Cross-fertilization versus transmission: 
Recommendations for developing a bidirectional approach to psychotherapy dissemination research

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Abstract  
Psychotherapy researchers are increasingly engaged in collaborations with clinical practitioners and mental health administrators. Each party brings its own perspectives, values, and agendas to bear in these encounters. Viable research-practice collaborations depend on understanding and negotiating some of the tensions in these relationships. In this article, we discuss the contexts that prevail for various participants in a psychotherapy dissemination study as well as the values, goals, costs, and benefits related to research participation. This article is a collaboration among the researchers, mental health administrators, therapists, and clients involved in an ongoing treatment dissemination study. Our recommendations for research-practice collaborations are based on our experiences and dialogues over the course of this study.

Key words: Dissemination, effectiveness, research-practice collaborations, science and practice

Over the past decade, interest in dissemination research on mental health treatment has grown significantly (Addis, 1997; Addis, Wade, & Hatgis, 1999; Barlow, Levitt, & Bufka, 2000; Strosahl, Hayes, Bergan, & Romano, 1998). Dissemination research ranges from studies of the real-world effectiveness of treatments that have been found to be efficacious in controlled clinical trials (Wade, Treat, & Stuart, 1998) to studies of various psychotherapy training methods. This interest in dissemination research is partly in response to changes in mental health service delivery (e.g., the evolution of managed care) and partly due to momentum in psychotherapy outcome research (e.g., the proliferation of empirical support for treatments of specific disorders) (Chambless & Hollon, 1998; Wilson, 1996, 1998). Economic changes in service delivery are such that, for better or worse, many cost-saving measures now govern mental health practice, including session limits, larger caseloads, reimbursement only for treatment of diagnosable psychological problems, and ongoing usage review by insurance boards. At the same time, evaluation or outcomes research has become a central part of mental health service delivery itself. Increasingly, agencies and clinicians want and need to monitor client outcomes. Third-party payers periodically require therapists to demonstrate the need to continue therapy with each client. In short, psychotherapy research is intersecting with psychotherapy practice in new and changing ways. In this article, we address questions about the forms research takes when it arrives in practice settings, how it is viewed, and how it can be transformed.

From one perspective, dissemination research is a fairly
straightforward process. Treatments that have been shown to be efficacious in tightly controlled, internally valid, randomized clinical trials are transferred to clinical practice and evaluated in real-world effectiveness studies. Consistent with the “medicalization of psychotherapy research” (Goldfried & Wolfe, 1998; Hayes, Barlow, & Nelson-Gray, 1999), the process resembles the dissemination of pharmacological and medical treatments from controlled research to clinical practice. From another perspective, the appropriate goals and strategies for psychotherapy dissemination research are less clear-cut (Addis, 2000; Kordy, 1995). Researchers and practitioners bring potentially divergent assumptions about knowledge and expertise to bear on their work. At the risk of overgeneralizing, treatment researchers tend to trust empirical findings, whereas practitioners seem to place more faith in their own and their colleagues’ direct experiences with clients (Cordova & Koerner, 1993; Dawes, 1994). In addition, dissemination can involve bringing a treatment to a setting that is vastly different from the one in which it was initially evaluated. Context differences, such as financial pressures, disincentives for spending time on training activities, session limits, and heterogeneous client populations, may affect the viability and effectiveness of a treatment in clinical practice. Other questions arise as well, such as how to package a treatment and train clinicians in order to optimize user-friendliness of a new therapy.

Different styles of dissemination give rise to alternative solutions to these potential problems and questions. One approach to dissemination is to think of it as transporting a technology from one context (research or academia) to another (practice). Here the process is relatively unidirectional and hierarchical; researchers, and perhaps clinicians, develop knowledge products and front-line practitioners receive them. Another view is that dissemination is encompassed by a wide range of processes that result in the increased use of research products by those in the mental health professions (Addis, 2000; Addis & Hatgis, 2000). In the latter case, dissemination is conceptualized as a joining of research and practice; the relationship between the two parties involved is characterized by a metaphor of cross-fertilization rather than by a metaphor of transmission. The assumptions and implications of this approach include the idea that good dissemination research involves transformations on both sides of the process: research and practice shape each other. Researchers with this mindset are likely to regard the work of understanding and navigating the aspects of clinical practice contexts that are inhospitable to research (e.g., productivity pressures) as an integral part of the research process itself. Likewise, practitioners can make interventions into research, for example, by posing their own research questions and by challenging some of the underlying assumptions researchers hold. Overall, the differences between the two views of dissemination can be understood as analogous to the differences between a monologue and a dialogue: in the first case, a listener receives a message; in the second case, both participants shape the communication and, in turn, perhaps shape each other.

We have come to see our work as imbedded in this second paradigm, and our intention is to assist others interested in developing similar research–practice collaborations. We begin by briefly describing a program of research that involves disseminating an empirically supported psychosocial treatment to a managed care clinical service setting. We then consider the experiences, agendas, and expectations of the different parties involved in the study. Here we invited members from the various groups (i.e., clinicians, mental health clients, mental health administrators, and clinical researchers) to articulate their own goals and agendas for the research and to discuss the particular difficulties and rewards they encountered. In our view, understanding the differences between our perspective as researchers and those of therapists, administrators, and clients is crucial to conducting successful dissemination and effectiveness research. In this regard, and for the sake of clarifying the different perspectives, we use the pronoun “we” to refer to the researcher’s perspective; we specifically mention therapists, administrators, and clients when we are representing their views. Finally, we offer recommendations for research–practice collaborations that reflect the most important themes in our joint experience of this project.

Disseminating an Empirically Supported Treatment for Panic Disorder to a Managed Care Service Setting

Several years ago we began a study to test the transportability of an empirically supported treatment for panic disorder to a managed care clinical service setting. The aim of the study was to examine whether it would be cost-effective to train practicing clinicians in Panic Control Therapy (PCT) (Craske, Meadows, & Barlow, 1994), a manual-based, empirically supported treatment. By cost-effective we mean that the effort, time, and money spent on training therapists in PCT would result in sufficient benefits, in terms of client outcomes and medical cost offset, to be worthwhile. PCT has exceptionally high efficacy levels in controlled studies (Barlow, 1990; Barlow, Craske, Cerny, & Klosko, 1989; Brown & Barlow, 1995; Klosko, Barlow, Tassinari, & Cerny, 1990; Shear, Pilkonis, Cloitre, & Leon, 1994); if it also performed well compared to treatment as usual (TAU) in a randomized effectiveness trial, this finding would support the further dissemination of PCT. Our research would also test a dissemination model that could be used for other empirically supported treatments. Finally, we saw this study as a unique opportunity to bring research to a practice setting, to develop a research–practice collaboration, and to learn about the process of forming such partnerships.

