Commentary on <u>A Novel Group Therapeutic Format in Cognitive Behavioral Treatment for Clients with Social Phobia in a Training Setting: A Case Study of One Treatment Group with Nine Clients</u>

When Novice Therapists Meet Their First Patients: Reflections and Questions on Training in CBT

JONATHAN D. HUPPERT [a,b], GIL CARMELI [a], & DANIEL GILON [a]

[a] The Hebrew University of Jerusalem, Israel

[b] Correspondence concerning this article should be addressed to Jonathan D. Huppert, Department of Psychology, The Hebrew University of Jerusalem, Mt. Scopus, Jerusalem, 91905 Israel.
Email: huppertj@mscc.huji.ac.il

ABSTRACT

Hougaard et al.(2008) report a case series on a mixed individual and group treatment for social phobia, suggesting that the treatment is efficacious. As a group who has just embarked on a similar training program, we comment on their endeavor from the teacher/student perspective with an eye towards pedagogy in training students to conduct CBT. Thoughts and questions regarding the treatment, the patients, the therapists, and the outcomes are raised in order to highlight the potential that exists in such training models.

Key words: social phobia; cognitive-behavioral therapy; evidence-based practice; training; pedagogy

The case series by Hougaard et al. (2008) provides an important contribution to the literature on training, treatment, and evidence-based practice. The article touches on many facets of the current status of clinical psychology and the training of future psychologists. The authors integrate issues of evidence-based practice (EBP) in psychotherapy, idiographic and nomothetic approaches, issues related to training of novice clinicians, longer versus shorter term therapy, group versus individual approaches, and CBT for anxiety disorders. We congratulate the authors on their thought-provoking work, which showed significant benefit for the majority of the patients in their program. The results are quite impressive (in line with other CBT programs for social anxiety), which is all the more important given the therapists were novice trainees. We agree that treatment of anxiety-disordered patients with CBT is an ideal scenario for beginning therapists, as it allows for relatively short term treatment with high success rates and also teaches the complexity of CBT, which cannot be taught through manuals and case studies alone. Just as for our patients, experience is indeed the best teacher.

THE CONTEXT OF OUR RESPONSE

In our response, we raise some questions that were triggered by various aspects of the description of the program and expand on some of the larger issues that are raised by these questions. To put our response into context, the first author has extensive experience treating patients with CBT and supervising and training individuals to conduct CBT for anxiety disorders, is involved in a collaborative effort of developing treatments to treat anxiety disorders including social anxiety, and has recently developed research and treatment courses for training students to conduct CBT for anxiety disorders. The latter two authors are MA students who have participated in this training, and provide a student perspective on Hougaard et al.'s endeavor. Each of the students who participated in the training conducted research in the form of a single case design, delivering CBT for panic disorder to a patient and evaluating the treatment. Each student also investigated a research hypothesis regarding the relationship among variables related to CBT for panic disorder (symptom severity, anxiety sensitivity), the use of safe people to cope with panic, adult romantic attachment style, and the therapeutic alliance. Thus, our experience was a bit different, in that it was the administration of standard CBT for panic disorder in the context of a research question. However, practically, many aspects of the two programs were quite similar.

THE QUESTIONS WE RAISE

We raise questions on a number of levels including: What is evidence-based practice?, What is the purpose of the study?, What are the mechanisms of treatment?, Who are the patients?, Who are the therapists?, What is the optimal way to teach them?, What is the best format of treatment for the patients and the trainees and how do we balance the needs of both?, and How and what do we learn from treatment failures (in this context)? As the reader can see from the list of questions, we cannot pretend to answer or expect Hougaard et al. to answer all of these questions, but we do believe that the questions themselves have significant value.

Evidence-Based Practice: What Is It and How Do We Teach It?

