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Obtaining Consensus in Psychotherapy: What Holds Us Back?

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Although the field of psychotherapy has been in existence for well over a century, it nonetheless continues to be preparadigmatic, lacking a consensus or scientific core. Instead, it is characterized by a large and increasing number of different schools of thought. In addition to the varying ways in which psychotherapy has been conceptualized, there also exists a long-standing gap between psychotherapy research and how it is conducted in actual clinical practice. Finally, there also exists a tendency to place great emphasis on what is new, often rediscovering or reinventing past contributions. This article describes each of these impediments to obtaining consensus and offers some suggestions for what might be done to address them.

Keywords: therapy alliance, clinical training, practice–research gap, psychotherapy integration, RDoC

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I once had a conversation with a physician where I lamented about the disjointed nature of the field of psychotherapy. I complained that there are many different schools of thought, with each having its own theoretical view about the therapy change process; that there exists a long-standing gap between therapy research and practice; and that instead of building on past knowledge, we seem to be rediscovering and/or replacing what we already know. His response was: "What do you expect of an infant science." An infant science? Over 100 years old and still an infant! This was several years ago, and things have improved since that time; it might be more accurate to view the field as having moved into its adolescence. Still, the question is: Why is this the case? Why haven't we advanced beyond this point? What do we need to do in order to move the field of psychotherapy toward greater maturity? The purpose of this article is to address these questions, beginning with some of the reasons for our difficulty in obtaining agreement and moving on to consider whether it is possible to move the field forward in reaching some consensus and, if so, how that might be done.[1]

There are at least three problematic issues that seem to contribute to the difficulty we have in obtaining a consensus within the field of psychotherapy: The first involves our long-standing practice of solely working within theoretical orientations or eclectic combinations of orientations. Moreover, not agreeing with those having other frameworks on how to bring about therapeutic change results in the proliferation of schools of therapy (Goldfried, 1980). The second issue involves the longstanding gap between research and practice, where many therapists may fail to see the relevance to their day-to-day clinical practice and also where many researchers do not make systematic use of clinical observations as a means of guiding their research (Goldfried, 1982).[2] The third issue is our tendency to neglect past contributions to the field (Goldfried, 2000). We do not build on our previous body of knowledge but rather *rediscover* what we already know or—even worse—ignore past work and *replace* it with something new. What follows is a description of how these three issues prevent psychotherapy from achieving a consensus, after which there will be a consideration of some possible steps that might be taken in working toward a resolution of these issues.

What Are the Obstacles to Reaching a Consensus About Psychotherapy?

Disagreement Across Theoretical Orientations

From early on, the field of psychotherapy has been characterized by the proliferation of different schools of thought

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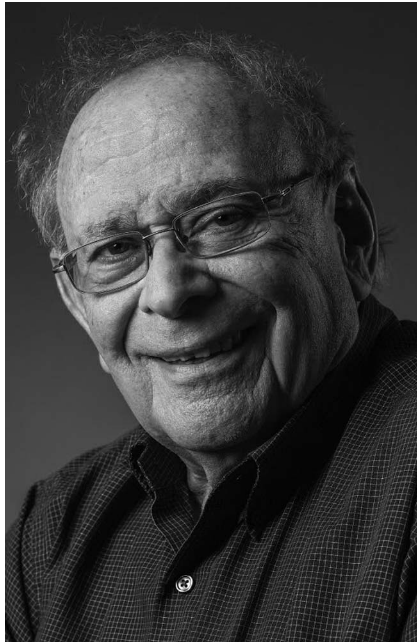
[1] It has been suggested by some workers in the field that *psychological treatments* should replace the term *psychotherapy.* There have been reactions against this, and it continues to be a point of contention. Because the term *psychotherapy* is the term used by most professionals, it will be used in this article as well.

[2] It might be noted that the field of psychotherapy is not alone in this regard; it has also been acknowledged to exist in medicine (DeLuca, Ovseiko, & Buchan, 2016) and in education (Finnigan & Daly, 2014).



Marvin R. Goldfried

to explain how people change, starting with Freud's followers' splitting off to develop their own varying approaches. Moreover, in a survey of over 2,000 clinicians, it was found that the vast majority of them followed more than a single theoretical approach (Cook, Biyanova, Elhai, Schnurr, & Coyne, 2010). This tendency toward proliferation has continued over the years, and a recent estimate is that there are now over 500 different schools of thought (Prochaska & Norcross, 2018).

Theory can play an important role in the development of different approaches to therapy. Although theories can help to advance a field, there can also be a downside. In his discussion of the tenacity with which theoreticians in psychology have held on to their theories, Boring (1964) has noted: "A theory which has built up the author's image of himself has become part of him. To abandon it would be suicidal, or at least an act of self-mutilation" (p. 682). The situation becomes even more complicated in an applied field such as psychotherapy, where social, political, and economic variables—and their associated referral networks—may continue to support the theory even after the limitations of the approach have been documented.

If Thomas Kuhn (1970) had to characterize the field of psychotherapy's current scientific stage of development, it would likely be preparadigmatic. This represents the earliest stage in the development of any given science. It is characterized as being made up of different schools of thought and models, about which there is no consensus or agreed-upon core of knowledge. This absence of consensus in psychotherapy is characterized not only by the specific theory and techniques associated with each approach but also by its unique language. In discussing the existence of competing paradigms within a field of science, Kuhn has noted that those "who held incommensurate viewpoints [can] be thought of as members of different language communities and that their communication problems [can] be analyzed as problems of translation" (Kuhn, 1970, p. 175). Thus, having different theory-based language systems prevents us from ever learning of any similarities and points of complementarity across orientations.

