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Clinical Management of Anxiety Disorders in Psychiatric Settings: Psychology's Impact on Evidence-Based Treatment of Children and Adults

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The role of psychologists in psychiatric settings has evolved over the past century from primarily conducting psychological evaluations to being the vital and integral link (sometimes the only such link) to the delivery of scientifically sound assessment and treatment methods. Consequently, the role of the psychologist, with respect to the scientist–practitioner model, has expanded to include collaborator with, consultant to, and teacher of our colleagues in psychiatry. In the integrated areas of research and treatment of anxiety disorders, psychologists have been at the forefront of developing, evaluating, and disseminating empirically supported methods for the range of these conditions in children, adolescents, and adults. Issues common to psychologists practicing in psychiatric settings are discussed in this article, specifically with reference to the tasks and issues encountered by the anxiety specialist.

In medical schools and teaching hospitals, one of the traditional as well as historical homes for psychologists has been in departments of psychiatry (Frank, 1997; Zimet, 1994). However, in a medical environment it is not always accurate to assume that doctoral-level psychologists will have parity among the staff or faculty physicians. Thus, establishing one's autonomy and credibility can be a hard-fought battle. Further, psychologists may not be considered full members of the "medical" staff but rather as ancillary or technical staff despite being licensed and able to function independently (Carmin & Roth-Roemer, 1998). Establishing a professional identity within a department of psychiatry is even more complex due to the limited understanding on the part of both psychiatric and nonpsychiatric physicians as to what psychologists are able to contribute and how the various mental health clinicians differ with respect to the services they can provide.

One important change within the context of medicine is the evolution of evidence-based treatment (Sackett, Richardson, Rosenberg, & Haynes, 1997). This approach, which first arose in the United Kingdom, is grounded in empirical evidence and holds that the acquisition and use of contemporary empirical knowledge can enhance patient care. Further, it is incumbent on practitioners to keep abreast of emerging, but valid, treatments (Chambless & Ollendick, 2001). It is not surprising, given the importance of research in psychology training, that clinical psychology has been at the forefront of a movement that embraces empirically supported treatment interventions (EST) in mental health practice (Task Force on the Promotion and Dissemination of Psychological Procedures, 1995). In fact, the recent Surgeon General's report on mental health (U.S. Department of Health and Human Services, 1999) underscores the need for such effective treatments. Thus, this is one area where medical practice and the science of clinical psychology share a common ground.

Among those areas where ESTs have been investigated, the treatment of anxiety disorders stands out. Several texts (e.g., Giles, 1993; Kazdin, 2000; Nathan & Gorman, 1998; Roth & Fonagy, 1996) and review papers (e.g., Chambless & Ollendick, 2001; Kazdin & Weisz, 1998; Ollendick & King, 1998) have critically examined the outcome literature and have made recommendations regarding which treatments are efficacious. With few exceptions, the use of cognitive–behavioral therapy (CBT) is supported for the treatment of anxiety disorders. Manuals have been developed as a result of clinical trials and are available for the treatment of panic disorder (Barlow & Craske, 1994), panic with agoraphobia (Craske, Meadows, & Barlow, 1994), social anxiety disorder (Hope, Heimberg, Juster, & Turk, 1999), generalized anxiety disorder (Zinbarg, Craske, & Barlow, 1993), posttraumatic stress disorder (Calhoun & Resick, 1993), specific phobia (Antony, Craske, & Barlow, 1995), and obsessive-compulsive disorder (OCD; Kozak & Foa, 1997; Steketee, 1999). For children, Kendall's (2000) Coping Cat Program has established its efficacy as a treatment for generalized anxiety disorder, separation anxiety disorder, and social phobia in 7–16-year-old youth. In addition, manuals are available for the treatment of school refusal (Kearney & Albano, 2000), social phobia (Albano, Marten, Holt, Heimberg, & Barlow, 1991; Beidel, Turner & Morris, 2000), and OCD (March & Mulle, 1998).

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One of the assets of CBT is that it is a common-sense approach to facilitating the acquisition of strategies for resolving the problems that typically cause patients to seek treatment (Freeman, Pretzer, Fleming, & Simon, 1990). Because a portion of the treatment involves psychoeducational interventions and the acquisition of skills aimed at reducing symptoms, it is appealing to patients. Likewise, CBT's strong basis in research coupled with the straightforward way in which treatment is both described and conducted make it similarly appealing to the broad range of mental health professionals.

