TREATMENTS FOR PSYCHOLOGICAL PROBLEMS AND SYNDROMES

EDITED BY
DEAN McKAY
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Treatments for Psychological Problems and Syndromes

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For Jack Rosenberg. Your memory will always be a blessing.

Dean McKay

Dedicated, with love, to Stacy, Emily, and Miriam.

Jonathan S. Abramowitz

To Jill, Ellie, Noah, and Maya with love. And, to my wonderful students over the years.

Eric A. Storch

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Introduction

Jonathan S. Abramowitz, Eric A. Storch, and Dean McKay

The field of mental health treatment has reached a point of maturity such that most major behavioral and psychological problems now have empirically supported interventions available for application. These treatment packages have been derived from conceptual models of psychopathology that draw on basic experimental and clinical research. Available treatment packages, usually made available through treatment manuals developed and tested for particular disorders listed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013), typically include multiple specific interventions. Yet, it is not always clear which components are essential and which are potentially less critical to good outcomes. Moreover, it might not be clear which components target which mechanisms of psychopathology. Accordingly, there might be insufficient guidance for clinicians when it comes to choices in treatment delivery; for example, when time constraints require use of the most essential components of an existing protocol, or when the presentation of a certain condition is more complicated than, or deviates from, descriptions and illustrations in treatment manuals. Further, it is conceivable that incorporating less effective treatment elements may actually hinder individual progress toward achieving wellness. Addressing these and other clinical conundrums can be challenging without clear and concise guidance that is based on the latest empirical research.

Accordingly, we have assembled this book to help the practicing clinician to more easily identify mechanisms that best explain observed psychopathology and then apply the appropriate empirically supported processes of change. Such an approach allows the clinician to practice as an evidence-based practitioner even when they may need to deviate from disorder-based treatment manuals. This approach also raises the question of whether traditional psychiatric diagnosis (i.e., based on the DSM-5) is necessary—a growing controversy in the mental health field. That is, if one conceptualizes psychopathology at the level of the individual mechanisms and processes, and then applies empirically supported techniques to reverse such mechanisms, what advantage is there to using diagnostic labels such as those in the DSM? It is our opinion that empirically supported practice begs a critical discussion of (a) mechanisms of psychopathology, (b) mechanisms of psychological change, and (c) a means for conceptualizing presenting behavioral and psychological problems and developing treatment plans that rely on valid perspectives unmoored from the current nosology.

This book was developed at an interesting time in the evidence-based practice movement. It has been just about 20 years since the standards for

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determining what counts as an empirically supported treatment were developed (Chambless & Hollon, 1998). These criteria stipulated that a minimum of two randomized controlled trials (RCTs) be conducted by two different research teams, and show efficacy for a treatment, compared to a placebo intervention, in order for the protocol to be declared empirically supported. The full set of guidelines was considered pathbreaking at the time, as this was the first time any set of standards was articulated to guide practitioners in making treatment decisions. At the time these standards were developed, RCTs were comparably rare, with few studies comparing to attention–placebo control conditions.

Now, close to 20 years later, RCTs are conducted with far greater frequency. Online registries have been developed where investigators can register their trials *a priori*, with primary and secondary variables of interests declared. Many journals require that RCTs submitted for publication be registered in order to be considered. The virtue of these registries is that it allows other investigators to evaluate the full corpus of available research, including those that might be null findings that never made it to publication, in order to have a complete account of the efficacy of a treatment protocol. Given that the criteria for empirically supported treatments were silent on the matter of unpublished or null findings, a protocol could be declared empirically supported if it met the two RCT criteria, even if there were numerous failed prior trials. This problem has been addressed in the newly crafted criteria for empirically supported treatments (ESTs; Tolin, McKay et al., 2015; Tolin, Forman, et al., 2015). There was an incremental movement already underway to deal with this as evidenced by the ubiquity of meta-analyses for specific treatment protocols, and the advent of the Cochrane reviews, which surveys in comprehensive detail the effects of specific treatment programs. As a result, we are now at the point where many treatments are fairly well understood with respect to their benefits and limitations and the components that are essential ingredients. Understanding what treatment elements are essential ingredients is the essence of evidence-based practice, whereby direct service clinicians can select components of treatment that are deemed scientifically supported for specific problems faced by their clients.

The aims of this volume are therefore threefold. The first is to shed light on both the empirically supported and the unsupported components of conceptual models of psychopathology. Second, the volume aims to identify empirically supported components of existing psychological interventions and the rationales for how multicomponent interventions are sequenced. Thus, this text provides clinicians with an understanding of the sequential nature of interventions, and the criteria for moving from one intervention to the next, particularly for seemingly disparate treatment procedures that form multicomponent treatment packages. The third aim is to illustrate specific ways of identifying mechanisms of psychopathology that might attenuate treatment outcome with established protocols, and help the clinician use empirically supported methods to address these obstacles.

All chapters in the book draw on available research evidence to make clear the connection between science and practice; and these chapters are organized into five sections. The first section offers an overview, and outlines the aims and scope of the text, as well as a brief history of the empirically supported practice movement. The second section addresses the three aims of the book as they relate to conditions for which there is extensive support for mechanisms of psychopathology and empirically supported psychological treatment procedures and processes of change. Given the unique complexities and extensive research base, two chapters cover treatments for psychopathology emerging from traumatic events. This is an important aspect of the book given the various controversies around the possible risk for dropout with evidence-based therapy for trauma (Imel et al., 2013). The third section covers areas of psychopathology and treatment for which there is *emerging* empirical support. The fourth section covers

domains of psychopathology for which there is only preliminary—or perhaps the potential for—evidence-based approaches to psychopathology and treatment. The fifth and final section focuses on mechanisms of psychopathology and change across the age span.

