The GENERAL Psychologist

Integration Themes
In Clinical Psychology

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Sociologists who have studied progress in science have made an important distinction—the difference between the "core" of knowledge versus the "research frontier" (Cole, 1992). The core is comprised of those findings that are accepted by the scientific community as being "true," that is, findings about which there is a consensus. By contrast, the research frontier consists of cutting edge contributions that are still being evaluated. Interestingly enough, a study by Cole of the grant review process has found that there is just as much disagreement in judging research proposals in the natural sciences as there is in the social sciences. In an observation with which many researchers can certainly relate, Cole suggests that the luck of the draw—namely, who reviews the grant proposal—has more to do with grant approval than the proposal itself. As he put it: "There may not be significantly more consensus in evaluating new scientific ideas than there is in judging nonscientific items such as human beauty, new works of art, or Bordeaux wines" (Cole, 1992, p. 19). And while psychology as a science and profession may have just as much disagreement at the research frontier as our colleagues in the natural sciences, the place where we differ is that we have problems in agreeing on what constitutes our core.

The problem that we have in agreeing about our core of knowledge is complex and multidimensional. In this paper, I would like to touch on some of these dimensions, as well as the past, current and future efforts directed toward creating a better integration within the field—especially clinical psychology. I might add that for each of these themes, my own initial involvement began with something personal, reflecting the not uncommon notion that the personal fuels the professional. These themes are: (1) Integrating Clinical Practice and Research; (2) Integrating Cognition and Affect into Behavior Therapy; (3) Integrating the Contributions from Different Therapeutic Orientations; (4) Integrating Past Contributions into Present Work; and (5) Integrating Gay, Lesbian, and Bisexual Issues into Mainstream Psychology.

Integrating Clinical Practice and Research

When I was in graduate school, Paul Meehl visited our program, and I was fortunate enough to be among a small group of students that went out to dinner with him. This was a rare treat, especially since I read virtually everything Meehl had written, and had enormous respect for his insights on research, practice and the philosophy of science. At one point during the evening, someone asked him the question about the extent to which his clinical work was informed by research. Without any hesitation, he replied: "Not at all."

As someone who was struggling to adopt the identity of scientist-practitioner, I left this memorable dinner disheartened. I don't think I ever fully recovered. The challenge of how we can close the gap between research and practice has stayed with me for all these years. Because I am attracted to challenges—my psychodynamic colleagues would characterize this as an unresolved conflict, and my experiential colleagues would probably call it unfinished business—I have continued to be intrigued with the integration of practice and research.

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Throughout most of my professional career, I have lived in both the worlds of the researcher and the clinician. Much of my teaching, research, and writing has placed me at the academic end of the spectrum. My continued involvement in clinical training and supervision, and my part-time practice of psychotherapy have all kept me in close touch with clinical reality. However, over the years, it has been an ongoing effort to bridge these two worlds.

Those who have studied the progress of science have made an another important distinction–this one between

the questions to be studied and the procedures for studying them. During the initial phase— the context of discovery— we have the "problem finders," who identify the important research questions that are likely to advance the field. Once these issues are identified, we move to the confirmation phase, where the "problem solvers" investigate the empirical status of those phenomena that have been identified by the frontline observers. In considering the relationship between psychotherapy practice and research, I have viewed clinical work as providing us with the context of discovery. Working with clients directly and discussing clinical cases with others can provide not only the challenge of translating general research findings to the individual case at hand, but also can afford us the opportunity to witness first hand the ever-varying parameters of human behavior and the change process. In one's role as therapist, the "problem finder" can garner clinical hypotheses to be studied under better-controlled research conditions.

In 1995, a Task Force that was formed within Division 12—The Society of Clinical Psychology—published a controversial report that attempted to delineate what at the time was called "empirically validated" therapies (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). The intent was to help move the field toward a greater consensus, based on what has been empirically been shown to be efficacious. However, several of us with a very definite commitment to having empirical support for our interventions had serious reservations about this report, and were particularly concerned that the methodological and conceptual constraints associated with outcome research might very well turn into clinical constraints for the practicing therapist. As a strong advocate of psychotherapy research (Goldfried & Wolfe, 1996, 1998), this dilemma may be thought of as reflecting a conflict between a wish and a fear: The wish is that therapy interventions be based on research; the fear, however, is that they might.