According to Sackett et al. (2000), evidence-based practice is the integration of the clinician's expertise and the patient's values with the best available research evidence. Hougaard et al.'s discussion of the combination of rule-based and case-based reasoning by Prentzas and Hatzilygeroudis (2007) seems to be another way of suggesting what Sackett and colleagues are also attempting to state: EBP requires some integration of idiographic and nomothetic approaches, without an over-reliance on either, given the limitations of either as an absolutist approach. This definition provides an intriguing conflict for novice therapists – how can they deliver evidence-based practice when they do not have their own clinical expertise to integrate? They need to rely on a number of sources including their supervisors, the clinical literature, and their instincts or intuition in applying the research evidence. But this raises a further question in Hougaard et al.'s report: are they applying the best available evidence? Their own report appears to be that they are applying an experimental program, and not one that is most supported by the evidence. For example, Mortberg et al. (2007) show that Clark's individual CBT is more

effective than Mortberg's intensive group CBT, though the latter was more effective than treatment as usual.

Treatment Mechanisms: Why or How Did the Treatments Work When They Did?

As Kazdin (2007) noted, we have ample data demonstrating that treatments work, but insufficient data explaining the mechanisms of our therapies. One of the lines that we have taken in our training clinic is to make cases both research and clinical cases. Thus, we examine potential mechanisms via frequent sampling of theoretically derived measures, and we monitor whether changes in proposed factors change with the initiation of specific techniques. Our work is preliminary in this area, but appears to be a potentially fruitful way of helping trainees see the connection between science and practice (cf. Hayes, Barlow & Nelson-Gray, 1999), and allows each student to examine areas of his or her interest, whether they be issues of habituation patterns, alliance formation, emotion regulation, adult romantic attachment, or other concepts from any theoretical school. Given Hougaard et al's positive efficacy data on a novel administration of a CBT program, the question of mechanism becomes all the more important.

What Was the Purpose of the Study?

As stated in Hougaard et al.'s (2008) section on the "Aim of the Study," its purpose was to test a novel treatment. However, in fact, the authors seem to be asking how effective is an intensive treatment format in a training clinic? Similar intensive formats for the treatment of social phobia have been shown to be efficacious (Lincoln et al., 2003; Mortberg et al., 2007); and therefore the authors avoid the ethical dilemma of using novel therapists who have never conducted any therapy to test a novel treatment approach. Yet, this is not clear from the article itself.

Who Are the Patients?

This is an essential question that raises a number of issues: What were the patients' expectations prior to treatment in terms of treatment length? What if a patient who had received 16 sessions of schema-focused therapy wanted more? How do you determine a maximum number of sessions?

Also, who determined if patients were suitable for the trainees and the program? It appears that no one is excluded once they are evaluated to have social anxiety. For example, when reading the initial recruitment description, we were hesitant regarding the case of Laila (prior to knowing the outcome) – the subclinical nature of her problems suggested that there were likely other problems also causing her to seek treatment, making her a less than optimal candidate for the program. It turned out that our intuition was correct. In such situations, is it better to leave one trainee without a patient, or to "push the limits" and allow a sub-optimal patient to enter? This is a complex issue that likely plagues many who are involved in training.

The question of whom to include in initial training cases is an important one. Many training models attempt to assign "simpler," more straightforward cases to novel therapists, prior to assigning cases that are more difficult to treat. In fact, one study showed that trainees obtained

similar results as experts in the treatment of OCD, precisely because trainees' cases started out less severe (Franklin et al., 2003). The notion that novice therapists should learn both CBT for social phobia (and panic) and also schema-focused therapy (which requires many more complicated issues to address) is an intriguing one. Does this provide good, real-world experience or information overload for beginning therapists? If patients can be divided into groups who are more likely to require schema-focused interventions and those who are less likely, it seems the latter would be better suited for initial training cases (see more below).

An issue intrinsic to all research on psychotherapy and in every training process is the tension of the benefits for the trainee and the benefits for the patient. One way our program attempts to deal with this issue is transparency—before patients had engaged in treatment they were informed about the research, about the identity of the therapists and of the supervisor, and of course they gave their signed consent. In our group we felt that the patient's voluntary participation and the goal of our training were not conflicting with each other. We knew that the effectiveness of our manual-based treatment was proven by many studies and the supervisor made sure that the students felt confident in their ability to improve their patients' welfare. We assume that for Hougaard et al., the situation was more complicated because the treatment they delivered was viewed as novel and even some of the instructors were skeptical about the program before it started. How did they deal with this issue?