In a survey of prominent therapists who were interested in having the field move away from having separate competing schools of therapy (Norcross & Thomas, 1988), the absence of a common language was indicated as one of the major obstacles in reaching a rapprochement. In addition, the respondents indicated that egocentric self-centered colleagues, the institutionalization of schools, short-sighted training programs, and inadequate research on the integration of the psychotherapies served as additional barriers. Human behavior is far too complicated for us to champion a limited subset of variables within the confines of any idiosyncratic theoretical orientation. The question is not *if*, but rather *when* certain variables and interventions are relevant.

The Gap Between Research and Practice

The practice of psychotherapy began with little, if any, empirical foundation but instead had its roots in clinical observation and experience. Despite the availability of considerable empirical evidence from psychotherapy process and outcome research (Muran & Lutz, 2015), many therapists continue to base their practice more on clinical experience than empirical evidence (Addis, 2002). To make matters worse, there are researchers and clinicians who have an underlying—and sometimes open—disdain for the other. Researchers often complain that clinicians do not read the empirical literature and instead base what they do on poorly articulated "clinical experience." For their part, a number of clinicians complain that the research is conducted by individuals who know little of what it is like to conduct therapy. At times this tension can be extreme, as reflected in the comment of one clinician who indicated that psychotherapy research is conducted "in the mechanical way that is so fashionable among many of our colleagues who are too frightened and too inept to establish an interpersonal relationship of a therapeutic variety with a patient" (Lehrer, 1981, p. 42). There can also exist an underlying resentment on the part of some clinicians for being excluded from providing input to the investigative process. As lamented by two practicing clinicians—who happened to be avid readers of the research literature—regarding the potential implications that therapy research might have for such policy decisions as which interventions will be reimbursed by insurance companies: "The standards and methods of clinical therapy will be set by those who do the least amount of

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clinical practice" (Fensterheim & Raw, 1996, pp. 169–170). At worst, the exclusive attention given to researchers' findings and inferences in guiding training and practice may be viewed as a form of "empirical imperialism" (Castonguay, 2011).

Although much has been written in the past on the need to disseminate research findings to the practicing clinician (e.g., Addis, 2002), relatively little has been said about what contributions clinicians can make to psychotherapy research. As noted by Kazdin (2008): "We are letting knowledge from practice drip through the holes of a colander," going on to suggest that it is possible to "plug up those holes to retain critical information, and we can feed this information into research designed to test hypotheses and add further support for what seems to be true from the data gathered in practice" (Kazdin, 2008, p. 155). Not only is this gap between research and practice a professional limitation for both researcher and clinician but it also can have a negative impact on the welfare of the client (Constantino, Coyne, & Gomez Penedo, 2017).

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The Disconnect Between Past and Current Contributions

The sociology of science is a field that is devoted to studying how science works. While researchers in various fields are studying physical, chemical, and psychological phenomena, the sociology of science has been studying the behavior of these researchers. One of the things that has been uncovered is that although there are some similarities between the physical and social sciences, there are also some important differences. An interesting similarity is that, at the cutting edge, there is just as much disagreement in the physical sciences as there are in the social sciences (Cole, 1992). Thus, in a study of grant applications and research articles addressing novel phenomena, there tends to be low reliability in both. Where the physical sciences are more advanced, however, is that there exists a *core* as well as a cutting edge. The core involves a body of knowledge, built on past research, where there exists a consensus among researchers. The problem with the field of psychotherapy is that we lack a common core and always seem to be at the cutting edge, not building upon past contributions and instead emphasizing what is "new." There are several reasons for this, such as the changing accepted methodology for studying psychotherapy, the emphasis that has been placed on the importance of what is new, and the norms of science itself.

Changing research methodology. Goldfried and Wolfe (1998) reviewed the shifts in research methodology used to investigate psychotherapy over the second half of the 20th century. The earliest research on psychotherapy occurred around the 1950s and asked the very general question: "Does psychotherapy work?" The research methodology at the time was in its early stages, was mostly naturalistic, and made little use of control groups or random assignment. The focus was on a wide array of different clinical issues, and there was little specification as to the nature of the therapeutic interventions. Beginning in the 1960s, with generous support from the National Institute of Mental Health (NIMH), psychotherapy research moved to a more sophisticated level of methodology. The question addressed during this generation of outcome research thus became: "Which specific intervention is efficacious in dealing with this specific target behavior?" In addition to outcome research, which focused on *whether* the therapy worked, there was also research on psychotherapy process—addressing *how* it worked.

In the mid-1980s, there was a sea change in the psychotherapy research focus and design, resulting from the significant paradigm shift within the NIMH toward a medical model of psychological problems. Specifically, the research methodology used in drug research replaced what had formally been called "outcome research" to study specific clinical issues. Thus, the focus shifted toward "clinical trials," modeled after the research approach to determining the effectiveness of psychoactive drugs. In this third generation, the question became: "Which multifaceted treatment procedures were efficacious in treating which *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) diagnoses?" The distinction was also made at this time between the "efficacy" and the "effectiveness" of therapy, which referred to whether the treatment worked in a controlled or naturalistic setting, respectively. In addition, the research funding needed for studying the psychotherapy change process was severely reduced. The priority to fund clinical trials in the treatment of complex *DSM* disorders continued for approximately three decades and only recently has been deemphasized. The change in funding priorities currently reflects an even greater shift toward a medical model, in which psychological disorders are viewed as involving "disorders of brain circuits" (Insel, 2012, p. 3). The current funding priority, called research domain criteria (RDoC), emphasizes the neurological, biological, and genetic correlates of cognitive, emotional, and social factors that are believed to be associated with various psychological problems. Although there are interesting implications in learning more about the biological correlates of psychological processes (Hershenberg & Goldfried, 2015), the NIMH has essentially shifted funding priorities to uncover biomarkers that could be used to develop new psychoactive drugs (Goldfried, 2016).

