The gulf between research and practice has, in many respects, widened in recent years, as seen in the movement away from Boulder model graduate training, and is accompanied by an increasing belief that one must be exclusively devoted to either clinical practice or research. Although the dilemma between science and practice may also exist in other fields (Beutler, Williams, Wakefield, & Entwistle, 1995), familiar questions continue to be asked for which answers are not immediately forthcoming. Why do researchers continue to fill the professional journals with empirical research that seems to have little relevance for the practitioner? How can practitioners offer their services to the public without concern for applying the most current research of their profession (or worse, making "scientific" claims that are not based on empirical research)? Unfortunately, accusations and polemics have frequently replaced attempts to create open dialogue, contributing even further to the separation between research and practice.

In this chapter, I refer to a number of personal experiences as both a researcher and a practitioner to illustrate the extent of the gap between research and practice and to suggest some possible new directions for ad-
dressing this problem. My professional career has been largely devoted to understanding what skills are needed for the successful practice of psychotherapy, what requisite therapist attributes underlie competent performance, how to train others to attain these abilities, and how to detect individual variability in performance. These activities have demanded participation in both the research and practice ends of our profession, and have forced me to give serious consideration to how these activities might be better integrated. I begin this chapter by focusing on how the activities of research and practice, as they currently exist in our field, create and perpetuate isolation. I then consider how each activity has the potential to contribute to the advancement of the other. Finally, I discuss some promising avenues for the synthesis of research and practice.

INTEGRATING CLINICAL PRACTICE: THE RESEARCHER’S DILEMMA

Assumptions about the separation of research and practice are common and often create the perception that it is not possible to dwell in both worlds. For example, when applying for my psychology internship, I had stated my long-term plan of being active both as a practitioner of psychotherapy and as a researcher in a department of psychology. During the internship, however, I directed all of my attention to clinical practice, and discussions with supervisors focused on the professional practice of psychotherapy. I once again became aware of the isolation within the worlds of research and practice when, a month into the internship, one of my primary supervisors seemed to question my devotion to the world of practice. He noted, “I think it’s a good idea to take a year to do some practice.” I was somewhat taken aback by this comment because I hadn’t previously mentioned to this supervisor that I had serious research interests, nor had I said anything indicating that I viewed my internship year as a hiatus from research activities. Had I been branded as the sole “researcher” of my internship class? Had I shown myself to be even more of a neophyte practitioner than I had previously thought? Had I accidently brought in research data and left it behind in the lunchroom or some other conspicuous location?

My supervisor’s comment had been a friendly invitation to discuss the shaping of career goals, but the comment also illustrates that research and practice are commonly perceived as separate domains, with radically different career paths. This was also an eye-opening and realistic portrayal of one of the unwritten rules of clinical psychology. That is, my supervisor had been correct to note that remaining on a research–academic career path would require not indulging in full-time clinical practice beyond the internship year. It is exceedingly rare to devote a year to full-time clini-
cal practice, beyond rudimentary training, and then enter the research–academic world (I can’t think of anyone who has done this). I had not previously realized that devoting more than the required amount of time to clinical practice would be viewed by some as equivalent to a “gap in the vita”—or worse!

The gulf between research and practice has also widened because of various marketplace forces that have drastically altered the nature of clinical practice. Researchers, who have a smaller portion of time to devote to practice, are less likely to invest more time to procure placement on managed care provider lists. In addition, many beginning researchers are effectively shut out of clinical practice by increasingly stringent and adversarial state licensing laws that require 1 to 2 years of postdoctoral clinical practice. Some states also place strict limits on the amount of time that can be taken to accumulate these clinical hours and do not make exceptions for researchers. To receive the privileges of licensure, the researcher must not only work 70+ hours per week doing research and teaching (with the accompanying worries of promotion and tenure) but must also “moonlight” in clinical practice to be recognized as a legitimate practitioner. Curiously, many of these unlicensed researchers are developing new treatments and are instructing the next generation of clinical practitioners.