To further orient the reader, each chapter follows a general format in which the nature of the psychopathology is first discussed. The focus is on *components* of relevant conceptual models, including an appraisal of their scientific support, rather than a review of major etiological theories. Next, each chapter turns to a discussion of empirically supported treatment components, including the sequencing of multicomponent interventions and the factors that can interfere with implementing these procedures. Finally, each chapter includes a discussion of how mechanisms of the psychopathology itself might interfere with treatment outcome, and how clinicians might adapt therapy to address these mechanisms and optimize treatment effectiveness. It is our hope that this edited text provides the field with a handbook for understanding the nature and treatment of psychopathology at the level of psychological mechanisms, with the broader aim of helping the field evolve from a focus on multicomponent treatment manuals for "mental disorders" to a more conceptually oriented process-based approach.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, *66*, 7–18.

Imel, Z. E., Laska, K., Jakupcak, M., & Simpson, T. L. (2013). Meta-analysis of dropout in treatments for posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, *81*, 394–404.

Tolin, D. F., Forman, E. M., Klonsky, E. D., McKay, D., & Thombs, B. D. (2015). Guidelines for identifying empirically supported treatments: Practical recommendations for clinical researchers and reviewers. *The Clinical Psychologist*, *68*, 16–21.

Tolin, D. F., McKay, D., Forman, E. M., Klonsky, E. D., Thombs, B. D. (2015). Empirically supported treatment: Recommendations for a new model. *Clinical Psychology: Science & Practice*, *22*, 317–338.

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Cognitive Behavioral Therapy: Empirically Supported Treatment and the Movement to Empirically Supported Practice

Jesse R. Cougle, Melanie A. Hom, and Natalie L. Matheny

Cognitive behavioral therapy (CBT) has shown efficacy for a range of psychiatric disorders across age groups and populations (Butler, Chapman, Forman, & Beck, 2006; Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012; Hollon, Stewart, & Strunk, 2006; Reinecke, Ryan, & DuBois, 1998; Stewart & Chambless, 2009). CBT can generally be administered over a limited number of sessions, leads to broad improvements in functioning, and does not come with the side effects of many medications or the high relapse rates associated with their discontinuation. Yet, despite its established efficacy, the best available evidence indicates that most individuals with a psychiatric disorder do not receive CBT (Wang et al., 2005). Also troubling is the fact that, among those who receive professional psychotherapy, CBT or other evidence-based treatments (EBTs) are rarely used (Wang et al., 2005).

Given this gap between science and practice, researchers have increasingly turned their attention toward the promotion and dissemination of CBT (Shafran et al., 2009). Organizations such as the Association for Behavioral and Cognitive Therapies (ABCT) have made the advocacy of EBTs, including CBT, one of their primary missions. Further, a handful of efforts have been made to disseminate CBT broadly through top-down institutional policies, including the Improving Access to Psychological Therapies program in England (Clark, 2011) and evidence-based training initiatives by the Veterans Health Administration (VHA; Karlin, Brown, et al., 2012; Karlin, Ruzek, et al., 2010).

The purpose of this chapter is to review issues related to the dissemination of CBT, including barriers and potential solutions. Because barriers occur on multiple levels, the possible leverage points are many and diverse (Harvey & Gumport, 2015). Dozens of essays have been written proffering strategies for the dissemination of CBT; we will assess these as well as propose some solutions toward this aim.

Barriers to the Use of Cognitive Behavioral Therapy in Psychotherapy Practice

Therapist Barriers

Despite the strong empirical support for its efficacy, many therapists do not use CBT. The prevalence of its reported use varies widely across studies, with some studies painting a bleaker picture of the situation than others. For example, one study found that, among those with bulimia nervosa who had received previous psychotherapy, only 6.9% indicated they received CBT (Crow, Mussell, Peterson, Knopke, & Mitchell, 1999). In contrast, a survey of psychologists who treat eating disorders found that 39% endorsed CBT as their primary treatment

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approach (Mussell et al., 2000), while a majority (65%) of the sample indicated that they used CBT techniques "always" or "often." Another investigation found that fewer than 20% of psychologists reported using exposure therapy for post-traumatic stress disorder (PTSD; Becker, Zayfert, & Anderson, 2004), and supportive counseling was cited as the therapy most often used for PTSD in a separate study (Ehlers, Gene-Cos, & Perrin, 2009).

Even among those who receive CBT, its delivery is often suboptimal. For example, one study examined self-reported treatment history in a small sample of individuals with obsessive–compulsive disorder (OCD). Among those who reported they had previously received CBT (40% of the sample), the procedures used met minimal criteria for adequacy in only a minority of cases (Stobie, Taylor, Quigley, Ewing, & Salkovskis, 2007). Additionally, though surveys have found that the vast majority of therapists report using CBT to treat anxiety disorders (Freiheit, Vye, Swan, & Cady, 2004; Hipol & Deacon, 2013), these same respondents indicated they rarely used therapist-assisted exposure. For instance, only 22% were found to use interoceptive exposure "sometimes" or "frequently" to treat panic disorder (Freiheit et al., 2004). An analysis of therapists who reported using CBT for eating disorders found that less than 50% of the sample used at least one core CBT technique consistently (Waller, Stringer, & Meyer, 2012).

