatment as usual (TAU) (n = 91). IMR participants showed significant improvement in knowledge about their illness and progress toward their personal goals and total IMR scale clinician rating scores at postintervention compared to the control group. No difference between groups was found in coping and social support.

Another study in the U.S. (Levitt et al., 2009) with 104 participants who were randomly assigned to either IMR (54 participants) or to a waitlist control group (50 participants) revealed significant improvement among the IMR completers in self-reported and clinician ratings of the IMR scale, symptom severity, and psychosocial functioning. No statistically significant difference was found between the groups in self-ratings of distress and the rate of hospitalization during the year before the study.

Results of a noncontrolled study conducted in the U.S. (Salyers, Godfrey et al., 2009), which included 324 participants from seven community mental health centers, revealed a significant increase in illness management skills and hope but no change in satisfaction with services at 6- and 12-month follow-ups.

One-year follow-up interviews with 36 IMR completers in Israel (Roe et al., 2007) revealed high levels of perceived helpfulness and improvement in IMR-related domains [i.e., cognition (52.8% re-
ported improved), social support (30.6%), and coping strategies (41.7%).

In Japan, 25 service users with schizophrenia were assigned nonrandomly to either the IMR program or to a waitlist comparison group (Fujita et al., 2010). IMR participants showed significant improvements in functioning, symptom severity, becoming engaged in self-management, social functioning, satisfaction with community living, daily living, and social relationships compared to the control group.

Despite empirical support and international implementation of IMR, little is known about the impact of professional background on consumer outcome. According to its developers, IMR can be delivered by practitioners that possess a variety of skills and expertise in counseling, nursing, occupational therapy, social work, and case management as well as be provided by trained peer specialists (Gingerich & Mueser, 2011). They emphasize that practitioners who deliver IMR need to build a rapport and focus on the positive rather than the pathology or deficits, generating confidence and hope that change is possible and that personal recovery goals are achievable (Gingerich & Mueser, 2011).

In recent years, consumer involvement in health care as peer supporters or peer providers has been reported as an effective way to advance recovery (Davidson, Tondora, & Ridgway, 2010; Repper & Carter, 2011; Salzer, 2002; Solomon, 2004; Swabrick, Schmidt, & Gill, 2010). A peer provider refers to a person with a serious mental illness who consumes ongoing psychiatric rehabilitation services and, at the same time, provides support for other people with serious mental illnesses based on his or her own experience in coping with mental illness (Davidson, Chimman, Sells, & Rowe, 2006; Solomon, 2004). It is argued that peer providers conducting groups is beneficial because of the group participants’ identification process with the group facilitator (Solomon, 2004), and because of the contribution of the facilitators’ personal experience to the IMR process (Salyers, Hicks, et al., 2009).

Recent studies focusing on consumer-led interventions such as Wellness Recovery Action Planning (WRAP; Cook et al., 2012) and the Health and Recovery Peer Program (HARP; Druss et al., 2010) provide support for the positive impact of consumer-provided services. For example, participants in peer-provided WRAP groups (Cook et al., 2012) showed significant improvement compared to those who received treatment as usual. The positive impact of peer-run interventions has been demonstrated in another recent study, which compared the outcomes of consumer-run HARP participants to a control group. The study revealed improved outcomes in a range of self-management and health outcome measures, including improvement in patient activation and greater likelihood of using primary care medical services (Druss et al., 2010). In another study (Salyers, Hicks, et al., 2009), participants in peer-provider-run IMR groups showed pre-post improvement in their recovery and increased knowledge regarding their mental illness. Analysis of interviews conducted with consumers and staff members supported the importance and contribution of firsthand personal experience and coping strategies. A recent APA press release (August, 2012) has emphasized the importance of examining whether the effects of psychotherapy (either positive or negative) occur due to the technique itself, the clients’/clinicians’ variables, or some combination of these three factors.

In conclusion, research demonstrates that IMR is an effective intervention and supports the effectiveness of consumers-led interventions. The impact of practitioner background on the fidelity and outcome of IMR is unclear. Accordingly, the current study objective is to fill in this lacuna by comparing the outcomes of people living with serious mental illnesses who completed IMR delivered by either mental health professionals, paraprofessionals, or peer providers, or a group that received TAU.