Who Are the Trainees and What Are They Learning?

This question seems concrete, but in fact raises questions that continue to exist throughout the world of clinical psychology. For example, what are the differences between paraprofessionals and professionals (Christensen & Jacobson, 1994)? And should a PhD in clinical psychology be required for practice (Peterson, 1996), as is the case in most of the United States, but not in many other countries (including the commentators')? The students who are participating in the training described by Hougaard et al. are in their fifth year of training (after 8 semesters), and receiving 2 semesters focused on CBT training. This focused training is relatively intensive, including 76 hours of teaching, much of it in intensive formats of more than 3 hours at a time (including classes, workshops, and conferences). In our own program, training is also extensive, but includes perspectives from multiple orientations. Does this occur in Hougaard's training as well? If so, how does the author's program facilitate a coherent theory for therapists just formulating their own perspective?

In terms of what the goals are in teaching CBT, one can reasonably state that there are both assessment (initial and ongoing) and treatment goals (formulations and techniques). In terms of the assessment, teaching is best done by doing after observing. Could assessments be conducted by the trainees under supervision instead of the trainee watching the supervisor, as was done in the Hougaard et al. program. Our experience in this area was a bit different from Hougaard et al.'s. Each student in our program derived a formal diagnosis for their client by administering a structured interview designed for this purpose, the Mini International Neuropsychiatric Interview, or "MINI." (Sheehan et al., 1997), in the presence of the supervisor, who asked additional questions when necessary, approved the diagnosis, and summarized the interview with the interviewee. We, too, experienced the issues of the messiness of diagnosis and

learned the practical aspect of administering a structured interview, both of which were extremely valuable. Of course, the ideal is to observe at least ≠one prior to such administration if at all possible.

The Essential Aspect of What the Trainees Are Learning Is the Conduct of Therapy

The Impact of the Individual Therapy on the Group Therapy

The question of how group therapy works when each client has their own therapist present is an intriguing one – that is, how does this affect the group dynamics? Specifically, how do the multiple therapists involved ensure that they are working together to provide the appropriate atmosphere and are not overly advocating for their own patient's needs to the detriment of others?

A related question involves the lessons learned by the trainees from the intensive group therapy that may generalize to their future practice. Another related question is whether the amount of supervision (30 minutes of reflection time daily) was sufficient to both supervise and process the 5 hours of therapy administered daily.

Formation of the Therapeutic Relationship

An important question in the Hougaard et al. program is whether the formation of the therapeutic relationship during treatment was discussed, and how any problems were dealt with. Although not addressed extensively in treatment manuals, our experience is that the formation of an alliance between the patient and the therapist is fundamental and essential. It was one of the processes in which we have taken an interest in our research, and we have found how well correlated the alliance and a client's general improvement are, although we have not been able to determine the causal direction of the association.

Following a Treatment Manual

Another interesting question in a program like Hougaard et al.'s is the student experience in learning to follow a treatment manual. In our own training program, it was also the first time that students followed a manual in conducting therapy. Importantly, the therapists sometimes encountered situations and difficulties which the manual did not cover. This was not because the manual was inadequately designed, but because by its nature a manual is limited and does not attempt to cover all the possibilities that life can bring into therapy. Generally, in a manual-based therapy there is tension between, on the one hand, the commitment to accept and relate to the patient and to the material spontaneously brought to the session and, on the other hand, to navigate between those issues and the ones that are dictated by the manual's protocol in order to move forward according to the plan. Some of the questions that we encountered included: How does the therapist relate to significant personal material that comes from the patient but does not relate directly to the disorder? What does one do when a patient comes without completing his or her homework? How, in such a case, can the therapist modify the planned session and socialize the patient into CBT and explain to the patient the importance of doing homework? The

supervision helped us (GC and DG) to deal with those issues and to realize that manual-based treatment is not at all an automatic procedure; it demands from the therapist a deep understanding of the underlying mechanisms of the disorder, creativity, flexibility, and an ability to adjust the treatment to the patient's specific characteristics, needs, and life contexts. Indeed, although all of the treatment cases in our group shared similarities, each of them was also managed in a unique way that was influenced by the personal style of the therapist, the patient's character and disorder, and the interaction between them.