Many reasons have been proposed for the non-use of CBT by therapists in the community. Perhaps the most important is that many therapists have not received adequate training in CBT. For example, one study found that only 20% of PsyD and 21% of social work programs required supervision in CBT, though most (PsyD 96%; social work 80%) required didactics in CBT (Weissman et al., 2006). It is noteworthy that these programs produce far more therapists that ultimately practice in the community than clinical psychology PhD programs.

Therapists also appear to hold negative beliefs about CBT and other EBTs that are typically unjustified. For instance, some report skepticism regarding the findings of randomized controlled trials of CBT and believe such trials do not include the types of "real-world" patients they see in their practice (Shafran et al., 2009). Others view EBTs as potentially harmful to the therapeutic relationship and believe that therapy manuals ignore and are inflexible to individual client needs (Addis, Wade, & Hatgis, 1999). Some therapists also prefer a more eclectic approach to CBT, where only select CBT skills or principles are integrated into their therapeutic framework. Additionally, therapists generally believe that they are already using effective treatment methods and are less open to using CBT for this reason (Shafran et al., 2009; Stewart, Stirman, & Chambless, 2012). Lastly, many report not having the time or financial resources to receive additional training in CBT or other EBTs (Stewart et al., 2012).

Institutional Barriers

The Diversity of Therapists Delivering Services in the Community

Much of the research reviewed on therapist attitudes toward CBT and its use surveyed PhD-level psychologists; however, master's-level counselors are more likely to be delivering therapy. These counselors tend to use CBT less often and are less equipped to do so (Addis, 2006; Addis et al., 1999). The diversity of service providers responsible for therapy delivered in the community challenges the dissemination of a single set of therapy techniques (e.g., CBT).

Within universities, psychology departments are generally CBT-friendly (Weissman et al., 2006), though more practicing therapists are trained in schools of education or social work. Unfortunately, there is little incentive for cross-area collaborations, let alone the promotion of CBT across departments. Psychology departments that offer courses and supervision in CBT often limit these courses to students in their department. Other departments are more likely to emphasize training and supervision in non-EBTs (Weissman et al., 2006). As a result, many graduate students who wish to receive training in CBT may not have access to it.

Accreditation Bodies and Funding Agencies

Therapist accreditation typically occurs on the state level in the United States. To date, there has been little willingness on the part of state licensing agencies and larger organizations such as the American Psychological Association to embrace evidence-based standards of care (Baker, McFall, & Shoham, 2008). Further, insurance companies tend to prioritize the cost of care over its quality; thus, many have increasingly looked to master's-level therapists—who may not have received training in EBTs—to administer treatment at a lower cost relative to doctoral-level providers. Consequently, there has been little incentive for mental health service providers to learn or practice CBT.

Patient Barriers

Harvey and Gumport (2015) recently listed multiple patient barriers that inhibit the dissemination of CBT in the community. Some barriers involved practical challenges, including lack of financial resources or childcare, which would be required to attend sessions. Furthermore, many who need treatment live in remote areas with few or no therapists, and many are unaware of the existence of EBTs for psychiatric disorders. Additionally, it may be difficult for patients to identify therapists who are truly proficient in delivering EBTs, including CBT. This can be burdensome to patients, since, as reviewed earlier, many therapists indicate that they practice CBT, though they often provide only suboptimal delivery (Freiheit et al., 2004; Stobie et al., 2007; Waller et al., 2012). How can patients discern adequate from inadequate CBT? Some additional patient barriers exist, which are reviewed below.

Client Outcomes May Extend beyond Symptom Reduction

Clinical psychologists and advocates of evidence-based practice focus primarily on symptoms of DSM-5 disorders as the criteria by which therapy must be evaluated via randomized controlled trials. This is a reasonable focus, given the impairment, disability, and other severe consequences (e.g., suicide, unemployment) associated with symptoms of psychiatric disorders, as well as the limited resources available to fund medical care. However, many individuals, including those with psychiatric disorders, see therapists for reasons other than the alleviation of symptoms. Indeed, in one study, one-third of respondents who sought mental health treatment over the past year did not meet diagnostic criteria for any psychiatric disorder (Wang et al., 2005).

Patients may seek therapy to address dysfunctional relationship patterns or chronic procrastination. Some may feel as if they are in a "rut" or that their lives are in need of direction. Others may seek a therapist because they feel that their lives lack meaning and their jobs and relationships are unfulfilling. Many see therapists because they lack social support and someone who cares for and listens to them. They may enjoy the support and sounding board provided by many therapists who may not practice CBT. These topics are not necessarily outside the boundaries of CBT, though they are not generally the focus of CBT-oriented training. Consequently, researchers and practitioners focused on delivery of EBTs may fail to appreciate the importance of these outcomes to the clients they treat. Further, though some recent efforts by positive psychologists show promise for improving outcomes related to happiness and sense of purpose (Duckworth, Steen, & Seligman, 2005), specific interventions in this area currently lack a strong evidence base (Bolier et al., 2013).

Non-evidence-based treatments, including many insight-oriented therapies, may be attractive to patients for the sense of meaning and coherence they provide, even if they rest on pseudo-scientific or false premises. There is evidence that nostalgia and thinking about childhood memories facilitates social bonding (Wildschut, Sedikides, Arndt, & Routledge, 2006), instills feelings of moral purity, and encourages prosocial behavior (Gino & Desai, 2012). Given that CBT is present-focused and

primarily concerned with symptom reduction, it may lack this advantage. Despite the many potential negative consequences associated with non-EBTs and long-term therapies, including their lack of efficacy with regard to symptom reduction and the dependency they may foster, it is important to appreciate what they might offer to understand why patients continue to select and receive them.