**Method**

**Study Design**

The study was carried out at 29 psychiatric rehabilitation agencies in the community in central Israel. Ethical approval was obtained from the Institutional Review Board at the University of Haifa. After receiving a detailed study explanation, all research participants provided written informed consent.

The study included two main conditions: in the first condition participants completed IMR (i.e., treatment condition), and in the second condition participants received treatment as usual (i.e., control condition).

The treatment condition included 29 IMR groups that were facilitated by 51 practitioners, who were trained in IMR, received enrichment training, and attended ongoing bimonthly group supervision while implementing the intervention (for approximately 9 months). The treatment condition was divided into three subconditions based on the practitioners’ background and professional training as follows: IMR groups facilitated by mental health professionals, by peer providers, or by paraprofessionals (see Figure 1).

**Participants and Procedure**

A total of 252 persons with a case record diagnosis of a serious mental illness participated in the study. The diagnosis of a serious mental illness was given for persons with at least 40% psychiatric disability determined by a medical committee that included a psychiatrist and was recognized by the Israeli National Insurance Institute. While we did not conduct diagnostic interviews for each participant, we note that among the over 16,000 people with at least a 40% psychiatric disability in Israel, 86% have a diagnosis of psychotic-related disorder (Struch, Shereshevsky, Naon, Daniel, & Fischman, 2009). Thus, it is likely that the majority of our study sample had a psychotic disorder. Inclusion criteria were fluency in Hebrew and providing informed consent. Participants in the treatment group were 210 consumers, who opted to attend an IMR group offered at the agency where they were receiving psychiatric rehabilitation services and had attended at least the first three IMR sessions. Consumers were not randomly assigned to one of the three IMR conditions, but whether they participated in an IMR group delivered by professionals, paraprofessionals, or peer providers was by mere chance, depending on the agency at which they happened to be consuming services. The TAU data was gathered from participants consuming similar services (e.g., housing, social and vocational services), the same agencies within the same geographic area. The major difference was that IMR was not provided at locations where the TAU group was assessed. The TAU group...
(n = 42) completed the same assessments (Times 1 and 2) as the IMR group and at the same confidence intervals (see Figure 2).

No differences in baseline demographic variables were observed between the IMR and TAU groups. The total sample at baseline assessment included 112 (44.4%) women and 140 (55.6%) men. Males and females were equally distributed between the two groups (IMR vs. TAU) [χ²(1) = 0.82, p = .36] and between the four subgroups (groups facilitated by practitioners, groups led by paraprofessionals and groups facilitated by peer providers) [χ²(3) = 1.13, p = .77].

Participants’ mean age was 43.5 (SD = 12.91) and on average had 11.4 (SD = 2.58) years of education. Most participants were Jewish (n = 244, 96.8%) and the rest were not Jewish (n = 8, 3.2%). Before treatment, no significant differences between the two groups (IMR vs. TAU) at Time 1 were found on age (t(248) = 3.2%, p < .01), years of education (t(248) = 1.34, p = .18), family status (χ²(1) = 1.97, p = .74), and religion (χ²(1) = 1.60, p = .36). Similarly, no statistically significant differences between these variables at Time 1 were found between the professional subgroups analysis between the three IMR groups [age (F(3,248) = 2.31, p = .07), years of education (F(3,248) = 0.97, p = .41), family status (χ²(12) = 10.53, p = .57), and religion (χ²(12) = 6.59, p = .88)].

A total of 29 IMR groups ran during the study period. Of these groups a total of 16 (55.2%) groups were facilitated by mental health professionals, six groups (20.7%) were facilitated by paraprofessionals working in the mental health system, and seven groups (24.1%) were facilitated by peer providers. Out of the 16 IMR groups facilitated by mental health professional, five were facilitated by one facilitator and 11 were facilitated by two. The majority of the mental health professional held a bachelor degree (n = 20, 74.07%) in social work or occupational therapy, and the rest (n = 7, 25.03%) held a master’s degree in social work or psychology. Out of the six IMR groups led by paraprofessionals (n = 11), one group was led by one facilitator, while five groups were facilitated by two facilitators. Out of the seven IMR groups led by consumers (n = 13), two groups were led by one facilitator, four groups were led by two facilitators and one IMR group was led by three facilitators. All facilitators completed 2 days of IMR initial training. This included theoretical and practical aspects of the intervention, and incorporated toolkit use. They also collectively attended bimonthly 2-hr group supervisions, and three additional training days during the 9 months of the intervention. Also, all practitioners turned in weekly progress note reports for which they received written feedback from the supervisors.