The principal investigator (Michael Addis) designed the study in which clients with a primary diagnosis of panic disorder were followed for 2½ years after assignment to a therapist. One group of therapists was trained in PCT, while the
other group provided standard care to the clients we referred to them. PCT training consisted of a 2-day workshop conducted by a certified PCT trainer. Our therapists included clinicians with master's degrees in social work or counseling psychology; one held a doctorate in clinical psychology. We screened clients with panic disorder to determine their interest in and eligibility for participating in the study; two training cases were assigned to each PCT therapist. The workshop trainer held six 30-minute telephone supervision sessions during the course of treatment for the training cases, and she reviewed audiotapes of each therapist's second training case to ensure that the therapist had learned to provide the therapy. Finally, the principal investigator and the research team held consultation meetings with the PCT therapists weekly and later bimonthly to discuss the cases in detail and to refine their knowledge of cognitive-behavioral principles in general and PCT in particular. During these meetings we touched on the particular challenges and benefits of using a manual-based treatment protocol with clients who have multiple diagnoses.

We recruited 80 adult clients and randomly assigned them to individual therapy with a TAU or PCT therapist. Therapists varied in level and type of prior training, years of experience, and type of degree. To be eligible for the study, clients had to have a primary diagnosis of panic disorder, either with or without agoraphobia, and this had to be the main reason they were seeking therapy. Clients varied in terms of comorbidity and severity of diagnosis. The only exclusionary criteria for client participation in the study were current suicidality, psychosis within the past 5 years, and substance abuse within the past 6 months. We are currently analyzing outcome data and continuing to follow the long-term status of clients treated in both conditions.

Originally, the study was designed as a collaboration with a large regional health management organization (HMO) that provided its own mental health services. Plans to collaborate with this HMO were based on data about their client population, the incidence of panic in this group, and the agreement that the research team would have access to long-term data, such as clients' pre- and posttreatment primary care, mental health care, and emergency room visits. However, before our research project began, the HMO discontinued providing its own mental health services and contracted with an independent outpatient agency to act as preferred provider of these services for the HMO's subscribers. Therefore, our collaboration shifted to include the staff of this private agency. These new research partners had not been involved in our initial research plans; instead, they inherited our project and us, much as we inherited them. Luckily for us, the administrators and clinicians at this agency were amenable to our work and found ways to integrate their goals with ours for our mutual benefit. What follows is an account of the process of that collaboration with these clinicians and administrators.

In the next sections, the various groups of participants discuss the context within which they operate as research collaborators. By context we mean the complex of individual and environmental factors that bear on each participant's work and research participation. To gain contributions from different perspectives, the research team invited interested parties from four participant groups to coauthor this article: research assistants, administrators, therapists from both TAU and PCT groups, and clients from both groups. We circulated an outline of topics and questions for contributors to write about or asked these questions during an individual interview. The outline included questions about each contributor's reasons for participating in the study; the costs, benefits, and tasks involved in doing so; the goals and expectations of participation; whether or not these were met; and the effects of participating on the contributor's therapy, services, and education. Additional items included questions about the contributor's impressions of research and recommendations for future research studies. See Table 1 for a summary of these perspectives.

The Client's Context

It hardly needs to be said that understanding the client's context is essential to conducting successful effectiveness and dissemination research. However, there are several variations in how researchers might consider the client's perspective. For example, a researcher might focus on the acceptability of a particular treatment as an important variable in its effectiveness (American Psychological Association, 1995). Or, a researcher might ask why clients participate in treatment research to begin with. Or, a researcher might consider how to take the goals of clients into account when designing and implementing treatment effectiveness and dissemination research.

Goals, values, and agendas. Perhaps the most striking, though not surprising, pattern of responses to our questions about the research process indicated that many clients did not consider the study to be significantly independent from their therapy for panic disorder. Clients were motivated to join the study because they felt it was a chance to find out more about panic, how to recognize it, deal with it, and ultimately control it. They sought personal relief from panic disorder, believing that participating in the study would provide this, and hoped their participation would help others with similar problems in the future. Interestingly, clients did not distinguish their own goals for participating in the research from the goals of the research itself. For example, none of the clients mentioned that a comparison of the different treatments for panic disorder was a main goal of the study, even though they were made aware of this fact before they agreed to participate. Thus, the overarching and more lasting impression clients held was that the purpose of the research was to learn how to treat panic disorder more effectively. This was consonant with the most often cited personal goal of obtaining effective treatment for panic disorder. Our clients valued finding the best treatment available and allowed researchers
Table 1. Multiple Perspectives in Psychotherapy Dissemination Research Collaborations

