



THE GAP BETWEEN RESEARCH AND PRACTICE: TOWARDS THE INTEGRATION OF PSYCHOTHERAPY

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La brecha entre investigación y práctica clínica constituye uno de los rasgos distintivos de la psicoterapia. Esta brecha se ha conceptualizado históricamente como un problema de diseminación unidireccional. Sin embargo, existen razones consistentes para considerar que la desarticulación entre ciencia y práctica también responde al modo en que se ha venido produciendo el conocimiento científico en el campo. En el presente artículo se desarrollan algunos de los principales aspectos que, hasta la fecha, han obstaculizado la construcción de una ciencia integrada de la psicoterapia y la implementación de la mejor investigación disponible en los entornos clínicos naturales. En particular, se presenta el paradigma de la Investigación Orientada por la Práctica (IOP) como una aproximación que aporta propuestas específicas para articular la brecha entre investigación y práctica con el doble propósito de mejorar tanto la calidad de los proyectos de investigación que se realizan como la práctica clínica habitual.

Palabras clave: Brecha investigación-práctica, Redes de investigación orientadas por la práctica, Investigación orientada por la práctica, Psicología clínica, Psicoterapia, implementación.

The gap between research and clinical practice is one of the distinctive features of psychotherapy. This gap has historically been conceptualized as a problem of unidirectional dissemination. However, there are compelling reasons to consider that the disarticulation between science and practice also responds to the way in which scientific knowledge has been produced. This article describes some of the main factors that, to date, have hindered the development of an integrated science of psychotherapy and its implementation in naturalistic clinical settings. The paradigm of practice-oriented research (POR) is presented as an approach that provides specific proposals to bridge the gap between research and practice with the dual purpose of improving the quality of both research projects that are carried out and routine clinical practice.

Key Words: Practice-research gap, Practice research networks, Practice-oriented research, Clinical psychology, Psychotherapy, Implementation.

Every time a person seeks services for mental health problems, we clinicians are confronted with the breadth of human experience that unfolds immediately after the first obligatory question: what has motivated you to come for mental health services? The uniqueness of each person often connects us with the psychotherapist's inevitable dilemma. The proposals for intervention from clinical guidelines, based on nomothetic research, may not be very sensitive to the particular needs of patients (Castonguay, Constantino, & Beutler, 2019a; Castonguay, Constantino, & Xiao, 2019b; Goldfried & Wolfe, 1996).

The intricate relationship between research and clinical practice is as old as psychotherapy itself (Cautin, 2011; Meehl, 1957). Perhaps at the core lies the epistemological

problem of reconciling the nomothetic and idiographic principles that define scientific production and clinical practice, respectively. Strictly speaking, this split transcends the boundaries of psychotherapy and constitutes a phenomenon which is present in any scientific discipline that claims to be applicable (O'Donohue, 2013).

In this paper, we aim to bring closer to our language a debate that is mainly taking place in Anglo-Saxon contexts, which is beginning to attract the attention of the Spanish-speaking scientific and professional community (Fernández-Álvarez & Castonguay, 2018). The main arguments that justify the development of a paradigm that pursues research guided by clinical practice are presented (Barkham, Hardy, & Mellor-Clark, 2010; Castonguay, Barkham, Lutz, & McAleavey, 2013; Castonguay & Muran, 2015) and, specifically, the need for a science of psychotherapy with greater clinical relevance are emphasized. We also outline a number of proposals that are based on the development of greater collaboration and integration of the work of

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researchers and clinicians (Castonguay et al., 2019b; Goldfried, 2019).

THE FOUNDATIONS OF PSYCHOTHERAPY

Psychotherapy can be defined as a helping practice of an invariably interpersonal nature that deals, in part, with the complexity involved in the interrelationship between two or more consciousnesses that develop a temporary bond for specific purposes (Norcross & Wampold, 2019; Prado-Abril, Gimeno-Peón, Inchausti, & Sánchez-Reales, 2019a; Wampold & Imel, 2015). Therefore, it is not possible to build a science of subjectivity without calling upon mental instances, which forces us to face the mind-body problem, and therefore to discuss the metaphysical status of consciousness (Kind, 2019). In other words, trying to objectify subjectivity is a highly complex undertaking, which poses serious problems of feasibility and is prone to criticism. There will be plenty of critics that consider it unnecessary and impractical to attempt to support psychotherapeutic practice in an ordered system of knowledge that includes the explanation and prediction of people's behaviors, emotions, and cognitions. There will also be those who solve the problem of consciousness by denying the causative power of mental states (Ramsey, 2008). In short, this is the challenge that Wundt faced at the very beginning of psychology: if the mind does not possess the capacity of causation (that is, to alter other mental and even physical states), then psychology as a science and psychotherapy as a practice have no reason to exist (Dazinger, 1979).

