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ScienceDirect

Behavior Therapy 45 (2014) 3–6

Behavior Therapy

www.elsevier.com/locate/bt

Introduction to the Special Series: Bridge Between Science and Practice

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On the Dissemination of Clinical Experiences in Using Empirically Supported Treatments

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This article addresses the long-standing gap that has existed between psychotherapy research and practice and the efforts that have been made to bridge it. It also introduces one such effort, which has consisted of 3 clinical surveys on the experiences of practitioners in using empirically supported treatments for panic disorder, social anxiety, and OCD. In contrast to attempts to close the gap by disseminating research findings to the clinician, the clinical surveys are intended to allow for practitioners to disseminate their clinical experiences to the researcher—and also to other clinicians. What we view as a "two-way bridge" initiative is a collaboration between the Society of Clinical Psychology, Division 12 of the APA, and the Psychotherapy Division of the APA—Division 29. The mechanism that has been established provides a way for clinicians to be a part of the research process, which we hope will provide evidence that can help to enhance our clinical effectiveness.

Keywords: empirically supported therapies; evidence-based practice; psychotherapy research; clinical trials; practice research networks

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0005-7894/45/3–6/$1.00/0

In 1952, Hans Eysenck published a provocative—but accurate—article on the gap between research and practice, arguing that there existed no good empirical evidence that psychotherapy worked. Some six decades and thousands of carefully constructed outcome studies later, we can happily

conclude that this is no longer the case. Indeed, a plethora of findings attest to the efficacy and effectiveness of our clinical interventions. And while the gap between research and practice has unquestionably grown smaller, it nonetheless continues to exist. With growing pressures for accountability from third-party payers, consisting of governmental agencies and insurance companies, the increasing emphasis on quality assurance, and the development of practice guidelines, the need to close this practice-research gap has perhaps become more pressing than ever before. Although there is no agency comparable to the Food and Drug Administration (FDA) to approve of psychotherapies that work, there nonetheless exists an unmistakable trend by psychotherapy researchers and clinicians to develop a consensus about what works.

The movement toward reaching a consensus is reflected in the question of how to best disseminate research findings to the practicing clinician (Kazdin, 2008). Clearly, limited time and lack of technical knowledge of research methodology and statistical analyses all serve as barriers. Some useful suggestions have been made, such as using case illustrations in the dissemination of findings (Stewart & Chambless, 2010). Still, an important barrier has been that the findings of randomized controlled trials (RCTs), focusing on specific clinical disorders, may not offer all the information clinicians need to know in order to intervene. Allen Frances, Chair of the DSM-IV, cautioned about the clinical limitations associated with our RCTs. Frances, also a practicing clinician, indicated the following in the introduction to DSM-IV, in which he highlighted the gap between our RCTs and the practice of therapy:

> Making a DSM-IV diagnosis is only the first step in a comprehensive evaluation. To formulate an adequate treatment plan, the clinician will invariably require considerable information about the person being evaluated beyond that required to make a DSM-IV diagnosis (American Psychiatric Association, 1994, p. xxv).

We would suggest that most practicing therapists are likely to agree with this, and that their own clinical experiences in using empirically supported treatments based on RCTs can provide the field with important complementary evidence.

The Importance of Evidence-Based Practice

In 1995, the Society of Clinical Psychology, Division 12 of APA, published the findings of a task force to delineate "empirically validated" therapies (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). Later referred to as empirically "supported" treatments, these interventions were found to be efficacious on the basis of RCTs. Extending the work on identifying empirically supported treatments, the Psychotherapy Division of APA, Division 29, developed a task force to review the research on identifying empirically supported aspects of the therapy relationship that contributed to change. The purpose of the task force—the results of which were summarized in *Psychotherapy Relationships That Work* (Norcross, 2002)—was not to negate the importance of technique, but rather to offer a more complete evidence-based explanation of the therapy change process.

As a result of considerable debate over the extent to which research findings could accurately specify empirically supported treatments that can be used in clinical practice, the American Psychological Association Presidential Task Force on Evidence-Based Practice (2006) acknowledged that while findings from RCTs provided invaluable research evidence, other sources of evidence were needed as well. For example, findings from other forms of research, such as basic research on the variables associated with various clinical disorders, as well as the findings on the process of change, are all potentially relevant. Much like the suggestion noted by Frances above, the task force emphasized that it was also essential that information about client characteristics, client preferences, and clinical expertise needed to be taken into account.

The Need for Dissemination in Both Directions

Just as it is important for practicing clinicians to base their interventions on empirical evidence, so is it important for clinical experience to inform research (Kazdin, 2008). There are numerous instances where this has been done. One example is Sobell's groundbreaking research that involved clinicians in the design and execution of a clinical trial in the treatment of substance abuse (Sobell, 1996). In another example, Eubanks-Carter, Burckell, and Goldfried (2010) compiled consensus information on how practicing therapists dealt with challenging situations involving patients' conflicts with parents. Those involved in more formal practice research networks have emphasized that one of the benefits of these clinical-research collaborations is the ability to identify those factors that may make it difficult to implement empirically supported treatment in clinical practice, such as client, setting, therapist, and treatment variables (McMillan, Lenze, Hawley, & Osborne, 2009; Zarin, Pincus, West, & McIntye, 1997). Thus, working within a practice research network, Castonguay and colleagues (2010) had practicing therapists share their clinical experiences about helpful and hindering events in therapy.