Consumers Are Generally Satisfied with the Therapy They Are Given

An additional patient-level barrier to the adoption of evidence-based practice is that patients have reported high degrees of satisfaction with the therapy they receive in the community, despite the theoretical orientation of the therapist who delivers it. The oft-cited Consumer Reports Survey for 1995 (Consumer Reports, 1995) on the effectiveness of psychotherapy has several important methodological shortcomings, though its overall conclusion—that consumers are largely satisfied with the psychotherapy they receive—has not generally been disputed. A more recent poll found that, of those who received treatment for a mental health problem in the past two years, 85% were satisfied with the care they received, and 80% found it effective (Harris Interactive, 2004). Though many patients are obviously dissatisfied with the therapy they receive, and treatment that is ineffective can be harmful to those who receive it (by, at the very least, preventing them from receiving effective treatment), it is important to acknowledge that the public on the whole is mostly content (and, on some metrics, quite pleased) with the quality of therapy administered at present. This represents a significant challenge for those seeking to implement changes in standards of care at government and organizational levels, since we may lack support at the grassroots level for such changes.

Patient Preferences for Non-distressing, Easy Treatments

Standard CBT for anxiety and mood disorders typically requires a certain level of effort from patients and a willingness on their part to confront distressing thoughts and situations. Homework often involves completing worksheets or conducting different exercises. For example, repeated fear confrontation via exposure therapy is integrated into most CBT protocols for anxiety disorders. Though exposure therapy might involve a greater degree of distress than other treatments, evidence suggests they do not lead to greater attrition rates than these treatments (Hembree et al., 2003). Even so, the work and distress required by many CBT protocols may make them less attractive to many patients.

Research Barriers

Much of the push toward evidence-based psychotherapy has come from CBT researchers, and much of their focus has been on effecting change at the administrative level. These changes involve persuading many of those in power (e.g., politicians, licensure boards) to adopt certain standards for psychotherapy and provide monetary support for evidence-based training and care. While these efforts are certainly worthwhile, they also involve many factors that are largely out of these researchers' control. However, there are multiple other areas that are more closely related to the responsibilities and work of researchers and that fall under their domains of influence.

There Are Too Many Empirically Supported Therapies

A few authors have commented on problems associated with the overabundance of therapies (Cougle, 2012; Harvey & Gumport, 2015; Weisz, Ng, & Bearman, 2014). For example, Harvey and Gumport (2015) note that this issue might make it difficult to identify which EBT to use or receive training in. They support the development and use of centralized resources, such as the American Psychological Association's Division 12 website (www.psychological treatments.org), to provide therapists and consumers with information regarding which therapies are effective. This website currently lists approximately 80 general therapies that the organization considers to be evidence-based.

Resources that provide accurate information on the many EBTs available are certainly helpful; however, the high number of existing EBTs is problematic for a few reasons. First, it can make it difficult for training programs and clinicians to determine which specific therapies to learn and use in clinical practice. Second, the vast number of therapies, along with their many different corresponding components, can also lead to quality control problems (Cougle, 2012). As a general rule, it seems more likely that we can ensure whether one specific treatment procedure is being administered adequately than that 20 different procedures (which may have been drawn from 10 different EBTs) are being administered adequately. Third, EBTs also typically come in packages with many different components, including some that have shown little to no efficacy. Indeed, one could conceivably add an EBT to the list by adding a single inert component to an established EBT and demonstrating the efficacy of this "new" therapy. Lastly, the existence of this overwhelming number of EBTs ignores real differences between EBTs that might make one better than another, including complexity, ease of implementation, and efficiency (Cougle, 2012).

Harvey and Gumport (2015) suggest that transdiagnostic or modularized therapies could help address issues related to the "too many therapies" problem, as one therapy or modularized protocol could potentially be used for many different clients with different diagnoses and clinical presentations. Although a handful of transdiagnostic treatment protocols have been developed (e.g., Barlow et al., 2010), it is not yet clear what the active ingredients of these treatment packages are or whether they represent an advance over existing treatments (Norton, 2012). Additionally, it is quite possible that a large list of disorder-specific therapies could similarly be replaced by a large list of transdiagnostic therapies.

Cognitive Behavioral Therapy Is Not Effective Enough

When studied in randomized controlled trials, CBT generally outperforms other treatments, especially for anxiety disorders (Hofmann & Smits, 2008; Tolin, 2010). Effectiveness studies that examined CBT in real-world, less controlled community settings have also demonstrated impressive outcomes in favor of CBT (Stewart & Chambless, 2009). However, some evidence indicates that CBT may decrease in efficacy as it moves from research settings to community practice (Weisz et al., 2014). For example, one recent meta-analysis found EBTs, including CBT, had only modest benefits (mean effect size = 0.29) over usual care for youths (Weisz, Ugueto, Cheron, & Herren, 2013). It is noteworthy that effectiveness studies typically involve extensive training and continuous supervision of community therapists by CBT experts. The dose and efficacy of CBT may drop substantially once these therapists are no longer receiving supervision and the interventions are removed from the control of its developers.

Despite encouraging evidence for the efficacy of CBT for anxiety disorders, research suggests that CBT is not more effective than other psychotherapies for depression. This is reflected in the British government's evidence-based guidelines for the treatment of depression (National Institute for Health and Clinical Excellence, 2009), which included CBT alongside a range of other psychotherapies (e.g., brief dynamic therapy, interpersonal therapy, counseling) as recommended treatment modalities. Effectiveness studies on psychotherapy for depression have found no advantage of CBT over usual care with regard to symptom reduction (e.g., Weisz et al., 2009). Additionally, a meta-analytic review found that peer support was as effective as CBT for the treatment of depression (Pfeiffer, Heisler, Piette, Rogers, & Valenstein, 2011).

