Available online at www.sciencedirect.com

ScienceDirect

Behavior Therapy 44 (2013) 541–547

Behavior Therapy

www.elsevier.com/locate/bt

SPECIAL SERIES

The Theory-Practice Gap in Cognitive-Behavior Therapy

Guest Editors: Brian Pilecki and Dean McKay, *Fordham University*

This special series is devoted to understanding the theory-practice gap in cognitive-behavior therapy (CBT). Although CBT enjoys considerable empirical support, and is widely recognized as an efficacious approach to a diversity of psychiatric disorders and includes many different forms of treatment, it is unclear whether clinicians are familiar with the underlying theories of the treatments they are practicing. Moreover, it is unclear to what degree an understanding of the theory is necessary for effective practice. Gaining clarity on the role of understanding underlying theory and identifying potential disparities between theory and practice may have implications for the way graduate training programs are structured and current professionals approach continuing education. A brief exploration of these implications will be offered by introducing issues related to the scientist-practitioner model and dissemination of efficacious treatments, in addition to an outline of potential advantages and disadvantages of knowing underlying theory. This special series will then feature several major approaches to treatment wherein the role of theory and practice are discussed.

Keywords: dissemination; theory-practice gap; training; service delivery

SINCE PSYCHOTHERAPY FIRST EMERGED as an intervention for the treatment of psychiatric conditions at the beginning of the last century, a dialectic has existed between the practice of therapy and the underlying theories explaining those therapies. More specifically, this dialectic refers to the differentiation between understanding the theories and mechanisms explaining how a therapy works and understanding, more simply, how to deliver the interventions that comprise that therapy. The history of mental health care has included many forms of therapy that were rich and unified in theory, yet lacking in empirical support (e.g., Freud), or required extensive training and many years of receiving therapy in order to be qualified to deliver services (e.g., psychoanalysis). Cognitive-behavioral approaches, on the other hand, have a rich underlying theory and have been developed with an implicit aim of dissemination to practitioners once scientific support for a particular intervention has been obtained. Over the last several decades, a solid body of research has been accumulated and resulted in a variety of empirically supported treatments for almost every type of mental disorder (Dobson, 2010). There are even well-developed approaches for clients who present with complex symptom manifestations (McKay, Abramowitz, & Taylor, 2010; McKay & Storch, 2009). Such therapies should, in principle, be based upon a clear understanding of the etiology and maintaining factors of a particular mental disorder, as well as a clear understanding of how a therapeutic intervention would lead to the reduction of symptoms. While these theoretical foundations are obviously important for researchers who are developing new therapies, it is less clear how important they are for practicing clinicians. In other words, to what degree should mental health practitioners be knowledgeable about the theoretical backgrounds of interventions that they are implementing? The "theory-practice gap," therefore, refers to the disparity between knowledge of the underlying theory and the applied interventions being delivered by clinicians.

To help illustrate with an example, Acceptance and Commitment Therapy (ACT) is a type of cognitive-behavioral therapy that was developed out of a body of experimental research known as relational frame

This special series was inspired by a symposium held at the annual meeting of the Association for Behavioral and Cognitive Therapies, Toronto, ON.

We would like to thank Thomas Ollendick for very helpful comments on an earlier version of this manuscript.

Address correspondence to Brian Pilecki, Department of Psychology, Fordham University, 441 East Fordham Road, Bronx, NY 10458; e-mail: pilecki@gmail.com.