Data were gathered at two time points; pre- and post-IMR intervention. Out of 291 optional participants to the IMR program, 210 (72.16%) agreed to participate in Time 1 assessment.

**Measurement and Evaluation Technique**

**Illness Management and Recovery scale.** The Illness Management and Recovery scale was developed as an outcome measure for the IMR program (Mueser & Gingerich, 2005). This version is a self-report questionnaire designated for IMR participants (not facilitators). The original scale comprises 15 items that reflect the outcome in the following content areas of the intervention: personal goals, knowledge of mental illness, involvement with significant others, functioning, symptoms, stress, coping,
relapse prevention, hospitalization, medication, and use of drugs and alcohol. The current study excluded items 14 and 15 assessing the use of drugs and alcohol because this IMR module was not implemented. The item rating options ranged from 1 to 5, with higher scores indicating better illness management and recovery. Previous research has provided evidence for the scale’s internal consistency, test–retest reliability and validity (Hasson-Ohayon et al., 2007; Levitt et al., 2009; Salyers et al., 2010). The IMR scale was previously back-translated into Hebrew and was found to have acceptable psychometric properties (Hasson-Ohayon et al., 2007; Roe et al., 2007). In the current study, Cronbach’s alpha coefficient for the entire scale (13 items) was 0.74.

**Illness Management and Recovery Fidelity scale.** The Illness Management and Recovery Fidelity scale is a 13-item scale that measures the extent to which the implementation of the intervention is consistent with the principles of the IMR program. For example, item 12 assesses relapse prevention. The rater should mark the degree in which the practitioners are familiar with the principles of relapse prevention training on a scale from 1 (Few or none are familiar) to 5 (All practitioners are familiar). Responses are ranked on a 5-point Likert scale ranging from 1 = not implemented to 5 = fully implemented (Mueser & Gingerich, 2005).

In the present study, fidelity assessments were performed using an integration of three sources of information: (a) practitioners’ weekly progress notes; (b) semistructured interviews conducted with the group facilitators (n = 25) 4 months after the start of the IMR group and again upon completion of the intervention; and (c) semistructured interviews conducted also with a group of IMR participants (n = 16).

Based on the information gathered from these various sources, the IMR fidelity scale was completed by two trained raters during a day-long visit at each agency. The two raters were senior social workers experienced in IMR training and supervision and were thus well familiar with the fidelity items and were trained to conduct fidelity ratings by the last author (D.R.), who was trained by a senior clinical psychologist in Indiana who had lots of experience with fidelity visits and himself conducted several fidelity visits in New Jersey. During an IMR fidelity visit, the raters reviewed charts and conducted brief interviews with staff and consumers. By the end of the day-long agency visit, the raters independently assessed the program and compared ratings. Discrepancies were resolved through discussion and additional data gathered if needed. IMR fidelity was completed in all 29 agencies at the end of the IMR intervention, 9 months after the original 2-day training. The IMR Fidelity scale has high interrater reliability (intraclass correlation coefficient = .97; McHugo et al., 2007) and high sensitivity to both implementation efforts showing change over time (McHugo et al., 2007; Salyers, Godfrey et al., 2010).

**Data Analysis**

Statistical analyses were performed using the PASW Statistics 17 software. First, an ANOVA was conducted to assess the extent to which the implementation of the intervention was consistent with the principles of the IMR program (IMR fidelity test). This analysis tested whether the groups reached a satisfactory level of IMR implementation. Second, to assess change over time (from Time 1 to Time 2 assessments) in IMR scale and its difference between the study groups, analysis of covariance (ANCOVA) was used.