Where does psychotherapy come from and what is it seeking?

Perhaps we need to go back to classical Greece in the 5th century BC to find the first psychotherapists. «*The logos of the Sophists is not an organ, a necessary instrument to show or demonstrate what it is, but a pharmakon, a remedy for the improvement of souls*» (Cassin, p. 750). Hence, psychotherapy as a practice seems to fit better with the conception of a *pharmakon* of language through which therapists, perhaps contemporary sophists, try to persuade the patient to feel better. However, psychotherapy seeks to be rigorous based on procedures supported by scientific programs. In other words, psychotherapy is an amalgamation of science and art (Hofmann & Weinberg, 2007) that requires the reconciliation of the *truth* of science with the *utility* and *aesthetics* of practice in order to find fruitful ways to build knowledge.

In clinical practice, everything that facilitates the elaboration and re-elaboration of certain notions, ideas, beliefs, schemas, emotions, and behaviors that in turn allow the construction of a personal script, an intimate narrative, that in no way deals with the objective status or quality of truth of things, is of interest. Perhaps it is at this point that science can provide psychotherapy with mechanisms to facilitate such persuasion based on the characteristics, needs and preferences of the

patients. It may seem like a paradox, but objectifying modes of subjectivation is the focus of study in the discipline.

Current situation of psychotherapy

Therefore, if we accept that psychotherapy is a practice that should be scientifically oriented and that its epistemological support remains open to be developed, we can continue with a brief description of its current status. Today it can be stated that psychological treatments, including psychotherapy, are more effective than the absence of treatment in improving symptoms and increasing quality of life (Chambless & Hollon, 1998; Chambless & Ollendick, 2001; Lambert, 2013; Wampold, 2019; Wampold & Imel, 2015).

However, it must be acknowledged and accepted with humility that findings in this field of research have been overestimated (González-Blanch & Carral-Fernández, 2017; Sakaluk, Williams, Kilshaw, & Rhyner, 2019). Likewise, although today the effectiveness of psychotherapy is indisputable, the great enigmas still do not have conclusive answers, in particular, the aspects related to the psychotherapeutic process, about *how* and *for whom* psychotherapy works. Probably, the lack of consensus in research on the principles of change (Castonguay et al., 2019a) has fostered the current *great debate* between the *specific factors* and the *common factors* which, beyond its interest, characterizes another crack in the development of the discipline (González-Blanch & Carral-Fernández, 2017; Hofmann & Barlow, 2014; Laska, Gurman, & Wampold, 2014; Wampold & Imel, 2015). However, the focus of the discipline typically remains in the development and dissemination of treatment models that are generally recognizable by three-letter acronyms (Paris, 2013). Similarly, the main solutions to the gap between research and practice seem to establish a mere implementation problem that prioritizes a one-way path in which research findings should be applied in clinical practice (Goldfried, 2019).

It is true that, at present, there is no better frame of reference than the scientific method for trying to construct a common language to separate the grain from the chaff and establish certain criteria for demarcation. However, under the halo of scientificity there are also questionable practices of action that put psychotherapy in the spotlight of the crisis of replicability of science (Leichsenring et al., 2017; Sakaluk et al., 2019; Tackett, Brandes, King, & Markon, 2019). In addition, there is an imbalance in the development of the science of psychotherapy in favor of empirical data, to the detriment of the conceptual construction and plausibility of the logic behind a treatment (Berg & Slaattelid, 2017).

In short, we believe that it is now appropriate to adopt a reflective attitude and to cultivate a healthy and moderate skepticism that will allow us to guarantee the advancement of knowledge in the most genuine way possible. Finding a way to transfer this attitude to institutional science is a priority to favor the development of a healthier discipline (Frith, 2019).