The researcher may also become frustrated by the inclusion of metatheoretical postulations that predominate the practice of some clinicians. Many of these clinicians practice from a psychoanalytic theoretical perspective and have little interest in empirical findings. I also rely on a psychodynamic theoretical orientation in my practice and have personally experienced how metatheory may transform clinical data. Although I have, at times, previously engaged in this sort of “wild analysis” (Anderson, 1986), I have become convinced of the dangers of theory that is not informed by more critical observational checks and formal empirical efforts. Equally frustrating for the researcher is the “lone ranger” mentality of some clinicians, who rely exclusively on their clinical wisdom, an entirely intuitive approach that is not informed by either research or theory.

Part of the problem, as I see it, is that the assumptions of many psychoanalytic theories are not easily testable, and most theorists are not interested in using research to modify theory (e.g., Grunbaum, 1984). As theory increasingly replaces systematic procedures for observation, its perceived explanatory powers grow exponentially. For example, one of my colleagues described a patient who had been slowly picking the fuzz from his sweater and carefully collecting it in his hand throughout the course of a session. The therapist conceptualized this incident as evidence for the patient’s oral-phase issues and his desire for enmeshment with the therapist because he had been symbolically “making a nest” from his sweater. I heard the audiotape recording of this session but believed that the patient sounded disengaged from the therapist and, if anything, his picking was...
self-punitive. "But then why did he carefully place the fuzz in his curled hand?" asked the therapist. This was a good question for which I have no answer. The therapist may have been "right" and may have been in a better position than I to understand the patient. From the lens of a scientist, however, I see this incident as an example of what may happen when global, untested theoretical postulates are used, unabated, to explain micro-observations of behavior.

Clearly, the researcher is at a loss for how to assist the practitioner in understanding highly specific incidents and may feel unfairly alienated when asked to explain behavior that is currently well beyond the reach of our science. However, clinicians must frequently make sense of powerful interpersonal transactions, with theory commonly as the only conceptual guide available. Although there are clearly limits to what research can do, I also believe that contemporary research—especially in the past 15 years—has been accumulating findings that could be of great use to the practitioner.

**RESEARCHER'S CONTRIBUTION TO PRACTICE**

Although a number of barriers have been established that discourage the researcher from venturing into the world of practice, the findings from contemporary applied research have the potential to greatly benefit practitioners. This increased applicability of research for clinical practice may be largely due to the move away from "horse race" comparison studies between treatments of competing theoretical orientations and toward an increased attention by some researchers to identifying effective processes within psychotherapy (Strupp, 1989).

One of the more valuable lessons that research has to offer the practitioner is the broad and pervasive influence of the therapeutic relationship. For example, research on the therapeutic alliance has repeatedly shown that a positive alliance between therapist and patient is related to good outcomes in psychotherapy (Horvath & Symonds, 1991). Although a positive therapeutic alliance has been found to be significantly related to outcome across therapeutic modalities (Gaston, Marmor, Gallagher, & Thompson, 1991), this relationship may be slightly higher when outcome is measured with interpersonal measures and somewhat lower when outcome is measured with symptomatic measures (Horvath & Greenberg, 1994). Research also shows that these relational qualities may be especially crucial in the early stages of treatment (e.g., O'Malley, Suh, & Strupp, 1983). The success of the therapeutic alliance construct is also evidence of how our profession may profit from the collaboration of practice, theory, and research. The construct arose out of observations from clinical work and was quickly incorporated into theory and later entered into the researcher's vocabulary (Horvath & Greenberg, 1994).
It is partly the cooperation of these practice and research communities that led me increasingly to focus more on basic relational qualities and less on pure technical considerations in my own clinical work. I believe that there have been a number of healthy by-products, increasing my therapeutic focus on the relational atmosphere and the transference. Perhaps the greatest change has been an increased interest in listening to my patient’s communications at face value and without translation into abstract, metatheoretical conceptualizations. This point was never lost with my post-doctoral mentor, Hans Strupp, who repeatedly emphasized to me, with only some humor, the essential principles of psychotherapy: “There are three essential ingredients to successful psychotherapy that you should carefully note: First, there is the relationship. Second, there is the relationship. And third, there is the relationship.” Could there be a better integration of clinical wisdom and scientific parsimony? I think not!

