INTEGRATING RESEARCH AND PRACTICE: WHAT HAVE WE LEARNED?

LEIGH MCCULLOUGH AND STEPHEN SOLDZ

As we read and reread the contributions to this book, we were struck by both the value of their unique contributions and the commonalities among chapters. Here we draw out some of the themes that we found common to several contributions. The elaboration of these themes allows us to assess the state of the research-practice relationship, as seen through the eyes of these scientist-practitioners. In several places we have taken the liberty to go beyond the individual contributions to draw conclusions and make policy recommendations that may not be endorsed by all the authors. In so doing, we hope to encourage discussion regarding ways to improve mutual understanding and collaboration between practitioners and researchers.

Many of the authors in this book gave us feedback on earlier versions of this chapter. We thank them for their help. We, of course, maintain responsibility for all opinions expressed.
RECOMMENDATIONS FOR COLLABORATION BETWEEN
PRACTICE AND RESEARCH

In reviewing the many and diverse chapters of this book, the contributing authors have offered many excellent suggestions. In the conclusion of this chapter, we wish to compile the main recommendations for improving relations between research and practice. These recommendations include the following:

1. There is a need for improvement in training.
2. Collaboration and communication between researchers and practitioners need to improve.
3. Researchers and practitioners need to collaborate in assessing outcomes.
4. There is a need for improved process research and single-case design.
5. Theory, qualitative analysis, and transtheoretical macroprocesses can play a bridging role in integrating research and practice.
6. Scientist-practitioners need to recognize the important role that passion plays in both the best research and the best practice.

IMPROVEMENT IN TRAINING: THE VIABILITY OF THE
SCIENTIST-PRACTITIONER MODEL

The professional contributions of the scientist-practitioners who authored this book demonstrate vividly the value of having professionals equally at home in the worlds of research and practice. The work of each remains clinically relevant while making significant contributions to the scientific understanding of the nature of psychotherapy. Whatever the final decisions on the balance of practical and research training in various graduate programs, we are convinced that there is great value to having a group of professionals who are at home in both worlds. To better develop these professionals, modifications in graduate training programs to increase respect for the conflicting demands of practice and research are called for.

However, as noted in the Addis and Anderson accounts of their graduate training, many “scientifically oriented” programs implicitly devalue clinical experience as a distraction from the research training that constitutes their raison d’être. As dramatically depicted by Anderson, many programs are beset by a contradiction: On one hand, the vast majority of graduate students become practitioners. On the other, their mentors often have intense disdain for practice, and all too often the graduate school dictum is “go into research or go to hell.”
One of the strongest proponents in this volume for improved training is Addis. He advocates an approach to the student process that is not from an "idealized ultimate scientist-practitioner" stance, but rather a realistic appraisal of the difficulty of integrating research and practice. He discusses the value of providing role models that successfully bridge both worlds, such as the authors represented here. Addis feels that access to such models will help students become aware of attainable integration and also help deter dichotomization. Perhaps role models can even help deter the split between clinicians and researchers all too common among the faculty in graduate programs.

Both McCullough and Goldfried point out the potential of research-based tools contributing to a deepening of clinical training. Psychotherapy transcripts, audiotapes, and videotapes, systematically examined, can be invaluable tools for training therapists in clinical skills while simultaneously fostering a deepening of the critical thinking more commonly associated with research training. Furthermore, greater attention to process research, which often has greater immediate clinical relevance than do other types of clinical research, could build bridges between practice and research even for the majority of students ultimately aiming at a clinical career. Such systematic process examination, combined with more careful attention to the measurement of outcomes, could increase practitioners' understanding of, and respect for, clinical research.

In developing new training models, it is important to remember that not all students will become active researchers, and a training system built on that assumption will lead to frequent disappointment. What we should strive for in graduate training is mutual understanding and respect, while accepting that the scientist-practitioner's career path is not for everyone.

Although this discussion has perhaps its greatest immediate salience in professional psychology graduate programs, it is also relevant to related fields struggling with the research-practice relationship. Both social work and nursing, for example, are increasingly emphasizing research training in their graduate programs. These fields may thus derive the lesson from the experience of psychology that systematic attention needs to be given to ways of building mutual understanding and respect between research and practice if the painful splits occurring in psychology are to be avoided.