**Results**

**IMR Fidelity Test**

In the present study, the fidelity test was conducted for the 29 agencies study groups in which IMR intervention took place. The mean score on the IMR Fidelity scale was calculated for each group category (i.e., 16 IMR groups facilitated by clinicians, six by paraprofessionals and seven by peer providers). All three IMR group categories maintained good fidelity throughout the study period with scores >3.8. ANOVA revealed that although clinicians reported the highest IMR fidelity mean scores (M = 4.14, SD = 0.33), no significant difference was found between these groups and those facilitated by paraprofessionals (M = 3.81, SD = 0.44) and peer providers (M = 3.84, SD = 0.38) [F(2,28) = 2.65, p = .09].

**IMR Practitioner Background Effects on Implementation**

To examine the impact and the role of the IMR practitioners’ background on IMR consumer scores, ANCOVA was computed with IMR score at Time 2 (posttreatment score) as the DV, group type as the IV, IMR at Time 1, and age and sex as the covariates. A significant difference was found between the groups versus the TAU group in IMR posttreatment score while controlling for IMR score at Time 1 and for age and sex [F(5,167) = 3.01, p = .03]. A post hoc Least Squared Differences demonstrated almost no change in IMR score between Times 1 and 2 for participants in the TAU group (M = 3.36, SD = 0.50), whereas the other three IMR groups demonstrated a significant change between Times 1 and 2 [for IMR groups facilitated by clinicians (M = 3.46, SD = 0.56, p = .02), for IMR groups facilitated by paraprofessionals (M = 3.66, SD = 0.51, p = .01), and for IMR groups facilitated by peer providers (M = 3.39, SD = 0.59, p = .04)]. It is noted that no significant difference was found among the three IMR groups themselves in IMR score at Time 2. Figure 3 presents change over time between the four study groups using the mean scores at Time 2.

![Figure 3. Differences in IMR mean scores along the four study groups between Time 1 and Time 2.](image-url)
1 and Time 2 (pre- and posttreatment IMR scores). Tests of equivalence, available on request, replicated these results.

Specificity Analyses

It has been reported that the IMR scale may be divided into three factors assessing coping strategies (items 6, 7, 9, 11), knowledge and goals (1, 2, 4, 8), and medications (13, 14, 15)\(^1\) (Hasson-Ohayon, Roe, & Kravetz, 2008; Sklar, Sarkin, Gilmer, & Groessl, 2012). It seems plausible to speculate that different facilitator types might differentially impact these different factors. Thus, further analyses were made to assess differences between the types of facilitators in these three different factors.

ANCOVAs were computed with coping strategies, knowledge and goals, and medications scores at Time 2 as the DVs, group type as the IV, IMR at Time 1, and age and sex as the covariates. No significant differences were found between the groups versus the TAU group in coping strategies \(F_{(3,167)} = .48, p = .69\) and in use of medications \(F_{(3,164)} = .40, p = .75\). A significant difference was observed when comparing the factor of knowledge and goal between the three types of facilitators \(F_{(3,167)} = 3.47, p = .02\). A post hoc Least Squared Differences demonstrated that IMR participants led by clinicians \((M = 3.25, SD = .86)\) or by paraprofessionals \((M = 3.53, SD = .67)\) performed significantly better in knowledge and goals setting in comparison with control \((M = 3.09, SD = .74)\). No statistically significant difference was found between IMR participants led by clinicians or by paraprofessionals to IMR participants led by consumers, and no difference was found between the latter to control \((M = 3.18, SD = .94)\).

Discussion

The current study uniquely examined the delivery impact of practitioners who were mental health professionals, peer providers, or paraprofessionals on consumer outcome and fidelity. The findings demonstrate the superiority of IMR over TAU, replicating prior research (e.g., Fujita et al., 2010; Hasson-Ohayon et al., 2007; Levitt et al., 2009; Salyers, Rollins, Clendenning, McGuire, & Kim, 2011). It is interesting that no significant differences were found in consumers’ outcome regardless if the practitioner was a professional, paraprofessional, or a peer provider. As previously found, IMR participants performed better in their knowledge of the illness and attainment of personal goals (Hasson-Ohayon et al., 2007). Also, all three IMR groups maintained good fidelity.