Research on the alliance also might provide a useful lesson about some of the issues involved in the successful collaboration of research and practice. The definition of the alliance is quite broad, which may allow it the flexibility needed to be useful for both researchers and clinicians. While practical and effective, the alliance construct remains somewhat vaguely defined, and it is unclear, for example, whether the alliance is made up of multiple underlying components or of a single general factor. This allows some flexibility in interpretation, both for the researcher and the practitioner, but may influence researchers (myself included) who wish to understand the nature and underlying causes of the alliance’s positive effect.

Another research area that has arisen out of the work of practitioners concerns the effects of affective experiencing in psychotherapy. Exploratory therapies, particularly Rogerian ones, have observed that encouraging clients to deepen their awareness and expression of emotion in therapy was related to positive outcomes. These clinical observations were then tested with a number of empirical studies that used Klein’s Experiencing Scales and similar measures, resulting in findings that linked experiencing to outcome (Klein, Mathieu-Coughlan, & Kiesler, 1986). The successes of the experiencing construct are limited by the same difficulties surrounding the alliance construct. Both phenomena are broadly defined, allowing for mutual understanding by researchers and practitioners. However, this also makes it more difficult for researchers to specify the nature and underlying causes of experiencing and equally difficult for the clinician to know how to differentially apply the findings from this research.

Recent research has elaborated the experiencing construct so as to make it somewhat more precise and clinically useful. Stiles et al. (1990), for example, developed a stage model that incorporated components of affective experiencing as well as more recent developments in experiential theory (e.g., Greenberg, Rice, & Elliott, 1993). The Assimilation of Problematic Experiences Scale is a developmental-stage model for therapy.
process and outcome that progresses from a client’s increasing awareness of problematic experiences toward cognitive insight and mastery.

As a graduate student, I became involved in attempts to apply Stiles’ scale to clinical cases (e.g., Stiles, Meshot, Anderson, & Sloan, 1992). As a member of Stiles’ research group, I presented one of my therapy cases for consideration in an initial attempt to apply the assimilation model to clinical material. This was a client whom I had been seeing in the department’s psychology clinic and whom I had boldly proclaimed as a remarkable clinical success (dare I say “cure”!)! Week after week, this client had demonstrated a willingness to explore her problems and had seemed to make numerous personal “discoveries.” As we examined the case with the scale, however, it was difficult to identify the events in which change occurred. Indeed, our group had great difficulty in identifying any of the client’s problematic experiences, and it became increasingly clear that she had spent most of her time reciting a series of neatly packaged “insights.” Furthermore, there had been little affective experiencing in her weekly reports, and her insights seemed canned and intellectual. We speculated that she had been attempting to ward off unwanted thoughts about other issues that were more personally meaningful (the first level of this scale). Examining this case with a research-informed focus (Soldz, 1990) was instrumental in altering my approach, and this marked a turning point in my work with this client toward greater focus on current and substantive issues.

It is important to note that the lessons from research will not only benefit the neophyte therapist but also the more experienced and savvy one. Perhaps one of the more valuable applications of a research orientation consists in the heuristic value of applying process methods and scales to one’s own clinical cases. As Strupp (1986) noted, many experienced therapists believe that some of the most basic and essential lessons from research are not applicable to themselves. For example, practitioners often readily agree that pejorative interpersonal communications by the therapist are harmful but that half also tend to believe that they are immune from such events. Research indicates, however, that the therapist who can withhold pejorative responses to a hostile patient is exceedingly rare!

Other aspects of the patient’s affective experiencing in therapy have been informed by my own research into the lexical use of affect in psychotherapy sessions. For example, I found that the total frequency of the affective language used by patients was not predictive of outcome, but the nature of the affect was (Anderson, 1995). Early in treatment, patients who spoke with a greater proportion of negative affect words were more likely to have good outcomes. In another study, I found that the strength of a person’s use of affect constructs to influence evaluative and behavioral constructs was indicative of mental health (Anderson & Leitner, 1996). What has made these types of studies personally useful in practice is my thorough knowledge of the data, including a working knowledge of the
affect lexicon and how these words are classified. The usefulness of this research is not so much in the creation of carefully planned interventions or in consciously counting words but, rather, in developing a larger knowledge base and well-rehearsed strategies for intervening.