Despite the methodological advances in psychotherapy research that have been made over the past five decades, the findings compiled to date are limited by the fact that they do not fully generalize to the way therapy is carried out in the real world. The clinical validity of this research has been compromised by several factors. One is the medicalization of outcome research, as compared with a view of clients' concerns as involving problems in living. External validity is also limited by the use of random assignment of clients to treatment conditions, rather than a research design that matches interventions to the case at hand. The research findings are constrained by the nature of our current therapy manuals, which typically lack the clinical flexibility to alter interventions during the course of treatment when needed. Finally, our outcome research fails to reflect clinical reality by primarily investigating theoretically pure therapies, which is not how most therapists practice. To close this gap between research and practice, the field needs to foster a more productive collaboration between clinician and researcher; to study theoretically integrated interventions; to use process research findings to improve our therapy manuals; to make greater use of replicated clinical case studies; and to focus on dimensionalized, as opposed to heterogeneous and categorical clinical problems.

Recognizing that our methodologically sophisticated psychotherapy research paradigm may very well have sacrificed clinical validity for the sake of internal validity, Division 12 has more recently instituted a standing Committee on Science and Practice (Weisz, Hawley, Pilkonis, Woody, & Follette, 2000). The function of this committee is not only to review existing findings, but also to encourage improved research designs, to work on more effective ways to disseminate findings to practitioners, and generally to forge a closer link between researcher and practitioner.

The scientist-practitioner interface is important in that it keeps us honest both as clinical researchers and as empirically informed clinicians. Without an ongoing clinical base, it is all too easy to get caught up in research trends and fads, rather than pursuing that which is useful to the practicing clinician. Not only is it important for clinicians to help foster more clinically meaningful research, but they may also serve a vital function in providing feedback to researchers regarding those empirically supported interventions that do, and do not, seem to work in actual clinical practice. Even after drugs have been approved by the FDA for clinical use, clinicians have the opportunity to feed back information about how well they fare in actual practice. I would hope that the Division 12 Standing Committee on Science and Practice develops a mechanism for providing such feedback.

Integrating Cognition and Affect into Behavior Therapy

Behavior therapy has clearly evolved over the past four decades, moving from its focus on specific actions to an increasing attention to cognitive aspects of human functioning. In the 1960s, behavior therapy was criticized for its exclusive focus on overt behavior and its reliance on classical and operant learning models that, while important and useful, had limited clinical value. This criticism led to increased openness to cognitive procedures within the field. In the 1970s, behavior therapists began to take notice of the accumulated knowledge and developments in basic cognitive science, and most began referring to their orientation as "cognitive-behavioral."

The role of emotional arousal in behavior therapy and cognitive-behavior therapy, on the other hand, is only recently undergoing a reevaluation. In the past, emotion has typically been viewed as something that needs to be reduced, and more emphasis was placed on behavior and cognition, as well as developing techniques for managing or containing affective arousal. For example, in a study by Wiser and myself, we found that in treating depressed clients, cognitive-behavior therapists viewed ***lowering*** levels of emotional experiencing as significantly contributing to the process of therapeutic change. In contrast, psychodynamic therapists

considered ***increasing*** levels of emotional experiencing to be clinically significant (Wiser & Goldfried, 1993).

Research has shown that although emotions can be affected by changes in the cognition (and vice versa), the emotional system also has a set of unique pathways that can be used to directly activate and change a client's emotional structures. Evidence from cognitive science and experimental psychology has linked emotion to personal meanings, and has emphasized the role of implicit meanings in the process of change (Samoilov & Goldfried, 2000). For example, two different types of knowledge have been described: One has been "tacit" knowledge, which involves the emotional-affective system, and the other involves "explicit" knowledge, a rational, logical knowledge system. Whereas the explicit or logical processing may influence rational judgments, the implicit or tacit processing, by contrast, is closely linked to emotion and is considered primary in changing global experiential states. Moreover, implicit meaning, together with its emotional overtones, is often evoked by sensory input, such as familiar sights, sounds and smells.

This influence of sensory input and emotion on implicational meaning can be illustrated with an experience I had during a trip to Poland, during which time my wife and I had visited Auschwitz and other concentration camps. It was an emotionally moving and highly personal experience, seeing the camps and viewing pictures of how people were transported there. That night, when the time came for us to board the train to leave Poland, we experienced some difficulty in locating the car in which our compartment was located. Amidst the crowd and confusion, where nobody spoke English, we were finally instructed to walk toward the front of the train. As we found ourselves at the end of the platform, our luggage fell off the cart, the whistle blew, and the train started to move. At that moment, I suddenly experienced an overpowering surge of fear and helplessness, and experienced a clear, felt-sense that we were being taken to a concentration camp! Even though there was a part of me that knew the train was really going to Prague, I nonetheless believed we were being shipped off to a camp.