In view of this, the need emerges to accept that the current state of our knowledge is provisional, fallible, and insufficient. Likewise, the need also arises to assume that complexity must be faced with an open, integrative attitude and with collaborative solutions.

PRODUCE RESEARCH IN THE LABORATORY, APPLY IT IN CLINICAL PRACTICE?

Over the years, a one-way model of implementation of science has prevailed. Knowledge is produced in laboratories and academic settings, and clinicians are expected to use it. The idea of implementing the best available evidence contains two partially true assumptions: First, that the available knowledge must be considered to be of sufficient value to merit dissemination and, second, the belief that such knowledge must be generated in research settings and then translated into clinical reality.

As we will attempt to show below, the construction of knowledge in psychotherapy has been dominated by an eminently biomedical vision (Lebowitz, 2019). This approach has facilitated the discussion on the usefulness of psychotherapy versus other types of interventions, such as psychopharmacology, but has seen limited potential in its applicability in natural contexts. In this sense, not all existing research deserves to be disseminated and part of the gap between research and practice can be explained by the sacralization of results obtained in randomized controlled trials (RCTs).

Among the many problems that characterize RCTs, the following can be mentioned: the lack of representativeness of the samples (Weisz et al., 2017), the rigidity of the procedures to guarantee a supposed experimental rigor (Beutler & Forrester, 2014), the focus on symptoms and discrete nosological categories (van Os, Guloksuz, Vijn, Hafkenscheid, & Delespaul, 2019), as well as the establishment of the criterion of effectiveness based on group averages that, in many cases, lose sight of individual trajectories and the phenomenon of variability (Barkham, Delgadillo, Firth, & Saxon, 2018). Also, a large proportion of research has been conducted in rich, Western, industrialized, democratic countries and usually on Anglo-Saxon, Caucasian, and educated individuals (Henrich, Heine, & Norenzayan, 2010). Therefore, the available knowledge is not at all representative of large sectors of the world's population. On the other hand, it is encouraging and inspiring to see the increase of research focused on the production of knowledge characterized by contextual and cultural sensitivity (e.g., Gómez, Iwakabe, & Vaz, 2019; Zimmerman, Barnett, & Campbell, 2020).

Empirically supported treatments (ESTs)

A source of heated debate in the scientific and professional community is the limited generalizability of findings from RCTs into clinical practice (e.g., Tortella-Feliu et al., 2016). ESTs

are a direct consequence of applying the RCT approach to specific mental disorders (Chambless & Hollon, 1998; Chambless & Ollendick, 2001). The list of ESTs has progressively multiplied in line with the emergence of new forms of psychotherapy, blatantly neglecting the broader and more inclusive notion of evidence-based practice (EBP; American Psychological Association [APA] Presidential Task Force on Evidence-Based Practice, 2006; Prado-Abril, Sánchez-Reales, & Inchausti, 2017; Prado-Abril et al., 2019a). Among the main criticisms received are concerns about the real strength of these treatments, the difficulty of choosing between two ESTs with similar efficacy, the clinical relevance of the research results, and the excessive proliferation of treatment manuals for specific disorders (Tolin, McKay, Forman, Klonsky, & Thombs, 2015).

In addition to the limited value that can be assumed for RCTs due to their lack of external validity, a great many other problems have been identified over the years. Recently, Sakaluk et al. (2019), in a meta-scientific review, found that estimates of power and replicability are relatively low for a non-negligible proportion of ESTs. For their part, Leichsenring et al. (2017) have delved into the biases that may affect the replication of psychotherapy research results. They succinctly describe biases related to loyalty to the preferred model in all parties involved in the process (researchers, clinicians, supervisors, reviewers, and editors); lack of integrity in the application of the treatment present in 96% of the RCTs (Pereplechikova, Treat, & Kazdin, 2007); lack of assessment of therapist effects, confusing the relative weight of the technique; overestimation of small effect sizes; flexibility in research designs with multiple measures that are subsequently selected as convenient, including unclear hypotheses that accommodate the results; small sample sizes; publication bias; and finally, arbitrary criteria for inclusion and exclusion of studies in meta-analyses. To conclude, Tackett et al. (2019) add the low inter-rater reliability of categorical diagnoses and other questionable research practices that complete the above list. Consequently, although there is growing interest in this area to improve the methodology, replicability, and transparency, and to establish an open science, there are still more problems than solutions.