<table>
<thead>
<tr>
<th>Participants</th>
<th>Goals</th>
<th>Values</th>
<th>Costs &amp; obstacles</th>
<th>Most valued outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients</td>
<td>Get relief from distress</td>
<td>Receive the best treatment</td>
<td>Audio tapping</td>
<td>Therapeutic relationships</td>
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<tr>
<td></td>
<td></td>
<td>Help others with similar problems</td>
<td>“Guinea pig” impressions</td>
<td>Increased knowledge about their problems</td>
</tr>
<tr>
<td>Therapists</td>
<td>Professional development</td>
<td>Career advancement</td>
<td>Loss of wages</td>
<td>High-quality supervision</td>
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<td></td>
<td>Connectedness</td>
<td>Learning</td>
<td>Scheduling difficulties</td>
<td>Participation in a learning environment</td>
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<tr>
<td></td>
<td>Learn to conduct a useful therapy</td>
<td>Work satisfaction</td>
<td>Evaluation apprehension</td>
<td>Enhanced sense of competence</td>
</tr>
<tr>
<td>Administrators</td>
<td>Bridge academia and</td>
<td>Maintain a profitable,</td>
<td>Perceived unfair distribution of benefits of participation</td>
<td>Improved client outcomes</td>
</tr>
<tr>
<td></td>
<td>clinical practice</td>
<td>competitive service</td>
<td>Time spent on nonrevenue-generating activity</td>
<td>Employee satisfaction</td>
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<tr>
<td></td>
<td>Protect and expand business</td>
<td>delivery system</td>
<td>Space and telephone use for research staff</td>
<td>Leverage to maintain and increase business</td>
</tr>
<tr>
<td>Researchers</td>
<td>Conduct a worthwhile study</td>
<td>Scientific knowledge</td>
<td>Service setting instability</td>
<td>Acceptance of practice setting as the thing we aim to understand through research rather than as a set of obstacles to overcome</td>
</tr>
<tr>
<td></td>
<td>Advance clinical practice</td>
<td>Academic career advancement</td>
<td>Compromises in original vision of the study as required by evolving practical limits</td>
<td>Extended, mutually beneficial work with clinicians</td>
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<tr>
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<td>through science</td>
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<td></td>
<td>Understand practice</td>
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<td>environments</td>
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<td>Advance a research</td>
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<td></td>
<td>program</td>
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to use their experiences to help other clients with similar needs. The agenda linked to these goals and values was to attend to one’s personal mental health needs while furthering knowledge that would help others.

Our interviews with clients suggest that, when designing effectiveness studies, researchers would do well to consider that participation only makes sense to clients if it serves to improve their mental health. If the extra work of participating in research does not afford clients a greater chance of improvement, it may not be worthwhile. This brings researchers up against some conflicting interests. First, monetary rewards for participation must be adequate to offset the inconvenience of the research tasks, but not so great as to coerce participation. Second, until a treatment is proven to be effective in a real-world setting, it is misleading to tell clients that they have a greater chance of improvement by participating in the study. Finally, even if a researcher believed that participation in the study would give clients a chance to receive a state-of-the-art therapy, it would be inappropriate to say so, because some clients would be likely to regard the control treatment as inferior, thus lessening their expectations and therefore their chances of improvement. These are tensions any dissemination researcher must reckon with. For us, it was clear at the onset that we did not know which treatment condition would be best for which clients. Although we believed that PCT was a highly efficacious treatment for panic disorder, we genuinely maintained the stance that some clients would fare better in the more flexible control condition.

Costs and obstacles. Obstacles to client participation were of utmost concern to the research team from the beginning. This was true mainly because the referral rate of prospective clients was lower than expected. Many of the clients we screened were willing to participate in the study; however, the reasons for clients not to participate were also important to us. Client participants interviewed for this article did not describe any salient costs and obstacles of participation. However, the research team observed various obstacles to participation based on interviews with the clients who refused to join the study. Some clients were unwilling to have therapy sessions audiotaped. Others only wanted medication without any therapy at all. Some had unshakable “guinea pig” impressions of research participants. Some wanted to participate in our research, but their insurance changed to a company that did not cover therapy at our host agency. Finally, some clients were so debilitated by panic disorder that they could not leave the house to come for therapy. These obstacles to client participation required creative compensatory strategies, which we discuss later. Overall, devising strategies to increase the rate of client participation and to maintain enrolled clients occupied an unexpectedly large proportion of our time and effort during the early years of our study.

Gains. Clients generally reported satisfaction with their participation in the research project. Regardless of the outcome of their treatment, clients cited positive relationships with therapists as a primary benefit of the study. According
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to one client, the greatest benefit of the study was her encounter with her therapist because "he wasn't judgmental and didn't make me feel as though I should get over it. . . . He validated my fears and didn't make me feel like I was less of a person." We were intrigued by such answers, which suggest that getting better may not be the sole determinant of a client's satisfaction with participation in a research study. Rather, it would seem that the client's feelings about the therapist color his or her views of participation in research and also perhaps of therapy itself. In addition, clients reported having a strong desire to learn more about panic. Most clients we interviewed reported that they had met this goal, even in cases in which they did not overcome their panic attacks. This suggests that the desire to gain knowledge about their problems may be an important factor in motivating clients to join research and to enroll in therapy. Like the therapeutic relationship, obtaining knowledge about their problems may have an independent effect on their satisfaction with research participation and therapy.

The Therapist's Context

Goals, values, and agendas. In our experience, therapists' goals and agendas for research participation focus on enhancing professional development, gaining expertise in new therapies, and furthering connections with a larger entity that could provide access to helpful resources. One therapist mentioned that she joined the study soon after getting hired in order to get connected with an interesting project at her new job. Another joined specifically to obtain training that would facilitate her applications for membership on insurance panels. Several others were primarily interested in training in cognitive-behavioral therapy to expand their areas of expertise and competence. If connectedness, professional development, and enhanced expertise are common goals of therapists, these values need to be taken into account when designing studies that require therapists' voluntary participation. The opportunity for therapists to achieve these goals may offset some of the tangible costs of research participation. When initiating a research project, dissemination researchers would do well to assess the kinds of goals and needs their study may help therapists to fulfill, especially considering how great an investment therapists must make when they participate in such a study.

Costs and obstacles. Of all the participants involved, therapists' accounts of the costs of participating in this study are among the most striking. PCT therapists in particular experienced scheduling constraints and absorbed some financial costs. As one therapist remarked, "I had to invest time into training and supervision. A cost of this within the agency environment has been a loss of productivity hours (i.e., wages). During part of the study, I worked at an off-site location, and, including travel time to supervision meetings, my productivity loss was 2 hours per week."

Another set of obstacles included therapists' skepticism and self-doubts. One therapist remarked that she was apprehensive regarding the efficacy of the protocol and unsure of her ability to perform the therapy and to obtain client compliance. Certain exercises, such as spinning a client in a chair to simulate sensations of panic, seemed to her like inflicting torture, yet she knew that her session tapes would be reviewed and that the supervisors would know if she had omitted that part of the treatment. We found that addressing therapists' ambivalence about using a protocol-driven treatment is a crucial aspect to successful dissemination (Addis, Hatgis, Soysa, Zaslavsky, & Bourne, 1999; Addis & Krasnow, 2000; Addis, Wade et al., 1999).