To the best of our knowledge, this is the first study to investigate the impact of practitioners’ background on IMR participants’ outcomes. The results reveal that the positive impact of IMR was not related to whether the practitioners delivering IMR were mental health professionals, paraprofessionals, or peer providers. Previous research that compared the effectiveness of professional and paraprofessionals’ interventions has concluded that no differences in outcomes exist (Chistensen & Jacobson, 1994; Solomon, 2004). One possible explanation might be the theoretical stance that emphasizes the central role of the therapeutic relationship in generating positive change, and that the actual critical ingredient for positive change is the opportunity to participate in weekly groups facilitated by someone with whom they have established a positive therapeutic relationship. Catty (2004) claims that therapeutic alliance is a healing factor that accounts for the various outcomes in different types of therapies. We can expect, therefore, assuming practitioners form a good therapeutic rapport, that IMR outcomes will be positive. Since a major part of mental health practitioner training across professions is establishing a good therapeutic alliance, participants in professionally run IMR groups would be expected to show improvement. The finding that participants in consumer-run IMR groups improved as well is also in line with the accumulating body of research showing that peer providers’ involvement in mental health services has a positive impact on consumers’ outcomes (Fukui, Davidson, Holter, & Rapp, 2010; Klein, Cnaan, & Whitegraft, 1998; van Gestel-Timmerman, Brouwers, van Assen, & van Nieuwenhuizen, 2012) and that peer providers can implement interventions as effectively as mental health professionals (Chimman, Rosenheck, Lam, & Davidson, 2000; Cook et al., 2012; Rivera, Sullivan, & Valentì, 2007; Salyers, Hicks et al., 2009; Schmidt, Gill, Pratt, & Solomon, 2008; Solomon & Draine, 1995; Felton, C. J., Stastny, P., & Shern, D., 1995). The finding that IMR outcomes of participants in IMR groups facilitated by paraprofessionals were as positive is somewhat surprising because they have neither the professional training in establishing a therapeutic relationship nor their lived experience as peers. On the other hand, the fact that they chose to become involved in the mental health field and have accumulated years of experience might have helped to develop their ability to build a rapport, which led to positive results.

An alternative explanation for the finding that IMR was effective, regardless of who delivered it, may be that the critical ingredient is the well-structured manual that generates positive outcomes as long as implemented with good fidelity. Indeed, IMR is a relatively detailed and user-friendly package of effective self-management strategies. As described earlier, all IMR providers in the current study received relatively comprehensive IMR training and ongoing supervision throughout the implementation and delivered the intervention with high fidelity, which might account for the good outcomes.

An interesting finding of our study relates to the fidelity scale of the IMR intervention. Clinicians’ exhibit better tendency, although not statistically significant, in implementing the IMR intervention compared to paraprofessionals and peer providers. This may be a result of the clinicians’ skills and training. Although peer providers and paraprofessionals have good experience to guide them in implementing the program, they may need to learn specific competencies (e.g., motivational and cognitive–behavioral ones) to better implement the IMR program (Salyers et al., 2010).

Several limitations of the study are appropriate to note. Methodologically, there was no control condition consisting of an activity other than IMR. Thus, this may moderate the study results of no difference between the three IMR groups. Consumers were not randomly assigned to one of the three IMR conditions and whether they participated in an IMR group delivered by professionals, paraprofessionals, or peer providers was by mere chance, depending on the agency at which they happened to be consuming services. Accordingly, a limitation of the current study is that no

\(^1\) In the current study, items 14 and 15 were omitted because this IMR module was not implemented, leading to one item (13) as the medication factor.
randomization was involved. Also, the current study estimates may be slightly biased due to the absence of accounting for agency grouping. Future study should examine IMR using a cluster randomized trial study design. Another limitation of the current study relates to the education level of the clinicians. In Israel, many social workers and occupational therapists earn a bachelor degree and are considered as mental health professionals. Therefore, the educational level between the three groups of IMR facilitators did not vary considerably, and thus may account for the lack of difference in consumer outcomes. Finally, it is unknown whether the results generalize to other populations or specific diagnostic subgroups.

Conclusion and Implication for Practices

The current study findings reveal that mental health providers with heterogeneous backgrounds (professionals, paraprofessionals, and peer providers) who received appropriate training and ongoing supervision can implement IMR with high fidelity that leads to positive outcomes. The implication of these findings is that the delivery of IMR may not be limited to mental health professionals but rather may be made possible for practitioners with diverse backgrounds. To assure high-fidelity implementation, which is associated with positive outcomes, sufficient training and ongoing supervision are crucial.

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