The fact that many therapies show equivalent efficacy for depression is both comforting and challenging. It is comforting in that it suggests that many depressed patients who are in therapy are receiving adequate, effective care, even if it is not from an evidence-based practitioner. It is challenging in that it makes it more difficult to argue for widespread adoption of certain evidence-based standards of care. Indeed, given

that clients very often present with depression as a primary or secondary complaint, many if not most therapists in the community—even those who are not amenable to CBT and EBTs—can already claim to be delivering "evidence-based" treatment.

The Absence of Dissemination Research

Researchers have bemoaned the lack of knowledge regarding the most effective methods for the dissemination of EBTs (McHugh & Barlow, 2010; Weisz et al., 2014). Training in CBT is often completed haphazardly and lacks a clear evidence base (Rakovshik & McManus, 2010). Little is known regarding the most effective and efficient methods for training therapists to achieve proficiency in CBT. To date, clinical researchers have focused primarily on improving the understanding and treatment of mental illness and have been less concerned with training methods and dissemination research.

Weisz et al. (2014) recently proposed several possible strategies for the advancement of dissemination research. Among their suggestions were: (a) shifting intervention research toward resembling the context of community practice; (b) resolving the problems of "too many therapies" by applying more stringent standards for what constitutes evidence-based treatment; (c) developing more efficient and accessible models of evidence-based care (e.g., using paraprofessionals, telehealth, self-help books); and (d) creating systems to monitor client responses to treatment and to provide feedback to clinicians.

Psychologists may be reluctant to conduct dissemination research because they see it as outside their purview. They may lack adequate training on research methods related to these topics. Additionally, research in this area, such as identification of the best training methods for therapists, is likely quite costly and labor-intensive. Even so, dissemination-oriented research holds much promise and is an important next step for advancing the widespread adoption of CBT and other EBTs.

Potential Solutions

Top-Down Solutions: Lessons from the United Kingdom

Worldwide, important efforts to disseminate EBTs have been made at the government level. Among the most noteworthy is the aforementioned Improving Access to Psychological Therapies (IAPT) program in the United Kingdom (Clark et al., 2009). The generously funded IAPT program trained nearly 3,600 therapists in EBTs for anxiety disorders and depression, and then employed them in services devoted to EBTs (see Clark, 2011). Early evaluations of this program have been encouraging, with 40.3% of patients reaching reliable recovered status at post-treatment and 63.7% achieving reliable improvement (Gyani, Shafran, Layard, & Clark, 2013). Unfortunately, outcomes were assessed without a control group comparison (e.g., usual care); thus, improvements due to natural recovery or non-specific therapy effects could not be ruled out. Interestingly, researchers were able to compare outcomes for IAPT-trained therapists who used CBT with those for counseling, and found that CBT was associated with better outcomes for generalized anxiety disorder, though both treatments produced comparable recovery rates for depression (Gyani et al., 2013).

While it would be difficult to implement an IAPT-style program in the United States because differences in these two countries' healthcare systems, several important lessons regarding pathways to dissemination of EBTs can be drawn from England's example. For instance, proponents of IAPT argued that EBTs were not currently available to a majority of the population, thereby underscoring a need for increased training of providers. Additionally, economists and psychologists maintained that the costs associated with improving access to EBTs would be recovered in savings from the reductions in disability and unemployment that would be achieved through the initiative. Indeed, recent data suggest that the initiative

led to improvements in these outcomes (Community and Mental Health Team, 2014). Furthermore, though the scope of IAPT was on dissemination of EBTs for anxiety disorders and depression, data from Gyani et al. (2013) suggest that efforts could have focused only on EBTs for anxiety disorders to achieve desired outcomes (though the broader focus may have made more sense politically). As more data emerge from the IAPT program, new dissemination efforts will be able to build on these and other lessons.

Focus Dissemination Efforts on Treatment Components rather than Treatment Packages

As reviewed earlier, while many therapists in the community report that they administer CBT, its delivery is often suboptimal (Freiheit et al., 2004; Stobie et al., 2007; Waller et al., 2012). Treatment packages typically have many components that have not been tested in isolation and whose use has little to no empirical support. The number and complexity of components included in a treatment can negatively impact dissemination efforts, making it more difficult to train therapists and ensure that they are administering the treatment as intended (Cougle, 2012). From a patient's perspective, it is also difficult to be confident that therapists who claim to be proficient in CBT or other EBTs are administering them optimally. An increased focus on specific, simpler, effective treatment components, such as exposure therapy for anxiety disorders or behavioral activation for depression (Mazzucchelli, Kane, & Rees, 2009), could increase the likelihood that EBTs are administered adequately. Such efforts could also assist consumers in determining whether they are receiving acceptable treatment by simplifying and decreasing the overwhelming number of options available to them.

Direct-to-Consumer Strategies

Direct-to-consumer marketing research for psychotherapy has received recent attention (Gallo, Comer, & Barlow, 2013; Gallo, Comer, Barlow, Clarke, & Antony, 2015) and could be beneficial for increasing awareness of EBTs. Given the difficulties inherent in changing therapist behavior, as well as problems associated with therapist claims regarding CBT that they administer, empowering patients through education on effective treatments for psychological disorders represents an attractive option. Some organizations, including the International OCD Foundation (www.ocfoundation.com), have worked to increase consumer awareness about EBTs (Szymanski, 2012). Furthermore, the promotion of self-help books and popular lectures incorporating descriptions of EBTs may also aid these efforts. Many resources on effective treatments are available online. We were pleased to find that current Wikipedia entries for several psychiatric disorders (e.g., panic disorder, OCD) provided accurate, fairly detailed descriptions of CBT for these disorders. Additionally, instructors should take advantage of the fact that a large portion of the public attends general psychology and abnormal psychology classes at colleges and universities; these classes represent ideal settings in which to educate the public on what is and is not an EBT. Education on EBTs could also be incorporated into high school psychology classes and mandatory health instruction. While these strategies will not directly address problems associated with the lack of EBTs in the community, increasing awareness and knowledge of EBTs will give assurances to patients that the care they are receiving is adequate and may increase the demand for EBTs (and consequently their supply).