Loss of wages and evaluation apprehension were not the only costs to therapists who participated in the study. There was also the incompatibility of delivering the protocol in the context of their other work demands. The agency did not schedule clients for the study in exactly the same manner as other intakes or referrals; thus study clients required a bit of special attention. In addition, there was pressure to schedule a study client sooner than other new cases. Finally, as one therapist remarked, "the protocol recommends weekly sessions, which were frequently unavailable due to my large volume of cases." PCT therapists in the study endured some reduction in their wages while learning a protocol that did not mesh well with other workplace demands and that seemed, to some, downright strange and difficult, and so raised their evaluation anxiety.

Special issues and difficulties pertained to the control group of therapists who provided treatment as usual. Although they are to receive training in PCT at the end of the study, during their initial years of participation, members of the TAU group sometimes felt excluded and perceived that they had missed out on some of the benefits of being on the research project. The research team was not in frequent contact with TAU therapists, leaving them to experience the added burdens of completing research paperwork and taping sessions without as many of the gains that PCT therapists reported. One TAU therapist addressed this disparity by independently investing time in her own development as a clinician. She remarked, "Although I was not in the group initially trained in the treatment protocol for panic disorder, I hoped that simply by having the opportunity to treat a high volume of patients with this disorder I would eventually develop—through sheer trial and error—a sense of what works and what doesn't to help these patients achieve symptom relief." However, this therapist did not rely solely on trial and error. Rather, she reported that, "Since the study began, I have been educating myself about the mind/body connection, reading up on a variety of relaxation techniques, and learning about the effects of exercise and diet on mood and stress. I have then tried to incorporate some of the fundamentals of mind/body work into a treatment approach that also invites exploration of the underlying issues." This account reflects one difficulty of maintaining a pure TAU control group: TAU therapists, such as this one, may shift their treatment ap-
approaches away from "treatment as usual" as a function of their participation in a study. Moreover, these comments underscore the importance of understanding and taking into account therapists' goals and agendas for participating in research. If study participation does not meet their goals directly or quickly enough, therapists may pursue these goals independently. Thus, dissemination researchers must be alert to therapist adherence to the new treatment (in our case, PCT), assess the therapy the control group delivers, and discern the extent to which the two groups overlap or not in terms of the type of therapy they provide.

**Gains.** Therapists in our study valued their research participation primarily for the opportunity to increase clinical skills and knowledge and for the quality supervision they received from the research team. As one said, "What has sustained my coping with a wage loss is the level of cognitive therapy supervision and the collegial supervisory environment afforded to me by this study. It exceeds what I experience at times within my own agency because it is a pure supervision environment, free of the administrative/managerial dogma of the agency. The principal investigator and research assistants continue to help and inspire me greatly. They are often the folks that I most look forward to connecting with due to their incredible brightness, creativity, and support and the challenges they provide me with. I hope to continue to be linked to them in some capacity beyond the completion of our work in this study." Another concurred that the level of supervision she received was excellent. She wrote, "I began to look forward to the group meetings and my interaction with the research team and other clinicians in the PCT group. The supervision was challenging, always supportive, and educational. The meetings provided a place for intense discussion of a specific symptom or of a particular difficulty with a client or with the treatment. Education and support were focused in a way that other team meetings could not permit. The format provided a wonderful opportunity to develop and enhance skills I use not only in PCT but also in my approach with other disorders. Through my participation in the study, I have learned an effective treatment for panic disorder, further developed my proficiency with cognitive-behavioral approaches, and have had the opportunity to meet and work with some wonderful people." We share these comments because they speak to some of the gaps therapists experience in typical work environments that research teams can fill, thus creating a valuable niche for themselves in practice settings. These gaps mainly include high-quality supervision, accessible avenues for professional development, and a culture of learning that is characteristic of the academic environment of many researchers but often absent in the fast-paced, high-volume world of service delivery.

In contrast with the research-practice hostility often discussed in the literature (Williams & Irving, 1999), our PCT therapists' overwhelmingly positive accounts of their research participation are striking. One possible explanation for this is that many working therapists may have little or no direct experience on a research project. Another is that working therapists may fondly remember their days in graduate school as the last time they received intensive training and supervision. Inexperienced with research, paired with an acculturated division between academia and clinical practice, may feed therapists' misconceptions of research. Likewise, many researchers, including ourselves, admit that they do not know much about therapists' training experiences and practice patterns. Thus, a collaborative research project such as ours can begin to bridge these gaps for both parties.

Even TAU therapists, who have yet to experience the training and focused supervision given to PCT therapists on our study, felt there were salient benefits of participation. The clinician who embarked on a process of self-education for treating panic disorder concluded that her goals for participation in the study had been met, although she had not yet had the training in PCT. She remarked, "A year into the study, I believe that I have developed strategies and approaches for working with panic and other anxiety patients that have been effective in helping them manage their anxiety, modify their level of stress, and think more compassionately about themselves. Moreover, I now find that much of what I have learned by treating panic patients carries over into my work generally, since stress and lifestyle factors inevitably affect mood and functioning regardless of the particular diagnosis. As a result of being a study participant, I believe I have become a more skilled and confident clinician overall. I have also derived great pleasure from working with the study patients who, as a group, stand out in my caseload as being unusually motivated to attend therapy sessions and to follow through on therapist recommendations." These comments speak vividly to our sense that therapists may pursue their goals for participating in research with or without the researcher's assistance and resources rather than wait for the research timetable to unfold. This orientation toward their goals is one of many issues that can be articulated during a preliminary brainstorming session, so that therapists and researchers can jointly devise strategies that satisfy the control group therapists' needs for growth and development without unduly jeopardizing the internal validity of the research design.