**BETTER COLLABORATION BETWEEN RESEARCHERS AND PRACTITIONERS**

Goldfried points out that there are times when both practitioners and researchers are deluding themselves in thinking that they alone will advance the field. But, as he emphasizes, both groups very much need each other. Either we will view ourselves as collaborators, or we will wind up...
adversaries. Which of those two relationships is going to be the most constructive and lead to the most productive activity? "If one views the split between clinicians and researchers from outside the entire system, it becomes more evident that both groups are deluding themselves in thinking that they alone will advance the field" (Goldfried & Padesky, 1982, p. 33).

However, as we discussed in the introduction, there are serious cognitive and stylistic differences between research and clinical practice that interfere with collaboration. Nonetheless, the primary message of this work is that these differences can be reduced, both within individuals and among researchers and therapists as groups. The chapters in this book demonstrate many ways in which these obstacles can be overcome. Anderson, for example, stresses the need for communication, humility, patience, and respect for the differing traditions, preoccupations, modes of thought, and communication styles characteristic of these two endeavors. He emphasizes that researchers need practitioners, who are greatly underused in the research process. Soldz supplements this message by emphasizing the importance of the patience and respect that arises from joint work on mutually important projects. It is through collaboration, they argue, that improved relations between these two groups will be developed.

Collaboration between researchers and practitioners can further be facilitated by the National Institutes of Health (NIH) and other major funding agencies. For example, many of the substance abuse treatment studies in which Soldz has been involved in recent years have included service provider advisory groups to help researchers design the studies, develop research instruments, interpret the findings, and give information back to the practitioner communities that were so generous in facilitating the research. Funding sources, such as NIH, could encourage such collaborative processes by including them in requests for proposals or by giving points for their inclusion in grant reviews. Notable is the fact that the federal Substance Abuse and Mental Health Services Administration already does this for many of the studies they fund. Researchers might also be encouraged to have active clinicians involved in their research projects from conceptualization through publication. Similarly, practicing clinicians might be included on grant committees.

**BETTER COMMUNICATION BETWEEN RESEARCHERS AND PRACTITIONERS**

Neimeyer (chapter 7, this volume) laments the difficulties of communication exemplified by the very different "languages" used in research and clinical endeavors. "Like a speaker of both Spanish and English, I am prone to take up one or the other in different conversational contexts,
drawing on the somewhat different resources of each 'language' to envision and navigate the world of psychotherapy a bit differently. . . . Neither represents a complete language,. . . . neither can claim superiority to the other, and. . . . both are evolving” (p. 144).

Anderson and others note that researchers do not often read practitioner journals or attend practitioner conferences, nor are clinicians likely to read research journals. He recommends, therefore, that researchers should proceed from journal publication to clinical publication. Practitioners, after all, have often complained of the impenetrability and lack of utility of research publications.

In the development of improved vehicles for communication, attention should be paid to the different needs and traditions of writings aimed at researchers versus practitioners. For example, if researchers expect therapists to pay attention to what they have to say, it would be right for the researchers to pay respectful attention to the issues, modes of thinking, and concerns of clinicians. In addition to helping researchers better to understand clinical practice, it is further necessary that the research community become more aware of practical issues that surround the practice of psychotherapy, such as concerns about the impact of managed care and the declining length of treatment.

The new mechanisms of communication between practitioners and researchers that are needed may include “clinically oriented publications” such as the new journals described by Goldfried, books of well-studied transcripts such as those described by McCullough, clinical manuals as developed by Elliott, research newsletters for clinicians, clinical briefings for researchers, new forms of collaborative conferences and case conferences, and so forth. Experimentation is needed—starting with the development of multiple channels of communication—to determine which mechanisms are most appropriate for communicating what information to particular audiences. Research from the domains of communication studies and adult development may prove useful here. Perhaps, also, the creation of sophisticated psychological “science writers” could also help bridge the communication gap.