In essence, the difficulty in obtaining an agreed-upon core within psychotherapy may in part be due to this ongoing shift in research methodology and its therapeutic focus. Our research efforts over the years do not seem to have had a clearly thought-out and programmatic strategy and has been

determined to a great extent by the changing views of the *DSM* and the research proprieties on the part of the NIMH.

The importance of what's new. As indicated earlier, the importance of what is new—the cutting edge—is inherent to scientific investigations. It is also something that is highly valued in our society at large. The tendency to focus on the new at the expense of the old is reflected in what has been occurring within cognitive−behavioral therapy (CBT). Some advocates within the field have argued that there is now a *third* wave of CBT, with an emphasis on mindfulness and acceptance (Herbert & Forman, 2011). In some instances, this new wave actually reflects earlier contributions but with new language. Thus, Hayes's acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 2003) talks about the importance of encouraging clients to act upon what they "value." In many respects, it is another way to speak of the importance of helping individuals to become more self-assertive by learning to behave in accordance with what they want and need—which had received considerable clinical and research attention in the 1960s and 1970s (Speed, Goldstein, & Goldfried, 2018). A change in language such as this clearly interferes with the scientific need to build upon past contributions. Notably, the changes in terminology for an established phenomenon results in changes in the key words we use to search the literature, preventing the field from retrieving previous clinical and research contributions—in this example, searching the literature for past contributions on "assertiveness."

The norms of science. In their early discussions of how scientific advances are made, sociologists once believed that scientists were totally objective and that the only stake they had in their efforts was the advancement of the field (Merton, 1942). As the sociology of science became more empirical, it was discovered that this conceptual depiction was far from the case (Merton, 1957). Based on detailed observations of how scientists actually behaved, it became clear that there existed fierce competition among them. Indeed, it was discovered that they were as much—and sometimes more—motivated to advance their careers than to advance the field (Reif, 1961), and research has demonstrated that citation practices within competing research settings are frequently selective, with the goal of putting one's own camp ahead of another's (Latour, 1987). In all fields—and psychotherapy is certainly no exception—there are professionals who are more dedicated to the advancement of their careers than to the advancement of the field. They each belong to a unique professional organization: AAM—Association for the Advancement of Me.

How Can We Overcome the Obstacles Preventing a Consensus?

The problems described earlier have been in existence for decades, and it is unlikely that any easily obtainable solutions are possible. Still, steps need to be taken, even if they represent only the beginning of an attempt to help move psychotherapy in the direction of an increased consensus. Thus, what follows is not offered as being *the* solution but rather potential beginning efforts.

Moving From Theoretical Orientations to Principles of Change

When we think about the different approaches to therapy, we often think of them in terms of their theoretical conceptualizations, with the three major orientations being psychodynamic, behavioral/cognitive–behavioral, and experiential/humanistic. We also think about them in terms of the specific clinical techniques and procedures that are associated with each orientation, be it interpretation, self-monitoring, or reflection. As is well known, there has traditionally been considerable disagreement at both the theoretical and the technique levels. However, at a midlevel of abstraction—somewhere between theory and technique—it is possible to consider principles of change that are common to most forms of therapy (Goldfried, 1980). Despite the very different theoretical underpinnings of these three orientations, some similarities may exist. For example, on the topic of fear reduction, the psychoanalyst Otto Fenichel (1941), noted the following:

> When a person is afraid but experiences a situation in which what was feared occurs without any harm resulting, he will not immediately trust the outcome of his new experience; however, the second time he will have a little less fear, the third time still less. (p. 83)

This same conclusion was reached by the behaviorally orientated Albert Bandura (1969), who observed this:

> Extinction of avoidance behavior is achieved by repeated exposure to subjectively threatening stimuli under conditions designed to ensure that neither the avoidance responses nor the anticipated adverse consequences occur. (p. 414)

Coming from different theoretical orientations, using a different language system, and perhaps using differing forms of intervention, the examples discussed here are strategically suggesting that having the clients do something that they may have been avoiding can be therapeutically helpful. As noted elsewhere:

> *To the extent that clinicians of varying orientations are able to arrive at a common set of strategies, it is likely that what emerges will consist of robust phenomena, as they have managed to survive the distortions imposed by the therapists' varying theoretical biases.* (Goldfried, 1980, p. 996; italics in original)

Thus, common principles, rather than the more abstract theoretical orientation or specific techniques, is where we may find consensus across schools of therapy. The specific

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intervention techniques may be thought of as methods of implementing a given principle. Moreover, some techniques may empirically be found to be more effective than others, depending on the nature of the clinical problem and characteristics of the client. Furthermore, as an alternative to a given school of thought, general principles of change may be used as a *starting point* for research, practice, and training.

In looking at the middle level of abstraction between the theoretical explanations of different approaches to therapy and their specific clinical techniques to find commonalities that appear to underlie different approaches to therapy, it may be possible to identify the following principles of change (Goldfried, 1982):

- Promoting client expectation and motivation that therapy can help,
- Establishing an optimal therapeutic alliance,
- Facilitating client awareness of the factors associated with his or her difficulties,
- Encouraging the client to engage in corrective experiences, and
- Emphasizing ongoing reality testing in the client's life.