Much of clinical research is also likely to be most usefully applied to the clinical work of those directly involved in the research process, and these practitioners who later read a research report of the findings will be hard pressed to apply the findings in clinical work. Practitioners may find it difficult to gain more than a cursory understanding of group-difference findings found in research journals. Therapists may also have difficulty finding and implementing measures from research into practice, even though some have made great strides toward making these measures more “user-friendly” (e.g., Greenberg & Pinsof, 1986; Ogles, Lambert, & Masters, 1996). Practitioners may also have problems in generalizing research into more tangible clinical applications. Although the increased number of newsletters and practitioner journals should continue to assist practitioners to make use of empirical findings, it might be useful to expand these avenues of communication to provide greater detail and to better link the data to clinical phenomena. Extensive clinical examples, perhaps videotapes of clinical phenomena that illustrate empirical principles, may make our research findings even more useful. However, creating this link may mean additional work for the researcher. Most researchers consider their work to be complete after publication of their findings in a professional journal. Practitioners may have difficulty making use of the lessons of research because the format of research journals tends to be more congenial to the production of future research than to the direct application of clinical work. However, researchers may be instrumental in developing new media for communicating data that is relevant to the types of problems that the therapist encounters.

INTEGRATING RESEARCH: THE PRACTITIONER’S DILEMMA

The practitioner’s underinvolvement in the research process does not appear to stem from a disinterest in research but is more likely related to negative attitudes of some researchers about clinical practice. The vast majority of practitioners are respectful of science and regularly read scientific journals but hold to a different scientific criteria of evidence than the researcher (e.g., Beutler et al., 1995, reported that 80% of clinicians regularly read scientific articles and journals). Beutler et al. also noted that researchers do not reciprocate this interest and generally fail to acknowledge the value of clinical practice. Thus, the practicing clinician is faced with the dilemma of finding a way to integrate research into his or her
practice, while gleaning this information from researchers who are often disinterested in the practitioner’s work.

Practitioners know that the environment in which most research takes place, the academic department of psychology, is often disdainful of clinical practice. Clinical faculty in many psychology departments may feel that their active interest in clinical work, clinical training, and the concerns of “service providers” are on the order of an ignominious secret. This fact alone illustrates the extent to which the concerns of practitioners are perceived by many as alien and disruptive to the activities of clinical science. For example, the research–practitioner faculty member often must take any practice-related activities to nonuniversity facilities. Although there are many reasons for this, other faculty who have no interest in practice are reluctant to acknowledge that the experience of practice informs research in vital ways (especially with psychotherapy process research) and is not simply a salary supplement. This attitude contributes to preventing departmental psychology clinics, if they exist at all, from developing truly applied laboratories for the intensive study of individual cases. Instead, these facilities often become a distant outpost in departments, serving only to meet minimal training requirements or perhaps as a site for a few larger studies.

Graduate students, the vast majority of whom become practitioners (even in clinical science programs), observe the intense disdain for practice by their mentors and are compelled to hide any genuine interest in a career as a service provider. For example, a colleague told me about his graduate training in such a department. When he asked a faculty member about career options, he was bluntly told, “Students who graduate from this program have two clear career paths. You can go into research or you can go to hell.” He also noted that those graduates of his program who went into clinical practice were simply erased from the faculty’s memory!

Practitioners may also be wary of researchers because they may perceive the conclusions drawn by some researchers as actively undermining the professional existence of practitioners. For example, Dawes (1994) concluded that because research shows no effects on patient outcomes for doctoral-level training in psychotherapy, there is no need to continue to train clinicians to be service providers. It is understandable that many practitioners would be defensive in the face of such an interpretation of the data. It is also arguable that practitioners may not be in the best position to render a fair and balanced interpretation of the research on training (and similar professional issues) because the practitioners’ livelihood will be influenced by the verdict. Clinical scientists who do not engage in the activities of practice are also potentially biased. Those who engage solely in practice or research belong to separate guilds with differing, and often conflicting, interests to promote in regard to training and maintenance of their group’s power. Research guilds, in academia, and applied
clinical guilds, in licensed practice, often battle over control of the same knowledge domain. As Krause (1996) noted, guilds exist through monopolies of their domain and protection of their skills:

The skill and the group possessing the skill were thus equated. Without solidarity in the guild system, the skill would no longer be a mystery. Without sole possession of the skill and the tools to use it (which often meant fighting closely related crafts over turf) the guild had no power. (p. 5)

It may be that the “turf battles” between researchers and practitioners have grown in recent years because there is greater pressure from outside forces to compromise the integrity of both research and practitioner guild systems (i.e., compromises in the tenure system and in managed care). These turf battles often emerge over issues of state licensing, professional associations, and the curriculum in clinical programs. Arguably, those who are engaged in both research and practice may be able to be the most objective in interpreting the meaning of controversial data (e.g., studies showing no treatment outcome differences between trained practitioners and paraprofessionals) because they have both the understanding of the scientific issues of inference and, perhaps, the least conflict of interest. Scientists who engage in practice may also have a deeper understanding of the intricacies involved in psychotherapy and training, allowing them to be more attentive to the potential confounds that might exist in past studies and thus less likely to accept some studies at face value.

PRACTITIONER’S CONTRIBUTION TO RESEARCH

A 20-year-old college student who was exceptionally bright and driven came for several sessions of psychotherapy. He was depressed and somewhat anxious, which he attributed to having little personal sense of his identity and what he valued. He complained of having simply coopted his parent’s goals and values without having struggled to find his own answers. Throughout the therapy, which lasted a little over a year, he came to realize that much of his need to achieve related to the hope that others would approve of him. My sense was that he had realized that he wanted others to accept him as a “whole” person and not simply perform for the approval of others. He ultimately decided to leave school for a year or two and move to another state to become a ski instructor. It was not his belief, nor mine, that this decision was reactive or impulsive, and we spent the final 2 months of therapy considering the implications of this decision.

Can such an ending to therapy be considered a “good” outcome? He clearly improved in regard to symptom reduction, and I considered him to
have made some structural change as well. However, he was at an impasse, and it seemed that we had progressed as far as possible without further maturing on his part, which would require him to have experiences that would help shape his identity. His parents, however, had a completely different view of the outcome, which I became thoroughly aware of when he told them of his decision to leave school. They were convinced that their son was “throwing away” his life by leaving school, and their view was likely representative of society's view of this outcome. Yet the parent's assessment of his outcome was also valid in that there could be some serious consequences to his decision, and I was also sympathetic to their point of view.

Although the above case would likely be considered successful in most research settings, the practitioner must often consider a wide variety of competing values that are intertwined within the context of a person's life. The fact that clients may change in numerous ways highlights the importance of contextual factors for both researcher and clinician. In the above case, the client had improved in some regards but had not changed in other ways—the evaluation of the outcome depends, to a large extent, on whose perspective and values are considered. Unfortunately, research to date has often neglected this multidimensional view of outcome, and the few complex outcome models that exist (e.g., Strupp, Hadley, & Gomez-Schwartz, 1977) have not received sufficient empirical attention (Lunnen & Ogles, 1998).

The goal of the treatment researcher is, by and large, to remove the contextual aspects of treatment to isolate the effects of specific techniques and outcomes. The practitioner, however, tends to be more cognizant of the fact that techniques are always applied within a wide variety of contexts.

The practitioner is typically faced with a highly diverse patient population and often must negotiate the problems of external validity on his or her own. The practicing clinician will frequently treat patients who would have been excluded from many studies because the selection criteria from large-scale efficacy studies often exclude the majority of patients who apply for treatment. Those patients who are the least disturbed (e.g., who do not have dual diagnoses), and who are especially suited for the planned intervention, tend to be the patients who are selected. Treatments are of circumscribed duration and highly controlled, often through the use of a treatment manual (Seligman, 1995).

