The Gap Between Science and Practice: A Conversation

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The authors, friends, colleagues, and collaborators for almost 60 years engage in an informal discussion concerning the gap between science and practice. They identify some sources of the problem, some manifestations of it, and point the way to some possible solutions. The articles in this special section, because of their use of data collected in a naturalistic setting and the prominent role of clinicians, are viewed as one of many promising directions for the reconciliation of the activity of researchers and the needs of clinicians.

Clinical Impact Statement
There is a longstanding gap between science and practice in clinical psychology. ***Question:*** What are the reasons for this gap, and what can be done to reduce it? ***Findings:*** The authors discussed these questions, pointed to the disconnect between clinicians and researchers in training and in reward systems, and suggested how greater contact between them could lead to more meaningful research being performed and used. ***Meaning:*** The increase in contact and greater breadth in methodology could produce more transportable results. ***Next Steps:*** Development of these connections and adoption of new methodologies should be undertaken.

STRICKER: *Our job, Marv, should we choose to accept it, is to discuss the gap between science and practice, with inspiration from the important articles in this special section. I think the gap is real, but it is less profound than it once was. There was a time when transportability was a major issue, and I am reminded of Ogden Nash's reference to one-way thinking on a two-way street. Scientists berated clinicians for ignoring the contributions of their research, while the clinicians were convinced that the research had nothing to do with practice. It is easy to recognize that both had elements of truth to their position. I once wrote about the relationship of science and practice by quoting Oscar Hammerstein's song in "Oklahoma": "The cowmen and the farmer should be friends." Now, if not friends, at least they are not enemies. I wonder if you agree with my observation about a narrowing gap, and if you do, to what do you attribute the change?*

GOLDFRIED: *I do agree that the gap is less profound than it had been 20 or 30 years ago. But it nonetheless is still there and is something that I find to be very professionally distressing. Interestingly enough, we are very much alike in thinking about how cowmen and farmers might be friends—an association that I've always had when I think about the tension between researchers and clinicians. Unlike cowman and farmers, where their interests are very different, one would think that practitioners and researchers in the area of psychotherapy would be concerned with the same goal, namely, improving how we can help our clients. The one-way street is a very apt metaphor, and there currently exists attempts on the part of researchers to "hand down" research findings that might be used clinically. This is all part of a move toward greater empirical accountability—which is most certainly important—but I'm not quite sure whether or not what researchers are doing is providing clinicians with the information they need (see Goldfried & Wolfe, 1998). An encouraging theme of the articles*

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in this special section is that many of the efforts directly involve clinicians and are primarily motivated from clinical interest and priorities, rather than a need to publish or further an academic agenda.

STRICKER: *I agree that things are not where they should be, but I feel a little better about what is out there. Of course, what is available is not used as much as it deserves to be. I can think, off the top of my head, of two research programs that have changed the way I practice, and they are both well represented in this special section. First is all the work on outcome assessment. It is clear that, as clinicians, we are not good judges of how effective we are, and asking the patient, by means of one of a variety of possible measures, how we are doing provides that information. I now use it regularly with all my patients. Several of the articles in this special section address not only the importance of routine outcome assessment but also the process of implementation* (Drill et al., 2018; Fowler et al., 2018; Youn, Xiao, et al., 2018). *In addition, many of the articles in this special section directly address the complexity of the implementation process itself* (see Oswald, Boswell, Smith, Thompson-Brenner, & Brooks, 2018; Sauer-Zavala et al., 2018; Wolk et al., 2018; Youn, Valentine, et al., 2018). *Second is the work on therapeutic ruptures, which I was also happy to see represented in the special section articles by* Drill et al. (2018) *and* Youn, Xiao, et al. (2018). *There is good evidence that detecting and healing ruptures adds to the efficacy of our work. Of course, as addressed at different points in the section articles, the use of outcome assessments may alert us to ruptures that we might have missed during the session.*

On the other hand, as much as I try to educate my students about outcome assessments, and they usually are quite willing to try it, they often deal with supervisors who are less familiar with the literature who object to the practice. Similarly, because the rupture literature often has a psychodynamic presentation, more CBT-oriented students are less convinced, even though there is good literature demonstrating that it is an effective strategy within a Cognitive Behavior Therapy (CBT) setting.

GOLDFRIED: *I'd guess we should be a bit careful when we talk about research in a general sense. There is research and there is research. Yes, what you are talking about is the kind of research that directly can speak to the practicing cli-*

nician. And I also believe it is relevant to CBT therapists, should they be interested in reading that literature.