Promoting client expectation and motivation that therapy can help. Jerome Frank (1961) has suggested that the therapeutic endeavor itself could be helpful by virtue of its ability to instill hope and the possibility that change can occur. Freud similarly placed on emphasis on the importance of the patients' expectation that analysis could be successful (Gay, 1985). Recognizing that they might have some doubts, he suggested that at least a patient's skepticism should be a "benevolent skepticism" (Freud, 1916/1963). In more recent years, it has been demonstrated that clients who have not yet contemplated the necessity of change are unlikely to respond well to therapy (Prochaska, Norcross, & DiClemente, 2013).

There exists an early research literature on the importance of expectations for therapy (e.g., Goldstein, 1962), and after a hiatus of several years, renewed research in this area has demonstrated the importance of patients' initial expectations regarding therapy. This more recent research has demonstrated that for a variety of clinical problems, expectations can influence whether or not a patient will terminate prematurely (e.g., Swift, Greenberg, Whipple, & Kominiak, 2012) and also the extent to which the treatment will be successful (e.g., Constantino, 2012).

In a related vein, there also exists extensive empirical support on the negative impact that the lack of motivation to change has on treatment and how that can be addressed clinically. Based on clinical observations in working with unmotivated individuals with substance abuse problems, Miller and Rollnick (2002) and numerous other researchers (e.g., Sobell & Sobell, 2003) have demonstrated the clinical utility of motivational interviewing, whereby the therapist validates patients' reluctance to change and then gradually helps them to recognize the consequences of not changing and the benefits of doing so.

Thus, clinical observation and research evidence support the importance of positive expectations and motivation to change—all of which is independent of the specific theoretical orientation of the therapy.

Establishing an optimal therapeutic alliance. Quite apart from what different therapy orientations believe to be the primary procedural ingredients in therapeutic change, it is nonetheless acknowledged that a good therapy relationship is needed as a context in which to implement the therapeutic intervention (Muran & Barber, 2010). The argument of which is more important—the technique or the relationship—fails to recognize the important interaction of the two (Goldfried & Davila, 2005). As any therapist well knows, the goal of Session 1 is Session 2, and the nature of the therapeutic connection with the client plays an important role in making this happen.

Based on the writings of Bordin (1979), the therapeutic alliance is defined as the existence of not only a good bond between therapist and client but also an agreement between the two as to the goals of therapy and the methods that may be used to achieve these goals. Following this clinical observation by Bordin, there have been several decades of research to demonstrate the importance of the alliance across different therapeutic orientations (Muran & Barber, 2010; Norcross, 2011), making it a most important transtheoretical principle of change.

Facilitating clients' awareness of the factors associated with their difficulties. One of the reasons that individuals often fail to change is that they often do not recognize and make use of those life experiences that might help them to change. Sullivan had an interesting concept to describe this when he spoke of "selective inattention" (Sullivan, 1973); people are often unaware of what causes them to have certain problems in living and what can be done to improve their lives. Freud underscored the importance of an alliance between the therapist and the "observing ego" of patients, which is used to help patients become better aware of the neurotic aspects of their functioning (Freud, 1916/1963). Depending upon one's theoretical orientation, the process of stepping back and observing oneself has been called *self-observation, executive functioning, decentering, reflective functioning, insight, observing ego, witnessing, metacognition,* and *mindfulness.* Although different labels are used, it involves clients' getting a better awareness and perspective of their thoughts, emotions, behavior, needs, and wants; the significance of life events; the impact the behavior of others makes on them; and the impact that they make on others.

Regardless of their theoretical school of thought, therapists help their clients to become better aware of what works and what does not work in their lives, as well as the reasons why this is the case. The specific formulation of therapists'

may differ, and the way in which they may facilitate this better understanding may vary, but it all reflects the principle of therapeutically increasing clients' awareness. At times, this awareness in itself can produce important changes, such as when clients recognize that their interpretation of the motives of a significant other are incorrect. At other times, the awareness may be preparatory to some actual changes in how they deal with others, such as asking a significant other for something rather than getting angry in the anticipation that they might not get what they want. A review of the theoretical, clinical, and empirical literature on the principle of increasing awareness may be found in Castonguay and Hill (2007) and Norcross (2011).

Encouraging clients to engage in corrective experiences. Alexander and French suggested to their somewhat surprised—indeed shocked—psychoanalytic colleagues some years ago that there can be instances where patients can change *without* resolving early conflict (Alexander & French, 1946). In line with the psychodynamic characterization of therapy as being a form of after-education, they indicated that the nature of the therapeutic interaction in and of itself may contribute to change. And although Alexander and French characterized this as being a "corrective emotional experience," it may also be seen more generally as a corrective cognitive and behavioral experience as well.

The corrective experience may be thought of as clients' doing something that they have not done before—despite their anticipatory thoughts and apprehensive emotions that something negative might happen—only to learn that their unrealistic predictions were not forthcoming. Thus, individuals who fearfully avoid speaking up and expressing themselves because they unrealistically anticipate a negative reaction from others may have a corrective experience by taking the risk of saying what they want to say and learning that the reactions of others were not negative—and at times may even be positive. In a special edition of the journal *Cognitive Therapy and Research* (Brady et al., 1980), a diverse group of well-known therapists of different orientations acknowledged that the corrective experience was a core principle of change. Thus, such therapists as Brady, Davison, Dewald, Egan, Fadiman, Frank, Gill, Kempler, Lazarus, Raimy, Rotter, and Strupp categorized the importance of new experiences from within their orientation as being "essential," "basic," "crucial," and "critical."