**The Administrator's Context**

**Goals, values, and agendas.** The goals of administrators for the project were similar to those of therapists but with a field-wide or agency-wide focus. One administrator wanted to use his role to "help bridge the worlds of clinical practice and academic research and to facilitate research which could examine strengths as well as weaknesses of introducing empirically supported manual-based treatment into clinical practice within a managed care environment." Another administrator's emphasis was more concrete, in that he hoped to "use this research to offer a state-of-the-art treatment, get
staff trained for free, and market our clinic more competitively to insurance companies and managed-care organizations.” Emphasizing the practical implications of our collaboration, he stated, “We understood that offering an effective treatment for panic disorder would be an important enhancement in our provider profile, enabling us to remain on insurance panels. It would give us leverage to increase our business and to protect the business that we have.” Our administrators expressed the view that, in the realm of for-profit mental health care, without a solvent and competitive service delivery system there is no realistic avenue for delivery of any mental health treatments, effective or otherwise.

Whether or not we agree with this perception or endorse this state of affairs, as researchers interested in practice settings we recognize that these are the constraints within which clinic administrators do business. To conduct research under these conditions, administrators and researchers need to work together to construct an alliance that takes these goals into account. A researcher needs to understand how their project, worthy as it may seem to them, can be seen as a deterrent or an irrelevancy to administrators who are concerned with the immediate issues of generating revenue and staying in business. With such an understanding, researchers are in a better position to know what they can offer to make a research project worthwhile to the clinic administrators.

Costs and obstacles. Initially, we needed the support and active facilitation of key members of the administrative staff in order to gain approval to conduct our study at the outpatient clinic. In the words of one clinical director, “Our corporate driven clinic did not inherently support any research effort.” It was necessary for the clinical administrator on the clinic’s executive board to convince board members that their chief concerns would not be compromised. First, PCT training would be on clinicians’ own nonreimbursable time. Second, the university or the research grant, not the provider agency, would cover all the training costs. Third, clinician’s training would not otherwise affect their weekly productivity. A decline in reimbursable services while therapists received training would have been unacceptable. Finally, any supervisory involvement on the part of the clinical director would be on his own time. From the perspective of the board of directors and the clinical director fee-for-service is the ever-present reality in this managed care era. In this realm, if clinicians are not providing reimbursable services, they are not generating fees and not supporting their salaries.

In addition to board members’ concerns, administrators had to address clinicians’ concerns as well. Initially, clinicians were not flocking to participate in the study. First, if therapists were not going to be reimbursed for their training, why should they get involved in the research study when they could see more patients during the time it took to train? Second, clinicians’ nonreimbursable administrative duties under managed care, such as patient progress updates, were already impinging on their own time. When staff turnover or productivity pressures caused therapists to discontinue their participation in the study, the research team called on clinic administrators to help replenish the supply of participating therapists. This required brainstorming about whom to invite to join the study and how to approach them. Administrators needed to communicate that they supported the research project and valued the fact that therapists took the time to learn these skills, even if they could not reimburse therapists for training time.

Finally, administrators were concerned that this research effort would only mean more hassles for an already challenged administrative staff. The intake department experienced the greatest challenges. Intake staff already had several HMO and quality assurance standards to satisfy, such as minimizing the percentage of phone calls not answered within 30 seconds, the number of patient-abandoned phone calls, and the percentage of patients not scheduled for an intake within 10 business days. Devoting the extra time required to ask patients who called with complaints of anxiety if they were interested in participating in a research project was the last straw for some of the hardworking intake staff. “Why would we do research here? We don’t get paid for it!” was the common cry of administrative staff. Yet, in order to keep the study going, the clinical directors had to support the patient referral process. They did this by stopping by the intake department to inquire about the study, tracking referrals into the study on monthly statistical reports, and calling meetings between intake and research staff to brainstorm and solve problems. At various times when staff turnover in the intake department placed additional pressure on intake workers, senior administrators stopped by to remind them of how important their role was to the success of the research.

Another type of effort required of the clinical director was to run political interference and act as a diplomat when various members of the complex organization had different concerns and agendas. As he stated, “A project such as this one needs someone available to step in as needed in order to help put out the various fires that erupt along the way.” It continued to surprise clinic administrators how many unsuspected pitfalls we encountered. As one administrator recalled, “we thought we had crossed all our ‘t’s’, dotted all our ‘i’s’, but then we discovered that our subject reimbursement plans fell under the jurisdiction of the Department of Public Health, in addition to the HMO, the clinic, and the university research review boards.” Pertaining to another moment of tension, he observed, “Staff changes at the HMO presented the opportunity for us to ruffle someone’s feathers, mostly because there were new feathers to be ruffled. We were able to laugh about these problems in retrospect, after we solved them.” As one of the clinical directors reminded us later, “We have so many bosses, some days we forget who all of them are.”

The overarching message from these observations is that administrative support is important at the beginning of a research–practice collaboration and absolutely essential throughout the process, but only in crucial moments. The administrators at our host agency learned that at certain points
we would call on them to intervene, and that their interventions would be necessary for the continuation of the project. In between these moments, however, we were self-sufficient, and they could forget about us for a while. This is another example of the kind of relationship building that can get well underway at a preliminary brainstorming session about the hopes and expectations for the research process.

Gains. According to clinic administrators, the gains of participation in this study thus far have been powerful. However, as one administrator mentioned, the potential gains may be even more significant. "Everybody involved stands to benefit," he maintained. "HMO's benefit if we're correct about the decreased utilization of medical benefits and costs of services. Of course, patients also benefit if we establish and disseminate effective interventions for distressing psychological problems such as this one. Clinical staff benefit by their increased sense of efficacy and competence. This is hard work that they do. Feeling that one knows what they are doing, and can see the positive outcomes, helps a therapist to resist burnout, to stay with this work, and to feel good about it. In addition, of course the organization benefits if it can increase its marketing potential and build its business."

"Finally," he continued, "from the clinical director's standpoint, having our agency participate in research such as this is beneficial, because it helps people to feel good about working here, thus potentially reducing staff turnover, which is and has been a real problem for us. At agencies like ours, because of the terribly low reimbursement rates and the margins required to stay in business, the days of clinical supervision are long gone. The only people who receive supervision in this agency are those whom we take on as licensed clinical social workers or psychology interns. We agree to temporarily provide these staff members, who represent about one-tenth of our staff, with supervision in order for them to obtain independent licensure. A research study such as this offers the opportunity for clinicians to learn a new skill that they don't have to pay for and get excellent supervision in a way that employers cannot realistically provide. I believe that is going to increase job satisfaction, and decrease staff turnover."