I think we have been sold a bill of goods by the National Institute of Mental Health (NIMH) *for the past three decades, which has led us to believe that the only significant research needs to be clinical trials* (Goldfried, 2016). *Certainly, within the field of medicine, that is the case. I do not think that this approach to research, namely, having a complex therapeutic package deal with a heterogeneous diagnostic category, is what the therapist needs. It serves the purpose of demonstrating that therapy works, but not how, when, and with whom. One encouraging aspect of this special section is that it highlights clinically motivated initiatives to investigate process—rather than just outcome—in routine settings* (Drill et al., 2018; Youn, Xiao, et al., 2018). *Nevertheless, I think we find ourselves in the position of having research in the field directed by an outside source, namely, the NIMH. And although it had been guided in the past by many psychologists on the staff, it has become more medically dominated and is geared more to advancement of psychiatry and the development of new drugs rather than to the practice of psychotherapy.*

STRICKER: *I couldn't agree more. I think the turnaround in the impact of research came when Division 12* (Society of Clinical Psychology) *set up a task force to address what was ambitiously referred to as empirically validated treatments. They then recognized that validated was an oversold word and cut back to empirically supported treatments* (ESTs), *which has become something of a shibboleth for people who love science and know little about practice. Unfortunately, by using randomized controlled trials* (RCTs) *as the sole basis for inclusion on the list* (similar to the NIMH stance), *they maximized the reduction of threats to internal validity, but did so at the expense of external validity—namely, relevance to real clinical practice. The ability to generalize from research to practice is essential to the clinician, and narrowly defined patient groups* (with little possibility of comorbidity, which is omnipresent in practice) *and necessary use of manuals, which can reduce clinician flexibility, are not likely to make results readily generalizable.*

I should clarify that I believe strongly in evidence-based treatment (EBT), *but that is different from ESTs. Some of the articles in this series used the terms interchangeably,*

and that overlooks the essential difference between the two. It comes down to what constitutes "evidence." Is it only based on an RCT, as the EST lists would have it, or are there broader sources of evidence, as EBTs affirm? The American Psychological Association (APA) has defined EBT as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences." That allows for the consideration of data from many types of studies, such as quasi-experiments, as well as the experience and expertise of clinicians. As we have already stated, a strength of the work in this special section is the common theme of prioritizing the perspectives of clinicians. EBT also takes into account cultural considerations and the preferences and characteristics of the patient (Youn, Valentine, et al., 2018), *and those, of course, are the largest source of variance contributing to patient outcome. As you point out, many researchers who are engaged in clinical trials do not take into account the conditions that exist in the clinical sphere. Conversely, the school mental health study described by* Wolk et al. (2018) *is an excellent example of conducting an experiment in an ecologically valid context.*

GOLDFRIED: *And it also includes basic research on emotion, cognition, behavior, and various form of psychopathology, which is addressed in the article by* Fowler et al. (2018). *The RCTs address the question of whether certain therapy works. Process research findings can inform the clinician of* how *it works, and the basic research can answer questions of* what aspects *of the client or what conditions in the client's life need to be the focus of therapy— such as emotion dysregulation or maladaptive behavior. These are the kinds of research findings that are of particular interest to the practicing clinician, more so than the results of clinical trials.*

As I said before, the NIMH has been dictating the kind of research that gets the funding, which then becomes the primary focus of a researcher's agenda. However, that agenda is dictated more by funding, rather than by what clinicians need. What makes matters even worse is when certain researchers denigrate clinicians for not paying attention to their research findings. In essence, there is a basic difference in the needs of researchers and clinicians in this context, where the career needs of researchers may be dictated by what gets funded, and the clinician's needs

are how to work with individual clients. Indeed, Drill et al. (2018) *explicitly address the role of funding, or lack thereof, in their article.*

STRICKER: *As you note, the issue, and it should be equally so for science and practice, is not whether psychotherapy works but how it works. For practitioners, they have little doubt that it works, being convinced that they are being helpful to the patients with whom they work. For scientists, research has demonstrated over and over that psychotherapy improves the well-being of patients. Furthermore, and despite the efforts of those who construct lists of ESTs, the Dodo Bird seems to reign supreme, as, with the exception of a few isolated instances, the search for Treatment by Patient interactions has not been very productive.*