Relationally oriented psychodynamic therapists see this corrective experience as occurring within the therapeutic interaction. CBT therapists place a greater emphasis on between-sessions homework experiences, such as those that provide clients with "exposure" that serves to reduce avoidance behavior. Regardless of where the experience takes place, or whether the label that is used to describe it is phenomenological or observable, the corrective experience appears to be an important principle of change. The recognition of the importance of corrective experiences has not been confined to therapists. As Eleanor Roosevelt, who went from being a shy young woman to a major international force, once put it: "You must do the thing you think you cannot do" (Albion, 2013). For a more detailed discussion of the corrective experience from a theoretical, clinical, tk;2and empirical point of view, see Castonguay and Hill (2012).

Emphasizing ongoing reality testing in the client's life. The corrective experience serves to update original expectations that have prevented clients from behaving in ways that are more conducive to adaptive functioning. Because one such experience is unlikely to lead to long-lasting change, therapists need to encourage clients to have additional corrective experiences, in essence engaging in ongoing reality testing, until there exists a critical mass of corrective experiences to allow for more stable and long-lasting changes in expectations, feelings, and behavior.

In many respects, this principle of change may be thought of much like the psychodynamic concept of working through, which is said to involve repeated thinking, reevaluation, and processing of experiences. Ongoing reality testing involves an increased awareness that further facilitates corrective experiences—involving changes in thoughts, feelings, and behaviors—which further feeds into an increased awareness that can be used to again facilitate corrective experiences.

To summarize how these general principles of change occur throughout the process of therapy: Clients change when they are (a) motivated and have positive expectations of change; (b) work with a therapist with whom they have a good alliance; (c) become better aware of what is causing the problems in their lives; (d) take steps to make changes in their thinking, feeling, and behavior; and (e) engage in ongoing reality testing by creating a synergy between increased awareness and actual corrective experiences.

The increased interest in the idea that principles of change, rather than theoretical schools of thought, may be a better way to advance the field was the motivation behind a task force sponsored jointly by the Society for Clinical Psychology (Division 12 of the American Psychological Association [APA]) and the North American Society for Psychotherapy Research. In the publication of the task force findings, Castonguay and Beutler (2006) reviewed the evidence-based principles associated with clinical interventions for dysphoric disorders, anxiety disorders, personality disorders, and substance abuse disorders. For each of these clinical problems, they reviewed relevant principles of change regarding the nature of the treatment (e.g., degree of structure), the domains of interpersonal issues, the characteristics of the client, and the behavior of the therapist. Castonguay and Beutler also presented, very much mirroring clinical reality, evidence for how therapists can match

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the nature of the intervention so as to best fit client characteristics.

Westen, Novotny, and Thompson-Brenner (2004) have similarly argued for a research strategy that would focus on transtheoretical principles of change, rather than one that examined the extent to which a given school of therapy was efficacious in treating a *DSM* disorder. They suggest that, rather than treatment manuals based on theoretical schools of thought, a more fruitful approach would be to develop transtheoretical treatment manuals that deal with data-based principles of change. This view echoes that of Rosen and Davison (2003), who have maintained that empirically supported principles (ESPs), not empirically supported treatments, would be more likely to advance the field. As succinctly summarized by them:

> A focus on identifying ESPs does move us forward by redirecting the attention of academic psychologists, practicing clinicians, and students to where it should be—on mechanisms of change. A system focused on ESPs also is less likely to be influenced by proprietary concerns and the undue influence of particular interest groups. Principles of behavior change, after all, cannot be trademarked, for they belong to science. (Rosen & Davison, 2003, p. 309)

Closing the Gap Between Research and Practice

In describing how research advances are made in the sciences, sociologists have noted that there is an important distinction between those who are "problem finders" and those who are "problem solvers" (Wilkes, 1979). The basic and most important function of the problem finders is to identify important research questions that are likely to advance the field. Once these questions have been identified, it is the role of problem solvers to investigate them with controlled research. The important interaction between first-hand observation and scientific investigation was dramatically illustrated by a 16th-century physician, Paracelsus (Ackerlnecht, 1973). He argued that what was being studied in academic circles failed to take into account the direct clinical observation. Paracelsus's contributions are credited with creating a major revolution in the practice of medicine.

There is another reason why it is important to use both clinical observation and empirical research to obtain a consensus, namely that both approaches can be biased. Much has been written about the theoretical and personal biases of therapists'. However, it has also been documented how bias also exists in research (Mahoney, 1976; Polanyi, 1946). To obtain reliable findings and conclusions about psychotherapy, what is needed are converging methods of inquiry, so that when agreement is found in clinical observation and empirical research, there is the likelihood that what has been found is a robust phenomenon.

Although the original Boulder training guidelines (Raimy, 1950) recommended that graduate education in clinical psychology follow a scientist–practitioner model, this has not been as successful as originally intended. Many training programs have given lip service to this model over the years, but programs that have actually been able to provide training that integrates the two are more the exception than the rule. An institutional index of the more general gap between research and practice within psychology as a whole has been the formation of the Association for Psychological Sciences; researchers who were former members of the APA founded this alternate professional organization because of their dissatisfaction with what they viewed as APA's guildlike emphasis. The Academy of Psychological Clinical Science was similarly formed by clinical psychologists having a greater dedication to clinical research; they developed the Psychological Clinical Science Accreditation System as a way of accrediting clinical programs having a more research emphasis.