The practice of CBT has, with a few notable exceptions (e.g., Aaron Beck, Joseph Wolpe, Stewart Agras) been the domain of psychologists. It is only recently that psychiatry residency training standards were expanded to require that psychiatry residents receive training in this form of psychotherapy. As a result, cognitive–behavioral psychologists are able to fill a valuable teaching and training role within departments of psychiatry.

By its very nature, models of CBT treatment often involve collaboration between psychologists and psychiatrists. Quite often, a psychologist will provide psychotherapy and a psychiatrist will provide pharmacotherapy. Practitioners of CBT recognize the utility of pharmacological interventions and may work collaboratively with their medication-prescribing colleagues. Medications are viewed as tools that are useful for anxiety-symptom management, particularly in the early stages of treatment when significantly disabling anxiety symptoms can impede the patient's ability to engage in CBT. For example, short-term use of a benzodiazepine may assist a housebound agoraphobic in getting to his or her therapy appointment. Research demonstrates that medications may have a faster onset of response and provide relief from anxiety in the short term, with CBT having a more gradual response but providing lasting benefits over the long term. Relapse rates are high for patients whose medications are discontinued, making the cessation of pharmacotherapy difficult for many individuals, whereas patients receiving CBT generally continue to show improvement beyond the end of active treatment (e.g., see Barlow, 2001; Heimberg, 2001).

In fact, there are manualized approaches based on outcome data that encourage the use of CBT interventions as a means of facilitating benzodiazepine discontinuation in patients with panic disorder (Otto, Jones, Craske, & Barlow, 1996; Otto et al., 1993). In addition, the psychologist's training in empirical methods, specifically in single-case designs and functional analysis, can facilitate the physician–psychologist collaboration in tracking specific target symptoms and informing decisions to step up or decrease the intensity of either or both treatment modalities. We have found this aspect of our training most useful in the treatment of children and adults with anxiety disorders.

Thoroughly assessing and identifying problem behaviors (e.g., amount of time spent washing hands in an adult or child with OCD), along with the careful monitoring of the frequency and intensity of symptoms, facilitate decisions regarding whether to use medication in addition to CBT and how to adjust the treatments. The psychologist and psychiatrist, in conjunction with the parents and child or with the adult patient, review the baseline symptom data and establish both the expected target dates for a response with CBT and the estimated magnitude of response. If the patient is unable to make the expected progress and both distress and disability continue or worsen, then the decision may be to begin a medication trial. The treating clinicians continue to assist with tracking symptoms and response, and they use these data to make adjustments to the treatments.

The Utility of Treatment Manuals

Despite their acknowledged impact on the development, evaluation, and dissemination of EST, the advent of treatment manuals has not been uniformly met with open arms. Given that CBTs stress individualized treatment that is based on an idiographic case formulation, the use of a treatment manual would seem to be a contradiction (Kanfer & Saslow, 1969; Wolpe, 1977).

By necessity, the use of a treatment manual depends on a clear diagnosis. In the area of anxiety disorders, the *Anxiety Disorders Interview Schedule for DSM–IV* (*ADIS–IV;* Brown, DiNardo, & Barlow, 1994) and its child counterpart, the *ADIS–IV: Child Version* (Silverman & Albano, 1996), are structured clinical interviews that allow clinicians to systematically derive a diagnosis. These instruments have become the gold standards in anxiety disorder diagnosis. In specialty clinics, especially those housed in university medical centers, most of the patients who are seen are first evaluated using the *ADIS–IV* or a similar structured clinical interview. Although the use of a structured clinical interview provides a rich source of information about symptoms and symptom severity, its administration is time consuming and may make it cumbersome in some clinical settings.

A packet of self-report instruments is typically administered to the patient to further refine the diagnostic process, in addition to parent and teacher report measures in the case of children and adolescents. A wide array of questionnaires are available to assess the presence and severity of specific anxiety disorder symptoms as well as related constructs, such as anxiety sensitivity, fear, depression, and general distress. As a result, there are multiple methods and time-efficient means for accessing ample baseline information that can then be used as a way to evaluate progress throughout the remainder of treatment. Often, these measures or other means of self-report (such as a patient daily diary form) are built into a treatment manual.