NEED FOR COLLABORATION IN TREATMENT EVALUATION AND ASSESSING OUTCOMES

The assessment of the outcomes of clinical interventions is important, both to respond to the demands for accountability characteristic of the current health care climate and to guide attempts to provide improved services (e.g., the development of improved therapies). The measurement of outcomes provides numerous opportunities for collaboration between researchers and practitioners. Members of the two groups can cooperate in
the development of new outcome measures, leading to more user-friendly measures, as advocated by Anderson, for example. Such collaborations are simultaneously likely to have the positive effects discussed by Soldz, and to help ensure that the resultant measures are clinically relevant as well as psychometrically sound.

The field could benefit from the development of a widely used omnibus instrument such as described in chapter 6. But in lieu of a single instrument, many specific measures currently exist. Goldfried recommends that clinicians be encouraged to use existing tools that they are familiar and comfortable with. Such tools include the Beck Depression Inventory, the Role Construct Repertory Grid, the Minnesota Multiphasic Personality Inventory, the Structural Analysis of Social Behavior, or target complaint ratings. The Inventory of Interpersonal Problems, which assesses a range of interpersonal presenting problems of psychotherapy patients, is another good example here (Horowitz, Rosenberg, Bauer, Ureno, & Villasenor, 1988). These measures, obtained at intervals during treatment, can be a great way to provide feedback about the effectiveness of treatment.

The Policy Makers

There is a whole constituency or group of stakeholders that has not been addressed in this discussion: the policy makers. They range from federal and state bureaucrats to payers (including managed care companies, employers, insurance officials, etc.). These groups are having a profound influence on practice in the field of psychotherapy, and yet they are often ignored by the research world and in the discussions of the relationship of research and practice. These forces are moving rapidly and strongly. Already the nature of psychotherapy and other psychosocial treatments has been transformed through their influence. The calls for accountability and periodic outcome measurements are radically changing the terms of the debate in a way that is almost invisible to a reader of any of the major research journals in the field.

For example, in Massachusetts, the main trade association for the large mental health clinics has adopted an outcome measurements initiative, whereby all patients at their participating clinics (numbering in many thousands a year) will be receiving a standardized intake and periodic outcome measurement, partly as a response to the influence of Medicaid managed care in this state. As another example, federal initiatives are under way to encourage all states to develop outcomes monitoring systems for publicly funded substance abuse treatment. These types of initiatives are growing rapidly, much more rapidly than the influence of traditional researchers. Thus research is being forced into the clinical realm in a way that often is carried out by people—such as program evaluators, health
services researchers, economists, and for-profit companies selling outcomes instruments—who are different from traditional psychotherapy researchers and triggered by different issues and arising out of different traditions.

Note that only a few of the authors have devoted much attention to these issues. The image of therapy and practice that most of us have, is that of the traditional private practice clinician, a model that is rapidly diminishing, either through the transformation of therapists becoming salaried employees, or the new model of quasi-employment of people on managed care panels where significant decision making is being done by officials of managed care companies, transforming what are nominal private practitioners into virtual employees. Although there is considerable uncertainty regarding the future of managed care in particular, it seems likely that in the future we will continue to see an evolution toward organized systems of care of one type or another. Very few of our contributors, including ourselves, seem to acknowledge the public sector practice of therapy or the trends just described that may herald the decline of the private practitioner as the primary provider of psychotherapy. As pointed out by Benjamin, however, much of the managed care provision of “treatment” amounts to nothing more than a 6-session assessment and has little to do with therapy at all. Despite whatever transformations occur in the way psychotherapy is delivered, there does remain and will remain the need to find effective ways to heal human suffering. Private practice, at least for some, may remain because it may be that the only way patients can obtain a significant period of treatment is to pay directly for the service.

In any case, as demonstrated by the contributors to this book, psychotherapy research, through elucidating the nature and processes of change, has great potential to contribute to the development of more effective treatments. Greater efforts are needed, however, to figure out how it can be incorporated into the evolving structures of health care delivery. The research on short-term psychotherapy, for example, has been translated into procedures and methods that can be used in a managed care setting, but research sometimes ends up accomplishing far less than anticipated.

