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Invited Essay

Use of empirically supported interventions for psychopathology: Can the participatory approach move us beyond the research-to-practice gap?

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ABSTRACT

Dissemination, or distribution, of empirically supported interventions (ESIs) for psychopathology remains a significant challenge. This paper reviews the principles of community-partnership research (CPR) and explores why CPR might improve distribution of psychological ESIs. Benefits of CPR include building trust, pooling resources and knowledge, and better serving a community by directly involving its members in the design and implementation of research. In addition, after establishing a community's trust using CPR, researchers are likely to be better positioned to partner with communities in the further distribution of ESIs via community networks. This paper reviews the case of dissonance-based eating disorder prevention interventions to provide an example of how CPR can facilitate the adoption and distribution of an ESI by a community, in this case, sororities. CPR also presents a number of challenges, however, because it is time consuming and does not always align with funding mechanisms and research designs used in randomized controlled trials. Further, CPR does not necessarily solve the challenge of training providers, though it may help with problem solving. Ultimately, we suggest that the benefits of CPR far outweigh the challenges, and hope that more researchers will adopt these practices so that more individuals can benefit from empirically supported psychological interventions.

Introduction

Psychopathology intervention research has produced marked advances over the last few decades. Perhaps most significant has been the development of empirically supported interventions (ESI). To date, rigorous clinical research has determined that several interventions reliably reduce symptoms, risk factors, and/or risk for onset of psychopathology. Despite these advances, it is also clear that the use of ESIs in everyday clinical practice and real world settings remains limited. Surveys regarding the use of ESIs such as cognitive-behavioral therapy (CBT) for bulimia nervosa and exposure for posttraumatic stress disorder (PTSD), obsessive compulsive disorder (OCD), and panic disorder – all of which are backed by a substantial evidence base – indicate that only a small subset of clinicians use ESIs on a regular basis (e.g., Becker, Zayfert, & Anderson, 2004; Freiheit, Vye, Swan, & Cady, 2004; Pederson Mussell et al., 2000; Rosen et al., 2004). In short, most ESIs are rarely used in clinical practice (i.e., there is a gap between research and practice). Several excellent articles have reviewed this research practice gap and the lack of progress distributing ESIs from research to clinical practice (e.g., Barlow, Levitt, & Bufka, 1999; Crits-Christoph, Wilson, & Hollon, 2005; Westen, Novotny, & Thompson-Brenner, 2004; Young, Connolly, & Lohr, 2008).

This article explores the viability of alternative approaches to disseminating ESIs. Specifically, we examine the potential benefits and challenges of community-based participatory research for health, which we refer to as community-partnership research (CPR), in expanding clinical utilization of ESIs. Although participatory approaches such as CPR are well recognized in health psychology, nursing, social work, and public health fields, this approach typically has not been used to disseminate ESIs for psychopathology, despite recognition that partnerships between clinicians and researchers might be fruitful (e.g., Chorpita & Nakamura, 2004; Kendall, 2002; Westen, Novotny, & Thompson-Brenner, 2005). Thus, we review CPR methods and principles in the context of disseminating ESIs and argue that CPR could improve use of ESIs in clinical settings. As part of our discussion, we will provide a case example involving the dissemination of dissonance-based interventions (DBIs) for eating disorder (ED) prevention. We then discuss some benefits and challenges of using CPR, and offer

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general observations about what we have learned during our efforts to disseminate DBIs for EDs. The authors of this paper include both researchers and a member of a community partner promoting DBIs. Because this paper is written for researchers, however, we largely write from a researcher perspective.

It is important to note that we are not arguing for abandonment of traditional efficacy or effectiveness trials. Similarly, we recognize that other researchers have used CPR to develop other ED prevention programs (e.g., see Piran, 2001). As can be seen below, however, ED prevention DBIs are unique in that they are supported by an evidence base that was constructed using CPR *and* traditional efficacy/effectiveness clinical trials. Thus, we suggest that although CPR is not a stand-alone solution, it is a vital piece of the dissemination process. Moreover, we suggest that CPR and traditional efficacy research, which may be viewed as quite different approaches to research, can be complimentary.