An important implication of such clinical feedback has been studied by sociologists, who have investigated factors that have contributed to the advancement of science. In this work, they have made a distinction between the *questions* that need to be studied and the *methods* for studying them (Wilkes, 1979). During the context of discovery, the questions to be researched are identified by what has been referred to as "problem finders." Once these questions have been highlighted, researchers—"problem solvers"—enter the picture, representing the verification stage in the scientific process. We would suggest that practicing therapists, based on their direct experience in working with clinical problems, may be thought of as the problem finders. Therapy with clients not only presents them with the challenge of translating research findings so that they can be applied to the individual case at hand, but it also affords them the opportunity of witnessing firsthand the ever-varying parameters of human behavior and the psychotherapy change process. From this experience, the practicing therapist can then be in a position to suggest to the problem solvers—and also to clinical colleagues—those important, clinically relevant variables that are in need of research study. This process of "problem finding" can also help to uncover those important mediating and moderating variables relevant to specific patient populations that may not have been highlighted in the findings of clinical trials, such as those associated with racial, ethnic, and sexual minorities.

The past and current acknowledgment that treatment failures have the potential to identify ways to improve the effectiveness of our interventions is relevant here. In 1982, Chambless and Goldstein (1982) highlighted the importance of clinician-researcher collaboration in identifying problems associated with the treatment of agoraphobia. In their book *Treatment Failures in Behavior Therapy,* Foa and Emmelkamp (1983) acknowledged that "Contact with clients has taught us that clinical practice is not as simple as that portrayed in the textbooks," adding that "… It seems that once a technique was endorsed as effective, it became almost taboo to admit that sometimes the expected positive results were not obtained" (p. 3). In more recent years, the topic of what we can learn from treatment failures continues to be discussed (Dimidjian & Hollon, 2011).

Building a Two-Way Bridge Between Research and Practice

The ongoing attempt to close the gap between research and practice has consisted of ongoing, but not always successful, efforts to disseminate the finding of RCTs to practicing clinicians. We would suggest that the mixed success of these efforts has been due, in part, to the fact that this has been a one-way bridge. As indicated earlier, not only have clinicians found the results of these studies to be limited, but there also exists an undercurrent of resentment on the part of practicing therapists that "… the standards and methods of clinical therapy will be set by those who do the least amount of clinical practice" (Fensterheim & Raw, 1996, pp. 169-170). We would therefore suggest that the field is in need of ways in which practicing clinicians can be involved in the research process. Indeed, as has been demonstrated by Sobell (1996), clinicans' active participation in certain aspects of the research process can increase their receptivity to the dissemination of research findings.

As part of their day-to-day activities, clinicians are continually confronted with the challenge of identifying those moderating, mediating, and contextual parameters that can be crucial in implementing their interventions—including those treatments that have been determined to be empirically supported. As such, practitioners are a rich source of clinically based information and hypotheses that are in need of research, which can occur if the bridge between research and practice were to be two-way.

In 2010, the Society of Clinical Psychology, Division 12 of the APA, began an initiative to build a two-way bridge between research and practice. Given that efforts to delineate empirically supported therapies have used the RCT model employed by the FDA, it was argued that what was needed was a feedback mechanism similar to that employed by the FDA. After a drug has been approved for use, practitioners can offer feedback based on their clinical experiences in using the treatment in practice. This two-way bridge initiative for obtaining feedback on the use of empirically supported therapies in practice was expanded in 2011 to become a collaborative effort together with the Division of Psychotherapy of the APA—Division 29. The committee guiding these efforts is made up of the authors of this introduction, who are researchers and practitioners.

The articles that follow in this series consist of the findings of the first three surveys of the two-way bridge initiative, which has focused on panic disorder, social anxiety, and generalized anxiety disorder. The next two surveys will focus on PTSD and obsessive-compulsive disorder. In each of these surveys, practicing clinicians were asked to identify those variables that interfered with successful symptom reduction. The specific variables varied from survey to survey, but reflected the following categories:

- variables associated with the patient's symptoms
- other patient problems or characteristics

- patient expectations
- patient beliefs about symptoms
- patient motivation
- social system (home, work, other)
- problems/limitations with the intervention procedure
- therapy relationship issues

It is hoped that the identification of these variables will provide important hypotheses for therapy researchers to investigate, but also point to issues that can provide valuable information to beginning and seasoned practitioners that can enhance their clinical effectiveness. This two-way bridge initiative is based on the premise that both the clinician and researcher have something important to offer in forming a consensus and in developing practice guidelines. As has been stated elsewhere:

> The experience and wisdom of the practicing clinician cannot be overlooked. But because these observations are often not clearly articulated… [and]… may be unsystematic or at times idiosyncratic… it is less likely that these insights can add to a reliable body of knowledge. The growing methodological sophistication of the researcher, on the other hand, is in need of significant and… [clinically]… valid subject material. [In short], our knowledge about what works in therapy must be rooted in clinical observations, but it must also have empirical verification. For the researcher and clinician to ignore the contributions that each has to make is to perpetuate a system in which no one wins (Goldfried & Padawer, 1982, p. 33).

Conflict of Interest Statement

The authors declare that there are no conflicts of interest.

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Received: June 27, 2013
Accepted: September 26, 2013
Available online 6 November 2013