Available online at www.sciencedirect.com

ScienceDirect

Behavior Therapy 45 (2014) 51–55

Behavior Therapy

www.elsevier.com/locate/bt

INVITED COMMENTARY

Advances Toward Evidence-Based Practice: Where to From Here?

Thomas H. Ollendick

Virginia Polytechnic Institute and State University

Evidence-based practice has a long history; however, attempts to bridge the gap between science and practice have been only partially effective and much work remains to be done. Part of the problem has been the unilateral approach associated with dissemination of research findings to clinical practitioners. In this special series, Goldfried and colleagues (2014–this issue) suggest a two-way bridge, in which practitioners are afforded the opportunity to disseminate their rich clinical experiences to researchers as well. In this manner, a more collaborative working relationship is espoused. Surveys of practitioners on the use of CBT procedures in the treatment of panic disorder, social anxiety disorder, and generalized anxiety disorder are described. The findings are reviewed and limitations associated with the surveys are noted. Finally, future directions are suggested for rapprochement, hopefully resulting in a greater synthesis of research and practice.

Keywords: evidence-based practice; science-practice gap; dissemination

A LITTLE OVER 60 YEARS AGO, Eysenck (1952) published his now (in)famous review on the effects of adult psychotherapy. Boldly, he asserted, psychotherapy practices at that time were no more effective than the simple passage of time. Shortly thereafter, Levitt (1957, 1963) reviewed the child psychotherapy literature and arrived at a similar conclusion. These reviews were not only long overdue; more important, they were highly controversial and led many clinicians and researchers to question the continued viability of the psychotherapy enterprise.

Address correspondence to Thomas H. Ollendick, Ph.D., Virginia Tech, Child Study Center, 460 Turner Street, Suite 207, Blacksburg, VA 24060; e-mail: tho@vt.edu.

0005-7894/45/51–55/$1.00/0

Fortunately, and as noted some years ago by Kazdin (2000), they also served as a wake-up call and led to a host of developments including advances in our understanding of diverse psychopathologies, improvements in our psychiatric diagnostic nomenclature, enhancements in assessment and treatment practices, and developments in experimental designs for the study of processes and outcomes associated with our psychosocial treatments. In turn, these advances resulted in well over thousands of clinical trials and spawned major meta-analyses that critically examined the effects of psychotherapy (see Hofmann, Asaani, Vonk, Sawyer, & Fang, 2012, for a recent meta-analysis of 269 meta-analytic studies). Consistently, these reviews and meta-analyses demonstrate that active psychotherapies (largely cognitive behavioral therapies [CBT], but not exclusively so) perform better than waiting-list and attention-placebo conditions (and, in several studies, outperform pharmacological interventions); moreover, in several studies, it is becoming clear that some forms of psychotherapy work better than others for certain kinds of problems. As a result, much progress has been made and the field of psychotherapy has moved well beyond the simple question, "Does psychotherapy work?" to identify the efficacy of *specific* treatments for individuals who present with *specific* behavioral, emotional, and social problems. The field has also advanced to include questions of *how* these psychotherapies work and the conditions *under which they work* (i.e., questions of mediation and moderation). This is a most exciting time in the field of psychotherapy practice and research. As a profession, we truly have much to offer!

It should be noted that this movement to identify treatments that work is part of a larger zeitgeist labeled "evidence-based medicine" (Sackett, Richardson, Rosenberg, & Haynes, 1997, 2000), which has come to be referred to as "evidence-based practice" in psychology (see American Psychological

Association Presidential Task Force on Evidence-Based Practice, 2006). Evidence-based practice is at its core an approach to knowledge and a strategy for improving the outcomes of treatment that uses research evidence to improve client care. It is not wedded to any one theoretical position or orientation. It holds that treatments, of whatever theoretical persuasion, need to be based on objective and scientifically credible evidence. To be sure, evidence-based practice highly values information obtained from randomized control trials (RCTs); however, it also values information obtained from basic research, research on psychopathology, open clinical trials, observational studies, logical intuition, personal experiences, and the testimony of expert clinicians. Some of these latter forms of evidence are not necessarily "bad" or "not useful." Rather, they are simply less credible and acceptable forms of evidence from a scientific, evidentiary-based standpoint. Still, it must be quickly asserted that they are invaluable in the generation of hypotheses and questions for scientific scrutiny and verification.