Once there is a clear diagnosis, a treatment manual facilitates functional behavior analysis, selection of targets for treatment intervention, and treatment planning. In this way, a manual increases the likelihood that treatment will be administered in a similar manner for individuals who have the same presenting problem or diagnosis (Eifert, Schulte, Zvolensky, Lejuez, & Lau, 1997) and, at the same time, allows treatment to be individualized. Although the goals for treatment may be particular to the individual, the overall conceptual model for treating a given anxiety disorder will be consistent across diagnoses. For example, the items contained in an exposure hierarchy for a patient with social anxiety disorder will be unique to that individual. The elements of treatment (e.g., psychoeducation, training in anxiety-management skills, exposure to avoided situations, cognitive restructuring) will be consistent across individuals with that diagnosis. In this way, treatment manuals provide an inherent structure for treatment that obviates the potential problem of flawed, idiosyncratic decision making of individual therapists (Wilson, 1997).

One hazard related to the use of manuals is inadequate training of therapists in their application. Despite what critics may suggest, using treatment manuals is not akin to painting by the numbers. If

treatment manuals are applied in a rigid, noncollaborative fashion, there is considerable chance that their use will lead to ineffective treatment and poor outcomes. In a study by Eifert, Evans, and McKendrick (1990), patients who were in a treatment condition that targeted their specific problem fared far better than patients who were in a treatment condition that did not focus on their specific problem. If clinicians are not able to acknowledge the individual differences that shape their patients' problems, then treatment will be frustrating for all involved.

Consistent with the suggestions of Eifert et al. (1997) and Kendall, Chu, Gifford, Hayes, and Nauta (1998), clinicians are encouraged to use anxiety-treatment manuals in a flexible manner. In order to utilize a manual to its best advantage, clinicians need to have a well-developed understanding of the psychopathology of anxiety disorders and be well versed in how to construct a comprehensive, cognitive–behavioral case formulation. Those who are so trained can then select the most appropriate elements from a manual for use with their patients. For example, there are a number of variations on how an individual with panic disorder with agoraphobia may experience his or her symptoms. For some of our patients, interoceptive exposures (i.e., exposure to the physical symptoms, such as tachycardia, shortness of breath, etc., that are associated with panic attacks) may be the first component of exposure treatment, or sometimes the only necessary one. For others, interoceptive exposure and in vivo exposure (i.e., exposure to avoided situations) will be needed. For yet other patients, treatment will begin with cognitive restructuring, as a patient may identify his or her anxiogenic thoughts as a trigger for the panic attacks. Rigidly applying a template for treatment without acknowledging variability in problem presentation or not having a strong conceptual foundation ignores individual differences and does not bode well for treatment outcome.

This need for a flexible approach to the use of manuals is essential for another reason. The research participants involved in the development of these manuals are, in many instances, different from the clinical population that is seen in a psychiatry clinic, a tertiary care medical setting, and/or an anxiety specialty clinic. Research studies require that participants meet strict inclusion and exclusion criteria. As a result, there may be minimal comorbidity and/or complexity in participants' presentations. This is seldom the case in a nonresearch clinical setting and in university medical centers where patients are seeking out specialized care. Comorbidity between the various anxiety disorders as well as depression is more often the rule than the exception (Kessler et al., 1994). At present, there are no manuals that address how to structure treatment in order to incorporate more than one disorder. Trying to treat each disorder sequentially may prolong treatment unnecessarily. Further, such an approach may not take limitations of the disorder that is not being treated into account. It would be understandably difficult for the patient who suffers with social anxiety disorder as well as OCD that centers around contamination fears to engage in a social anxiety exposure that involves shaking someone's hand. Rather, exposures that take both disorders into account need to be considered when a hierarchy is being developed or treatment will encounter significant obstacles and will potentially fail.