As noted earlier in this article, the attempt on the part of psychotherapy researchers to get clinicians to realize that they may benefit from their empirical efforts has essentially represented an attempt to build a one-way bridge between research and practice. However, philosophers of science have indicated that an important initial step in conducting well-founded research is developing research questions and issues from what has been called the "context of discovery." In a personal disclosure of how he has conducted research over the years, Neal Miller (in Bergin & Strupp, 1972), an award-winning researcher, indicated that his most impactful research findings started with his initial informal observations. These observations, which occurred before any formal research was conducted, were what convinced him that a phenomenon existed. Once personally convinced, he would then conduct well-controlled research to convince his colleagues. One may usefully think of clinical observation as constituting the context of discovery.

An important example of how clinical observations can be used as the context of discovery in the development of a research study was the work of Linda Sobell (1996) in developing a clinical trial for the treatment of addictions. The research project was carried out with the support of the Ministry of Health in Ontario, Canada, which was interested in having research findings used by practicing clinicians. The dissemination of research findings to therapy settings has been somewhat limited in its success (e.g., Graham et al., 2006), and to achieve this goal, Sobell worked directly with those clinicians in the community who had been treating patients with addictions, collaborating with them in developing the intervention so as to address those issues that they observed in clinical practice. Not surprisingly, it was found that when clinicians were involved in developing and conducting research, they were likely to put into practice the findings of this research. Noting that this was a collaboration in which everybody benefited, Sobell acknowledged that "I reached more agencies, more practitioners, and ulti-

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mately more clients than in my 25 years in the field" (Sobell, 1996, p. 316).

This attempt to close the gap between research and practice is reflected in the work of Castonguay, Barkham, Lutz, and McAleavey (2013), who have made a cogent case regarding the need to have therapy research taking place within an actual clinical context. Although such research cannot be as tightly controlled as can outcome research–clinical trials, the absence of stringent controls and less internal validity can at times be offset by external validity and also what it says to the practicing clinician. It should be emphasized that this practice-oriented research is not offered as a substitution for clinical trials but rather a complementary source of evidence (Barkham, Stiles, Lambert, & Mellor-Clark, 2010).

A particularly important way in which clinicians and researchers may collaborate in naturalistic settings has involved practice research networks (PRNs). As one type of practice-oriented research, PRNs rest on the active collaboration of researchers and clinicians in all aspects of empirical studies, from the selection of topics to investigate and the design and implementation of research protocols to the analysis and dissemination of findings (Castonguay, 2011). Reflecting the breadth of conceptual and clinical interests shared by both clinicians and researchers, PRN investigations conducted in different clinical settings (e.g., independent practice, training clinic) have addressed a wide variety of different clinical phenomena, such as what clinicians and clients have observed to be helpful and hindering factors during the course of treatment (see Castonguay et al., 2013). Here again, PRNs, and practice-oriented research as a whole, are not proposed to replace controlled therapy research, but the convergence of findings from these two epistemological approaches can most certainly add greater confidence in the reliability and validity of the findings from each other. And although much fewer empirical studies have so far emerged from practice-oriented research compared to traditional (researcher-driven) research, lessons learned from clinician−researcher partnerships across three continents have recently been laid out to foster more collaborative and practice-based investigations (Castonguay & Muran, 2015).

As indicated earlier in this article, there is an underlying antagonism between researchers and clinicians in some quarters, where researchers view clinicians as being behind the times by not using research findings and clinicians complain that practitioners are disinterested in studying the issues seen in clinical practice. Stereotyping such as this occurs in other professions as well, such as the field of education, which has similarly been struggling to close the research−practice gap. In their book titled *Using Research Evidence in Education*, Finnigan and Daly (2014) have reported that facilitating personal contact between teachers and researchers has been helpful in closing the gap. This is clearly consistent with the work of Sobell and those involved in developing practice research networks.

Dissemination as a two-way bridge between research and practice. In addition to attempting to close the gap between research and practice by having collaborative contacts between clinicians and researchers, there has been the use of implementation science to disseminate research findings to the practicing clinician (Madon, Hofman, Kupfer, & Glass, 2007). Implementation science focuses on understanding and overcoming the obstacles to changing clinical practice that may exist in a given setting (e.g., policy issues) so as to increase the likelihood that dissemination can be successful. An example of the use of implementation science to disseminate research findings to the clinician has been the work done within the Veterans Affairs setting (Karlin & Cross, 2014).

Additional attempts at dissemination have involved practice-friendly reviews of the basic and applied research literature written specifically for the practicing clinician. This has occurred in book form (e.g., Lebow & Jenkins, 2018) and also within the context of periodic reviews within journals such as the *Journal of Clinical Psychology/In Session* and the *Journal of Psychotherapy Integration.*

Another attempt to close the gap between research and practice was an initiative taken in 1995 by the Society of Clinical Psychology (Division 12 of the APA), which paralleled the procedure used by the Food and Drug Administration (FDA) to determine whether new drugs could be approved for clinical use. Based on randomized clinical trials, a listing was made of empirically supported treatments (ESTs) that had been shown to be efficacious for various *DSM* diagnoses. As indicated earlier, however, many practicing clinicians did not react favorably to the EST initiative, considering it a one-way bridge, whereby research findings were presented as the guidelines for clinical practice.