Hougaard et al.'s Mixture of Two Goals in Their Program

From a pedagogical perspective, it seems that the ideal circumstances for beginning therapists would be to provide individual cases and individual supervision from the outset, using what appears to be the most effective form of treatment for social phobia disorder – specifically, that based on Clark and Well's model (1995; Clark et al., 2003, Clark et al., 2006, Mortberg et al., 2007). Otherwise, it seems that the authors are mixing two goals: developing a new method of treatment administration and teaching students how to conduct CBT. Given the time commitments by the therapists and patients in Hougaard et al.'s intensive program (almost twice that in Clark's program), are his student therapists learning to provide the most efficient, effective treatment? Given that some have argued that many individuals with social phobia can be treated in non-intensive, brief therapy (e.g., Wells & Papagiourgio, 2001), it seems that other models of training could allow similar success rates with greater exposure for trainees to more patients. A clarification by Hougaard et al. regarding why they believed that the intensive group model would be a more effective training model than focusing on individual therapy would be very important.

In terms of the pedagogy of training, there are a number of models that have been tested (Sholomaskas et al., 2005; Miller & Mount, 2001). These studies suggest two important aspects of ensuring that what is learned is actually implemented: first, the experience of conducting therapy after learning theory and practice conceptually, and second, the careful evaluation of specific techniques taught during supervision. However, these are derived from studies in which experienced therapists taught novel models, not studies examining the graduate training of novice therapists. Hougaard et al.'s experience is a contribution to CBT training with novice therapists and hopefully will encourage the additional research that is needed in this area.

In the first author's experience, there are a number of aspects of training that are ideal. First, providing a clear theoretical foundation in CBT and in the background of the techniques to be used (via readings and manuals), while first overwhelming to many beginning clinicians, can also help provide them with direction and assist them with case formulations. Second, seeing an experienced therapist in action is invaluable. There is a clear attempt to do this in the training by Hougaard et al. They describe each day of the intensive group therapy week as follows:

> The clinical psychologists lead the first two hours of the day with the whole group present and then design exercises, mostly to be carried out in small groups with 4 (or 5) clients and 4 students, with the students as therapists the rest of the day. The purpose of this format is to present students with therapeutic models and to provide them with the opportunity of gradually learning to be in charge of the group therapy (2008, p. 2).

However, since this exposure to experienced therapists was integrated within the treatment, it may not have afforded optimal processing of what was happening in the therapy via discussion with the therapists. Ideally, shadowing a case prior to treating a case can be an invaluable experience. Even watching a video of a full treatment may be a reasonable substitute, though it seems to be second-best. Availability for answering questions immediately following the session, while questions are "hot" also seems extremely valuable. In Hougaard et al.'s format, it could be that a 30 minute break between switching from large to small group could also include a therapist consultation/discussion to allow for some of this processing.

Our experience has been that in the individual cases treated in our group, there were many issues that arose requiring tailoring of the treatment to the patient. This was possible due to a strong connection between instruction and supervision that included discussion of the issues after each hour of therapy and allowed an adequate solution. While the close supervision of therapy sessions each week was time consuming (including supervisor observation of videotaped sessions prior to supervision), the students benefitted from both the guidance and the confidence instilled in them, knowing that they were prepared for the next session and beyond. In addition, close supervision allowed discussion of minor problems and stylistic alterations, as well as reframing for the students who might have focused on minor errors during any given session. It is not clear from Hougaard et al.'s case study how much these opportunities existed in their program.

Finally, when the trainee does treat their own case, it is helpful if the outcome is successful. Unfortunately, given how much the patient contributes to this, it is not always predictable from the outset. In Hougaard et al.'s report, there was a considerable amount of success, and some of this was due to using empirically supported assessments and treatments (along with good clinical intuition), which helped predict who would need more treatment, and the extent of response to the social phobia treatment. The issue of failures is considered next.