Exploring Other Mechanisms of Treatment Delivery

Developing and evaluating novel methods of treatment delivery may also help increase access to evidence-based care (Kazdin & Blase, 2011). A number of computerized treatments for depression and anxiety have yielded promising findings (e.g., Amir & Taylor, 2012; Williams, Blackwell, Mackenzie, Holmes, & Andrews, 2013).

Computer-assisted programs for CBT (e.g., Craske et al., 2009) have the potential not only to increase access to care but also to ensure the fidelity of CBT being provided. Self-help books, Internet sites, smartphone and tablet applications, and paraprofessional-administered EBTs could also help disseminate EBTs. Continued exploration of these and other intervention methods could significantly expand the possibilities for innovation and growth in this area.

Concluding Remarks

We have discussed many barriers to the dissemination of CBT and other EBTs. Others have discussed many additional barriers that we were not able to touch on, including pseudo-scientific beliefs held by both therapists and patients (Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2013). In closing, we aim to impress that, although some degree of movement toward dissemination of evidence-based care may occur through changes made to government and accreditation board policies, we suspect that widespread adoption of EBTs in clinical practice is unlikely to come through top-down policies alone. Rather, changes must be made at multiple levels and will require investment from various stakeholders, including national organizations, researchers, therapists, and patients. While there are many challenges associated with the movement toward widespread adoption of evidence-based practice, we hope that the strategies discussed here might help to advance the field's efforts in the dissemination of EBTs.

References

Addis, M. E. (2006). Methods for disseminating research products and increasing evidence-based practice: Promises, obstacles, and future directions. *Clinical Psychology: Science and Practice*, *9*(4), 367–378. doi:10.1093/clipsy.9.4.367

Addis, M. E., Wade, W. A., & Hatgis, C. (1999). Barriers to dissemination of evidence-based practices: Addressing practitioners' concerns about manual-based psychotherapies. *Clinical Psychology: Science and Practice*, *6*(4), 430–441. doi:10.1093/clipsy.6.4.430

Amir, N., & Taylor, C. T. (2012). Combining computerized home-based treatments for generalized anxiety disorder: an attention modification program and cognitive behavioral therapy. *Behavior Therapy*, *43*(3), 546–559. doi:10.1016/j.beth.2010.12.008

Baker, T. B., McFall, R. M., & Shoham, V. (2008). Current status and future prospects of clinical psychology: Toward a scientifically principled approach to mental and behavioral health care. *Psychological Science in the Public Interest*, *9*(2), 67–103. doi:10.1111/j.1539–6053.2009.01036.x

Barlow, D. H., Farchione, T. J., Fairholme, C. P., Ellard, K. K., Boisseau, C. L., Allen, L. B., & May, J. T. E. (2010). *Unified protocol for transdiagnostic treatment of emotional disorders: Therapist guide*. Oxford, UK: Oxford University Press.

Becker, C. B., Zayfert, C., & Anderson, E. (2004). A survey of psychologists' attitudes towards and utilization of exposure therapy for PTSD. *Behaviour Research and Therapy*, *42*(3), 277–292. doi:10.1016/S0005-7967(03)00138-4

Bolier, L., Haverman, M., Westerhof, G. J., Riper, H., Smit, F., & Bohlmeijer, E. (2013). Positive psychology interventions: A meta-analysis of randomized controlled studies. *BMC Public Health*, *13*, 119. doi:10.1186/1471-2458-13-119

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive–behavioral therapy: A review of meta-analyses. *Clinical Psychology Review*, *26*(1), 17–31. doi:10.1016/j.cpr.2005.07.003

Clark, D. M. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: the IAPT experience. *International Review of Psychiatry*, *23*(4), 318–327. doi:10.3109/09540261.2011.606803

Clark, D. M., Layard, R., Smithies, R., Richards, D. A., Suckling, R., & Wright, B. (2009). Improving access to psychological therapy: Initial evaluation of two UK demonstration

sites. *Behaviour Research and Therapy*, *47*(11), 910–920. doi:10.1016/j.brat.2009.07.010

Community and Mental Health Team, Health and Social Care Information Centre. (2014). *Psychological therapies: Annual report on the use of IAPT services: England—2013/14*. Retrieved from http://digital.nhs.uk/catalogue/PUB19098/psyc-ther-ann-rep-2014-15.pdf

Consumer Reports. (1995, November). Mental health: Does therapy help? *Consumer Reports*.

