

Why the Scientist-Practitioner Schism Won't Go Away

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Discussions about the scientist-practitioner schism rarely rise above the level of cliché. To judge from the rhetoric, there is broad consensus that the schism is pointless and self-defeating. We hear periodic reminders (often coincident with *American Psychological Association* elections) that the fates of science and practice are intertwined. We hear exhortations that we should just “all get along.”

The exhortations are probably well meaning, but they are sadly naive. The schism is getting wider, not narrower. The issues that divide clinicians and researchers run too deep for feel-good answers.

The Role of Psychology Departments

In years past, university psychology faculties included both researchers and clinicians. The groups came into regular contact, and even researchers with little interest in clinical matters developed some understanding of the clinical enterprise. This is no longer true. Over the past ten to fifteen years, real clinicians have been disappearing from major research universities. The faculty members who remain know less and less about clinical practice. At worst they are antagonistic to the clinical enterprise and at best they do not understand it. This is true even in clinical psychology programs, which are now dominated by faculty members who do not actually treat patients.

There are structural reasons for this, and they are not likely to change soon. One reason has to do with “publication inflation” (analogous to “grade inflation” in our public schools). The quantity of publications needed to get and keep a faculty appointment at a major research university has become extreme. With precious few exceptions, no one who devotes real time to patient care can publish at the necessary rate. University departments also depend on the grant money researchers generate. For these reasons, as clinicians retire from university faculties, they are replaced by “clinical researchers” with little or no psychotherapy experience. The trend is toward clinical psychology departments without clinicians.

A graduate student in Yale’s “clinical” psychology PhD program told me she wanted to learn to do in-depth clinical work, but felt she could not let this be known in her department because it would be a black mark against her. In her clinical program, actual clinical practice is frowned upon. She confided that she did not even know where to turn to get in-depth clinical training. She recounted an incident in which she had asked a senior clinical faculty member for advice on finding a personal therapist. He responded, “Why would you want to do that? Research shows it doesn’t do anything.”

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Most real clinicians regard significant personal therapy as prerequisite to doing serious clinical work. And of course, hun-

dreds of studies attest to the benefits of psychotherapy. But in this “clinical” professor’s eagerness to malign the clinical enterprise, he forgot about the hundreds of published studies. Apparently he was thinking of a recent study that failed to show a treatment effect, which (in his mind) overrode decades of prior research. Inexplicably, he also forgot a fundamental research principle—that a study cannot prove the null hypothesis.

If this were an isolated incident, it would not deserve mention. But it is not isolated; it is illustrative. The professor is a renowned clinical researcher at one of our finest universities, and the attitude he expresses is found in academic departments everywhere—including APA accredited clinical doctoral programs. Faculty members communicate in subtle and not so subtle ways that clinical experience is unimportant and that students can learn whatever they need from a manual. The departments routinely farm out the truly clinical components of the curriculum (e.g., psychotherapy supervision) to adjunct faculty who have little say in department affairs. Clinical researchers disregard the cumulative insights of generations of clinicians and instead conduct studies that implicitly (or explicitly) assign greater evidential weight to the self reports of college freshman. Indeed, researchers often regard clinicians as too “biased” to provide useful research data. (No one would argue that college freshman are better at reading x-rays than radiologists, because the radiologists are too biased by prior theory and experience; but we see analogous arguments in the psychological literature all the time.) In these and other ways, researchers undermine the clinical enterprise daily.

As clinicians have disappeared from the ranks of university faculties, real clinical training has moved increasingly to the professional schools. The consequences for psychology are unfortunate. In university departments, theory and research develop in isolation from the crucial data of clinical observation. In free-standing professional schools, clinical training may occur in a context divorced from the scholarly and intellectual traditions of university life and the critical thinking it fosters. Training in both kinds of institutions is thus impoverished, and the scientist-practitioner schism grows ever wider.

The Role of Outcome Research

Clinical psychologists are under siege in the current healthcare environment. Some believe this is an area where researchers benefit clinicians, by conducting outcome and efficacy studies that clinicians need to respond to managed care. *In fact, the opposite is more often true.* Managed healthcare companies use research results to bludgeon clinicians and deny treatment. They justify this by citing studies that purport to show that frequency and duration of treatment are irrelevant. Most academic researchers are unaware of how managed care companies use and misuse their findings.

