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**The Clinician, the Clinician-Researcher,  
and the Contextual Behavioral Science Research Agenda**

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**Abstract**

The research agenda described in the Report of the ACBS Task Force on the Strategies and Tactics of Contextual Behavioral Science Research (Hayes et al., 2021) calls for investigations that address many pressing needs clinicians encounter daily, and I highlight several: the study of assessment methods and tools, the study of interventions, the study of change processes in treatment, and the study of functioning and well-being. I also describe two topics that are important to clinicians that were not featured in the Report: clinical decision-making and the case conceptualization. Finally, I highlight ways the CBS research agenda lends support to clinicians' efforts to undertake research in their practice settings.

**The Clinician, the Clinician-Researcher,  
and the Contextual Behavioral Science Research Agenda**

The research agenda described in the Report of the Association for Contextual Behavioral Science (ACBS) Task Force on the Strategies and Tactics of Contextual Behavioral Science Research (Hayes et al., 2021) is strikingly pragmatic. It does an outstanding job of addressing many pressing practitioner needs. I describe several here. I also point to the ways the proposed research agenda falls short by failing to address clinicians' needs for research on the topics of clinical decision-making and case conceptualization. I conclude by highlighting the way several features of the ACBS research agenda support research that clinicians conduct in their clinical practice settings. I offer some examples of this type of research and discuss some of the practical issues that arise in research of this sort.

## **The Research Agenda Described in the Task Force Report Addresses Many Needs of Practitioners**

I describe several research priorities described in the ACBS research agenda in the Task Force report that align well with pressing needs of practitioners. This list is not exhaustive by any means.

### **Assessment tools and methods**

The proposed ACBS research agenda is helpful to clinicians by calling for the development of tools and methods for conducting fine-grained longitudinal assessment on multiple tracks (e.g., self-report, behavioral, and physiological) and for alternatives to traditional psychometrics, which tends to focus on between-subject differences rather than on repeated assessment of the same individual over time, as occurs during treatment. The Report also calls for the development of tools to assess functioning and well-being; clinicians are currently over-dependent on measures of symptoms and pathology. And the Report calls for the development of new methods, including online tools, to facilitate collection and analysis of intensive longitudinal data. All of these would be a huge boon to clinical practice and would also aid practitioners who wish to conduct research using data they collect in their practice, as I discuss later.

Practitioners also need a sound measure we can use to assess our clients' progress toward their idiographic treatment goals. The limited availability of tools to track progress toward idiographic treatment goals is likely a heritage of our field's focus on treating symptoms and DSM disorders rather than helping patients reach idiographic goals that include well-being and functioning.

### **Interventions**

The CBS research agenda's call for research on kernels (that is, interventions, rather than the whole ear of an empirically supported protocol (Weisz et al., 2011) is hugely helpful to the clinician. Clinicians appreciate the flexibility of kernels, and in fact we daily unpack the empirically supported treatment (EST) protocols designed to treat disorders in order to pull out the interventions our client seems to need at that moment. But without empirical studies, we can't feel confident that when we dismantle EST protocols to select kernels we are using evidence-based strategies.

### **Change processes in treatment**

Change processes are hugely important to clinicians. Information about change processes and tools to measure them in the moment can yield the information clinicians need to guide decision-making during treatment by helping the clinician answer questions such as, "Is the kernel of exposure producing the change process I am hoping for?" "Is the exposure producing habituation or inhibitory learning or both or neither?" We need tools to assess change processes in the moment in our office, in our virtual office, and outside the session during the patient's homework practice.

Several years ago I treated a patient who met criteria for OCD with exposure and response prevention. The patient could approach some feared situations when I was with her and

seemed to show a bit of habituation but reported that she was too frightened to do exposure exercises outside the session. So I judged that she needed hands-on help doing the exposures and I referred her to an intensive treatment program that could give her that help. But when she returned from that treatment, the patient did not seem improved. I consulted with the therapist who had provided the intensive treatment. The therapist responded to my query about her experience working with the patient by telling me the interventions the therapist had delivered. But when I asked her, “Did the patient learn anything in the therapy?” the therapist was unable to answer that question. This example illustrates the over-focus in the intensive treatment program my patient attended, and in fact in my own work with her, on the behavior of carrying out the intervention, and our under-focus on the issue of understanding and assessing the change process in the patient that the intervention might (or might not) produce. The research on change processes and tools to assess change processes that the ACBS Task Force Report calls for is sorely needed.

### **Functioning and well-being**

Patients care a lot about functioning, and as a result, clinicians do as well. Patients come to psychotherapy asking for help entering the dating world and meeting a partner, finding a satisfying and meaningful vocation, and functioning better and feeling happier in a dysfunctional work setting, for example. The current treatment literature, which provides protocols to treat DSM disorders, doesn't always provide much guidance to help the clinician address these functioning and well-being goals. In addition, likely due to our field's emphasis on treating symptoms of DSM disorders, practitioners tend to over-focus on reducing symptoms and distress and disorders, forgetting that reducing symptoms and distress and disorders does not necessarily result in improved functioning or well-being. The ACBS research agenda's call for more studies of functioning and well-being is a boon to clinicians and their patients.