The use of clinical practice guidelines (CPG)

The generalization of ESTs crystallizes in the existence of various CPGs such as those of the American Psychological Association (APA), the Canadian Association for the Treatment of Mood and Anxiety (CANMAT), the National Institute for Clinical Excellence (NICE) or those of the Ministry of Health in our context. The recommendations are derived from RCTs, considered to be the highest degree of evidence among research designs aimed at testing whether an intervention works. Therefore, meta-analyses, which synthesize RCTs around a specific research question, are the main criteria for establishing effectiveness. Among other



things, this is one of the main reasons why cognitive behavioral therapy (CBT) is considered the gold standard of contemporary psychotherapy, even though the evidence does not always show its superiority over other models (David, Cristea, & Hofmann, 2018).

On this point too, however, criticism is beginning to spread. Norcross and Wampold (2019), regarding the recent APA CPG on post-traumatic stress disorder in adults, literally speak of tragedy. On their own terms, they state bluntly that «*The quest was noble indeed, but the ending proved largely unhappy and unproductive. We think it is not stretching the metaphor to suggest that the fatal flaws involved rigid positions and doctrinaire decisions predicated on a biomedical model as opposed to a psychological or contextual model. The tragic decisions led to serious neglect of, inter alia, the therapeutic relationship and clinical responsiveness and thus ignore factors that would lead to more effective services for patients suffering from the effects of trauma*» (Norcross & Wampold, 2019, p. 391). Nevertheless, and consistent with our own convictions, Norcross and Wampold (2019) highlight the value of CPGs both in nurturing practice and in guiding clinical training, provided that they are properly constructed and consider all available evidence.

Manualization versus flexibility in clinical practice

Another element of discussion, which is closely related to the two previous points, is the impact that applying a specific step-by-step treatment protocol as indicated in its reference manual, or doing so by taking the manual as coordinates to be followed with flexibility, can have on the results of psychotherapy. Manualization is a departure from the pre-eminence of RCTs, which contrasts with the natural tendency of clinicians to be flexible and to be guided by their intuition and clinical experience in adapting to the needs of patients (Gyani, Shafran, Myles, & Rose, 2014).

Some reference studies are of great interest and are worth mentioning here. The studies by Hoyer et al. (2017) and Marques et al. (2019) explore this issue under conditions of regular clinical practice by applying CBT in individuals with social anxiety and post-traumatic stress disorder respectively. In the case of Hoyer et al. (2017), no significant difference was found between following the manual step by step and being flexible in its execution, both conditions being equally effective. Furthermore, Marques et al. (2019) add that adaptations that are consistent with the theoretical basis of the manual produce greater benefits. However, perhaps the most comprehensive and consistent work on this topic is the recent systematic review by Truijens, Zühlke-van Hulzen, & Vanheule (2019) who conclude that there is insufficient evidence to justify recommending manualized treatments over adaptations that clinicians make in their daily practice. In the same line, the meta-analysis by Flückiger, Del Re, Wampold, and Horvath (2018) shows

how the therapeutic alliance evolves favorably when psychotherapy works, regardless of the clinician's degree of adherence to the treatment manual. Finally, it should be noted that this debate does not consist of structuring versus destructuring, but rather that manualization implies a strict series of steps to be followed that establish or anticipate a future in the psychotherapeutic process that on many occasions does not materialize, which requires a redirection that the manuals do not contemplate.

From the above overview, it should not be inferred that RCTs, the backbone of current knowledge, are not necessary. However, in themselves they are not sufficient to build a solid foundation for communication between science and practice (Barkham et al., 2010; Castonguay et al., 2013). In this sense, it is relevant that research programs succeed in reducing the tendency to spread procedures with a high degree of overlap between them (Tolin et al., 2015), based on brands (Hofmann, 2019) and acronyms (Paris, 2013), and that they aim to clarify the principles and mechanisms of change that operate in psychotherapy (Castonguay et al., 2019a).