Despite these strong endorsements, some of the administrators' expectations and goals had not yet been met. As one clinical director remarked, "The agency's participation in the study has not been as lucrative to us yet as we would have liked, partly because health care service delivery has been in such chaos that we spend all of our time trying to put out fires as opposed to marketing our services. Furthermore, this organization has gone through so many staffing and corporate level changes that actually being able to use the research more productively or proactively has not been easy. However, the potential is there for us. I look forward to being able to review the final results of the study. The preliminary results are strongly positive, especially the findings that the average number of sessions utilized to treat this disorder has been lower than expected, and that many clients have remained panic-free over a period of time. We'll be interested in upcoming data about reductions in medical costs for the clients treated for panic disorder. If these findings are favorable, we will absolutely be able to market our agency as a provider of this cost-effective treatment."

Interestingly, despite this clear message of support, therapists expressed the impression that agency administrators demonstrated insufficient support of the study. This was especially true in terms of the therapists' perception of the agency's inflexibility about productivity requirements and the mandate that all therapists move from salaried status to fee-for-service, thus risking loss of income if training activities curtailed productivity. These apparent contradictions are another set of topics that can be aired and discussed in an early-phase brainstorming session. Furthermore, they highlight the fact that strains exist in the relationships not only between researchers and practitioners, but also between practitioners and administrators, and that the research process is likely to evoke these strains.

The Research Team's Context

Goals, values, and agendas. The researcher's main goal is to advance clinical practice using the tools of empirical science. A secondary goal for a researcher, which may at times take precedence, is to complete the ongoing project, generate publications from the data, and advance his or her research program. Certain values underlie these goals, including the value for knowledge gained through scientific methods and the value for academic career advancement.

Like therapists, research assistants working on the project shared the goals of advancing their education and professional/career development. Research assistants hoped to use their participation in the study (a) to learn how to conduct treatment outcome research, (b) to learn about training and supervision methods for manual-based and cognitive-behavioral therapies, and (c) to facilitate career choices between research, training and supervision, and education. The research assistants' agenda involved negotiating the challenges of continuing to learn and develop when their participatory roles became mechanical or rote. Research assistants resolved this conflict in different ways. Some expanded their clinical role to include training others and participating in supervision. Others developed research skills by initiating projects based on their own intellectual interests. Thus, when the structure of their roles became a constraint, research assistants expanded their participation beyond the formal confines of their jobs.

Costs and obstacles. A substantial set of obstacles and potential difficulties for the research team derived from working within the vicissitudes of a mental health service business. During the 4 years since the inception of the study, multiple shifts in the broader structure of services and corporate ownership have taken place. First, as mentioned earlier, the HMO that had signed on to be the site for the research subcontracted its mental health services to a smaller mental
health service agency. In turn, this agency went from being the preferred provider of mental health services for members of the HMO, which ensured a large pool of patient referrals to the agency and to the study, to being one of many providers competing to provide mental health services for the HMO's enrollees. This agency went up for sale more than once during our tenure; it has now been sold. There has been staff turnover at every level, including our primary liaisons, the director and clinical director. There have been three different directors of the intake department and a turnover of approximately 10 staff members over 3 years in this three- to four-person department. Therapist turnover has also been a regular occurrence: 9 of the 16 therapists who joined the study have now left. Finally, staff turnover at the HMO has produced some fallout for us as we forged relationships with administrators who have since left or were reassigned, requiring us to start anew with their replacements. Our study most commonly came to the attention of these new colleagues only after a problem had arisen, as is often the case in high-paced businesses. Equal parts impressed and surprised, one research assistant stated that she wondered how we managed to "continue to do research in an environment that continually changes shape and function."

One important strategy for the research team was to identify the departments at the agency that would be important throughout the study and to maintain alliances with them, despite staff turnover. In order to accomplish this, research assistants attended departmental meetings and kept up with staff changes in the intake, billing, and reception departments, all essential contacts for the smooth functioning of the study. We established particularly strong collaborative working relationships with members of the intake department, reflecting our reliance on them for the success of the study.

To navigate the many obstacles we encountered, we revised some of our ideas about the minimum requirements of the study. Though we hoped the clinic would remain solvent and in operation, given the economic environment, we believed this was not a guarantee. Likewise, we hoped to keep therapists who joined the study from the very beginning, thus maintaining common training experiences and sustaining a control group of therapists roughly matched on number of years in practice and type of training, although this was clearly not within our control. When referrals into the study tapered off, we varied the client recruitment methods to expand the opportunities for client enrollment.

We also changed our ways of thinking about our own contributions and responsibilities. Research assistants all agreed that the project required far more energy and time than expected—more time even than they had devoted to other jobs during graduate school. This required making compromises in other areas, such as declining extracurricular clinical training or devoting less time for independent writing projects. Research assistants often compensated for these compromises by expanding their roles on the study. Because the goals of many groups needed attention, the facilitative function of the research assistants became critical to the research project. We strove to maintain a systemic perspective, attending to the different goals and agendas of each party and communicating well about inter- and intragroup difficulties throughout the process.

Finally, we revised our thinking about the minimum amount that clients would have to do to participate. Clients' perception that their participation in the study was independent from their therapy for panic disorder probably functioned to increase their willingness to participate; however, it may have also diminished their sense of accountability for the extra tasks, such as completing questionnaires and attending follow-up visits, which their research participation required. We realized that some clients would never show for treatment at all and devised ways to maintain their participation in the study if they agreed. We revised our thinking about medication use. Although PCT works without medication, we decided that constraining medication use in PCT would threaten external validity and harm therapeutic rapport with clients seeking medication. In general, we learned to be flexible in ways that ultimately expanded our allegiance to the external validity of the study, while sacrificing some internal validity. In essence, this was one of the most crucial shifts that enabled us to continue the project with a positive vision of its new formations rather than focus on its losses and compromises.