Obviously, the question then remains as to whether manuals are applicable to "real" clinic populations. One way to assess this highly relevant question has been the use of benchmarking strategies (e.g., Wade, Treat, & Stuart, 1998) that allow for the assessment of how transportable and generalizable EST may be. The results of controlled treatment-outcome studies using manuals are taken as the benchmarks for participants' responses. Thus, disorder-related behaviors (e.g., number of panic attacks) or scores on instruments assessing symptoms relevant to a particular anxiety disorder that form the core of research for manual development are then regarded as the benchmarks for treatment response in clinical settings. Clinic patients' responses to manualized treatment can then be compared with those of research participants. The study by Wade et al. suggests that community-based treatment for panic disorder that used a 15-session CBT protocol was as effective as in the original research protocol despite differences in settings, clients, and treatment providers. Further, the notion of using a manual as well as a meaningful method of assessing ongoing progress in treatment allows the clinician to generalize research data to individual patients. The application of manuals for the treatment of other anxiety disorders to various clinical settings still remains to be done. However, it would appear that manuals are a treatment strategy that may generalize to a variety of settings.

Multidisciplinary Approaches to Treatment

One of the benefits of working in a medical setting is access to individuals from a variety of disciplines with whom one can collaborate. Most obvious are the linkages between psychologists and psychiatrists. As noted previously, there is always the potential for tension in such a relationship. Among the tensions that can occur are those due to long-standing differences between the professions, the movement by some psychologists to obtain prescription privileges, and issues of parity in the medical setting. Alternatively, the similarities between the two professions can allow individuals from both disciplines to support each other's efforts, and the differential strengths of each can result in a mutually beneficial synergy in clinical, research, and teaching pursuits.

The most frequent collaboration between psychologists and psychiatrists occurs when a patient with an anxiety disorder requires pharmacological treatment. Just as there is a literature addressing the psychotherapeutic approach to the treatment of anxiety in adults, there is a similar evidence-based literature addressing the psychopharmacological approach to treatment (e.g., Nathan & Gorman, 1998). Well-controlled studies supporting the efficacy of medication treatments of anxiety disorders in youth are just starting to emerge (e.g., Research Unit on Pediatric Psychopharmacology Anxiety Study Group, 2001). Forming an alliance with a physician who appreciates the empirical basis for biologically oriented interventions allows both clinicians to approach treatment in a similar manner. If the prescribing physician does not have a fundamental appreciation for CBT and either indirectly or directly suggests that CBT is not an appropriate modality for the treatment of anxiety, clearly the patient will be placed in an awkward position. Psychologists who eschew the use of medication or who attempt to make recommendations regarding medication management that are outside the scope of their expertise run the same risk of alienating their patient, their physician colleague, or both. A very clear advantage of working within a department of psychiatry is the expertise of one's colleagues. Many psychologists who specialize in the treatment of anxiety disorders are knowledgeable about the medications used to treat these conditions and

can use their knowledge to support their medical colleague's recommendations. It is essential that psychologists and psychiatrists collaborate with one another when treatment is being provided by more than one individual. At one of our clinics, the anxiety disorders staff is an integral part of the medication management clinic supervision hour. Residents, psychology trainees, and faculty psychiatrists and psychologists participate and have the opportunity to discuss mutual patients and learn from one another.

Multidisciplinary treatment also occurs when intensive outpatient (IOP) treatment or inpatient (IP) treatment for anxiety is a consideration. For most faculty/staff psychologists, providing all of the IOP or IP treatment for their own patients is impractical due to the time commitment involved. For example, a typical IOP treatment for someone diagnosed with OCD would involve at least 90–120 min of treatment 5 days per week for at least 3 weeks. An IP protocol would involve up to double the amount of treatment time. In order to provide this degree of intensive treatment, multiple CBT providers are typically involved. A clinician skilled in the evidence-based CBT technique of exposure and response/ritual prevention (ERP) functions as a team leader. The leader works with the patient to develop treatment goals and then to orchestrate how those goals are executed. In our settings, psychology graduate students, interns, and fellows, psychiatry residents, nurses, and social workers may be involved as team members. An additional benefit of a multiple-provider model is that the patient is exposed to several trained clinicians who may approach his or her problem in a novel manner.