On the other hand, what practitioners would find valuable and what scientists should be seeking are answers to how therapy works— the focus of process rather than simply outcome research (Youn, Xiao, et al., 2018). *As an example that I noted previously, the detection and healing of ruptures contributes to the efficacy of treatment, regardless of the home orientation of the practitioner. Most importantly, the therapeutic alliance* (including agreement as to goals and tasks as well as the therapeutic bond), *particularly as experienced by the patient, is the largest contributor of variance to outcome that is under therapeutic control, again, regardless of the home orientation of the practitioner* (Norcross, 2011). *And you made a great point about basic research. It is not only psychotherapy research that can be of value to the practitioner, but also research that adds to our understanding of human activities.*

GOLDFRIED: *George, it might not come as a great surprise to find that we both agree on so many things. After all, we have been colleagues for more than 50 years. The research on common issues, dilemmas, and processes that cut across all forms of therapy are precisely the kinds of research that is needed. When a process researcher looks at therapy videos or transcripts, the goal is to address that question "What did the therapist do to make an impact?" And this is precisely what the clinician wants to know namely, "What can I do to make a therapeutic impact?" As Barry Wolfe reported after more than 20 years of his being a staff member at the NIMH, once clinical trials became dominant in the 1980s, funding was cut back on process research.*

I do have a sense; however, more researchers are starting to recognize that we may have reached the limit of what we can know in the use of clinical trials, and that research on more specific principles of change may be more important. It is of particular interest that the orientation that has led the field in research over the years—the cognitive–behavioral approach—has had relatively little to say about process research. When I became interested in conducting process research in the 1980s, I got no help by reading the CBT literature or going to the behavior therapy meetings. Instead, I joined the Society for Psychotherapy Research (SPR), *comprised mostly of psychodynamic researchers, which has had a long history of studying the process of change.*

STRICKER: *I think we came to the same place via very different paths. I started with a commitment to psychodynamic work but gradually began to appreciate the contributions that CBT and humanistic approaches could make to the care that I provided. That led us both to focus on psychotherapy integration* (Norcross & Goldfried, 2019). *Now, here we are viewing the gap between practice and science and still looking for a way to achieve integration.*

I must add that I have become much less committed to psychodynamic theory, although I still use it to formulate cases, and less concerned about the origin of the interventions I employ. Instead, I am impressed by the importance of the relationship that can be established with the patient and the impact of the common factors. These are supported by the research, but I think they were derived from my experience and then confirmed by research. I wonder how often that is the case for practitioners and leads some to denigrate research.

In any case, the process of learning from what we do, using research as we can and confirming or disconfirming hypotheses as we go, exemplifies the local clinical scientist, which is a model I feel is useful at all levels of training and practice (Stricker & Trierweiler, 1995).

GOLDFRIED: *So, in the final analysis, Skinner was right: Our behavior is shaped by what works for us. So even though we start from different orientations, as long as we are in good contact with clinical reality, making observations rather than getting too caught up in theory, we are more likely to see the same thing clinically. Certain things work, and other things do not work. Moreover, what* does not work from a CBT point of view may be approached by using either a psychodynamic or humanistic contribution.

So much of the problem that we experience in obtaining consensus among therapists is communication: we use different language systems (Goldfried, 2018). *When we are actually looking at clinical phenomena, however, some of the similarities that are distorted by our jargon become more obvious to us. So, if there's a rupture in the therapy alliance, any decent clinician, regardless of his or her orientation, will need to address this. If they do not, they do so at their peril. In addition, if the patient is not motivated to change, whether we call it resistance or noncompliance, it needs to be addressed for the therapy to move forward. I guess what I'm saying is that we need to observe what therapists from different orientations do, to try to ferret out the common principles of change. I'm not quite sure that I really like the term "common factors," as they may or may not all be related to the change process. So, therapists of all orientations conduct their therapy in a room, typically with the door shut. Although this is a common factor, it hardly is essential to the change process.*

STRICKER: *I wish you wouldn't use a phrase like "in the final analysis." In any case, of course when I speak of common factors, I am not referring to things like we both sit in chairs* (or on a couch). *Instead, I am thinking of such factors as a therapeutic alliance, exposure, a corrective emotional experience, expectations, hope, a provided rationale, and beneficial therapist qualities. I know that you have referred to these as principles for at least a generation, and I have no problem with that terminology.*

The collection of common factors (and my list is not complete or definitive) *does bring up an interesting question about appropriate control groups in RCTs. In drug trials, a placebo is a drug that resembles the one being tested but has no active healing agents. In psychotherapy research, using a wait-list control, or some other less-than-credible alternative, does not constitute a placebo, not only because of the absence of a blind, but because the lack of presence of the common factors does not make the untreated group identical to the tested treatment in all but the active agent. The common factors are active agents and must be included in any reasonable RCT. For that reason, I rarely pay attention to any RCT that does not directly compare at least two mean-*

ingful treatments, and these can only provide outcome information, which almost always is equivalence. I am much more interested, as you are, in process research, which may teach us something that we do not already know.

