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ScienceDirect

Behavior Therapy 45 (2014) 47–50

Behavior Therapy

www.elsevier.com/locate/bt

INVITED COMMENTARY

Can We Talk? Fostering Interchange Between Scientists and Practitioners

Dianne L. Chambless

University of Pennsylvania

In response to three surveys of (mostly) cognitive-behavioral practitioners about barriers to treatment success with cognitive-behavioral therapy for patients with generalized anxiety disorder, panic disorder, and social phobia (McAleavey, Castonguay, & Goldfried, 2014-this issue; Szkodny, Newman, & Goldfried, 2014-this issue; Wolf & Goldfried, 2014-this issue), the author proposes several methods for tapping clinical expertise in the development and dissemination of psychological interventions. These include: following surveys with interviews of a subset of clinicians to obtain richer information, systematically incorporating answers to questions and problems trainees raise in supervision in efficacy or effectiveness trials, organizing clinical roundtables at meetings of the Association for Behavioral and Cognitive Therapies to discuss ways to address barriers identified in these surveys, and encouraging papers on these topics in *Cognitive and Behavioral Practice*. At the same time the author emphasizes that clinical observations are not facts and need to be verified in empirical research.

Keywords: cognitive-behavioral therapy; anxiety disorders; dissemination; training; treatment manual

Clinical observations are an important source of advancement in psychotherapy. In 1963 a frustrated psychoanalyst, Aaron T. Beck, published his observations of the cognitive psychopathology of 50 depressed patients he had seen in psychotherapy or psychoanalysis (A. T. Beck, 1963). In this paper, Beck described the automatic nature of depressive cognitions, their perseveration, and their uncritical acceptance by patients. He further observed the specificity of particular kinds of thoughts in leading to the affect of depression and noted that the content of other thoughts would lead to different emotions such as anger. All of these observations have received copious empirical support by now, but Beck's proposal that depression should be viewed as a cognitive disorder was radical for its day and represented an important contribution by an innovative clinician. These clinical observations were only the first step for Beck and were followed by some critical actions: First, Beck was careful to make systematic observations of the depressed patients in his practice and to compare them to his observations of patients with disorders other than depression. Second, he began not only his program of research on cognitive aspects of psychopathology and its treatment but also his highly effective campaign to draw young researchers into work on these ideas. The rest, as they say, is history. To use the terms Goldfried and colleagues (2014-this issue) employed in their introduction to this special section, Beck was both a *problem finder* and the *problem solver*, and such people are the leaders who take our field forward.

Are there ways in which clinicians who do not have the resources or interest in being both problem finders and problem solvers can contribute to the improvement of current psychotherapy approaches? Goldfried and colleagues (2014-this issue) have rightly advocated for the importance of a two-way dialogue in which clinicians communicate their observations and concerns to researchers, who should then take these into account in treatment refinement and training. In addition, I would argue that clinicians have an important role to play as problem solvers. Clinical observations are a vital source of hypotheses, not only about factors that may bolster or hamper success in treatment (and that is the emphasis of this special series) but also about interventions that might overcome detrimental

Address correspondence to Dianne L. Chambless, Ph.D., Department of Psychology, University of Pennsylvania, 3720 Walnut Street, Philadelphia, PA 19104-6241; e-mail: Chambless@psych.upenn.edu.

0005-7894/45/47-50/$1.00/0

factors. The front-line practitioner has considerable opportunity to try various approaches to working around a barrier and may have fresh ideas to offer. The researcher's essential contribution is to systematize observations and subject them to empirical test. This is a critical piece of the science-practice dialogue. Most innovations in my own work began as a clinical hunch, but there were also clunkers in those hunches that I later discarded on the basis of research findings.

I now turn to consideration of ways to bring clinical expertise into the treatment development, validation, and dissemination processes. Dissemination of CBT is advanced by the development of more and more elaborated treatment manuals in which the authors describe the interventions and then consider likely barriers in treatment that clinicians will need to negotiate. Developing such a manual pulls together in one place rich information on implementing a treatment and fosters training and dissemination. Having the material in one place is essential for dissemination and training, in that we cannot expect busy clinicians to track down multiple sources to guide their use of a treatment. Also, for a manual to be acceptable, it must address the reality of work in the field with complex patients. Otherwise, clinicians are likely to toss it aside (Stewart, Chambless, & Baron, 2012).

Abundant opportunities to tap clinicians' expertise exist in the context of treatment development, efficacy trials, and effectiveness studies. Once an innovation has been developed in psychotherapy, the long slog of writing treatment manuals, empirically testing the intervention's utility, and determining the boundaries of its efficacy (with whom and under what circumstances does this approach work?) begins. This is the province of the psychotherapy researcher, but the researcher may partner with talented clinicians in the research team to develop the treatment and the treatment manual. Feedback from therapists in pilot studies and research trials and from students leads to elaboration of the treatment manual. For example, if the manual authors make notes of the questions and problems the protocol therapists bring to supervision across the course of the trial, they can address these concerns in the next version of the treatment manual, incorporating suggestions from the trial therapists as to how to manage the problems. When a treatment has proved promising enough in controlled efficacy trials, it is time for treatment effectiveness studies, in which an intervention is tested in community settings under clinically representative conditions. New problems are likely to emerge at this stage. As treatment researchers train and supervise staff in community mental health centers, health maintenance organizations and the like, they have the opportunity to learn much about the snags clinicians encounter in using their treatment in less controlled settings. This provides more opportunity for elaboration of the treatment manual, in that a good manual will have lots of examples of how to approach typical problems that come up in the implementation of the treatment.

A second opportunity is to be found in the specialty clinic devoted to treating a particular type of disorder. Such clinics allow clinicians the opportunity to observe the effects of the treatment approach on patients with a similar problem outside of research trials and to experiment with ways to overcome obstacles to treatment progress. The practitioners in such sites develop high levels of expertise and have much to offer the researcher who interacts with them. When the researchers and clinicians are housed in the same site, as is the case for specialty clinics in some psychiatry and psychology departments, there is ample opportunity for exchanges if the researcher takes advantage of it. The researcher can then test the most promising ideas and add those that pan out to the treatment manual.

A third opportunity comes from the writings of those remarkable clinicians who, despite their case loads, carve out time to write about their clinical work. In the cognitive-behavioral therapy (CBT) world, two ready examples are Robert Leahy (e.g., Leahy, 2001) and Judith Beck (e.g., J. S. Beck, 2005). Their writings are replete with ideas about how to cope with problems encountered in applying CBT that psychotherapy researchers would do well to test.

Goldfried and colleagues (2014-this issue) have developed a fourth strategy in which the authors of the articles in this special section have surveyed clinicians to obtain their input on difficulties they find in applying empirically supported CBTs for several different anxiety disorders. The benefit of this approach is that it provides the opportunity to get input from a larger sample than the previous three methods I have outlined. The drawback, as with all survey research, is that the responses are quite limited in the information they can convey by the survey format. For example, clinicians mentioned comorbidity as a source of difficulty in their treatment of patients with panic disorder, generalized anxiety disorder, and social phobia (McAleavey, Castonguay, & Goldfried, 2014-this issue; Szkodny, Newman, & Goldfried, 2014-this issue; Wolf & Goldfried, 2014-this issue). There are at least several ways in which comorbidity might be a problem: The clinician might have difficulty deciding what the focus of treatment should be in the presence of multiple disorders; the clinician might find the comorbid disorder interferes with the execution of the treatment