The movement to develop, identify, disseminate, and use empirically supported psychosocial treatments (initially referred to as empirically "validated" treatments; see Chambless & Hollon, 1998, and Chambless & Ollendick, 2001, for reviews) has been a controversial one. On the surface, it hardly seemed possible that anyone could or would object to the initial report issued by the Society of Clinical Psychology of the American Psychological Association in 1995 or that the movement associated with it would become so controversial. Surely, identifying, developing, and disseminating treatments that have empirical support should be encouraged, not discouraged, especially by a profession that is committed to the welfare of those whom it serves. Sensible as this may seem, the task force report was not only controversial; moreover, and unfortunately, it served to divide the profession of clinical psychology and related mental health disciplines.

Against this backdrop, much has been written about evidence-based practice and attempts to bridge the gap between science and practice in the last 15 to 20 years (cf. Davison, 1998; Kazdin, 2008; Norcross, Beutler, & Levant, 2006; Ollendick & King, 2012; Sobell, 1996; Weisz, Ugueto, Cheron, & Herren, 2013). As a result, the gap between science and practice has grown smaller, although it surely still exists. In this provocative set of papers, Goldfried et al. (2014–this issue) have taken an innovative approach to this vexing problem: they argue that a two-way bridge is necessary to close the gap even further. To wit, they suggest it is not enough to simply disseminate research findings to the practitioner (as has typically been the case—a one-way solution); rather, it is also important for practitioners to disseminate their clinical experiences to the researcher so that a joint consensus on "what works" can be determined (a two-way solution). Their approach is similar to that of the Food and Drug Administration (FDA), which encourages feedback from medical practitioners about how well drugs—once approved for use—fare in the clinical setting. With the FDA, medical practitioners are requested to file incident reports when they encounter problems in the use of any given drug in their routine clinical practice. So, too, here Goldfried and colleagues actively solicited (via online surveys) the experiences of practitioners on the use of various CBT techniques in the treatment of panic disorder (Wolf & Goldfried, 2014–this issue), social anxiety disorder (McAleavey, Castonguay, & Goldfried, 2014–this issue), and generalized anxiety disorder (Szkodny, Newman, & Goldfried, 2014–this issue). It should be noted that, very much in the spirit of evidence-based practice and all that it implies, the surveys were focused not only on the treatment itself but also on therapist, patient, and contextual variables that might serve as barriers to the effective use, and eventual efficacy, of these interventions. It should be further noted that surveys of clinician experiences with treatment for other disorders are expected to occur in the future. For now, however, the surveys are limited to these three major anxiety disorders. Moreover, they are limited to the experiences of practitioners using CBT. The reason for this restriction appears to be that the evidence base for use of CBT is stronger than it is for other interventions at this time (see Hollon & Beck, 2013, for review). Again, this decision is not unlike that of the FDA, which welcomes feedback on "approved" drugs in routine clinical practice.

What can we conclude from these surveys? What are the limitations associated with the surveys? And, where do we go from here? As is evident in the individual papers, a similar set of questions were posed in the online surveys to the various practitioners (338 clinicians in the panic disorder survey, 276 in the social anxiety disorder survey, and 260 in the generalized anxiety disorder survey). Commonalities in responses across the disorders were evident: treatment techniques commonly used by the practitioners included psychoeducation about the respective disorders; use of cognitive restructuring, examination of behavioral avoidance, and in vivo exposures during the sessions; and assignment of homework activities between sessions and relapse prevention strategies following the interventions.

In reference to barriers to successful treatment, a significant percentage of the respondents (38% to 44%) indicated difficulties associated with arranging