GOLDFRIED: *Sorry about the reference to analysis George. You psychodynamic folks always find extra meaning in words. Sometimes a word is just a word. But what I really find interesting is that as a practicing clinician, who is also an academic, you clearly identify certain kinds of research that are, and are not, relevant to your practice. I regret to say that there are academics who know little about actual practice and only know what is in the literature. Some very astute observer once noted that research ideas that are born in the literature are destined to be buried in it.*

That is where there is something very special about the series of papers in this issue of the journal. The questions that they are addressing, even though they may not all lend themselves to the tight methodology we see in clinical trials, are born out of clinical observation and curiosity. Really good researchers know that informal, direct observation is the context of discovery, in which important research questions are born. Neal Miller, of Dollard and Miller fame, once indicated that he had wasted lots of his research efforts in studying phenomena that were not there. Instead, he eventually decided to first use informal observation to convince himself *that something was there, after which he would design a methodologically controlled study that could convince his colleagues.*

STRICKER: *I am struck by how we have been justly critical of approaches by scientists that have little effect on practitioners, such as outcome research in general and RCTs in specific. What we have not done is point to potential alternative approaches that might have more impact. I have always liked quasi-experimental designs (*Oswald et al., 2018*), as they trade some protections against challenges to internal validity with an often-compelling increase in external validity. Rather than knowing more about less, those designs allow us to know with less certainty about more. I think qualitative research deserves more emphasis than it gets, as it allows us the possibility of getting into the mind of both the therapist and the patient. The article by* Oswald et al. (2018) *is a case in point. I also think practice research networks are ideal settings for having scientists and practitioners work together in a mutually respectful way and pro-*

*duce evidence that will be valuable to both (*Youn, Xiao, et al., 2018*). As long as we stay in the context of discovery, case studies can be very compelling and generate many fruitful hypotheses. The flaws of each of these approaches (as well as those of RCTs) point to the need for converging evidence rather than the reliance on any single study.*

The articles in this section are a step in the right direction. They all are studies undertaken in naturalistic field settings. For example, the laudable work of Sauer-Zavala et al. (2018) *is being conducted within community-based organizations that serve homeless individuals and families, a context that has received very little attention in the psychotherapy research literature. Overall, the section contributors present some interesting findings and much to recommend future research. They also point to some of the difficulties inherent in field research (*Drill et al., 2018*;* Fowler et al., 2018*;* Wolk et al., 2018*). There are a great many moving parts, and changes in midstream can undermine a promising study (*Sauer-Zavala et al., 2018*). The research is subject to the vagaries of the context, and changes in administration, personnel, and budget can make important differences in the conduct of the research. Nonetheless, I think it is worth the effort.*

GOLDFRIED: *I very much resonate to your last comment that "it is worth the effort." There indeed is considerable effort that is involved in the kind of research that is described in this issue. The term "challenge" is frequently used throughout the contributions and is a core focus of the articles by* Drill et al. (2018) *and* Youn, Valentine, et al. (2018), *among others in this section. And what is very important to openly acknowledge is that many of the people who are involved in this research are doing so to advance the field, rather than their careers. When academics conduct research, they are interested in advancing the field, but it also is crucial for them to advance their careers. For some individuals, sad to say, much of the research they do is done primarily to advance their careers. The clinicians who are involved in practice-oriented research will not really be advancing their careers, but instead are sharing their clinical observations and findings with other clinicians, with the primary goal being to improve the practice of psychotherapy. They are indeed pioneers who deserve respect and admiration from all of us.*

STRICKER: *Great point, Marv. Let us look at the reward systems in both contexts. For the practitioner, the only reasons to do research are to contribute to the field and to satisfy intellectual curiosity, but time is a zero-sum game. Every minute and bit of energy spent in research is taken away from earning money, building a practice, and just relaxing. For academics, aside from these rewards, they also are motivated by promotion and tenure. To use a cliché, they must publish or perish. Therefore, any energy spent on practice activities detracts from the research that will determine the viability of their careers. Sadly, the same goes for energy devoted to teaching, ostensibly the activity for which they were hired.*