Treatment Failures

As has been argued elsewhere, case studies do provide a rich depiction of treatment which can be lost in group data. One of the issues that can be demonstrated via case studies is that even in our effective treatments, with typically 60-75% of the patients showing good outcomes, there are 25-40% who are treatment failures. The examination of treatment failures has a long and rich tradition (e.g., see Foa & Emmelkamp, 1983). The specific reporting of the nonresponders in Hougaard et al.'s case study here follows such a tradition, although the authors could have highlighted more what they learned from the failures and what decisions might be made differently in the future (especially for trainees, where initial success is highly rewarding and provides a sense of competence).

As noted above, one of the lessons we take home from our experience and Hougaard et al.'s is the need to carefully screen and include only individuals who appear appropriate from the start. The fact that Laila's individual sessions were focused on PTSD and not social phobia should have indicated not that she was unable to benefit from therapy, but that the focus should have been on PTSD and not social phobia until the former issues were remitted (and apparently

other issues related to areas like family conflicts were also addressed). It seems individual treatment would have been better for both Laila and her therapist in this case.

In addition, for the novice therapist, patients should present with sufficient severity that a detectable response is possible. The fact that Cecilia did not respond well seems to have been potentially detectable at the beginning of therapy due to this issue. Cecilia scored in the normal range on the SPS and SIAS to begin with (the authors note a one standard deviation above normal, but this means that she was also one standard deviation below clinical), suggesting that while she may have met criteria for social phobia disorder, there was either something wrong with her completion of the self-report questionnaires or something that was exaggerated in the ADIS. It seems that someone with such low scores may benefit from a short version of treatment without the need for such intensive work as was provided her. On the other hand, she may simply be someone for whom determining outcome is more difficult (hindsight is 20-20!). In addition, Mona scored a 46 on the SCID-II (two times above the threshold), seeming to indicate substantial personality issues, along with a specific social phobia diagnosis that appears to be in the moderate range. Thus, for Mona personality issues were likely primary rather than social anxiety. This may indicate that the threshold for a patient treated in such training programs should be a score of less than 40 on the SCID II screener, especially for someone with non-severe social anxiety.

What Is the Ideal Way to Supervise New Therapists?

This is another issue that we would raise. The authors describe that approximately 64 hours of supervision were provided for the group of 8 therapists and 9 patients. Given that these are new therapists, would group or individual supervision have been better? On one hand, group supervision provides exposure to multiple cases, including feedback to other therapists and the potential to participate in thinking about other cases. On the other hand, novice therapists often need significant guidance in a non-threatening environment where they can be provided with clear, genuine feedback about ways to alter their behaviors in order to help them become more effective therapists. Many novice therapists feel quite incompetent at first, and they may find the group experience humiliating or difficult. One potential solution to this (if resources are available) is to split supervisions into some that are individual and some that are in a group format. When fewer resources are available, problem sessions may be selected to focus on individually, on an as needed basis.

CONCLUSION

As teachers and students involved in a training program for CBT for anxiety disorders, it was very interesting to read Hougaard et al.'s article. It is reassuring to read that in other places in the world students are doing research about therapy that is similar to what we have done, and with success. All of the students who participated in our seminar felt that it was one of the more significant learning experiences they had so far in their M.A. program, and we are sure that for the students in Hougaard et al.'s program, their learning was also significant and rewarding. We hope that continued emphasis on the integration of research and clinical work, of idiographic and nomothetic approaches, and of evidence-based practice into the training curriculum of novice

therapists continues to permeate throughout the world of clinical psychology. Hougaard et al.'s case study provides an excellent model of how to enact such integrations, a model from which other programs can learn a great deal and build.

REFERENCES

Christensen, A., & Jacobson, N. S. (1994). Who (or what) can do psychotherapy: The status and challenge of nonprofessional therapies. *Psychological Science*, *5*, 8–14.