Some clinicians may be concerned that multiple providers will increase the opportunity for splitting or related problems. Obviously, communication among team members is a critical variable that helps to reduce such problems. To offset problems with splitting, everyone on the team must communicate with each other regarding problems or successes they have encountered with this method of intervention. Clinicians who are more comfortable with conducting treatment as a solo endeavor need to consider basic logistical issues. Clinicians must remember to ensure that an out-patient chart is accessible to all of the team members, as the chart will be needed for documentation purposes and follow-through on assignments from the previous day. Lack of communication, power struggles among team members, or a lack of uniformity with regard to theoretical approach can disrupt treatment significantly. To illustrate, we treated a patient diagnosed with OCD and schizoaffective disorder. He was receiving intensive ERP treatment while participating in a partial hospitalization program. The anxiety disorders staff was very consistent in their approach to the patient. Members of the partial hospital staff, who were not trained in the treatment of anxiety disorders, suggested that underlying sexual identity issues were causal to the patient's OCD and freely communicated their observation to the patient. It took considerable diplomacy to explain to these staff members what effect their treatment approach was having on the patient. Likewise, in-service training was provided to partial hospital staff to familiarize them with OCD and its treatment and to inform them that the application of a psychodynamically oriented approach to OCD treatment had little empirical support in the literature (see Franklin & Foa, 1998, for a review).

Within the context of a medical setting, psychologists who specialize in anxiety disorders treatment are also called upon to provide a wide range of consultative services to colleagues from departments other than psychiatry. These services may include some form of relaxation or stress-management training. Further, anxiety specialists may be asked to assist with desensitizing patients to invasive or fear-provoking medical procedures. These consult requests may involve helping patients with claustrophobia manage their anxiety in a magnetic resonance imaging scanner, desensitizing patients with diabetes who have needle phobias to giving themselves insulin injections, or assisting patients with congestive heart failure or asthma in reducing their anxiety or panic symptoms.

Barriers to Treatment

Despite the efficacy of CBT and the availability of manuals for anxiety disorders treatment, barriers to treatment still exist. First, there are not a sufficient number of CBT-trained anxiety disorder specialists to whom patients can be referred. There is a particular dearth of appropriately trained individuals the farther one gets from major population centers. Patients who are closer to a psychology graduate program or a university medical center have a better chance of finding an anxiety specialist who has been trained in EST. However, proximity to either of these teaching institutions is not a guarantee that there will be clinicians skilled in these areas of practice. Complicating matters further is the possibility that the skilled clinicians may be available but may be accepting into treatment only those individuals who meet narrowly defined criteria for an ongoing research protocol.

As noted previously, the patients who seek treatment at specialty clinics located within departments of psychiatry often have a complex diagnostic presentation. Although manual-based treatments may suggest that the typical patient with panic disorder (or a patient who is socially anxious, etc.) can complete treatment in 12–15 sessions, treatment of longer duration may be needed for patients with multiple diagnoses. Further, university medical centers that house specialized anxiety-treatment programs are often viewed as having staff with the necessary experience and expertise to manage patients who are labeled "treatment resistant." Thus, not only may the diagnostic picture be complicated, but the severity of the patient's problem(s) may also be an issue that affects treatment duration. The era of managed care and insurance benefits that cover a maximum of 20 sessions per year has not been able to address how to provide effective, evidence-based services for individuals whose needs clearly outstretch the limits of their insurance coverage. Third-party payers are only recently becoming better informed of how IOP treatments may be best utilized. Some benefits will cover IOP programs, but this is inconsistent across insurers and policies. Insurers are still perplexed at the need for a 90+ min session, which is typically recommended for therapist-directed exposures, and may balk at payment or refuse to reimburse for more than the "standard" 60-min hour. We have, on occasion, found that working with a case manager and providing that individual with copies of the treatment-outcome literature supporting the effectiveness of exposure treatments may aid in securing the necessary authorizations for what they may have heretofore viewed as an unusual approach to therapy. Likewise, seeking authorization for extended appointments before, rather than after, the fact has been a relatively successful strategy.

One of the struggles that a psychologist trained in EST for anxiety disorders often encounters within a department of psychi-

atry is a lack of understanding of CBT. The majority of psychiatrists have received psychotherapy training that has largely concentrated on psychodynamic approaches. Their psychotherapy education is in addition to training that emphasizes a biological approach to psychiatry. Fortunately, with residency education now requiring training in CBT, newly trained psychiatrists have a better understanding of CBT. However, there is still considerable variability with respect to the amount of CBT training that psychiatry residents receive. It is not unusual for a psychologist to be the sole proponent of CBT or other empirically based approaches to treatment within his or her department. Biases or misinformation about the fundamental nature of CBT still exist. Psychiatrists, social workers, and psychiatric nurses as well as psychologists who are not versed in EST or CBT theory and case formulation have been known to comment on how behavioral treatment leaves patients vulnerable to symptom substitution or that CBT does not get to the core issues and thereby leaves patients vulnerable to relapse. We have had the misfortune to have received referrals from non-CBT-oriented clinicians who tell us to send their patients back after we have completed our treatment so they can then do the "real" work of therapy.

