

INVITED COMMENTARY

Can We Talk? Fostering Interchange Between Scientists and Practitioners

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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.

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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

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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

program (e.g., a depressed client is too lacking in energy or too pessimistic to carry out homework assignments); or in trying to juggle multiple problems the clinician may find he or she cannot do a good job of addressing any of them. For example, Gibbons and DeRubeis (2008) found that the more the therapist focused on a patient's comorbid anxiety symptoms in treatment of patients with major depression, the worse the patients did on both anxiety and depression. However, the survey data, as presently obtained, do not tell us the nature of the comorbidity problem with which clinicians are struggling. Perhaps interviews with a subset of surveyed clinicians would add richer data that would clarify some of these points.

Also of limited utility for taking us forward in elaboration of a manual or in treatment innovations are the cases where the surveyed clinicians essentially endorsed the nature of the disorder itself as barrier to treatment. For example, fear of rejection is such an essential part of social phobia that it is hard to imagine socially phobic clients without it (see McAleavey et al., 2014-this issue, Table 3). Any decent manual should already address this aspect of social phobia extensively. In other cases, however, the clinicians point to important challenges to the success of CBT that we would do well to address. For example, 37% of clinicians reported that resistance to directive interventions was a barrier to treatment of panic disorder (Wolf & Goldfried, 2014-this issue) and 56% of clinicians treating social phobia or GAD reported the same (McAleavey et al., 2014-this issue; Szkodny et al., 2014-this issue). Given the directive nature of CBT, this is indeed a challenge for clinicians to manage—one on which treatment manuals are generally silent. Research on this point is emerging and confirms that GAD clients observed to be resistant in treatment sessions are likely to do less homework and perhaps as a result improve less with treatment than less resistant clients (Westra, 2011). Moreover, Zickgraf et al. (2013) found therapists have greater difficulty adhering to the treatment protocol in CBT for panic disorder when clients are resistant. Resistance thus appears to be a case where CBT needs to be augmented. Westra has shown that preceding CBT for GAD with four sessions of motivational interviewing leads to better treatment outcome for clients who are high worriers, perhaps through lowering resistance, and Meyer and colleagues (2010) found that only two sessions of motivational interviewing prior to CBT for obsessive-compulsive disorder led to better treatment outcome.

Resistance is an example where clinical observations are leading to treatment innovations in CBT for anxiety disorders, although Westra's findings (2011) need replication and extension. In contrast, other ratings provided by the surveyed practitioners

pose questions as yet unanswered. For example, in the case of GAD (Szkodny et al., 2014-this issue) and social phobia (McAleavey et al., 2014-this issue), over a third of respondents indicated that clients with perfectionistic/obsessive personality traits are particularly difficult to work with. This has certainly been the case in my own clinical work. I know of no empirical work to date verifying these traits specifically as a predictor of negative outcomes in CBT for anxiety disorders. In prognostic research these traits have typically been grouped together with other Cluster C personality disorders, which, as a group, have been shown to predict poor outcome in treatment for panic disorder (Telch, Kamphuis, & Schmidt, 2011). However, patients with some Cluster C traits (e.g., dependent traits) are easier to deal with than those with perfectionistic/obsessive traits. Perfectionism per se has been shown to be related to poor treatment outcome for major depression (Blatt, Zuroff, Bondi, Sanislow, & Pilkonis, 1998), although not to outcome for obsessive-compulsive disorder (Chik, Whittal, & O'Neill, 2008). These discrepant results may reflect the different methods used for assessment of perfectionism. Riley and colleagues (Riley, Lee, Cooper, Fairburn, & Shafran, 2007) have developed and performed initial tests of a 10-session CBT intervention for perfectionism. However, it is unclear how perfectionism as defined in research to date matches with the concept of perfectionistic/obsessional traits the clinicians surveyed had in mind. Moreover, an add-on treatment requiring 10 additional sessions poses difficulty in the age of managed care, as many patients are severely limited in the number of treatment sessions they can receive. It would be more helpful to have interventions that could be integrated with standard CBT for anxiety disorders.

How might we tap clinical expertise on managing clients with perfectionistic/obsessional traits in CBT for anxiety disorders as well as other barriers that have yet to draw empirical research attention? One possibility would be through the use of the clinical roundtables at the annual meetings of the Association for Behavioral and Cognitive Therapies (ABCT). Organizers would need to make it clear that the roundtable is being organized to brainstorm ideas for dealing with these difficult cases rather than as a venue for the experts to hand down their knowledge. Finally, CBT already has a vehicle that was expressly designed for discussions of issues of importance to clinical practice: the journal *Cognitive and Behavioral Practice*. Why not develop papers for this journal designed to collect the best clinical thinking available on how to manage the most common barriers presented in this section's surveys? Such papers, if the editors could draw in skilled clinicians

who may not be prone to publish under ordinary circumstances, could provide a rich set of ideas for subsequent research. Some of the best clinicians I know are disinclined to do any writing themselves but would likely be willing to pair with someone else who would interview them and include their thoughts in a publication.

In summary, the papers in this special section represent an important innovation in bridging the science-practice gap. I hope this is only the beginning and that approaches will be developed to foster a flow of ideas to close the gap—ideas which must then be subjected to empirical scrutiny to determine their ultimate utility.

Conflict of Interest Statement

The author declares that there are no conflicts of interest.

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