Recent cognitive neuroscience findings by LeDoux (1996) have revealed a neural pathway that leads directly from the thalamus to the amygdala—the "emotional brain"—which allows the amygdala to receive direct input from sensory organs and to initiate a reaction before the information is registered by the neurocortex. According to LeDoux, signals that have higher emotional significance are more likely to be responded to by the amygdala, such that events that are highly emotional are registered at subcortical—emotional—levels. Thus, knowing with the heart can occur separately from knowing with the head.

These findings have direct implications for psychotherapy: In order to restructure emotional meaning, interventions must target not only cortical, but also subcortical levels. Although space limitations do not permit me to go into detail as to how this might be accomplished, suffice it to say that I believe that the use of experiential therapy techniques by cognitive-behavior therapists, so as to increase emotional arousal, can hold great promise. Which brings me to the next integrative theme: Integrating the contributions from different therapeutic orientations.

Integrating the Contributions from Different Therapeutic Orientations

It is hard for me to recall exactly when I began to experience the limitations of my cognitive-behavioral orientation. I suspect it was a gradual process that brought about this change. However, I do recall one pivotal event that occurred to me in the mid-1970s when I was demonstrating the course of therapy for a group of graduate students behind a one-way mirror. The point of the demonstration was to illustrate how cognitive-behavior therapy may be used to increase self-assertiveness in an otherwise very submissive woman. Although I had carefully selected a client for whom assertiveness training would be relatively straightforward, I found myself confronted with an unexpected and repeated dilemma during the course of therapy: Should I do what my best clinical sense told me to do, or should I respond the way a cognitive-behavior therapist was supposed to respond? For example, during one session, I found myself thinking along the following lines:

> This client really needs to get in better touch with her feelings, and that's what we need to be working on at this time. Not only that, but she needs feedback on how she's being submissive in dealing with me right now. But I can't do that. I would no longer be practicing cognitive-behavior therapy. It would only confuse the students. However, if I were really working with this woman clinically, that's what I would do. Why do I have this strange feeling that it would be "cheating" if I did something that wasn't behavior therapy?

With some trepidation, I decided I would finally reveal my dilemma to the students. When I went back to speak to them after the session, I confessed that I was not practicing the way I usually did, as I wanted to show them what "pure" behavior therapy looked like. They were very supportive, and they assured me that they would much prefer to watch me conduct therapy in the way I believed to be most effective. I vividly recall this experience as one in which I had "come out" from behind the one-way mirror.

Thus, I became interested in psychotherapy integration, a topic that has a long past but a short history (Goldfried & Newman, 1992). The idea of creating bridges across theoretical orientations was briefly considered in the early 1930s, but it was not until the 1980s when it moved from being a latent theme to a clear area of interest. Norcross and Newman (1992) identified a number of factors that contributed to this more recent interest in psychotherapy integration. These include the confusion and fragmentation caused by the proliferation of

different schools of thought; a realization that no given approach could successfully handle all clinical cases; a growing pressure for accountability and consensus; the focus on specific clinical problems and practical ways of dealing with them; therapists' opportunity to observe and to experiment with approaches other than their own; the development of an interest in common factors that cut across all forms of treatment; and the existence of a professional network–the Society for the Exploration of Psychotherapy Integration: SEPI– that provided a context within which consideration of psychotherapy integration could take place.

The Society for the Exploration of Psychotherapy Integration (SEPI) is an interdisciplinary organization of professionals interested in approaches to psychotherapy that are not limited by a single orientation, as well as the interrelationship between research, theory and practice. The primary objectives of SEPI are to encourage communication and to serve as a reference group for individuals interested in exploring the interface between differing approaches to psychotherapy. SEPI also serves an educational function by publishing a journal; by encouraging ongoing collaborative research on the process of psychotherapy; by keeping members up-to-date concerning books and articles relevant to rapprochement among approaches; and by sharing clinical approaches and guidelines that reflect themes of convergence and complementarily.