Given these limitations, researchers can do little to assist clinicians in negotiating how to make these interventions within a complicated clinical context. Research has only been moving incrementally toward answering the following basic question: “What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances, and how does it come about?” (Paul, 1969, p. 44). This
Attention to contextual complexity is often viewed as a nuisance variable by the researcher. However, as Leitner (1995) noted, “clinicians are likely to demand that assessment devices be more relevant to complex clinical realities” (p. 57). Because practitioners spend an inordinately larger amount of their time negotiating numerous contextual factors (i.e., what intervention may be most beneficial to this individual, at this particular moment, within the specific history of this unique patient-therapist relationship?), the researcher may learn directly from the practitioner about the numerous contextual factors of clinical practice, if only to understand the sources of such nuisance variables. Ironically, the direct knowledge about delivery of psychotherapy and interpersonal processes, acquired through extensive training, may be one of the most valuable, yet underused, observational tools available to treatment researchers.

As Stricker and Trierweiler (1995) have aptly noted, research data that are collected in clinical practice are exceedingly complex because both the participant (or “subject”) and the scientist contribute to the phenomenon being studied. Thus, the relationships among psychotherapy researcher, therapist, and patient may also have “generative” qualities, because of both demand characteristics and experimenter effects. These influences are not readily recognized in psychotherapy research, even though they have been repeatedly demonstrated in social psychological research (e.g., Orne, 1962; Silverman, 1977). Gergen (1973) and Rychlak (1985) have even suggested that these effects are not simply confounds but are analogous to Heisenberg’s uncertainty principle in physics because the observation of interpersonal phenomena, by definition, cannot be unobtrusive and necessarily influences the nature of the phenomenon being studied.

Extensive experience with clinical practice may be one of the best means for developing methods and measures that are sensitive to the complexity of most therapeutic settings. Contextual influences were the focus of a study that examined the potential influence of demand characteristics in the Vanderbilt II Psychotherapy Study, a study on the effects of manualized training. The main findings of the study were that therapists applied more of the interventions from the manual after training but that patient outcomes were not significantly altered. Anderson and Strupp (1996) examined how the results were influenced by the research setting and role demands of patients and therapists. Using interviews that were specifically designed to measure demand characteristics, we found that those patients who were especially aware of their role as a “subject” in the experiment had outcomes that were dramatically different from those patients who did not report such demands. Patients who experienced high demand characteristics had outcomes that were consistent with the researchers’ hypotheses, even though these hypotheses were not directly communicated to patients by the researchers. These effects existed for patient and therapist
assessments of outcome but did not exist for the outcome assessment of independent clinicians. Furthermore, therapists altered their approach to treatment with those patients who were acutely aware of their role as a “subject” and did not use the manualized interventions that had been taught by the researchers. That is, therapists seemed to withhold the research-based interventions when they sensed that their patients were sensitive to being in a research project.

When patients play the role of a “subject,” they generally do so at the expense of deepening their understanding of core issues and of their ability to make use of therapy. Leitner (1985) has highlighted the distinction between “roles,” as in the many social roles that most people use (e.g., “subject,” “patient”), and the more difficult roles, which refers to the unique capacity that another can play in more vulnerable aspects of intimate relationships. As Leitner noted, roles often protect or prevent one from taking the risks to develop role relationships. If some research methods create greater demand characteristics and increase the patient’s awareness of their role as “subject,” then it may be more difficult to develop a role relationship. Regardless, attention to the research context is required by the therapist. We found that some therapists were reluctant to explore the patient’s role as a “subject” even though these therapists readily explored a variety of other limiting roles and maladaptive patterns. The issue of demand characteristics, then, has the potential to dramatically distort the nature of treatments that occur in a research setting and to likewise distort the validity of research findings. One solution to this methodological problem would be to increase the involvement of the participants in the research process, which would also help narrow the gap between research and practice. The use of a participant–observer research paradigm would imply a reconsideration of our view of scientific control. For example, the researcher who also engages in clinical practice would be a participant–observer, as would his or her clients. Such a model would also imply that patients and therapists in research studies would no longer be treated as “subjects,” but as true collaborators in the research process.