Cougle, J. R. (2012). What makes a quality therapy? A consideration of parsimony, ease, and efficiency. *Behavior Therapy*, *43*(3), 468–481. doi:10.1016/j.beth.2010.12.007

Craske, M. G., Rose, R. D., Lang, A., Welch, S. S., Campbell-Sills, L., Sullivan, G., … Roy-Byrne, P. P. (2009). Computer-assisted delivery of cognitive behavioral therapy for anxiety disorders in primary-care settings. *Depression and Anxiety*, *26*(3), 235–242. doi:10.1002/da.20542

Crow, S., Mussell, M. P., Peterson, C., Knopke, A., & Mitchell, J. (1999). Prior treatment received by patients with bulimia nervosa. *International Journal of Eating Disorders*, *25*(1), 39–44. doi:10.1002/(sici)1098–108x(199901)25:1 < 39::aid-eat5 > 3.0.co;2-w

Duckworth, A. L., Steen, T. A., & Seligman, M. E. P. (2005). Positive psychology in clinical practice. *Annual Review of Clinical Psychology*, *1*, 629–651. doi:10.1146/annurev.clinpsy.1.102803.144154

Ehlers, A., Gene-Cos, N., & Perrin, S. (2009). Low recognition of posttraumatic stress disorder in primary care. *London Journal of Primary Care*, *2*, 36–42.

Freiheit, S. R., Vye, C., Swan, R., & Cady, M. (2004). Cognitive–behavioral therapy for anxiety: Is dissemination working? *Behavior Therapist*, *27*(2), 25–32.

Gallo, K. P., Comer, J. S., & Barlow, D. H. (2013). Direct-to-consumer marketing of psychological treatments for anxiety disorders. *Journal of Anxiety Disorders*, *27*(8), 793–801. doi:10.1016/j.janxdis.2013.03.005

Gallo, K. P., Comer, J. S., Barlow, D. H., Clarke, R. N., & Antony, M. M. (2015). Direct-to-consumer marketing of psychological treatments: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*. doi:10.1037/a0039470

Gino, F., & Desai, S. D. (2012). Memory lane and morality: How childhood memories promote prosocial behavior. *Journal of Personality and Social Psychology*, *102*(4), 743–758. doi:10.1037/a0026565

Gyani, A., Shafran, R., Layard, R., & Clark, D. M. (2013). Enhancing recovery rates: Lessons from year one of IAPT. *Behaviour Research and Therapy*, *51*(9), 597–606. doi:10.1016/j.brat.2013.06.004

Harris Interactive. (2004). Therapy in America 2004. Retrieved from http://www.harrisinteractive.com/industries/pubs/Pacificare_Behavioral_Health_Psychology_Today.pdf (June 13, 2005)

Harvey, A. G., & Gumport, N. B. (2015). Evidence-based psychological treatments for mental disorders: Modifiable barriers to access and possible solutions. *Behaviour Research and Therapy*, *68*, 1–12. doi:10.1016/j.brat.2015.02.004

Hembree, E. A., Foa, E. B., Dorfan, N. M., Street, G. P., Kowalski, J., & Tu, X. (2003). Do patients drop out prematurely from exposure therapy for PTSD? *Journal of Traumatic Stress*, *16*(6), 555–562. doi:10.1023/B:JOTS.0000004078.93012.7d

Hipol, L. J., & Deacon, B. J. (2013). Dissemination of evidence-based practices for anxiety disorders in Wyoming: A survey of practicing psychotherapists. *Behavior Modification*, *37*(2), 170–188. doi:10.1177/0145445512458794

Hofmann, S. G., Asnaani, A., Vonk, I. J. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapy and Research*, *36*(5), 427–440. doi:10.1007/s10608-012-9476-1

Hofmann, S. G., & Smits, J. A. J. (2008). Cognitive–behavioral therapy for adult anxiety disorders: A meta-analysis of randomized placebo-controlled trials. *Journal of Clinical Psychiatry*, *69*(4), 621–632.

Hollon, S. D., Stewart, M. O., & Strunk, D. (2006). Enduring effects for cognitive behavior therapy in the treatment of depression and anxiety. *Annual Review of Psychology*, *57*, 285–315. doi:10.1146/annurev.psych.57.102904.190044

Karlin, B. E., Brown, G. K., Trockel, M., Cunning, D., Zeiss, A. M., & Barr, T. C. (2012). National dissemination of cognitive behavioral therapy for depression in the Department of Veterans Affairs Health Care System: Therapist and patient-level outcomes. *Journal of Consulting and Clinical Psychology*, *8*, 707–718. doi:10.1037/a0029328

Karlin, B. E., Ruzek, J. I., Chard, K. M., Eftekhari, A., Monson, C. M., Hembree, E. A., … Foa, E. B. (2010). Dissemination of evidence-based psychological treatments for posttraumatic stress disorder in the Veterans Health Administration. *Journal of Traumatic Stress*, *23*(6), 663–673. doi: 10.1002/jts.20588

Kazdin, A. E., & Blase, S. L. (2011). Rebooting psychotherapy research and practice to reduce the burden of mental illness. *Perspectives on Psychological Science*, *6*(1), 21–37. doi:10.1177/1745691610393527

Lilienfeld, S. O., Ritschel, L. A., Lynn, S. J., Cautin, R. L., & Latzman, R. D. (2013). Why many clinical psychologists are resistant to evidence-based practice: Root causes and constructive remedies. *Clinical Psychology Review*, *33*(7), 883–900. doi:10.1016/j.cpr.2012.09.008

Mazzucchelli, T., Kane, R., & Rees, C. (2009). Behavioral activation treatments for depression in adults: A meta-analysis and review. *Clinical Psychology: Science and Practice*, *16*(4), 383–411. doi:10.1111/j.1468–2850.2009.01178.x

McHugh, R. K., & Barlow, D. H. (2010). The dissemination and implementation of evidence-based psychological treatments. *American Psychologist*, *65*(2), 73–84. doi:10.1037/a0018121

Mussell, M. P., Crosby, R. D., Crow, S. J., Knopke, A. J., Peterson, C. B., Wonderlich, S. A., & Mitchell, J. E. (2000). Utilization of empirically supported psychotherapy treatments for individuals with eating disorders: A survey of psychologists. *International Journal of Eating Disorders*, *27*(2), 230–237. doi:10.1002/(sici)1098-108x(200003)27:2<230::aid-eat11>3.0.co;2-0

National Institute for Health and Clinical Excellence. (2009). *Depression: Treatment and Management of Depression in Adults. Clinical Guideline 90*. London: Author.