You mentioned earlier, quite accurately, how the agenda of NIMH has shaped the direction of many research efforts. Now add to that the criteria for promotion and tenure. Major research universities (and many research positions in hospitals) *hire young faculty members and expect them not only to produce research but to get funding to do so. Is it any wonder that their energy is spent doing as NIMH bids? Follow the money, and you will end up where we find ourselves, discussing a disconnect between the research produced and the needs of practitioners. Are there any ways out of this?*

GOLDFRIED: *I cannot think of a way to eliminate research funding as a most powerful reinforcer. What I do know, however, is that there are currently some very convincing reasons why we as a field need to close the gap between research and practice. We are being challenged by forces outside the system—namely, by biological psychiatry and third-party payers—to demonstrate that we can agree about how therapy works. An attack from outside the system can serve as motivation to get our act together and for researchers and clinicians to work toward obtaining a consensus in the field.*

You mentioned earlier something about the one-way street between research and practice, where the researcher attempts to disseminate findings to the practitioner. In trying to change this into a mutually beneficial collaboration between researchers and practitioners, Divisions 12 (Clinical) *and 29* (Psychotherapy) *of the APA have developed a collaborative effort to create a two-way bridge between research and practice* (www.stonybrook.edu/twowaybridge). *On the basis of surveys of practicing clinicians using empirically supported treatments* (ESTs) *in routine clinical practice for various anxiety disorders, several clinically observed issues were raised by practicing clinicians who are in need of empirical research that was not provided in the clinical trials from which the ESTs were derived* (Goldfried et al., 2014). *In essence, it represents an effort to disseminate clinical observations—the context of discovery—to the researcher about clinically born problems in need of empirical investigation. Like the articles in this series, it's about how cowmen and farmers can be friends.*

STRICKER: *I think we have done a nice job of describing some of the obstacles to transportability, such as funding and other reward systems, attention to questions that are not of concern to practitioners, and flawed research designs. We also have looked to some solutions, such as more naturalistic settings for more flexible research designs, seeking convergence in findings, practice research networks, the two-way bridge you described, and generally, more attention to questions of interest to practitioners. I'd like to finish up with some thoughts about how we got to where we are.*

Training in clinical psychology was modeled after the recommendations of a conference in Boulder in the late 1940s. The conferees recommended a novel and ambitious approach, aimed at producing scientist–practitioners (S-Ps). *Training programs for other helping professionals were content to restrict themselves to training practitioners, but psychology would undertake to train people in both science and practice, knowing full well that graduates probably would veer toward one or the other. For the first 20 years, almost every training program claimed an S-P model, yet science was spelled with a capital S and practice with a small p. After all, the senior faculty members were all accomplished scientists, and they hired junior faculty members in their own image. Furthermore, as we have mentioned, the reward system encouraged the new hires to concentrate on their research productivity and ignore clinical training. Some graduates of these programs really took to this model and became S-Ps* (we both are from that generation), *but most were content to seek jobs in practice, which was their intent when they entered the program. Unfortunately, they felt ill-prepared for their careers* (I treasure the training I received, but my meaningful doctoral clinical training all took place during my various clinical placements).

This disparity between student goals and program model led to the professional school movement and the development of the PsyD. These schools usually endorsed a practitioner–scholar model (Don Peterson, who developed the PsyD, thought this was a redundant term, as all practitioners were scholars—would it were so). These programs usually were formed at smaller schools or free-standing institutions, and so the usual criteria for promotion and tenure were not present and many practitioners were hired for the faculty. Graduates were happier and felt better trained, but a clear dichotomy was developed between the science programs and the practitioner ones, even though many still claimed an S-P model.

What I find interesting is that the curricula of the two types of programs are remarkably similar, because both strive to satisfy APA requirements for accreditation. All students still receive nominal S-P training, regardless of the type of program. I still think this is the best model, but the courses are taught somewhat differently, both in content and in attitude. The gap we are addressing is narrowing, but it still exists, and the solution probably lies in the training students received. I wish I had some good ideas about how to do more to correct it. Do you?

GOLDFRIED: *I wish I could say that I do. Certainly, the efforts of those who have contributed to this special section of the journal represent a step in that direction. I hope that you and I have highlighted some of the issues involved in the clinical research gap, and the torch may now need to be passed to graduate students and young professionals, who need to ask themselves: "What do I want the profession in which I will be spending the rest of my career to be like?" And "What can I do to make that happen?"*

STRICKER: *That should wrap it up for us Marv. I've enjoyed the opportunity to collaborate with you again, even in this unorthodox format. Thanks for participating. I hope our readers benefit from this exchange as much as we've delighted in doing it.*

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