Even more distressing is when patients are "preprogrammed" by our colleagues to treat the CBT therapist as a temporary adjunct to the therapy process. This has never been more difficult than in the case of a 9-year-old child who was referred by her psychodynamic therapist for treatment of separation anxiety disorder. The child had been receiving weekly (sometimes twice weekly) play therapy since age 6, although the parents could not identify any clear treatment goals beyond "improving her self-esteem." Despite this long-standing therapy, the child's anxieties persisted and often exacerbated. After 5 weeks of CBT involving goals, graduated exposure, and age-appropriate cognitive restructuring, the child commented, "Dr. Albano, I know that you're not meant to be the kind of therapist that sees a kid for more than a few weeks, but could I come back again sometime to talk about some other things?" Clearly, some preprogramming and misinformation was provided to the child about CBT. Similarly, CBT may be described to patients as "the power of positive thinking" or as self-talk capitalizing on ineffective aphorisms.

Fortunately, these inaccurate points of view are changing, as both mental health professionals and the public are becoming increasingly better informed with respect to how and why CBT works. Anxiety specialists need to take advantage of every opportunity to educate their colleagues about the availability of effective treatment. Grand rounds, in-service seminars, lectures to student groups, or journal club all may provide forums for disseminating such information. Organizations such as the Association for Advancement of Behavior Therapy (AABT), the Anxiety Disorders Association of America (ADAA), and the Obsessive Compulsive Foundation (OCF) have served many consumers well by providing information through their Web sites and publications about the benefits of CBT, and they often provide suggestions for finding a CBT therapist in their area.

The psychologist who ranks among a scant few practitioners of EST in a department of psychiatry can be viewed as a competitor, especially because anxiety disorders may be perceived as the domain of those trained in and more comfortable with psychodynamic treatment. This situation is a delicate one because there will no doubt be colleagues who firmly believe that psychoanalysis for OCD or play therapy for separation anxiety disorder constitute effective approaches to treatment. Although there may be anecdotal or case descriptions to support these latter positions, a degree of finesse is needed when countering the claim that such approaches are grounded in adequate research. No matter how gently one draws attention to the scarcity of controlled-outcome literature in these areas, the person bearing this information is not likely to be greeted with open arms. We have encountered these types of discussions within our respective departments. It may be helpful to refer skeptical colleagues to texts that review the outcome literature. In particular, the text authored by Roth and Fonagy (1996) has been well received, as one of the authors is a prominent psychoanalyst.

Achieving Parity

Embracing EST in general, and CBT for the treatment of anxiety disorders in particular, can be a double-edged sword. Cognitive–behavioral therapy is rarely the prevailing approach in a department of psychiatry; consequently, psychologists may feel isolated, because theirs is among the few professional disciplines that receive training in CBT. The majority of a CBT-trained psychologist's colleagues may, quite literally, speak another language. Because psychologists occupy only a few of the positions in psychiatry departments, this isolation may be further reinforced. The value of psychologists' training in evidence-based approaches to psychotherapy does, however, allow them to make a unique contribution within medical settings.

Authoritative resources, such as the Surgeon General's report on mental health (U.S. Department of Health and Human Services, 1999), and reviews published by the Cochrane Library at Oxford University are ushering in an era in which empirically based treatment studies are informing decisions about what strategies are effective for which disorders. This movement toward evidence-based medicine has been making progress in psychiatry. To a large extent, clinical psychologists' training has its foundation in clinical science. With the initiation of the Division 12 Task Force on the Promotion and Dissemination of Psychological Procedures (1995; see also Chambless & Hollon, 1998; Chambless & Ollendick, 2001), ESTs are gaining prominence. Physician education, whether in medical school or residency, leaves limited time for training in research methodology or how to evaluate what constitutes effective treatment. In the area of anxiety disorders, the outcome literature unequivocally supports the use of CBT. With a few notable exceptions, this is a domain that is by and large unique to psychologists.