Prochaska’s chapter suggests a model for using research knowledge in a forceful and far-reaching way to guide new forms of practice. To make a strong impact on large numbers of people, he is in favor of implementing research-based systems through programs involving government, business, and health care. Prochaska says clinicians and researchers together need to be proactive to create the future of behavioral health care, or the future will be created for us. He sees the future (based on science and service) in which organizations will be transformed from illness services to health services, shifting from an almost exclusive reliance on cutting costs to a large investment in preventing costs. He even envisions “change management experts”—proactive, preventative, and population-based—applying inter-
active technologies as well as interpersonal skills to continue to be at the cutting edge.

**Empirically Supported Treatments**

Despite their potential benefits, an emphasis on the potential limitations of empirically supported treatments (ESTs) is apparent in most of the chapters in this book. Most of the authors, researchers all, appear to be at least as troubled about the dangers of ESTs as straitjackets for the field as they are pleased by their potential benefits. Benjamin, for example, argues strongly that the EST approach may be "penny-wise and pound-foolish" and may result in depriving us of long-term therapies so needed for the more severe (notably personality) disorders. Goldfried emphasizes that clinical work varies greatly, while research protocols do not. Anderson raises the point that a focus on ESTs often distracts from the primarily interpersonal nature of psychotherapy. Dahlbender and Kaechele complement Anderson's arguments with a focus on what they see as some of the political aspects of the EST movement. Addis, who, among our authors is most sympathetic to the intent toward identifying and training in ESTs, still has reservations regarding the degree to which the research leading to identification of ESTs is applicable to the majority of patients seen in real-world clinical settings.

There are several additional issues only tangentially raised in the chapters in this book but that are crucial nonetheless. Underlying much of the critique of ESTs is that few of these "empirically supported treatments" have actually been shown to be more effective than more common alternative treatments. At the current state of knowledge, that a treatment is not on the approved list is far from evidence that the approach is ineffective.

A further concern with ESTs as practice standards is how new, more effective therapies will be developed if therapists are restricted in their experimentation. Unlike pharmacology, where the enormous profits that accrue to the developers of new drugs motivate drug companies to spend hundreds of millions of dollars in research and development, in psychotherapy, as with food supplements, there is no funding source that will underwrite any such large-scale development efforts. Mandatory practice standards thus threaten the development of new treatments. Such issues will have to be resolved prior to wide-scale adaptation of ESTs or other forms of binding practice guidelines. Nonetheless, as noted, there are increasing trends toward accountability and evidence-based or science-based practice. Where the proper balance lies between accountability and clinical intuition and experimentation is far from clear. As the struggles of our authors suggest, this issue will remain with us for quite a while.

David Winter points to what may be the best solution given the
current extent of our knowledge. He notes that although the British National Health Service is interested in identifying therapeutic approaches for which there is clear evidence of efficacy, they caution against an “overprescriptive, cookbook approach,” which might “stifle innovations” in therapy. The solution of the National Health Service was not to limit reimbursement to therapies that have empirical validation, but rather to insist that those therapies provided must be willing to subject themselves to research evaluation (Roth, Fonagy, & Parry, 1996). In other words, if proponents of a therapy model are not willing to cooperate in evaluation, the model should be out of the game.

IMPROVED PROCESS RESEARCH AND SINGLE-CASE DESIGNS

Abundant clinical trials have demonstrated that psychotherapy works, but we are only beginning to understand how it works, as well as for whom and under what conditions. One of the most promising ways we have of answering the pressing questions of patient-specific treatment is through controlled, intensively recorded and studied, single-case experimental designs. Optimally we might envision in the coming decades a worldwide accumulation of hundreds or even thousands of well-executed, single-case studies (following a standardized format) to begin to discern specific mechanisms of change.