Norton, P. J. (2012). A randomized clinical trial of transdiagnostic cognitve-behavioral treatments for anxiety disorder by comparison to relaxation training. *Behavior Therapy*, *43*(3), 506–517. doi:10.1016/j.beth.2010.08.011

Pfeiffer, P. N., Heisler, M., Piette, J. D., Rogers, M. A. M., & Valenstein, M. (2011). Efficacy of peer support interventions for depression: A meta-analysis. *General Hospital Psychiatry*, *33*(1), 29–36. doi:10.1016/j.genhosppsych.2010.10.002

Rakovshik, S. G., & McManus, F. (2010). Establishing evidence-based training in cognitive behavioral therapy: A review of current empirical findings and theoretical guidance. *Clinical Psychology Review*. doi:10.1016/j.cpr.2010.03.004

Reinecke, M. A., Ryan, N. E., & DuBois, D. L. (1998). Cognitive–behavioral therapy of depression and depressive symptoms during adolescence: A review and meta-analysis. *Journal of the American Academy of Child & Adolescent Psychiatry*, *37*(1), 26–34. doi:10.1097/00004583-199801000-00013

Shafran, R., Clark, D. M., Fairburn, C. G., Arntz, A., Barlow, D. H., Ehlers, A., … Wilson, G. T. (2009). Mind the gap: Improving the dissemination of CBT. *Behaviour Research and Therapy*, *47*(11), 902–909. doi:10.1016/j.brat.2009.07.003

Stewart, R. E., & Chambless, D. L. (2009). Cognitive–behavioral therapy for adult anxiety disorders in clinical practice: A meta-analysis of effectiveness studies. *Journal of Consulting and Clinical Psychology*, *77*(4), 595–606. doi:10.1037/a0016032

Stewart, R. E., Stirman, S. W., & Chambless, D. L. (2012). A qualitative investigation of practicing psychologists' attitudes toward research-informed practice: Implications for

dissemination strategies. *Professional Psychology: Research and Practice*, *43*(2), 100–109. doi:10.1037/a0025694

Stobie, B., Taylor, T., Quigley, A., Ewing, S., & Salkovskis, P. M. (2007). "Contents May Vary": A pilot study of treatment histories of OCD patients. *Behavioural and Cognitive Psychotherapy*, *35*(3), 273. doi:10.1017/S135246580700358X

Szymanski, J. (2012). Using direct-to-consumer marketing strategies with obsessive–compulsive disorder in the nonprofit sector. *Behavior Therapy*, *43*(2), 251–256. doi:10.1016/j.beth.2011.05.005

Tolin, D. F. (2010). Is cognitive–behavioral therapy more effective than other therapies? A meta-analytic review. *Clinical Psychology Review*, *30*(6), 710–720. doi:10.1016/j.cpr.2010.05.003

Waller, G., Stringer, H., & Meyer, C. (2012). What cognitive behavioral techniques do therapists report using when delivering cognitive behavioral therapy for the eating disorders? *Journal of Consulting and Clinical Psychology*, *80*(1), 171–175. doi:10.1037/a0026559

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*(6), 629–640. doi:10.1001/archpsyc.62.6.629

Weissman, M. M., Verdeli, H., Gameroff, M. J., Bledsoe, S. E., Betts, K., Mufson, L., … Wickramaratne, P. (2006). National survey of psychotherapy training in psychiatry, psychology, and social work. *Archives of General Psychiatry*, *63*(8), 925–934. doi:10.1001/archpsyc.63.8.925

Weisz, J. R., Ng, M. Y., & Bearman, S. K. (2014). Odd couple? Reenvisioning the relation between science and practice in the dissemination–implementation era. *Clinical Psychological Science*, *2*(1), 58–74. doi:10.1177/2167702613501307

Weisz, J. R., Southam-Gerow, M. A., Gordis, E. B., Connor-Smith, J. K., Chu, B. C., Langer, D. A., … Weiss, B. (2009). Cognitive–behavioral therapy versus usual clinical care for youth depression: An initial test of transportability to community clinics and clinicians. *Journal of Consulting and Clinical Psychology*, *77*(3), 383–396. doi:10.1037/a0013877

Weisz, J. R., Ugueto, A. M., Cheron, D. M., & Herren, J. (2013). Evidence-based youth psychotherapy in the mental health ecosystem. *Journal of Clinical Child & Adolescent Psychology*, *42*(2), 274–286. doi:10.1080/15374416.2013.764824

Wildschut, T., Sedikides, C., Arndt, J., & Routledge, C. (2006). Nostalgia: Content, triggers, functions. *Journal of Personality and Social Psychology*, *91*(5), 975–993. doi:10.1037/0022-3514.91.5.975

Williams, A. D., Blackwell, S. E., Mackenzie, A., Holmes, E. A., & Andrews, G. (2013). Combining imagination and reason in the treatment of depression: A randomized controlled trial of internet-based cognitive-bias modification and internet-CBT for depression. *Journal of Consulting and Clinical Psychology*, *81*(5), 793–799. doi:10.1037/a0033247