Gains. One clear benefit for the research team has been to accept (if not welcome) the difficulties of conducting research in a practice setting as the stuff dissemination and effectiveness research is made of. We have worked to adopt the stance that good effectiveness research aims to understand clinical practice. With this disposition, the difficulties of doing research in real-world practice settings have invited us to ask more questions and to deepen our understanding of the context in which we work. By doing research with this stance, we have been able both to affect and to be affected by the practice setting. Several examples of these effects on us come to mind. First, the idea that we needed to write this article as a collaborative piece came from the new perspectives we have gained while conducting this study. In particular, we have come to realize that understanding the practice context of the research project is essential for good dissemination research and is only attainable through dialogues with various partners in the research–practice collaboration. Second, we have been considering and discussing various alternative training methods, partly as an outgrowth of our observations of what is accessible, viable, and potentially most effective in a managed care setting. One example would be a peer consultation model in which clinicians establish expertise in a subset of empirically supported treatments and then share their training through consultation with peers. Third, exposure to this setting has driven many of our research interests into practice-related areas, such as training and practice variables affecting therapist burnout, therapists' models of psychotherapy practice, and systemic issues affecting practice in a managed care context.
Like therapists, research assistants reported learning more than they had anticipated and achieving unexpected levels of professional confidence and competencies. One outcome from participation in this research study was the impact it had on their own clinical practice. Research assistants, who typically practiced therapy with their own (nonstudy) clients, stated that learning about the evidence for this particular treatment and seeing it work encouraged them to use other empirically supported treatments. The structure of therapy sessions in PCT, as well as the emphasis on homework, client in vivo participation, and cognitive restructuring, were aspects of the treatment that research assistants found useful with their own therapy cases, regardless of the particular diagnosis or presenting problem.

Recurrent Themes

Perhaps the most important theme that emerged in the process of our research collaboration is that values and agendas that are self-evident to one party are often invisible or problematic to another party. As researchers, we had a clear sense of the value of free training in a state-of-the-art cognitive-behavioral therapy for panic disorder. Conversely, to the executive administrators, whose primary concern was maintaining productivity levels, even free training is costly if it takes the place of reimbursable activity. Likewise, therapists were not as eager to receive the training as we had expected, especially if it would cost them wages or personal time. Although researchers on the project regarded scientific investigation as a useful and progressive enterprise, some thought that participating in research required more effort and involvement more infringement on their privacy than they wanted to allow. Thus, certain members of our project questioned the closely held values and assumptions of others.

A second important theme of this discussion is the disparity between views of resources and costs. Administrators' and researchers' valued overlapped in places, but they were far from identical. In our case, both of these groups valued client improvement, but they differed in terms of what short-term risks or costs they judged to be worth the long-term gain of improved outcomes. These values diverge largely because the contingencies of the business and academic work environments differ significantly. For example, administrators operating a clinic are accountable to insurance companies. In turn, insurance companies typically value client access to services and low usage rates more than long-term client outcomes. Furthermore, when therapist job turnover is fairly high, it may not seem worthwhile from an administrator's perspective to invest money in staff training.

A third important theme is the interplay of cultural disparities between academia and clinical service settings that accompanies some of the value differences we observed. Whereas academics regard learning as an inherently valuable activity, this is not the case in a mental health service agency, where pressures do not allow for nonreimbursable activity. Likewise, supervision is not an absolute right in a competitive fee-for-service setting. Yet, clinicians and administrators wholeheartedly welcomed the opportunity for training and supervision to compensate for what is unavailable at high-paced service agencies, but only if it can be provided at minimal cost.

Finally, throughout our research process we came to appreciate the importance of negotiating and accommodating differences when parties have disparate values and goals. In long-term research such as ours, it is crucial that the parties involved maintain strong working connections, even when their differences are not resolved. For example, once therapy is over, clients may come to regard continued participation in long-term follow-up interviews as a burden. Even financial reimbursement for their time is insignificant to many clients for whom time is worth more than money. In such cases, our connections to our participants are based on interpersonal contact. We make ourselves available as resources to them if needed and try to remain connected to them over time through reminder letters and phone calls. If possible, we have the same research assistant make contacts with clients over the years to enhance a sense of continuity in their relationships with the research staff.

As we have discussed, a research collaborator's views of key resources, such as time, money, supervision, and training, depend to a great extent on his or her context. When conflicts arose among the agendas of the different parties on our project, it was helpful to remember the trade-offs and compromises each party was making in order for the research project to take place. If research teams were to begin with a collaborative mind-set, and if projects were funded as such, this would diminish the force of certain kinds of problems at the onset of a project (such as questions of who will pay for training). Indeed, our experience has shown that, in order for service agencies to be able realistically to participate in dissemination and effectiveness research, funding sources need to offset the costs these agencies and their staff endure as a result of their research participation. We are encouraged to learn that the National Institute of Mental Health (NIMH) has recently addressed some of these difficulties in their grant announcements for effectiveness and dissemination research. The Interventions and Practice Research Infrastructure Program is a specific NIMH funding avenue that targets partnerships between clinical service settings and academic institutions (NIMH, 2000). Likewise the National Institute of Drug Abuse (NIDA) has launched the Clinical Trials Network, which forges collaborations between university research centers and community treatment programs (NIDA, 2000).

Recommendations

With a better appreciation of the diverse agendas and interests that prevail in a treatment effectiveness study such as ours, we believe that those interested in research-practice
Dissemination Research Recommendations

In this regard, we have compiled the following set of recommendations for those embarking on research–practice collaborations. We offer these suggestions with the caveat that our experiences are specific to the context in which we have been working and that its particularities have shaped much of our perspective. The focus of our recommendations begins with research teams and broadens to include some suggestions for funding agencies.

A primary recommendation is that all parties preparing to embark on a search–practice collaboration conduct a series of initial conversations. We have dubbed these early conversations “prenuptial brainstorming.” The main goal is to have all parties articulate their goals for participating in the study: what they hope for in the end and what they want in the process. In this manner, all parties can gain an initial understanding of the conditions required for the other parties’ participation and an appreciation of the prevailing assumptions around the table about the kind of work that lies ahead.