Practitioners can play an important role in research because they are intimately involved in these and other contextual factors that exist in the therapeutic relationship. Without working with practitioners, researchers may not be able to discover the intricacies of outcome and process measurement. However, because practitioners are also participants, they may not always be aware of how or why the context influences their clinical work. Psychotherapy researchers may benefit from a strategy of collecting as many unique reports, or lenses, as possible to fully “expose” the phenomena being studied (e.g., Packer & Addison, 1989). Clearly, the practitioner’s perspective is one lens that has been underused in psychotherapy research.
CONCLUSION

Although the relationship between research and practice may often appear to be analogous to a stormy marriage (Elliott & Morrow-Bradley, 1994), a working relationship is necessary for the sustenance of any applied science. I have come to see the separate activities of research and practice as necessarily interrelated and complementary, but not naturally well suited for one another.

The mix of cognitive and interpersonal skills used to perform research and practice is often quite different and not easily interchanged. For example, as both a psychotherapy researcher and a practitioner, I have found that the processes involved in each activity are sufficiently different to require time to transition when changing from one sphere to the other.

On the one hand, research skills place an optimal weight on critical and logical thinking. Research involves a cognitive style that involves procedural knowledge and a focus on control and exclusion of variables to achieve the most parsimonious explanation. Context is typically important only to the extent that it alerts the researcher to confounds that interfere with external validity or, at best, the existence of moderating variables that have a “fixed” position in the researcher’s nomenological net.

On the other hand, the practitioner's skills are more interpersonal, less critical, and often involve being open to a range of explanations (regardless of their formal logical integrity) that are taken at face value and from the perspective of another person. The practitioner is less narrowly attuned to the issue of parsimony and may be more prone toward the contextual nature of clinical data. Because of the complex and vast amount of meaningful data in the clinical setting, the clinician may best rely on implicit or tacit strategies. That is, the practitioner uses numerous clinical skills with little or no forethought, and often the clinician cannot immediately explain the complex processes used in reaching a solution. These processes of complex ways of knowing may be difficult for the practitioner to verbally articulate and are sometimes referred to as “clinical wisdom,” a phrase that is poorly understood but is certain to quickly boil the blood of some clinical scientists (e.g., Dawes, 1994). Researchers, for example, are often more interested in the clinician's formal cognitive decision-making strategies (e.g., diagnostic decision making) than in the interpersonal skills that occupy most of the therapist’s time. Another way to understand the practitioner's abilities is that they involve interpersonal intelligence or knowing (Gardner, 1983), whereas the researcher's talents may draw more heavily from traditional quantitative and verbal intelligences. These different problem-solving strategies may account for some of the disparagement between researchers and practitioners.

Perhaps the most important lesson to learn about the division between research and practice in our field is that there are no simple solutions...
for better integration of research and practice. The answers to how the gap can be narrowed are probably as apparent as are the answers to questions that both researchers and practitioners regularly ponder: What treatments are superior? What processes lead to good outcomes? How can therapists be optimally trained?

Creating better collaboration between researchers and practitioners will likely require a realization by both parties that answers are hard to come by in this field and will depend on cooperation. As Beutler et al. (1995) noted, the researcher may be more dependent on the practitioner in this regard. The advancement of our field will likely take place through open-minded inquiry and acceptance of alternative scientific paradigms. This goal may best be achieved through a more modest attitude and an appreciation for generating the right questions.

In conclusion, a number of changes in research and clinical activities may facilitate better cooperation in our profession. These changes might include greater concern for clarifying the goals and activities of clinical work. This does not necessarily imply specifying techniques in as narrow a manner as has been articulated through treatment manuals (Strupp & Anderson, 1997). However, researchers would be better able to collaborate with clinicians if there were more attention given to defining clinical activities. Another useful change might be for researchers and clinicians to find some common ground through greater use of naturalistic observation and qualitative research so long as there is structured use of the clinician’s skills.

Researchers may find clearer and less cumbersome avenues to communicate their research to clinician and make the tools for self-evaluation more accessible. Perhaps most important, both researchers and clinicians could better cooperate if each were considerably more humble. Although easier said than done, researchers could be less condescending about clinical work, and practitioners could be more amenable to the suggestion that the basic lessons of research are likely to apply to their own efforts.

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