Recognizing the possible limitations of the one-way nature of this attempt at dissemination, two empirically oriented graduate students in clinical psychology—the future of our field—argued that what was needed was a more collaborative effort between researchers and clinicians. On the question of how to close the gap between research and practice, they suggested that

> we the researchers should not be disseminating *onto* the clinicians but rather engaging in dialogues *with* the professional community as we create new interventions. We believe that if we continue to frame this issue as an "us" versus "them" predicament, we will perpetually be stuck where we are, and, even worse, may continue to grow further polarized rather than closer together. (Hershenberg & Malik, 2008, pp. 3–4)

Although the methodology used to delineate ESTs was based on how clinical trials led to FDA guidelines and procedures, there was a step missing in the EST initiative:

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Once a drug is approved by the FDA, there exists a mechanism whereby practicing physicians can provide feedback on its use in clinical practice. It is clear that research cannot determine all those variables associated with the effective use of an intervention clinically—be it a drug or psychotherapy—and therefore this is an important mechanism to determine its clinical effectiveness.

In a subsequent collaborative effort, the Society of Clinical Psychology, along with the Society for the Advancement of Psychotherapy (Division 29 of the APA), adopted a Two-Way Bridge initiative to establish a mechanism by which practicing therapists could disseminate information to researchers about their clinical use of the ESTs (Goldfried et al., 2014). The initiative surveyed practicing clinicians, asking for their clinical observations when implementing various ESTs in clinical practice. In essence, this constitutes the other direction of the bridge by disseminating what was observed clinically—the context of discovery—regarding those important mediating, moderating, and contextual variables that may not have been studied in the clinical trials. In addition to asking questions about the nature of their interventions, clinicians were also surveyed about patient, treatment, and systemic variables that might have interfered with the use of ESTs in actual clinical practice. The delineation of those variables that created problems in the use of ESTs clinically helped the Two-Way Bridge initiative to identify clinically needed research issues requiring further empirical investigation. One particularly important finding in the feedback provided by practicing clinicians was that in addition to the severity of the anxiety disorder, the duration was an important variable related to clinical success. The longer the anxiety problem had been present, the less likely change occurred. And whereas severity is typically controlled for across conditions in clinical trials, duration is not and, based on clinical observations, should be in the future.

The overarching goal of this initiative is to create a collaborative synergy between clinicians and researchers, so that each can have a voice in forming a consensus. Surveys have been conducted to disseminate clinical observations on the treatment of panic disorder, social anxiety, obsessive–compulsive disorder, and general anxiety disorder, and the results are posted on the Two-Way Bridge website: www.stonybrook.edu/twowaybridge.

Closing the gap and clinical training. To actually make the scientist–practitioner model work, concerted efforts that deliberately facilitate the integration of research and practice need to be made within training programs. There are a number of ways in which this can occur. Constantino and colleagues (2017) have suggested that clinical training be directly focused on research findings that reflect the commonalities that exist across theoretical orientations. Specifically, clinical methods that have research support (e.g., how to repair therapy alliance ruptures, interventions to facilitate motivation) can be used to develop training modules. Boswell and Castonguay (2007) have similarly urged that clinical training programs focus on evidence-based common issues and principles that cut across therapy orientations. They also recommended that supervision be conducted by faculty members who can then serve as role models of scientists and practitioners. Ideally, these faculty supervisors should also be involved with direct therapy intervention.

These suggestions can be considered to be upstream work, whereby a dedication to linking research to practice and advancing the field and not a given orientation can occur early in one's professional career. This early education can also involve learning to think outside the box, not solely learning what currently exists, but also knowing the political, economic, and social forces within the field that may be hindering the development of a consensus. Within the sociology of science there exists the phenomenon of the "invisible college," where like-minded professionals throughout the country (and world) have worked together to obtain an agreed-upon objective (Wagner, 2008). This new generation—adept in social media, which has been able to create revolutions and affect elections—can use this new technology to develop an invisible college that is dedicated to advancing the field. Their common dedication can be to advance the field in which they plan to spend the rest of their careers.

Integrating Past and Current Contributions

As has been noted earlier, the emphasis on the cutting edge and finding something new is inherent in how science works. Within the field of psychotherapy, this has unfortunately resulted in the proliferation of new treatment packages or schools of therapy. This may take the form of a new theoretical approach to intervention or may consist of a modification of an existing approach. And because the field of psychotherapy has an applied aspect to it, the rewards may be financial as well as professional. Along with a new school or approach, there also exists an ownership factor, with the developer being the leader of those who make use of it.

Instead of placing an emphasis on developing new approaches to treatment, the field of psychotherapy needs to focus more on rewarding new *knowledge*—reliable clinical observations and empirically grounded research findings that belong to the field in general, rather than a given orientation, school, or individual. For example, research findings associated with the process of change or general principles may be both new and useful to both clinician and researcher but not necessarily owned by any professional. In essence, the focus should be more on *what* is right, not *who* is right. Process research does this when it addresses the question "*What did the therapist do* to make an impact, both

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within the session and more generally?" This empirical focus of process also provides an answer to the clinical question often raised by practicing therapists, namely "*What can I do* to make an impact, both within the session and more generally?"