In short, there is little doubt that the classic one-way implementation approach of research to routine practice has not, at least until now, allowed for the consolidation of an EBP (Castonguay et al., 2019b; Castonguay & Muran, 2015). There are solid arguments for considering that these two issues, both the dissemination of what already exists and the need to generate more individualized and clinically relevant knowledge, are what constitute the gap between research and practice.

STRATEGIES TO IMPROVE DISSEMINATION

One of the proposals for overcoming the problem of dissemination aims at a more effective dissemination of the contents produced that is based on the assumption that clinicians do not usually consume research and therefore do not apply those procedures that have proven to be effective (Tortella-Feliu et al., 2016). It is not clear how much knowledge therapists should have about advances in psychopathology, treatment techniques, and other areas of relevance to practice, but a more effective dissemination of the contents produced should contribute to a better collaboration between science and practice.

Another reason that has been attributed to the lack of dissemination of research has been the proliferation of treatment protocols specifically designed for diagnostic entities whose validity and clinical utility is questionable (Deacon, 2013), with the emergence of a science of psychotherapy that pivots on a conception of psychopathology in full transformation (Hopwood et al., 2019). The answer has been the creation of transdiagnostic protocols that allow their application in a psychopathological spectrum that shares common vulnerabilities and therefore requires intervention for concurrent processes (Harvey,



Watkins, Mansell, & Shafran, 2004; Fairburn et al., 2009). The possibility of training therapists in transdiagnostic interventions applied to a heterogeneous set of patients has propelled the transdiagnostic approach as a way of disseminating evidence-based treatments (McHugh & Barlow, 2010; Youn, Sauer-Zavala, Patrick et al. 2019). Despite the empirical production of self-proclaimed transdiagnostic protocols, many of the interventions continue to contemplate discrete entities of psychopathology instead of addressing the basic processes underlying dysfunctionality, undermining the purpose of the transdiagnostic enterprise, which is, above all, to develop a general theory of dysfunction (Mansell, 2019).

However, the main cause of the lack of dissemination is attributed to a problem of logistics and resources (Kazdin & Blase, 2011). Psychotherapy cannot always reach all places and therefore, the development of alternative modes of delivery has been proposed, as well as to create alternative psychological treatments to psychotherapy to meet the existing demand. Thus, digital technologies have emerged strongly, which are proposed as an efficient way of dissemination. In the last decade, treatments through the Internet and videoconferencing have grown exponentially (Andersson, Titov, Dear, Rozental, & Carlbring, 2019). Strictly speaking, although they may constitute an important contribution to the dissemination of psychological treatments, the great unknown is to what extent this type of approach allows the deployment of the type of interventions carried out in traditional psychotherapy. Although the available evidence is auspicious, it should be considered with caution given that the vast majority of these data come from RCTs with non-naturalistic samples and focused mainly on symptom reduction.

FROM EVIDENCE-BASED PRACTICE TO PRACTICE-BASED EVIDENCE

If EBP is defined as the integration of the best available research with clinical expertise and patient characteristics, preferences, and culture (APA, 2006; Prado-Abril et al., 2017; 2019a), practice-based evidence (PBE) consists of the «*conscientious, explicit, and judicious use of current evidence drawn from practice settings in making decisions about the care of individual patients. Practice-based evidence means integrating both individual clinical expertise and service-level parameters with the best available evidence drawn from rigorous research activity carried out in routine clinical settings*» (Barkham & Margison, 2007, p. 446, cited in Barkham et al., 2010, p. 23). In other words, it involves producing research in the clinic, with clinicians, and applying it in clinical practice.

Next, as a complement to the reasons given so far, we will try to justify the need for additional research to the existing body of work that can be substantiated, designed, evaluated, and implemented within the clinical contexts themselves. PBE is not strictly a novelty, and has a long history of research (e.g., Borkovec, Echemendia, Ragusea, & Ruiz, 2001). In

fact, its definition is currently included in the conceptual framework of *practice-oriented research* (POR; Castonguay et al., 2013). POR brings together the traditions of psychotherapy research that have dealt with naturalistic settings and that have focused on implementation as a constituent element of their action program from the beginning and not as a final link in the research process (Castonguay et al., 2013).