A number of authors, including Goldfried, McCullough, and Elliott (see chapters 1, 2, and 6, this volume, respectively), advocate that therapists and clients explore the value of audio, video, or transcribed recording of treatment. Video recording is now frequently done in surgery and in athletic coaching. Close scrutiny of the session allows the therapist, like a football coach, to understand how important events were actually sequenced. Furthermore, this allows the therapist as well as researchers to assimilate therapy content that is often too complex, too fast-paced, and too emotion laden to grasp fully while it is ongoing.

Recording of the therapy process can provide the necessary behavioral grounding so that comparisons among treatments can be made even decades from now. Inevitably, methods will change, and treatments will change, but the frequency, intensity, and duration of maladaptive behavior and treatment interventions (if carefully documented) can be compared across time.

For many psychotherapy researchers, the ultimate goal of research is to improve actual therapeutic practice. Our authors provide illustrations of several ways such goals can be achieved. Many, for example, modified their own therapy practices as a result of their research findings. Some went so far as to develop treatment manuals in order to communicate their deepened understanding of the clinical process. Others view the research—
practice relationship as a necessary, yet never quite harmonious and always difficult, attempt at cross-fertilization between those with different tastes, styles, and agendas.

Both Goldfried and McCullough tell stories of trying to conduct a live demonstration to colleagues of a pure therapy technique and finding they could not adequately address the needs of the patients they were treating by rigidly adhering to one model. Goldfried describes how his colleagues encouraged him to "come out" from behind his one-way mirror demonstration, and follow his clinical intuition rather than a treatment manual. Both Goldfried and McCullough went on to develop new forms of therapy to encompass their clinical impasses.

Many of the contributors are implicitly adopting a craft model in which psychotherapy is seen as a skilled endeavor, based on slowly acquired knowledge and understanding and requiring adaptation to the unique characteristics of the material—in this case—the patient and the relationship, that perhaps may never flow on a one-to-one basis from scientific findings, but nevertheless, would be enriched and improved through scientific understanding. Research can inform through providing a skeptical framework for challenging cherished beliefs, examining the actual outcomes of therapeutic activity, and suggesting new perspectives on change processes. At the same time, researchers need to remain ever mindful that, in the minds of numerous clinicians, many common research strategies appear to simplify the complexity of artful interaction almost to the point of absurdity.

The authors of this book drive home the point that the relationship of research to practice is not one way. They emphasize that research on psychotherapy has a tremendous amount to learn from those who practice it. The consensus of most is that clinical work serves, at a minimum, as an arena for a discovery process—and research as a refinement, if not a radical revision—of that discovery. Practice is "search." Ultimately, most of the authors come down on the side of a collaborative model, whereby a greater whole can be forged from the cooperation of researchers and practitioners, and from the researcher and practitioner within each of us.

Many of the authors address the theme of the human relationship as at the core of good therapy of whatever persuasion. They thus argue that clinicians should remain free to follow their intuition, and that researchers should follow, humbly and respectfully, behind those on the front lines who are interacting under fluid circumstances with ever-changing patients.

**THE BRIDGING ROLE OF QUALITATIVE ANALYSIS, TRANSTHEORETICAL CHANGE PROCESSES, AND THEORY BUILDING**

One of the dilemmas of psychotherapy research is whether to investigate a particular model of therapy when the conclusions may only be...
relevant to practitioners of that particular model (and we have, of course, hundreds of different models). An alternative is to try to identify generic change processes that are transtheoretical.

There is far less research out there than clinical decisions to be made. It takes decades to do clinical trials, and it takes years to do process studies. Therefore, we have thousands of clinical decisions, for which there exists only a handful of research findings. So it is at the macrolevel that research is likely to have a broader impact. From a wide-range perspective, the more encompassing or inclusive our research hypotheses, the more useful they are going to be for clinical work. So, perhaps to make research more conversant or more helpful to clinical work, we need to find the common factors that all can recognize.

Although many of our authors have developed their own models of therapy, they also have used qualitative analysis to describe many generic processes within these models. We briefly summarize the processes they have identified here. Goldfried studied the clinical process at a level of abstraction somewhere between that of theory and technique to find common principles that promote change, such as (a) client expectations, (b) therapeutic alliance, (c) alternate ways of understanding, which sets the stage for (d) corrective experience. Goldfried uses these common principles as starting points and then returns to clinical observation to study them further.

