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Reactions to the Call to Reboot Psychotherapy Research and Practice: Introduction to Special Section of Comments on Kazdin and Blase (2011)

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The field of clinical science has made great progress in developing evidence-based treatments, but we have failed to reach our fundamental goal of reducing the prevalence of mental illness in society and its devastating effects on psychosocial functioning on a large scale (Baker, McFall, & Shoham, 2008). We can often help a given individual who is struggling with mental illness, but how are we to stem the tide of human suffering?

In “Rebooting Psychotherapy Research and Practice to Reduce the Burden of Mental Illness,” Alan Kazdin and Stacey Blase (2011b) argued that individual psychotherapy, the dominant method used to deliver treatment, cannot possibly meet society’s overwhelming mental health needs. The rates of mental illness are too high; approximately half of all Americans will meet diagnostic criteria for at least one psychiatric disorder during their lifetime (Kessler & Wang, 2008), yet over half of these individuals will not receive treatment (Kessler et al., 2005). Given the variability in the reasons people do not receive professional help (e.g., lack of access to a trained clinician, stigma, cultural obstacles, limited resources), a one-size-fits-all model of treatment delivery is not now, nor will it ever be, effective. Kazdin and Blase thus advocate for development of a portfolio of treatment delivery methods, including harnessing available technologies, such as web- and phone-based interventions, providing treatment in everyday settings (rather than exclusively in the therapist’s office), using nontraditional providers of interventions, promoting self-help approaches, and using the media to communicate prevention and intervention messages to large segments of the population.

Kazdin and Blase call for radical reform in how we think about delivering prevention and intervention approaches. They note that it will be critical to identify the mechanisms of change underlying successful interventions to determine how they can be abbreviated for broader dissemination without losing their essential ingredients. Also, they outline the need for a

national database that can be used to establish a baseline and reference point for examining change in the burden of mental illness over time, as well as the key predictors and moderators of burden reduction. Although they acknowledge that a shift toward a broad portfolio of delivery models will be controversial and raise new challenges for traditional mental health providers, they also argue that the only way to effect widespread change is to connect with other disciplines outside of standard practice (e.g., in epidemiology, nutrition, math modeling, technology development, etc.) and to dramatically alter what we construe as being under the exclusive purview of therapists.

This call to action would demand change in our research, service delivery, grant funding and training models. Recognizing that calling for such a dramatic shift in the field would elicit strong responses, *Perspectives on Psychological Science* put out an open call for comments on Kazdin and Blase’s proposal. The caliber and diversity of the 26 submissions made it quite challenging to select only 6 to include in this issue. (Additional comments can be submitted and viewed in the online version of the original article at <http://pps.sagepub.com/content/6/1/21>. full; click on “Read all comments” under the Reader Responses sidebar, then click “Full Text.”) Submissions were rated for likely impact, intellectual rigor, originality, and overall quality. The final selection of comments offers a diverse set of perspectives on how we can most effectively shift toward reducing the global burden of mental illness.

Varda Shoham and Thomas Insel (2011, this issue) provide a unique perspective on the Kazdin and Blase article, writing in their roles as the Director (Insel) and Special Assistant to the Director, Division of Adult Translational Research and

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Treatment Development (Shoham) of the National Institute of Mental Health (NIMH). They argue that reducing the burden of mental illness requires more consistently and carefully considering for whom simplified intervention and prevention approaches will be sufficient and for whom more extensive approaches will be needed. To achieve this goal of determining what type and level of intervention are needed for a given individual, they outline the importance of Attribute by Treatment Interaction (ATI) research, which examines how a given individual characteristic (e.g., baseline symptom severity, age of illness onset) interacts with the treatment conditions to predict treatment response. They review stories of success and failure in ATI research, highlighting initiatives from NIMH that can help support ATI research to advance more personalized prevention and intervention work.