In this context, practice research networks (PRNs) are one of the main avenues for conducting PBE to complement the knowledge generated by EBP (Barkham et al., 2010; Castonguay et al., 2013), but they are also a strategy for promoting the implementation of EBP (Castonguay, Youn, Xiao, Muran, & Barber, 2015a; Lucock et al., 2017). PRNs are gaining strength in the current panorama established by POR, consolidating themselves as a global movement with an increasing degree of institutionalization. Some of the main ones are that of Pennsylvania (Borkovec et al., 2001), the Center for Collegiate Mental Health (Locke, Bieschke, Castonguay, & Hayes, 2012), the Northern Improving Access to Psychological Therapies PRN (Lucock et al., 2017), Aiglé Foundation (Fernández-Álvarez, Gómez, & García, 2015), and APIRE PRN (West et al., 2015).

After decades of POR accumulating experience, successes, and failures, two aspects stand out above the rest when considering a project of this nature. The first one is the need to establish a strong commitment aimed at building on the available knowledge. In this sense, integration in psychotherapy is one of the essential aspects that can favor the association between research and practice given the global trend towards integration in clinical contexts (e.g., Castonguay, Eubanks, Goldfried, Muran, & Lutz, 2015b; Norcross, Karpiak, & Santoro, 2005; Prado-Abril, Fernández-Álvarez, Sánchez-Reales, Youn, Inchausti, & Molinari, 2019b). Secondly, it is essential that researchers and clinicians collaborate, establishing a two-way communication flow and working together on research projects that are potentially applicable in everyday practice.

Building Practice Research Networks

The creation of PRNs can be an ideal format to pursue both of the above aspects and ultimately contribute to the integration of research and clinical practice (Castonguay & Muran, 2015). Firstly, it is easier for clinicians to believe in the relevance of research content to their clinical practice if it is worked on collaboratively with researchers. Secondly, direct feedback would be obtained, contextualized in the healthcare reality itself, on the usefulness of the measures proposed by the research program. In short, doing POR within the framework of a network would not only facilitate the dissemination of the best evidence provided by traditional research, but would also promote access to PBE by fostering more useful and potentially more effective scientific production.



In this way, the study of phenomena relevant to the clinical reality can be encouraged and the search for excellence by clinicians can be promoted and instilled (Prado-Abril et al., 2017), facilitating the development of habits such as deliberate practice (Rousmaniere et al., 2017; Prado-April et al., 2019a) or personal and reflective practice (Bennett-Levy & Finlay-Jones, 2018), while the routine of science-based supervision could be established in the unit (Callahan & Watkins, 2018). In summary, if research is present in the early development of the clinicians themselves and is overlapped with their increased professional competencies, it would undoubtedly contribute greatly to closing the gap, at least for the clinicians that are trained in this way.

However, among the pitfalls and challenges in building and implementing PRNs is the potential perception that such networks are irrelevant or hinder clinical performance itself (Youn et al., 2019). Therefore, it is crucial to have direct feedback from those who are involved, or will be involved, in order to establish the best ways to initiate such a process. Previous experience shows how proceeding in this way increases the positive evaluation that clinicians make of research programs, it modifies their behavior, and this has a positive impact on patients (e.g., Tasca et al., 2015).

One element that is proving to be useful for the materialization of PRNs is the implementation of systematic outcome monitoring of the psychotherapeutic process (Boswell, 2019; de Jong, 2016). In this case, the advantages are perhaps more immediate for researchers since access to clinical samples is often the big obstacle to research in this field. However, the advantages of initiating this care culture are also shown to be useful for patients and therapists. In particular, it has been shown to be useful in preventing and reversing processes of deterioration that therapists cannot detect (Delgadillo et al., 2018; Shimokawa, Lambert, & Smart, 2010). It should be noted that the process of implementing outcome monitoring should always consider contextual specificities, in particular the organizational culture in which it is incorporated. That is, it is advisable to create a specific battery according to the characteristics of the care center, including the therapists who work there, the patients who attend for therapy, and the type of clinical conditions that are usually addressed. For example, at the Aiglé Foundation, the incorporation of monitoring using the OQ-45 is classified into three modalities depending on each therapeutic process: every session, every three sessions, or every five sessions. Numerous monitoring systems exist (Drapeau, 2012), although there are times when the development of new instruments can be useful.