### **Clinicians' Needs Not Addressed by the Research Agenda Described in the ACBS Task Force Report**

The research agenda described in the ACBS Task Force report falls short of meeting clinicians' needs in its failure to call for research on the topics of clinical decision-making and the case conceptualization.

#### **Clinical decision-making**

Significant numbers of patients fail to benefit from psychotherapy. For example, in a meta-analysis of 92 studies of treatment of Major Depressive Disorder, (Cuijpers et al., 2014) reported that 48% of patients who received psychotherapy responded to it (response was defined as a symptom reduction of at least 50%). In addition, a small proportion (4% to 10%) of psychotherapy patients deteriorates (Cuijpers et al., 2018). And when patients do not respond to treatment or worsen, clinicians have difficulty responding effectively. We are also poor at recognizing deterioration when it occurs. (Hatfield et al., 2010) studied 70 cases of patients who showed a reliable deterioration (14 points) between the intake session and a session during the first 10 sessions of therapy on the Outcome Questionnaire-45 (OQ-45) used to assess patient symptoms and functioning. They found that in only 21.4% cases did the clinician's progress

notes make any mention of the client's deterioration. In a second study that examined a larger deterioration (at least 30 points on the OQ-45) between two consecutive sessions, only 31.7% of progress notes mentioned any client deterioration. The clinicians appear literally not to be registering the patient's worsening. Even worse, clinicians do not appear to be aware that they are poor at assessing their patients' status, as they do not adopt progress monitoring tools that will help them solve the problem (Jensen-Doss et al., 2016). And when they notice lack of progress, clinicians do not appear to take effective action. (Kendall et al., 1992), in a survey study, found that psychologists reported that in 41% of cases of patients they cared for that were failing to make good progress, the psychologist planned to continue to implement the treatment they were using without any change.

Perhaps clinicians have poor skills for handling of lack of progress and failure in psychotherapy in part because many of us who were trained to use empirically supported protocols were trained to follow the protocol but not to problem-solve in a systematic manner when the patient fails to respond to treatment or when other difficulties, such as noncompliance or therapy-interfering behavior, appear on the scene (Shiloff, 2015). Studies of strategies clinicians can use to solve problems that interfere with treatment success (e.g., patient nonadherence, therapist nonadherence, ruptures in the relationship with the therapist) are sorely needed. Clinicians need help solving these problems in a systematic and thoughtful and unbiased and evidence-based way. We need empirically supported algorithms or strategies to help us answer questions such as, Given my patient's failure to respond to the treatment I'm providing, it best for me to persist with my current interventions, or ought I make a change now? If I make a change, what change is most likely to be helpful to this patient? If the patient has multiple symptoms and disorders and problems, how do I help my patient build a sensible list of treatment goals and make a priority order of treatment targets?

### **Case conceptualization**

The case conceptualization or case formulation is an idiographic hypothesis about the psychological factors that predispose, precipitate, and perpetuate an individual's symptoms, problems and disorders. The case conceptualization guides the clinical work in many ways. It helps the clinician identify the treatment targets (generally the perpetuating mechanisms, such as experiential avoidance, behavioral avoidance, intolerance of uncertainty, anxiety sensitivity, repetitive negative thinking) that, if changed, will help the patient accomplish their treatment goals. It helps the therapist personalize the treatment, including by addressing issues of race, ethnicity, culture, and other aspects of diversity (Hayes et al., 2011). It helps the therapist build a collaborative relationship with the patient to support the hard work of the therapy and prevent a premature termination (Gates et al., 2021). It helps the therapist solve problems, for example by helping the therapist identify that a patient behavior that occurs in the therapy session and impedes the treatment (e.g., patient reluctance to propose an agenda for the session) appears to be perpetuated by the same mechanism (e.g., fear of disapproval) that drives many of the patient's other problems (Kohlenberg & Tsai, 1991). In a case formulation-driven approach to treatment, the therapist collects data in every session to test the hypotheses that the interventions that flow out of the formulation are effective in helping the patient accomplish their idiographic goals and in producing the change processes that are expected to lead to progress toward the goals (Persons, 2008). Using this approach to treatment, if the patient fails to make progress in

treatment, the therapist can review the formulation of the case and collect more assessment information to determine whether an alternate formulation can be developed that can suggest different and more effective interventions (J. B. Persons et al., 2013). The formulation, thus, is an essential guide to clinical decision-making and effective clinical work.

Despite its central importance to the clinical enterprise, the case conceptualization has received surprisingly little research attention. Clinicians need research to answer many clinically important questions about the case formulation, including: What is the treatment utility of the case conceptualization; that is, does it contribute to improved outcome and reduced dropout? What structure or format of a case conceptualization has the greatest treatment utility for any particular patient population or set of presenting problems or type of patient goals? When is it most useful to build a formulation using inductive network models and when is it most useful to build a theory-based case conceptualization? What skills or tools can help clinicians build a useful case formulation? How can clinicians use the formulation to select a treatment target that will most efficiently and effectively lead to change?