Marc Atkins and Stacey Frazier (2011, this issue) suggest that the time is ripe for adoption of a multilevel model of care that subsumes universal prevention strategies, targeted efforts with high-risk populations, and more individualized management of persons with intensive needs. Comprehensive integration of prevention and intervention services across these three levels ideally would extend the reach of mental health services while decreasing the number of individuals needing more costly and time-intensive individualized treatment. Atkins and Frazier stress that the success of this public health approach would necessitate investing to a much greater degree in the training and support of nontraditional providers in nontraditional settings (e.g., laypersons in natural community settings, personnel in social-services agencies). They note how their proposal is consistent with the goals of recently enacted health-care reform in this country, as well as recommendations from the World Health Organization.

Bruce Chorpita and colleagues (2011, this issue) argue that the field has overemphasized knowledge production to the detriment of knowledge management. In particular, they argue that whereas the focus on developing new evidence-based treatments has led to many positive advances in clinical care, it has also created an untenable situation. There are so many separate treatment manuals that there is no way that a given psychologist can possibly learn even a fraction of them, or know how to combine them for clients with comorbidity. Instead, Chorpita and colleagues propose a shift in emphasis to focus on knowledge management: novel approaches to develop, administer, and organize interventions. They outline a variety of strategies that can be used to aggregate our existing knowledge, such as discerning the essential "practice elements" to treat a given set of symptoms by looking at which clinical procedures are commonly associated with good treatment outcomes across clinical trials.

Idit Shalev and John Bargh (2011, this issue) share an innovative proposal to leverage priming strategies developed by experimental social psychologists for the modification of non-conscious processes that perpetuate maladaptive behavior. They describe how a variety of simple visual or physical experiences (e.g., inducing feelings of physical warmth) could be used to promote feelings of social warmth, goals of emotion

regulation, or adherence to treatment. To date, such methods have been used only to modify nonclinical behavior in research contexts. Shalev and Bargh suggest that variants of these techniques potentially could be individualized, presented via contemporary technological devices, and deployed widely at low cost to set the stage for clinically relevant change.

Brian Yates (2011, this issue) makes the case that we must do more to investigate different modes of delivering treatments, so that we can reduce costs and reach more people. He advocates for funding to evaluate different delivery methods (rather than just different treatments) and challenges researchers to make delivery costs more explicit in their calculations of cost effectiveness. Yates cites numerous examples of delivery systems that have the potential to reduce resource use and costs, yet still pass on most (if not all) of a given treatment's effectiveness, including Internet-based interventions, automated phone interventions, and video-based interventions. He argues that we know a lot about the ingredients (treatment approaches) needed to help people who are suffering, but we need to study the "spoon" (delivery method) that passes these ingredients along to the hungry client: "Just as therapy is no longer an art but a science based on research evidence gathered in clinical settings, so too can be its delivery" (p. 498).

Denise Sloan, Brian Marx, and Terence Keane describe a plethora of recent service-delivery innovations launched by the Veterans Health Administration (VA) to enhance the mental health care provided to the almost 2 million veterans in this country (2011, this issue). First, the VA is leveraging technological resources such as the Internet, smartphones, and videoconferencing to expand the reach and availability of potentially anonymous services. Second, the VA is investing in the training and support of laypersons for the provision of mental health care, including VA chaplains, VA police, and peers. Third, the VA has committed to systemwide dissemination and implementation of evidence-based treatments for mental health problems, necessitating the development and evaluation of large-scale training, consultation, and monitoring strategies. The VA's efforts provide excellent models for the comprehensive dissemination and implementation of such treatments on a nationwide scale.

Finally, the special section concludes with an incisive reply from Kazdin and Blase (2011a, this issue). As evidenced both by their provocative, original article and by the strong response it has already elicited in the field, change is afoot in intervention science. These commentaries flesh out many of Kazdin and Blase's suggestions and highlight the diverse means by which these issues are being tackled. Kazdin and Blase provide an exciting forum for conceptualizing, implementing, and disseminating strategies aimed at reducing the burden of mental illness. The current special section continues this important conversation.

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