0005-7894/44/541-547/$1.00/0

theory (RFT; Hayes, Strosahl, & Wilson, 1999). There are no official training requirements for being an ACT therapist; in fact, it is possible to learn how to deliver ACT interventions after attending a 1-day workshop or reading a manual, as such interventions have been designed to be portable and easily accessible. On the other hand, RFT is an advanced theory of applied behavioral analysis that requires familiarity with a highly technical behavioral language and a stepwise learning of behavioral concepts; it has a reputation for being difficult to learn without some degree of effort (Torneke, 2010). Therefore, is it important for a clinician delivering ACT interventions to understand the RFT explanations for how such interventions can be effective. It may be that such an understanding of RFT would lead to better treatment outcomes or, alternatively, that developing such an understanding may be unnecessary and a poor use of a clinician's limited resources. Indeed, recent survey data show that the willingness of practitioners to acquire new therapeutic skills is highly dependent on the time required to learn the new skills (Stewart, Chambless, & Baron, 2012). In addition, it was found that practitioners were more willing to receive further training and hold positive attitudes towards a research study that included a case study than one that did not (Stewart & Chambless, 2010). Therefore, training of new interventions has to be focused, pragmatic, and yoked to the kinds of cases likely to benefit from that intervention in everyday practice. Where does this leave theory knowledge? Knowing to what degree clinicians should understand underlying therapeutic theories may have vast implications for training and dissemination of empirically supported treatments, especially given the increasingly alarming financial limitations faced by the mental health care field (National Alliance on Mental Illness, 2011). First, a brief a history of the relationship between science and practice will be provided. Then, advantages and disadvantages to knowing underlying theory will be commented upon, followed by a brief explication of the relationship between the theory-practice gap and issues with dissemination of treatment.

Training Scientists, Training Clinicians: Different or the Same?

The relationship between theory and practice was perhaps most clearly defined in the development of the Boulder model of graduate training (Raimy, 1950). This model, also known as the "scientist-practitioner" model, emphasizes the need for psychologists to be trained in both research and clinical skills. That is, all clinical psychologists should be trained in how to conduct, understand, and evaluate psychological research, even if pursuing a purely applied career, because such knowledge would allow for a more scientific, and therefore potentially more effective, approach to the delivery of mental health care services. Doctoral training programs have since largely followed this model (Belar, 2000). A recent poll of 165 clinical psychology training programs found that 90% of their training directors identified their program as scientist-practitioner or clinical-scientist (Hunt, 2008). Another study also found that Psy.D. programs, though generally less focused on developing students who produce original research, still offered comparable training in research methods and statistics knowledge in comparison to Ph.D. programs (Rossen & Oakland, 2008). While emphasizing the need for training in both research and practice, the Boulder model was initially intended to promote a flexible approach whereby graduate programs could vary in their emphasis on research or practice, a feature of the model that is perhaps overlooked in more recent discussions (Stricker, 2011). Though the Boulder model clearly articulated a dichotomy between clinical practice and research, it has also been argued that such a dichotomy is actually a false one, since all clinical practice should be grounded in science (McFall, 1991). From this perspective, all professional psychologists are,[1] in essence, scientists who vary only in the degree to which they are involved in the management and delivery of mental health care services.[2] Though this former statement may sound provocative and may have been more intended to call attention to what was then a perceived imbalance between science and practice, McFall and others have continued to argue that the field of clinical psychology exists in a state akin to the state of medicine before its scientific reform in the 1900's due to the disproportionate number of psychologists who value personal experience over research evidence, use assessment procedures with questionable empirical

[1] In McFall's, 1991 "Manifesto" he states: "I tell them that all clinical psychologists must be scientists first, regardless of the particular jobs they fill after they earn their degrees; that becoming a clinical scientist does not mean that they are committed to working in a laboratory or university; and that choosing not to receive the best scientific training possible, by purposely opting for a training program that does not emphasize scientific training, means that they will not be prepared to do any form of psychological activity as well. What I am saying to them, of course, is that all forms of legitimate activity in clinical psychology must be grounded in science, that all competent clinical psychologists must be scientists first and foremost, and that clinicians must ensure that their practice is scientifically valid"(posted on the web site for the Society for a Science of Clinical Psychology).

[2] While we are making the case that, based on all available evidence, doctoral training programs promote empirically supported approaches, we also recognize that, in actual practice, many providers deviate significantly from this model (for detailed discussion of this problem, see Lilienfeld, Lynn, & Lohr, 2003).