In her generic theory, Benjamin identified five processes: (a) agree to fight problem, (b) learn to recognize problem and reasons for it, (c) block maladaptive patterns, (d) enable will to change, and (e) learn new patterns. Neimeyer and Winter used the overarching conceptual scaffolding of personal construct theory and its emphasis on personal-meaning-making as the essential component of therapy to guide their research. McCullough applies the well-studied behavioral principles of exposure and response prevention to “desensitize” conflicted feelings in psychodynamic treatment. In her model, the responses to be prevented are the maladaptive defensive behaviors. Exposure is to feared inner experience such as grief or anger, and later to appropriate expression of those feelings interpersonally.

Shiang adapted Beutler and Clarkin’s Systematic Treatment Selection by incorporating cultural considerations to guide her clinical work because these principles help order the overwhelming amount of information from the client and help guide her clinical thinking. Her modifications of these processes include the following four areas: (a) client variables, including culture; (b) client–therapist relationship and cultural match; (c) treatment contexts; and (d) psychotherapeutic strategies and procedures.

Prochaska has six identified stages of changes that indicate readiness for psychotherapy: (1) precontemplation (it’s not my problem); (2) contemplation (I’m not sure I’m ready to give up my problem); (3) preparation
(I’m not sure what to do); (4) action (I’m not sure I can keep doing it); (5) maintenance (I’m getting it), and (6) termination (I’m home free).

Elliott’s research-derived principles include the following six elements: (a) connect with and respect the client, (b) offer a warm empathic relationship, (c) facilitate client collaboration, (d) facilitate optimal client processing or experiencing, (e) foster client growth and self-determination, and (f) facilitate completion of specific therapeutic tasks.

We can see much overlap in these generic processes. More than one author has noted the importance of attention to the following elements: (a) client and therapist factors, (b) therapeutic connection or alliance, (c) the blocking or preventing of maladaptive processes, (d) corrective experience, and (e) maintenance of gains. Furthermore, these common factors are easy to understand and to teach to clinicians.

Studying these broad-reaching transtheoretical processes appears to be a way to get the most mileage out of research efforts that will have the greatest relevance to practicing clinicians. The identification of major change processes also is of utility for theory building, which is addressed below.

Theory Building in Research–Practice Collaboration

Scientific research always has a strong relationship with theories and theory building. Theories are, to varying degrees, formalizations of the current understanding of the causal mechanisms involved in a domain. Theories are thus one of the main mechanisms whereby understanding can be communicated between researchers and practitioners.

Clinicians are often fond of theories because they communicate ideas about what phenomena a therapist should pay attention to and contain ideas about what processes are likely to facilitate change. Thus, behavioral theories attract the clinician’s attention to the client’s repetitive behavioral patterns and to the possible reinforcers in the environment, while cognitive theories focus attention on the thinking processes of the client. Many schools of therapy are based on a particular theoretical system, and clinical changes are often expressed in theoretical terms.

Given that both researchers and clinicians are interested in theories and theory development, theory construction and elaboration constitutes a potential important common ground between practitioners and researchers. In many instances, clinicians will find research results more comprehensible if those results are expressed in theoretical terms rather than as isolated empirical findings. Similarly, as clinical intuitions become codified in theories, the theories become more amenable to comprehension, resulting in testing and refinement by way of research practice. Thus, at a minimum, theories constitute a possible common language between therapists and researchers. The testing and refinement of theories may also constitute
a fertile area for creative and mutually beneficial collaboration between
researchers and practitioners.

The field is, in the language of Kuhn (1977), in a paradigmatic state
in which there are many competing theories, with no consensus in the
field as to the most fertile approach to pursue. Each of these competing
theories attempts to express part of the truth about human problematic
functioning and ways of changing that functioning. Strong collaboration
between researchers and clinicians in developing and refining theories may
help the field to move to the next stage.

Improved theories can be used by therapists to guide therapeutic prac-
tices. Theories may also offer a more flexible way to communicate research-
based conceptualizations of desirable practice than do more rigid manual-
based approaches.