Clark,D.M., Ehlers, A., Hackmann, A., McManus, R. Fennell, M., Grey, N., Waddington, L. & Wild, J. (2006). Cognitive therapy versus exposure and applied relaxation in social phobia: A randomized trial. *Journal of Consulting and Clinical Psychology, 74*, 568-578.

Clark, D.M., Ehlers, A., McManus, F., et al. (2003). Cognitive therapy vs fluoxetine plus self-exposure in the treatment of generalized social phobia (social phobia disorder): a randomized controlled trial. Journal of Consulting and Clinical Psychology, 71, 1058-1067.

Clark, D.M. & Wells, A. (1995). A cognitive model of social phobia. In: R.G. Heimberg, M.R. Liebowitz, D.A. Hope & F.R. Scheier (eds.), *Social phobia: Diagnosis, assessment, and treatment*. New York: Guilford.

Foa, E.B. & Emmelkamp, P.M.G. Eds. (1983). *Failures in Behavior Therapy*, Wiley, New York.

Franklin, M. E., Abramowitz, J. S., Furr, J. M, Kalsy, S., & Riggs, D. S. (2003). A naturalistic examination of therapist experience and outcome of exposure and ritual prevention for OCD. *Psychotherapy Research, 13,* 153–167.

Hayes, S.C., Barlow, D.H., & Nelson-Gray, R.O. (1999). *The scientist practitioner: Research and accountability in clinical and educational settings*. New York: Pergamon Press.

Hougaard, E., Madsen, S. S., Hansen, L. M., Jensen, M., Katborg, G. S., Morsaa, L. et al. (2008). A novel group therapeutic format in cognitive behavioral treatment for clients with social phobia in a training setting: A case study of one treatment group with nine clients. *Pragmatic Case Studies in Psychotherapy* [Online],Vol. *4*(4), Article 1, 1-52. Available: http://hdl.rutgers.edu/1782.1/pcsp_journal.

Kazdin, A.E. (2007). Mediators and mechanisms of change in psychotherapy research. *Annual Review of Clinical Psychology*, 3, 1-27.

Lincoln, T. M., Rief, W., Hahlweg, K., Frank, M., von Witzleben, I., Schroeder, B., et al. (2003). Effectiveness of an empirically supported treatment for social phobia in the field. *Behaviour Research and Therapy, 41*, 1251–1269.

Miller, W. R., & Mount, K. A. (2001). A small study of training in motivational interviewing: Does one workshop change clinician and client behavior? *Behavioural and Cognitive Psychotherapy, 29,* 457–471.

Mortberg, E., Clark D.M., Sundin, O., & Aberg Wistedt, A. (2007). Intensive group cognitive treatment and individual cognitive therapy vs. treatment as usual in social phobia: A randomized controlled trial. *Acta Psychiatrica Scandinavica*, *115*(2), 142–154.

Peterson, D. R. (1996). Making psychology indispensable. *Applied & Preventive Psychology, 5,* 1-8.

Prentzas, J. & Hatzilygeroudis, I. (2007). Categorizing approaches combining rule-based and case-based reasoning. *Expert Systems, 24*, 97-121,

Sackett, D.L., Straus, S.E., Richardson, W.S., Rosenberg, W., & Haynes, R.B. (2000). *Evidence-based medicine: How to practice and teach EBM*. New York: Churchill Livingstone.

Sheehan, D.V., Lecrubier, Y., Harnett-Sheehan, K., Janavs, J., Weiller, E., Bonora, L.I. , Keskiner, A., Schinka, J., Knapp, E., Sheehan, M.F., Dunbar, G.C. (1997). Reliability and Validity of the MINI International Neuropsychiatric Interview (M.I.N.I.): According to the SCID-P. *European Psychiatry, 12*, 232-241.

Sholomskas, D., Syracuse , G., Rounsaville, B.J., Carroll, K.M. (2005). We don't train in vain: A randomized trial of three strategies for training clinicians in CBT. *Journal of Consulting and Clinical Psychology,73,* 106-15.

Wells, A., & Papageorgiou, C. (2001). Brief cognitive therapy for social phobia: a case series. *Behaviour Research and Therapy*, *39*, 713–720.