### **The CBS Research Agenda Supports Clinicians' Efforts to Conduct Research in Their Practice Settings**

A strength of the ACBS research agenda is the way it lends support to clinicians who wish to conduct research in their clinical practice settings. The ACBS research agenda supports research by clinicians by prioritizing the study of many questions that clinicians take up daily in their clinical work and in fact already collect data to try to answer as part of their clinical work. And the Report calls for the development of new methods, including online tools, to facilitate collection and analysis of intensive longitudinal data of the sort that practitioners need for clinical purposes and that also have great research potential. Finally, the ACBS research agenda places a high value on idiographic research, including single case experimental designs. Studies of a single case are ideally suited to clinical practice, where the clinician's usual level of analysis and data collection is the single case. As the classic Hayes (1981) paper points out, the overlap between research using a single case experimental design and good clinical work is extensive.

For all these reasons, the research agenda described by the ACBS report offers excellent opportunities for practitioners to contribute to the enterprise by conducting research in their clinical practice setting. In an elegant example, (Thompson et al., 2021) showed, using a nonconcurrent multiple-baseline design that, contrary to prediction, changes in psychological flexibility occurred both in patients receiving exposure and response prevention and in those receiving ACT for treatment of symptoms of OCD. Other recent examples include the finding by (Lear et al., 2021) that psychological inflexibility predicts client non-disclosure in psychotherapy, and the demonstration by Jensen et al. (2020) that homework compliance was greater when the therapist assigned homework that was congruent with the patient's report about what they learned during the session than when the homework assignment did not match up with the patient's reported take-home message.

The potential for CBS practitioners to contribute to the ACBS research agenda is strengthened by the facts that many CBS practitioners have research training and likely already are collecting a lot of data to guide their clinical work. And several recent developments make it

easier than ever to contribute research in a clinical practice setting. New methodologies have been developed for studying intensive longitudinal data from a single case (Piccirillo et al., 2019), new developments in technology make it easy and inexpensive to collect assessment data during treatment using secure online tools that patients can access from their smartphone. And the open science movement is increasing access to the scientific literature and to free open-source software for collecting data, conducting statistical analyses, and more. and for practitioners to access the scientific literature and other tools (e.g., statistical packages) they need for research, and to collaborate with investigators anywhere in the world.

Despite their potential to make research contributions, few clinicians, even those with research training, conduct research. Those that do so must overcome numerous obstacles and impediments. They must obtain library access or other access to the research literature, they must obtain access to institutional review board or other ethical review of their projects, and they must obtain informed consent for research from their patients, to mention only a few of the challenges that clinicians encounter. I will briefly discuss the issues of ethical review of research and informed consent here and refer interested readers to other resources for more information.

During our university or professional school Ph.D. training, we obtained an ethical review of our proposed research from a federally registered institutional review board of the sort that most of us do not have access to in our private practice settings. To begin to address this obstacle, it's important for practitioners to understand that a federally registered IRB is only one route to obtaining an ethical review of a proposed piece of research. As Persons, Osborne, and Codd (2021) report, federal law only requires review of research by a federally registered IRB in certain circumstances, most prominently when the project receives federal funding. If the project is self-funded, as research is likely to be in a clinical practice setting, where the clinician can fold the research into the clinical operation, clinicians can obtain an ethical review of their research proposal using other mechanisms, including via an informal committee and process the investigator establishes. Persons et al. (2021) describe options for conducting such a review.

Informed consent is another essential element of ethical research. Patients who provide data for research must provide informed consent for use of data they provide in research, even if the data are collected as part of the clinical work and the clinical work is not modified to serve research ends. Clinicians can obtain informed consent from their patients to use data in the clinical record for research purposes by adding a paragraph to their standard research agreement asking patients to provide this consent. An example is posted at <https://oaklandcbt.com/resources-for-clinician-researchers>.

Discussion of the complete range of issues that clinicians who are conducting research confront is beyond the scope of this article. I refer interested readers to (Persons, in press) and to the edited book by Codd III (2018), which offers accounts by several clinician-researchers of their models for building research into their practice and describes solutions to many of the challenges clinician-researchers encounter. Finally, I encourage readers to consider forming a community within the ACBS to support research, as recommended by Holman & Koerner (2014). Members of the Association for Behavioral and Cognitive Therapies recently developed Special Interest Group for Research in Clinical Practice, which offers research-minded practitioners access to a community of colleagues who can help each other solve the many

problems the scientist-clinician encounters. ACBS members who are also ABCT members are invited to join this group or might wish to form their own.

In summary, the CBS research agenda described in the recent Report of the ACBS Task Force calls for research on many topics that can directly benefit clinicians and would benefit clinicians even more if it also called for research on clinical decision-making and case conceptualization. A strength of the proposed ACBS research agenda is the encouragement it offers to clinicians who wish to undertake research in their clinical setting.

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