Although SEPI provides support for colleagues in their efforts to establish a foundation for the legitimate practice of therapies based on integrative models, this is not SEPI's mission. Because it is an educational, clinical, and scientific organization, and because it is inconsistent with SEPI's purpose to sanction any one particular approach, it does not provide certification or accreditation, endorse any approach to integration over any other, sponsor any training programs, or participate in any political activities. In short, it serves as a context in which psychotherapy integration may be studied.

One of my own interests has been to study the commonalities that exist across theoretical orientations. Setting aside theoretical jargon that is associated with different therapeutic orientations, it is possible to derive from the clinical literature a handful of common principles that cut across different schools of therapy (Goldfried & Padawer, 1982). I have suggested that these principles may be thought of as existing at a level of abstraction somewhere between the observable clinical methods and the more high-level theoretical explanations that are proposed to explain why these methods might be helpful.

To begin with, there seems to be agreement that the change process is facilitated initially by clients' *expectations that therapy will help*. Another important common mechanism of change involves the presence of an *optimal therapeutic alliance*, providing a significant interpersonal context in which change can take place. Clinicians of different orientations have also written about the therapeutic importance of *increasing clients' awareness* of alternate ways of understanding themselves and their environment. This new awareness often sets the stage for what many believe to be at the core of therapeutic change, namely the *corrective experience*, whereby clients take the risk of behaving in a therapeutically positive way despite their anachronistic doubts and fears. Much of therapeutic change then involves an *ongoing reality testing*, consisting of an increased awareness—insight—that facilitates corrective experiences—action—which, in turn, further enhances an ongoing cycle of awareness and corrective experiences.

That these commonalities can emerge despite the varying theoretical starting points suggests that they represent very significant underlying principles of change. Still, these common principles are too general to be used therapeutically by the practicing clinician, and more detailed guidelines are needed. Thus, one may use these common principles as starting points, suggesting potentially fruitful and clinically meaningful arenas in which to conduct psychotherapy process research. The more detailed guidelines resulting from such process investigations may be thought of as parameters of these common change principles. I believe that starting from principles of change, rather than from a particular therapeutic school of thought, is likely to be more fruitful in advancing the field.

In order to advance our field, we also need to deal with the issue of integrating past contributions into present work, the next theme I would like to address.

Integrating Past Contributions into Present Work

There are times when I sit in my office and contemplate my collection of journals. To the left are the old, faded ones, and I can recall the many hours I pored over them as a student. At the time, the material in them was new and exciting. Like everyone else, however, my energies are now focused on desperately trying to keep up with those journals on the right—the current literature. Although times have certainly changed since I attended graduate school, much of what is included in the literature of the past continues to be relevant today. I doubt that many people read this literature, let alone cite it. However, it pains me when I think of those researchers and clinicians that dedicated so much time, energy and devotion to producing it, especially when I reflect on the negligible impact that much of their work has made on the field.

Why is this the case? Two of the factors that make it difficult for us to draw on contributions from the past include the language barriers that characterize the field, and also the value that is attached to what is new.

Although our theoretical language allows us to readily communicate with colleagues who share our orientation, it prevents us from reaching a consensus. Interestingly enough, however, a close reading of the literature at times reveals that once we can get beyond an author's theoretical jargon, we may find that what is being said may be quite similar to what others have said, but in different ways. For example, in 1969, Bandura described the reduction of fearful behavior as follows:

> Extinction of avoidance behavior is achieved by repeated exposure to subjectively threatening stimuli under conditions designed to ensure that neither avoidance responses nor the anticipated adverse consequences occur (p. 414).

Some years earlier, Fenichel (1941), well known for his opaque use of psychoanalytic jargon, had described the very same process of fear reduction. In this description, however, he was surprising clear in his use of the vernacular:

> When a person is afraid but experiences a situation in which what was feared occurs without any harm resulting, he will not immediately trust the outcome of his new experience; however, the second time he will have a little less fear, the third time still less (p. 83).

There is a long history in psychotherapy of rephrasing concepts into one's own unique language system, dating back to Freud. In fact, in 1924, Pierre Janet complained that after visiting with him, Freud began to use his own jargon in writing about what Janet had been saying all along. As stated by Janet:

> In these publications, he changed . . . the terms that I was using; what I called psychological analysis he called psychoanalysis, what I called psychological system . . . [to refer to associative reactions to past trauma] he called complex; he considered repression what I considered a restriction of consciousness (p. 41).