There is a natural bridge between psychiatrists who specialize in psychopharmacological treatments and psychologists trained in CBT for anxiety disorder treatment. Both disciplines embrace the empirical basis for their interventions. When discussing the need for an evidence-based approach to psychotherapy, psychiatrists will often appreciate that the kind of critical thinking needed for treatment selection of a medication is no different than for selecting a form of psychotherapy. We have pointed out to psychiatry residents that their reasoning skills are excellent when asked why they would not prescribe Zyprexa, an antipsychotic medication, for the treatment of panic disorder. We encourage them to use the same reasoning when opting for a psychotherapeutic intervention. Further, there are parallels in the research designs that make it a

relatively easy task for psychiatrists familiar with double-blind, placebo-controlled studies to appreciate the scientific underpinnings of anxiety disorders treatment. Psychologists and psychiatrists who endorse evidence-based approaches thus find a common ground and view the process of intervention selection in a similar manner.

A more controversial area wherein psychologists are given parity is on in-patient units. Individuals with severe OCD, and in some cases other anxiety disorders (e.g., a housebound agoraphobic), may require hospital admission. A considerable amount of training is needed to be able to successfully treat an individual whose symptoms are sufficiently disabling to require a hospital admission. It is imperative that a team of mental health professionals execute treatment. Our experience is that the anxiety disorders specialist assumes a leadership role in this situation. Again, this is a balancing act in that it is infrequent that psychologists have admitting privileges or are able to write orders. Thus, a solid working relationship between the psychologist providing treatment and the admitting psychiatrist needs to be in place. It is rarely the case, however, that an attending psychiatrist or psychiatric resident will have the training in CBT to provide effective psychotherapy. The collaborative efforts of team members, including nursing staff, social workers, and other professionals who are involved in an individual's treatment, are essential.

Conclusions

As the science of clinical psychology continues to advance in the area of anxiety disorders treatment, so does the role of the psychologist continue to evolve. This is particularly the case in specialty treatment programs located within departments of psychiatry. The movement of the medical community toward the use of evidence-based approaches to treatment is in many ways causing physicians to appreciate more fully the contribution that psychologists can make to the efficacious and effective treatment of individuals diagnosed with anxiety disorders. Department chairs in psychiatry are aware of the changes that require their residency education programs to include CBT training as well as the results of the psychotherapy outcome literature on public awareness. As university medical centers have had to become more fiscally responsible and to endure the impact of managed care, the use of shorter term, effective approaches in psychotherapy, such as CBT for anxiety disorders, has not been lost on administrators.

There are clearly issues that influence the practice of psychology in psychiatry departments. More and more, psychologists who have defined areas of expertise are being recruited for psychiatry faculty or staff positions. Generalist training is less desirable. As directors of our respective anxiety disorder programs, we look for individuals who have experience using CBT methods in treating this patient population. Having training of this kind implies that the psychologist has a solid foundation in the basic principles of CBT as well as in the psychopathology of anxiety disorders and thus knows when and how to adapt a manual-based treatment protocol to the individualized needs of the patient. Likewise, there is a fundamental appreciation for how clinical data based on self-report measures, interviewer assessment, or observation are integrated into the treatment process as a means of gauging progress.

In some instances, psychologists need to depart from a model of treatment whereby the clinician is the only therapist. Intensive treatment for anxiety is not uncommon, and a single clinician may not have the requisite amount of time available to treat a patient. Team models, wherein the psychologist trained in CBT for anxiety can take a leadership role in either outpatient or inpatient settings, are a viable alternative to a sole-practitioner approach. The use of a team model permits the leader to then train others in an evidence-based approach while underscoring how various individuals' expertise can contribute to a coherent and comprehensive treatment plan.

Developing clinical or clinical research programs within a medical setting can be highly rewarding. However, such endeavors are unlikely to succeed unless there is clear administrative support for, and a departmental mission (or a department chair) that endorses, a movement toward EST. At our respective institutions, the psychiatrists who chair our departments firmly stand behind our programs. As a result, we are among a handful of nonpsychiatrists at our institutions who are the directors of clinics. Expertise in the area of cognitive–behavioral treatment of anxiety disorders and a commitment to collaborating with our psychopharmacologically trained colleagues have been necessary components of the successful operation of our programs.

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