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## Knowing What Works and Doing the Work: The Relationship between Research and Clinical Practice

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Sometimes in life, we hear something so often that it starts to lose its meaning. A word or phrase whose presence once conveyed important information becomes background noise. We may notice when that word or phrase isn't there, but we no longer process what it means when the word is there. For example, in the social sciences, we know that if something is described as "evidence-based practice," then that's a good thing. It means that particular practice is desirable, that it's based on sound reason and an existing body of research/data. But do we ever really stop to think about what "evidence-based practice" means?

These days, the term "evidence-based practice" is everywhere in the social sciences, it's constantly discussed. You can't escape it! It's integral to the social sciences in general and it's at the heart of everything ATSA does (see, for example, ATSA's mission statement). Has familiarity of the term bred contempt, however, or possibly even lead to a lack of understanding? For instance, we often discuss that there is a lack of professional, public, and policy connection between the language that is used in our field, such as the terms "pedophilia", "psychopath" and "child porn", but we often use them anyway! Is evidence-based practice another example?

With that in mind, let's look at the term "evidence-based practice." Let's really think about what evidence-based practice means in general, as well as what it specifically means for researchers and clinicians that evidence-based practice is at the core of ATSA's mission. Although it has been defined in different ways by different organizations (such as the [American Psychological Association](#)), it is worth exploring further as it has become applied.

The first part of the term, "evidence-based," obviously means



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*We are longtime members of ATSA dedicated to furthering the causes of evidenced-based practice, understanding, and prevention in the field of sexual abuse.*

*The Association for the Treatment of Sexual Abusers is an international, multi-disciplinary organization dedicated to preventing sexual abuse. Through research, education, and shared learning ATSA promotes evidence based practice, public policy, and community strategies that lead to the effective assessment, treatment, and management of individuals who have sexually abused or are risk to abuse.*

*The views expressed on this blog are of the bloggers and are not necessarily those of the Association for the Treatment of Sexual Abusers, Sexual Abuse: A Journal of Research & Treatment, or Sage Journals.*

based on evidence. The key to understanding what the term means to ATSA (and the social sciences more broadly), however, is what exactly is meant by the word “evidence.” In this particular context, what we mean is research. Rigorous, empirical research. Not a few case studies or anecdotal data, but multiple studies with appropriate analyses and large enough samples to be able to draw conclusions about whether an intervention worked. Or, more specifically, enough rigorous studies for us to believe not just that a particular intervention worked in the samples in which it was used, but also that the intervention will work in different samples in which it has not yet been used. Reaching such a high level of evidence takes a lot of work and a lot of time, with the research process often starting with case studies, moving to small-sample pilot studies, and eventually reaching inferential analyses several years later. Each step in the process is important, however, and the slow, deliberate nature of the process is what eventually gives us confidence in the results generated by the process.

The second part of the term, “practice,” can best be thought of as an umbrella term meaning application. It essentially specifies that the research evidence is being used, with the manner of use different for different people. For clinicians specifically, practice means the elements of clinical work, such as risk assessment, treatment, and aftercare. And not just to the act of conducting a risk assessment or guiding treatment. Practice also refers to all the steps leading up to the risk assessment and to the treatment, such as the process of selecting which risk/need assessment methods are best suited to a clinician’s particular clients (e.g., adult, juvenile, male, female, developmentally delayed) and setting (e.g., inpatient, outpatient).

These two parts together make up evidence-based clinical practice. And just to be clear, both parts are needed. By definition, there’s no such thing as good, evidence-based clinical practice without good evidence, which is to say research. The history of clinical work in the field of sexual offending is littered with examples of this. For example, empirical research-led clinical practice away from unguided (and inaccurate) clinical assessments of risk and toward accurate empirically-identified risk factors and instruments. Research also helped treatment in the field move away from older, ineffective models (e.g., shaming) and toward models shown to result in better treatment outcomes (e.g., cognitive behavioral methods).

On the other side, the most well-designed, rigorous research study on treatment or risk assessment is a waste if it isn’t useful to front-line clinicians. And to be useful, the research needs to address a meaningful topic, to be structured in a way that applies to treatment or assessment in practice (not some idealized version of treatment or assessment that can’t be achieved in the field), and to be conveyed in a manner that’s accessible to clinicians. It needs to bear in mind the challenges clinicians face in the field, such as limited time and resources.

The fact of the matter is that good research and good clinical practice are inextricably entwined. For both to be optimally effective, each has to inform the other. Research is at its best when it’s guided by the needs and realities of clinical work. Clinical work is at its best when it’s guided by empirical research that has identified effective techniques. Trying to separate research and clinical practice, or researchers from clinicians, merely weakens both. It’s like separating a musician from her instrument. The former runs the risk of losing her playing ability, the latter runs the risk of becoming merely decorative. There is also the question of *who* conducts the research that defines evidence-based practice, is it research practitioners, policy researchers, or academics? Each brings a different perspective to the table, and potentially, a different threshold of evidence. This is not to be critical or dismissive, rather to say we need to guarantee consistency in criticality, reliability, and validity.

So, what does “evidence-based practice” mean? It means researchers and clinicians (and policy-

makers and supervision agents and everyone else working in the field of sexual abuse prevention) working in true collaboration with each other at each stage of the process, from knowledge generation all the way through to knowledge application. Each side must be open to the input and feedback from the other, which can only result in a stronger system and better outcomes. Only when research and clinical practice are combined are we optimally working toward our common goal of reducing sexual abuse.