A second factor that keeps us from building on past work is the importance given to what is new. I once asked a group of graduate students to generate as many associations that came to mind during the course of one minute when they thought of the terms "new" and "old." The results were telling. Virtually every association to "new" had positive connotations, such as "bright," "good," "better," and "fresh." Only about half of the associations to "old" were positive in nature, including such terms as "experienced," "wise," "solid," and "established." The remaining half consisted of terms like "worn out," "used," "boring," and "decrepit."

According to Webster's New Collegiate Dictionary, "new" is defined as "having existed only a short time." However, it is also said to mean "of dissimilar origin and usually of superior quality" as in "introducing new blood." By contrast, "old" is defined as "from the past—experienced," but also as "showing the effects of time or use" and "no longer in use: DISCARDED," as in "old rags."

To be sure, the focus on what's new is intrinsic to scientific progress in any field; indeed, it is the research frontier described earlier. Assuming that the field has an agreed-upon core of knowledge, it is the cutting edge that clearly should receive the most attention. When this is done in the absence of a core, however, we cannot expect the field to progress in any coherent way.

In order for our field to mature, we need to make use of our creative research and clinical energies to build upon, rather rediscover, what we already know. As documented by Staats (1983), the citation practices in psychology leave much to be desired. However, what has been done in the past is of more than "historical interest;" it potentially represents the foundation upon which a core consensus may be achieved.

What do we need to do to get there? Clinical-research collaboration is needed; theoretical barriers must be lowered; exclusionary jargon must be translated; and professional amnesia must be overcome. Among the ways this might be accomplished are by creating a better bond between researcher and clinician, facilitating dialogues among therapists of different orientations, and making use of a common language.

The final theme I would like to address is the need to integrate gay, lesbian, and bisexual issues into mainstream psychology.

Integrating Gay, Lesbian, and Bisexual Issues into Mainstream Psychology

For most of my career, my primary clinical and research interests have centered around clinical assessment and psychotherapy, particularly in the areas of behavior therapy and psychotherapy integration. However, this is about to change. After many years of silence, I have decided that it is time for me to come out professionally–not as a gay man, but as the father of a gay son. As a result, I am beginning to devote more of my professional energies to this fifth integrative dimension: integrating gay, lesbian, and bisexual issues into mainstream psychology.

A long-standing theme in the lives of gay, lesbian and bisexual (GLB) individuals has been the need to be in hiding—to be invisible. This has also characterized the field of psychology over the years, in that GLB professionals have remained closeted. It was as if GLB psychology was not telling, and mainstream psychology was not asking.

Since the Stonewall Rebellion a little over 30 years ago, which marked the beginning of a very dramatic gay rights movement, GLB individuals have been able to be more open about who they are. This trend has also been seen within psychology, in that there has been a marked increase in professional writings about GLB issues, typically by people who have decided to come out professionally. And while psychology in general has shown support for GLB concerns, the GLB literature continues to remain invisible to those outside the area, and has not been incorporated into the mainstream body of knowledge. GLB professionals are now telling, but mainstream psychology is not listening.

There are a number of issues in the GLB literature that, although having a direct bearing on topics currently receiving attention within mainstream psychology, nonetheless continue to remain "invisible." These include: teenage suicide; substance abuse; victimization and abuse; family psychology and couple relationships; adolescent development; aging; and psychotherapy (Goldfried, 2001).

Research findings have shown that gay and lesbian youth are far more likely to attempt suicide than are their heterosexual peers; approximately one out of three gay and lesbian individuals have attempted to end their lives. A reality that is also distressing is that the mainstream literature on suicide rarely mentions that gay men and lesbians are at greater risk.

In attending a conference on adolescent suicide in the late 1990s, a member of the audience was similarly shocked to learn that none of the experts that presented their work made any mention about GLB adolescent suicide. One presenter, during the course of her talk, raised the question: "What secret could be so terrible that you would rather kill yourself then tell?" As neither the presenter nor anyone else provided an answer, this particular audience member approached her afterwards and asked why she did not mention the higher risk of suicide among lesbian and gay adolescents. Her response was: "Oh, I never even thought about them."

It has been found that GLB individuals have higher frequencies of substance abuse. However, like suicide, mainstream research and reviews of the contemporary literature fail to take into account or report sexual orientation in its writings. Client characteristics reported in current research reviews of substance abuse include race/ethnicity, gender, SES, past arrests, suicide attempts, school problems, and family conflict. Nowhere is sexual orientation mentioned.