Several of our authors illustrate this process. Elliott, for example,
changed his theoretical orientation at least partially based on his research
findings, moving to a more experiential conceptualization of the therapeu-
tic change process. Prochaska created a new theory of change processes
and of stages of readiness for change; the resulting theory has been applied
by numerous clinicians and program developers in a wide range of domains.
Similarly, Benjamin has combined her extensive clinical experience with
her understanding of many contemporary strands of research to try to de-
velop a “generic theory” that not only might encompass both research and
practice but also guide and possibly improve therapeutic practice for
personality disorders. McCullough took the traditional Freudian conflict
model and reinterpreted it in learning theory and affect theory terms.

Thus, our recommendation, implicit in several of the chapters, is that
more explicit attention be given to theory development and propagation
as an area for fertile collaboration between therapists and researchers. The
development of better, more clinically rich and empirically supported the-
ories is likely to contribute to improved clinical practice.

Uniformity Myth of Research–Practice Integration

In working on this volume, we glimpsed indications of a “uniformity
myth” that many of our authors appear to be challenging: that clinical
practice should be based in some uniform or general way on research. Such
a myth obscures the nature of the research–practice relationship in that
not all research is the same. There is much variability in psychotherapy
research, including traditional randomized clinical trials (RCTs) of out-
comes, efficacy studies of treatments in real-world settings, development of
assessment instruments, many varieties of process research, from idiosyn-
cratic microprocesses to common factors or macroprocesses, as well as pro-
gram evaluation and health services research. Thus, there cannot be any
single research–practice relationship. Although this conclusion may seem

INTEGRATING RESEARCH AND PRACTICE
obvious, much of the discussion of the topic seems to assume that all research is of one sort, often randomized clinical trials. The authors discuss the research-practice relationship, as if an argument for the lack of utility of RCTs is an argument for the lack of utility of research in general. Although many of our authors have engaged in RCTs at various stages of their research programs, none have conceived of research as remotely synonymous with this particular research design. By the accidents of selection (many of the contributors we solicited for the book declined due to other commitments), the book does not contain contributions by any of the foremost proponents of RCTs, who have recently become involved with the movement to identify and promote empirically supported treatments (Beutler, 1998; Chambless, 1996; Chambless & Hollon, 1998; Kendall & Chambless, 1998).1

It is therefore essential to keep in mind what type of research we are referring to. When considering integration of research and practice, we might specify, for example, type of research, conditions, and patients. And, how well the research matches or replicates the actual process of therapy and if the process generalizes to other treatments.

ACCEPTANCE OF PASSION IN SCIENCE AND PRACTICE

One of the recurring themes among our authors was the passion, for both science and clinical practice, that drives researchers and therapists. This passion is an essential component of both high-quality science and excellent clinical practice. In each domain, the passion taps rational and intuitive cognitive processes. Prochaska, for example, concluded his chapter with a spirited account of the passion driving him. McCullough quoted Liam Hudson, who argued that bias (his term for passion) is an essential component of the research process. Goldfried told of Neal Miller, who confessed to being “quite free wheeling and intuitive” in following hunches, varying procedures, trying out wild ideas, and taking shortcuts in designing a study. Miller first convinced himself and then tried to convince his colleagues. Goldfried himself addressed the “artistry” and intuition that is necessary in the development of hypotheses.

In Benjamin’s chapter, passion shines through in her striving to maintain the highest standards for her clinical practice. Solds, in turn, expresses passion about the need for researchers and practitioners to collaborate.

Passion, by its nature, is never entirely rational. Thus, someone else’s passion very well may be perceived by those who disagree as wrong-headed bias. Nonetheless, passion will never disappear from either research or practice. In fact, its presence in both domains is another common element. If

1See the special section by Kendall and Chambless (1998).
researchers and therapists acknowledge and learn to value each other's passion, greater mutual respect might result, respect that could only further the collaborations we seek to foster. Thus, our final recommendation in assisting collaboration between research and practice is for the recognition that others' passions are probably not that different from one's own.

REFERENCES