Of course, goals and conditions can change, and they usually do. Therefore, we recommend periodically revisiting the prenuptial brainstorming session to articulate along the way the developmental progression of the collaborative relationships involved in the project. Ideally, a series of conversations would begin at the inception of the study and progress through the changing perspectives that come from working closely together, negotiating difficulties, making compromises, and trading gifts and favors. Knowing and remembering what people were looking for at the onset helped us to acknowledge the accommodations and adjustments that they made (or did not make) along the way to remain connected and committed to the project. It is also helpful to acknowledge at the onset of a project the probability of conflicting values, agendas, and interests among the various parties. Useful topics in such a conversation would include some of the themes discussed here, such as disparate views of the value of training and supervision or differing perspectives on the costs and benefits of research participation. Holding to a systemic perspective, we recommend that research teams strive to appreciate and work with these value differences rather than press for their reconciliation.

Our second recommendation is that research teams think carefully about the role of a TAU control group. Therapists in such a group may not receive rewards for participating soon enough to make research participation practical for them. Furthermore, they may drift toward the trained or experimental group in their practices as a function of working in the same environment and being naturally curious. Given that the benefits to them (such as training) often lie in the more distant future, the costs of participating in research are likely to be more salient for them. Thus, it is worthwhile to pay attention to participating therapists’ different needs and not to assume that these needs are met without particular efforts. An easy, though partial, solution came as a suggestion from one TAU therapist who felt hassled by the extra paperwork. He wished there had been periodic 10-minute “check-ins” along the way to address some of his frustration. Such conversations were clearly available, but the opportunities to interact with TAU therapists did not arise as often as they did with our PCT therapists, with whom we had bimonthly consultation meetings. Therefore, in order to counterbalance feelings of being taxed by their research participation, we recommend that research teams make special efforts to assess and address the concerns of control group therapists.

The third, and perhaps most important, recommendation is that research teams enter into their work in practice settings with the expectation that many of the central conditions of the context are likely to change. Come prepared with several alternate plans, both in terms of subject and therapist recruitment as well as methodology. In our case, one modification we made was to focus on research questions nested within the broader initial hypotheses. For example, we are looking at the relationship between treatment effectiveness and adherence to the protocol. This should allow us to approach our data more creatively and to compare the two treatment conditions along multiple dimensions.

We also recommend that researchers and treatment developers channel feedback from research–practice collaborations back into treatment development and evaluation strategies. For example, if a treatment protocol has cognitive-behavioral foundations, it is less widely transportable (i.e., to clinicians with backgrounds in self-psychology and other theoretical orientations) unless it also includes an introductory component to familiarize users with the theory behind the recommended practices. This observation comes directly from our experience of working with therapists who are representative of front-line clinicians and who have a range of training backgrounds. Our therapists were able to use the treatment protocol flexibly and to bring it to life with a range of clients as they gained a comprehensive understanding of the underlying theoretical concepts (Addis, Hatgis et al., 1999; Kendall, Chu, Gifford, Hayes, & Nauta, 1998).

Fourth, we recommend that funding agencies and reviewers encourage a wider range of methodologies. In addition to the randomized, controlled clinical trial, uncontrolled, discovery-oriented, and qualitative methods would be important avenues for explorations of some of the more complex questions that arise as researchers and practitioners continue to collaborate. For example, therapist and client conceptualizations of the goals and tasks of therapy are likely to affect the success of implementing a treatment protocol. Information such as this is not easy to obtain solely through quantitative methods. Furthermore, observational process studies of an exploratory nature would be useful for learning what treatment as usual actually consists of in a variety of settings. On the basis of this type of work, research–practice teams would be in a better position to know how they can best assist in the advancement of clinical practice.

It is also important to address the wide diversity of practice environments and research approaches. Members work-
ing in either context cannot afford to assume they know what the other offers or cares about without explicitly exploring these questions. Managed care environments are not only varied, but also constantly changing; thus ongoing responsiveness to the local setting features is an important stance for a research team to maintain. Researchers have a wide variety of skills and perspectives to offer in the practice setting. For example, in our project, training and supervision were key offerings the research team could provide. Access to the data on client outcomes would be another resource we can offer. Other research groups might be able to provide cognitive testing, workshops on report writing, professional stress management, burnout prevention, training opportunities beyond the scope of the project, and publication opportunities. Research teams would build more successful practice collaborations if they could find ways to complement resources at agencies where cost-cutting measures and productivity demands have reduced or eliminated nonrevenue-generating activities and services.

There is a need for research initiatives that focus on practice settings. Important questions remain unexplored, such as why clients participate in research. Funding needs to be directed toward demonstration projects of research–practice collaborations in order to move effectiveness and dissemination research forward (Addis, 2000). As it stands, typically leaner, community-based mental health clinics would be hard-pressed to participate in research that would further tax their staff and administration. Consequently, only agencies with wider profit margins and, possibly, a wealthier or more stably employed clientele would be financially able to participate in effectiveness and dissemination research, thus limiting the generalizability of findings. This is not the ideal scenario if we want to learn about how treatments perform in the full range of practice settings. Fortunately the NIDA (2000) and NIMH (2000) initiatives have begun to redress this imbalance.

In addition, we believe that partnerships between clinical and industrial organizational researchers would be useful for integrating an understanding of mental health business systems with treatment development, evaluation, and dissemination. As we mentioned earlier, efficacious treatments need to be viable in the world of service delivery in order for them to matter to clients, clinicians, and mental health administrators.

Finally, we recommend that researchers examine the social psychology of research–practice relationships. One set of studies might look at the function of certain cultural roles such as “scientist,” “teacher,” and “practitioner” in shaping these relationships. By articulating and questioning these roles, we may open up possibilities for more varied and constructive research-practice collaborations. As an example, hierarchical notions of expertise and specialized knowledge may limit the success of collaborations between practitioners and researchers.

In all, our work has brought us to the realization that treatment effectiveness and dissemination research are gratifying and complex in ways more controlled research is not. This type of work has encouraged us to expand our flexibility and creativity as researchers. Yet some of the observations and insights we have gained are not specific to dissemination research. Clients, therapists, and research assistants participate in research to improve their own situations, to help others, and to learn. However, their satisfaction with their participation on the project may be largely influenced by the therapeutic alliances and work relationships they form. Members of any research team will experience conflicting values and agendas, especially if the team is interdisciplinary. In our experience, acknowledging and working within the tension of these conflicts has been essential to the success of our project.

REFERENCES

Dissemination Research Recommendations