The psychology literature on physical and sexual abuse, victimization and post-traumatic stress is extensive. And while these issues are quite problematic among GLB individuals, they are typically ignored in the mainstream literature

Family issues play a major role in the lives of GLB individuals, involving such topics as the impact of coming out on family of origin and the considerations associated with establishing long-term partnerships. Yet, mainstream research and teaching assumes everyone in a family is heterosexual. As a result, theories about the nature of intimate relationships need to be rethought once we find that interactions believed to be linked to gender are also found to occur in same-sex partnerships.

The formation of a positive identity, a developmental task associated with adolescence, can be central to one's psychological and physical well-being. Issues involving GLB identity formation, societal stigmatization, and its consequences are rarely discussed in mainstream developmental literature.

GLB individuals face all of the same and numerous additional challenges as they grow older, and often need to confront these without family support. These issues are rarely considered in the aging literature.

Although GLB individuals frequently make use of psychotherapy services, surveys of therapists indicate that they do no feel qualified to work with this clinical population.

Despite the many advances that GLB individuals have made in society and within psychology, there nonetheless continues to be a stigma associated with doing work in this area. Typically, most of what has been done is by individuals who themselves are GLB. Consequently, for them to decide to focus on GLB issues professionally involves their coming out, as well as the possibility of putting themselves at risk of being marginalized within the mainstream community.

What can be done about this? A group of us recently formed a network within psychology of family members who have come out in open support of their own GLB relatives. Included in this network of family members are: mothers, fathers, sisters, brothers, grandparents, aunts, uncles, nieces, nephews, cousins, husbands, wives, sons and daughters. One of the goals of this network–AFFIRM: Psychologists Affirming their Gay, Lesbian and Bisexual Family—is to de-stigmatize research, practice, and teaching in this area. Bibliographies of those topics within the GLB literature having relevance to, but being ignored by mainstream psychology, have been posted on the AFFIRM Web site, to be used by mainstream professionals in their teaching, research and clinical work (www.sunysb.edu/affirm). These include bibliographies on such ignored GLB topics as adolescent development, teenage suicide, substance abuse, family and couples issues, parenting, partner abuse, aging, and psychotherapy.

Concluding Comment

In a lead article appearing in the ***American Psychologist*** in the early 1990s, Staats (1991) provided an account of the disunity within psychology, and pointed to where he believed we needed to head. He suggested that the progression from chaos and disunity to greater unity and consensus should involve a basic shift in our scientific goal—moving from one of preoccupation with finding the *novel*, to the inclusion of efforts to find *interrelationships*. As he argued, we need to simplify and to organize that which has already been found. At present, careers in psychology are made by making history, not knowing it. This reward system needs to be changed for us to move forward. Professional amnesia must be overcome; clinical-research collaboration is needed; theoretical boundaries must continue to be lowered; and exclusionary jargon must be translated.

How this can be brought about represents the real challenge. Thus far, no organization, no task force, and no committee have been successful in integrating psychology in general, or clinical psychology in specific. Still, such attempts at reaching consensus play a very important role in raising the consciousness of the field and in encouraging workers to devote their time and energy in moving in this direction. For example, in the 20 years that the Society for the Exploration of Psychotherapy Integration (SEPI) has been in existence, no unified statement or model has been produced. Still, I would argue that it has been successful in moving psychotherapy integration from being a latent idea to it becoming a definite area of interest. One is no longer an

outsider to be interested in integration. Indeed, the term "integration" is now prized by book publishers looking for a title that is likely to sell.

As I indicated at the outset of this paper, psychology has been struggling to form a knowledge core. I have highlighted a few areas in which integrative efforts can potentially help us move in that direction. I would like to close by referring to what Garner, Hake and Erikson suggested back in 1956, when they provided a strategy for building up a body of knowledge about a very specific area of psychology—visual perception. They raised the question of how much we had learned about perception was a function of the phenomenon itself, and how much a function of the methods that were used to study it. Their recommendation was to use more than a single methodology—as they called it, "converging operations"— to investigate the nature of perceptual processes, arguing that firm conclusions could only be drawn from studies that used different methods, but arrived at comparable findings. I believe that the same can be said in arriving at a consensus in psychology. As a field, we have a long history of taking different paths to study the same phenomena. To the extent that these different vantage points and methodologies lead us to comparable conclusions, the resulting findings are likely to be quite robust. It is here that we can find our knowledge core.

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