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The problem is not just that academic psychologists are unfamiliar with the practices of managed care. Generations of researchers have taken delight in outdoing each other in their efforts to “debunk” psychotherapy. Far from working to demonstrate its efficacy, many cannot wait to demonstrate its uselessness. They demand proof of efficacy that outstrips anything that has ever been demanded of any other healthcare profession. They conduct clinical research using populations that are not representative of real-world patient populations, and research on short-term therapies that few clinicians actually practice. Then they confuse empirically *non*-validated with empirically *invalidated*, and declare it “unethical” to practice any form of therapy they have not researched. If physicians had to meet the standards that research psychologists routinely demand of clinical psychologists, surgeons would no longer perform heart surgery. (This is not a random example; the effect size of psychotherapy is considerably larger than that of coronary bypass surgery.)

In fairness, many researchers are responding to pressures that are not fully under their control. Given the present publication inflation, they are under pressure to conduct studies they can complete and publish quickly. It would probably be professional suicide for an untenured faculty member to study long term psychotherapies while his colleagues accumulate publications based on twelve- to sixteen-session treatments. The problem is that these short term treatments do not mirror real world clinical practice.

A study by Drew Westen surveyed a random national sample of experienced clinicians, asking them to recall the last treatment they conducted in which meaningful psychological change had occurred. Then the clinicians were asked how long the treatment had taken. Irrespective of theoretical orientation, the clinicians reported that the treatments had lasted about one year. The findings dovetail perfectly with the findings of Martin Seligman's “Consumer Reports” study, which are based on patient report. One might think, therefore, that most clinical researchers would investigate treatments of approximately a year's duration. They do not. In general, clinical researchers ignore the views of both clinical practitioners and patients when designing “clinical” research. The result, inevitably, is clinical research that has little to do with the practice of psychotherapy.

Differing World Views

Some academicians may take offense at the suggestion that they are not real clinicians. But there are important differences between clinical researchers and clinical practitioners. Clinical researchers' allegiance is to data and hypothesis testing. They spend little or no time with patients. If they treat patients at all, it is in the context of a study and rarely for more than twelve to sixteen sessions. (If the patient is still in distress after that, they refer them elsewhere—i.e., to a real clinician.) If they treat patients at all, they select them based on specific study criteria. This usually means that suicidal patients are eliminated, and patients with dual or multiple diagnoses are eliminated. This eliminates the majority of patients seen in real-world practice.

In contrast, clinical practitioners' allegiance is to their patients. They treat the people who actually seek help, not just the fraction with highly circumscribed problems who meet specific study inclusion criteria. They develop intimate relationships with patients over time. They maintain their commitment for as long as it takes. They consult with physicians, hospitalize patients who cannot function, and accept responsibility for treating people who want to die. These are real differences. Nothing is gained

by pretending that clinical researchers and clinical practitioners are “really” in the same line of work.

We need to find ways to bridge the gap between scientists and practitioners, for the sake of both groups. Researchers need clinicians for the rich observational data they can provide. Clinicians need researchers to help counter a professional culture in which charismatic authority and cult-like “brand allegiances” often take precedence over critical thinking and evidence. But clinicians need researchers who take their clinical observations seriously. They do not need researchers who dismiss with disdain the data of the consulting room.

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Coda

The *de facto* bifurcation of psychology training into university departments and free standing professionals schools has institutionalized the scientist-practitioner schism. Our educational system ensures that future generations of clinical practitioners will have little appreciation for empirical research, and future generations of researchers will have little appreciation for clinical work.

The last hope for meaningful dialog may lie with journal editors and funding agencies. Empirical journals could include real clinicians (not just clinical researchers) as reviewers for “clinical research” papers, and NIMH could include clinicians as grant reviewers for clinical research projects. The clinicians just might point out the emperor's new clothes with respect to clinical interventions that could never be implemented in the real world, or methods so artificial that the findings could never plausibly inform clinical practice.

Likewise, practice-oriented journals could include empirical researchers among manuscript reviewers. The research-oriented reviewers might identify theoretical assertions and assumptions that are, in fact, empirical questions. They might encourage empirical research on these topics. They might force clinical theorists to consider and cite relevant empirical research where it exists.

The goal in both cases really boils down to “keeping them honest.” Of course, this solution requires that people who wield power and authority voluntarily relinquish some of it, in the service of a greater good. This does not seem to be human nature.

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