In considering what type of evidence is needed to form an agreed-upon core within psychotherapy, the question of whether an intervention works is clearly essential. However, the development of any treatment package or school should be based more on reliable evidence about human functioning and the change process and less on theory—or the belief on the part of the developer that certain variables are important. Thus, evidence that can be considered as relevant to psychotherapy can come from a variety of different sources, each addressing a different question (Arkowitz, 1992). Clinical trials using intervention packages address the question *whether* a given treatment works. Research on the process of therapy and potential principles of a change focuses more on *how* therapy works. In addition, basic research on psychopathology and human functioning—be it cognitive, emotional, or behavioral—are clearly crucial as well, because they can inform the practitioner about *what* needs to be changed.

Although the field of psychotherapy has become accustomed to thinking of research as involving clinical trials for *DSM* diagnoses, the shift in the NIMH research priority away from treating diagnostic categories may be useful in promulgating studies that can better advance the field. Because funding has been diverted from clinical trials of psychotherapy to translational research, it provides us with an opportunity to move away from the limitations associated with the *DSM*. Although there clearly exist concerns about the current RDoC funding priority that is intended to uncover biological bases for diagnosing and medically treating various clinical disorders (Goldfried, 2016), it nonetheless may have implications for providing the field of psychotherapy with information that is relevant to establishing a core. With the emphasis on RDoC to encourage translational research, referring to extrapolations "from bench to bedside," psychological as well as biological phenomena will need to be investigated.

Among the research domain's criteria associated with RDoC are such basic psychological processes as negative valence systems (e.g., anxiety, loss), positive valance systems (e.g., expectancy of obtaining a reward, reward evaluation), and cognitive systems (e.g., working memory, performance monitoring). Research on these basic psychological processes can have important implications for uncovering mediators and moderators relevant to psychosocial interventions, with the former referring to mechanisms (e.g., the patient's corrective experiences in relationships with others) and the latter to variables that affect the likelihood that change mechanisms will occur (e.g., the extent to which the patient is conscientious and is therefore more likely to follow through on homework). Interestingly enough, a strength of the second generation of psychotherapy research described earlier is that it dealt with psychological problems rather than disorders. Consequently, research that addresses more clinically relevant and focal dimensions such as emotional dysregulation, perfectionism, self-criticism, and the like have the potential for shifting our focus to cutting-edge information that has clear implications for what to treat with psychotherapy and the potentially effective ways to do it.

In addition, more needs to be done in dealing with the different and changing language systems that are used to describe a common phenomenon. A method needs to be developed whereby one can readily search the literature for clinical and research contributions that may be labeled differently. For example, it may entail having search engines that are used to gain access to the professional literature use a built-in thesaurus, which can retrieve material labeled in ways that may be different from the key words that are currently in fashion or are associated with a given theoretical orientation. Thus, an extensive past research literature on "social anxiety" may be retrieved if the work on "public speaking anxiety" were also searched.

Changes in editorial policy are also needed in order encourage contributions to the literature that builds upon, rather than rediscovers or reinvents, past contributions. The feasibility of journal editors' taking a stand on this is supported by recent efforts being made to change publication policies in dealing with the replication crisis in psychology, whereby findings have often failed to hold upon further investigation (Eich, 2014). Among other things, these efforts have entailed a preregistration of how the data will be analyzed, so that the use of varying statistical analyses to obtain statistical significance—likely resulting in nonreplicability—is discouraged. Thus, efforts need to be made to change the content that is being rewarded in the psychotherapy literature, rewarding only that which is actually new.

One final point may be made regarding the content that needs to be rewarded within the scientific pursuit of consensus. Inasmuch as psychotherapy has not yet been able to develop a core, integrative efforts to reach a consensus, even within a limited and specific aspect of therapy (e.g., how to effectively resolve therapy alliance ruptures), can themselves be considered as "new" contributions to the literature. That professional recognition can be rewarded for efforts at unification is illustrated by the Arthur W. Staats unification award that is presented yearly at the APA meetings by the Society of General Psychology (http://www.apadivisions.org/division-1/awards/index.aspx)

Concluding Comments

This article has offered some possible reasons that the field of psychotherapy, although existing for well over a

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century, continues to remain at a preparadigmatic level. The field of psychotherapy is characterized by separate schools of thought, the gap between research and practice, and the tendency to rediscover what had been known in the past. Although there most certainly are other reasons that the field has not more fully matured, these obstacles appear to be particularly salient.

Even with the suggestions for what might potentially help us remove these barriers, the reality is that these obstacles may not be easily overcome. There are many in the field who will continue to do what they had learned to do in the past and may be resistant to change. Real change may require changes in the graduate school curriculum, where new professionals can be trained to think about and work toward obtaining a consensus in the field (Hershenberg, Drabick, & Vivian, 2012). With the ever-increasing movement within biological psychiatry to look for medical treatments for psychological problems, there may be greater motivation for us to strengthen the field of psychotherapy by developing a strong evidence-based and clinically agreed-upon core. Indeed, one very visible practicing analyst has become a strong advocate of closing the gap between research and practice and has expressed this need to her colleagues (McWilliams, 2017).

There is nothing like an attack from outside the system—such as the view of psychological problems as diseases of the brain–to facilitate collaborative efforts. Moreover, there is likely much about psychological problems and how therapy can deal with them about which we can agree. The existing social media technology that has influenced elections and created revolutions may make it more possible than ever before to develop an invisible college of like-minded colleagues to work toward obtaining a consensus within psychotherapy. This collaborative effort needs to be directed toward providing a coherent understanding of how psychotherapy works, integrating clinical observations and empirical research, and having new contributions build on the past. This is an initiative in which clinicians, researchers, and patients can all benefit, and early career professionals may especially want to make changes in the field in which they will be spending their professional careers. Indeed, the time may be ripe to address the question: On what can we agree?

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