Community-partnership research (CPR)

Defining features

CPR involves engaging community partners in a manner that shares power and decision making to increase and integrate knowledge about health problems and improve problem solving (Israel, Eng, Schulz, & Parker, 2005). Communities are groups of individuals who have a collective identity involving emotional connection; shared symbol systems, values, norms, and interests; and a desire to address mutual needs (Israel et al., 2005). Practically, CPR involves bringing together people from diverse backgrounds (academics, agencies, community organizations etc.) to collectively address complicated social and health problems (Shoultz et al., 2006), or in the case of this paper – to foster greater use of ESIs for psychopathology. Participatory approaches such as CPR often are employed to address health disparities in the underserved (Israel et al., 2005). Because researchers typically are from "outside" the community, CPR requires researchers to address power issues and to give up the "solo expert" role for a position that recognizes that all partners bring expertise and legitimate goals to the process (Israel et al., 2005).

Israel et al. (2005) have outlined nine core principles commonly associated with CPR. Israel et al. note that because all partnerships are unique, one set of principles will not be equally applicable to all projects. Generally, however, CPR involves:

1. Recognizing that communities are entities to which individuals have membership and connection;
2. Building on community strengths and resources;
3. Fostering collaborative, truly equitable partnerships between researchers and community members;
4. Promoting co-learning and capacity building for all project partners;
5. Balancing the creation of new knowledge with provision of useful intervention so as to benefit all partners;
6. Focusing on the immediate relevance of health problems to communities and recognizing the multiple determinants of healthy behavior;
7. Using a collaborative, cyclical and iterative process;
8. Sharing results with all partners in a way that is respectful and useful; and
9. Making a long-term commitment to the community, project and future sustainability.

To illustrate how CPR differs from a more traditional research approach, we consider the following example. Using a benchmarking strategy (Wade, Treat, & Stuart, 1998), a researcher might design a study wherein masters-level clinicians deliver CBT for bulimia nervosa to determine if these professionals can produce comparable outcomes to those found in efficacy studies. This study clearly has the potential to produce useful information related to the process of dissemination. Yet, it does not dovetail with CPR values because the clinicians did not have input into the design of the intervention or research study, which might lead to unexpected problems. For example, the clinicians might know from experience that certain format or content features of the intervention are incompatible long-term with the setting in which they wish to conduct the intervention, a factor that might be overlooked if they were not consulted at the design phase of the study. Failure to address such issues may mean that the community may not be well positioned (motivationally or practically) to continue to use CBT after the study is completed. In sum, although this study is useful because it answers some important questions, it is also limited in terms of building the types of egalitarian partnerships that we likely need to close the research practice gap.

On the one hand, it may appear as though the goal of increasing use of ESIs, which are typically manualized, is incompatible with CPR because mere use of a manualized ESI means that part of a project agenda has been set (Piran, personal communication, 2007). On the other hand, however, applying ESI with CPR methods is akin to clinicians developing the collaborative relationship needed to conduct quality CBT. The clinician explicitly states that while he/she may know something about psychopathology, the client is the expert when it comes to his/her own life/goals/skills/deficits. Similarly, in CPR, researchers, who know something about a particular ESI, explicitly recognize that community partners have equal levels of critical expertise regarding the community's current status, goals, resources, and needs.

It should be noted that many communities, like many clients, want interventions that work. In our experience, the data supporting the success of DBIs have played a key role in expanding utilization of this ESI in many settings. For example, high school principals and school nurses were receptive to offering DBIs in their schools because DBIs had been found to reduce risk for onset of EDs and improve psychosocial functioning. Thus, we remain strong advocates of traditional efficacy research. In our experience, however, once the efficacy foundation has been laid, other methods, such as CPR, also become critical. An evidence base is necessary, but not sufficient, for dissemination.

Why might CPR help with dissemination of ESIs?

> *"Clinicians do not want to be disseminated on or disseminated at. A genuine collaboration between researchers and clinicians – in which researchers bring to bear empirical methods to test not only their own best guesses about what works but best practices identified empirically in the community – seems to us the most productive way to bring researchers and clinicians together in the quest for [evidence based practice]."* (Westen et al., 2005, p. 431)

In our opinion, this quote highlights one problem with many dissemination efforts. ESI researchers often appear to treat clinicians and other communities as groups who should be accepting, passive, and possibly even grateful recipients of what researchers have found. Chorpita and Nakamura (2004) describe this as inadvertently viewing clinicians as "empty vessels" to whom we "push out" product (p. 364). Given this stance, it is understandable that we, as researchers, become frustrated when communities appear to stubbornly refuse to use what we have developed, or as Westen et al. state, treat us as "occupiers rather than liberators" (p. 431). Use of CPR methods, however, may help create the genuine collaboration to which Westen et al. and others refer. In fact, as part