Finally, underlying every PRN is the fundamental assumption that any research project is based on the needs expressed by clinicians (and potentially patients) and, consequently, the joint development of the entire research process. To this end, as we previously mentioned, the existence of an active collaboration network with fluid horizontal communication is

essential. However, it is worth briefly mentioning the system and the socio-cultural context in which we find ourselves in order to understand possible tensions that could arise. For example, as we mentioned at the beginning of this paper (see, Frith, 2019), there are structural aspects of institutional science that push researchers into a certain publishing frenzy that may be incompatible with generating clinically relevant scientific knowledge. In this sense, from our point of view, a PRN should function under the fundamental principle that the clinic is sovereign. In other words, the clinician and the patient are the ones in the trenches and, whilst trying not to lose reciprocity, theirs is the reality that must always be weighed up first.

CONCLUSIONS

Throughout this article we have put forward some of the main arguments that support the need to carry out scientific research in the field of psychotherapy with greater clinical relevance. Similarly, we hope to have been able to illustrate the complexity of a discipline that results in an amalgamation of science and art that cannot be reduced to a mere empirical question. Otherwise, we run the risk of not addressing the *real* phenomenon. Finally, we will have fulfilled one of our main objectives if researchers see that they may be missing opportunities to identify critical areas of research and that they could do better scientific work if they paid more attention to the writings, concerns, and ideas of their clinical colleagues (Beutler, Williams, Wakefield, & Entwistle, 1995).

On the other hand, the current panorama presents a prevalence of mental health problems that, far from decreasing, is emerging as a global challenge for the next decade (Saxena et al., 2019). In this context, we are witnessing a significant increase in the consumption of psychotropic drugs, as well as a marked decline in the use of psychotherapy (Olfson & Marcus, 2010). Likewise, forecasts predict that in the next few years low-intensity psychological treatments will increase, particularly those supported partially or completely by digital technologies (Norcross, Pfund, & Prochaska, 2013). In addition, pseudoscientific practices are proliferating (Lee & Hunsley, 2015) and an important advance in the privatization of health care by tertiary sector organizations. All this, combined with the pronounced impasse in the improvement of the effectiveness of the procedures already known, pushes us to seriously evaluate the need of measures that strengthen the discipline so that it does not lose the presence that it has been able to build over the last decades.

Maximizing productivity is the guiding principle of many contemporary societies. In this context, psychotherapy appears as a counter-cultural device for these times. The complexity of psychotherapy, which must be informed by science but is constitutionally a task with artistic overtones, requires us to adopt a fine balance so as not to build simple answers, but at the same time it must be able to unravel the knots it faces with the purpose of advancing as a discipline



and generating more effective procedures. What is clear is that, if the gap between research and practice continues to widen, it will be disadvantageous for psychotherapy. This will lead to the emergence of cheaper, but not necessarily more effective, solutions to improve people's quality of life.

In this sense, it is essential to encourage collaborative work between researchers and clinicians by structuring two compatible efforts that can enrich each other. In this line, PRNs stand as a paradigmatic way of pursuing this common objective by coordinating the needs of both. Castonguay et al. (2010) offer a wise suggestion in this regard: try to ensure that the clinician does not make a distinction depending whether the task being performed responds to research or care objectives. If, for example, the clinician collects information for both clinical and research purposes, or tests interventions both to improve the progress of their patients and to assess the effectiveness of the measure; that is, if at all the times the activities are both clinical and scientific, then we will have achieved a good integration between research and practice.

Finally, in this paper we have limited ourselves to evaluating some of the reasons for the division between researchers and clinicians, and a number of proposals for overcoming it. This analysis leads us to explore the possibility of conceptual and, above all, operational integration between science and clinical practice. However, this integration requires a great willingness to enrich the work of researchers and clinicians, as well as fluid communication, and it will have to be implemented at multiple levels, inserting itself in the already fruitful developments that psychotherapy has been carrying out to favor its integration (Castonguay et al., 2019a; Goldfried, 2019). If we manage to advance in that direction, we are convinced that we will have a more solid discipline and it will be easier to focus efforts on the real objective of this whole issue, which is none other than to help people in need in the most effective way possible.

CONFLICTS OF INTEREST

The authors declare no conflict of interest.

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