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COMMENTARY

Contextualized Integration as a Common Playing Field for Clinicians and Researchers: Comment on McWilliams

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We comment on McWilliams's (2016) article, "Integrative Research for Integrative Practice: A Plea for Respectful Collaboration Across Clinician and Researcher Roles." Above all, we appreciate McWilliams's well-toned plea for considerate collaboration between researchers and clinicians. We also appreciate that obstacles have long made it difficult to meaningfully reduce the scientist–practitioner chasm, and McWilliams shrewdly highlights how some obstacles are becoming even more daunting to traverse. In general, we agreed with most of McWilliams's points. We also provide some respectful challenges or at least extensions or reframes. For example, to us, the researcher–practitioner divide is more than just an urgent conversation problem; rather, it has potential to do harm to patients. Also, although we too appreciate relational factors in the psychotherapy evidence base, it seems important to refrain from contributing to the artificial relational–specific factor dichotomy. We present a resolution of this divide, which we call *content-responsive psychotherapy integration* (Constantino, Boswell, Bernecker, & Castonguay, 2013). We also offer possible versions of efficient and immediately translational trainings, arguing against continued self- or peer-nominated experts passing down wisdom in long-form in-services. Similarly, while we champion hearing from "reputable" clinicians about important research topics, we believe that the determination of *reputable* needs to be based on clinicians' personal outcomes data. We also argue that it is important to move beyond the 4 established integration pathways by pushing for disruptive integrative innovations. Ultimately, our goal is to help locate the common playing field for researchers and clinicians and the most efficient ways to play together on it.

Keywords: science–practice integration, evidence-based practice, practice-based evidence, context-responsive psychotherapy integration

I (first author) was honored to be invited to comment on McWilliams's (2016) article. Still recalling the profound influence her psychoanalytic book series (McWilliams, 1994, 1999, 2004) had on me during my graduate training, and still referring supervisees to these books, I was eager to see what McWilliams had to say on topics that dominate my professional interests: researcher–clinician collaboration and psychotherapy integration. I was also enthused to share this exercise with two graduate trainees who, like me, identify most predominantly as psychotherapy researchers, though ones who also practice.

Well aware of the widening distance between those who identify largely as researchers and those who identify largely as clinicians, we appreciate McWilliams's cogent plea for not only considerate collaboration between these camps but also for repositioning psychotherapy integration at the center of

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a field that requires treatment personalization and constant responsiveness to multivariate pressures and professional obstacles. Although McWilliams is not alone in her plea, her voice as a leader in the field of psychotherapy is sure to be heard. We heard it, and we also had remarkably convergent reactions among our team. These reactions spanned points of agreement, some respectful challenges, some inspired elaborations or reframes, and some suggested future directions. We share in this article, in chronological order through McWilliams's piece, the reactions that we found most central to a clearly shared goal of resolving professional divide and promoting mental health. We aim for our comments to be not only reactionary but also prospectively useful and anchored in a novel model of psychotherapy integration.

In her introduction, McWilliams shares that practitioners with whom she comes into contact enthusiastically agree that clinically relevant research that truly represents their practice is important. Complementing McWilliams's experience of talking to practitioner audiences, we also see this attitude when practitioners engage in our research. For example, we found in a pilot survey of mental health stakeholders' perspectives on using routine outcome monitoring (ROM) data and feedback derived from them that therapists not only had positive attitudes toward ROM but also were interested in learning how best to apply ROM data to their practice (Boswell, Constantino, Kraus, Bugatti, & Oswald, 2016). It seems clear that clinicians' desire to consume and apply practice-relevant research is high; thus, it is important not to interpret the science–practice divide as simply reflecting each camp's disinterest in the other.

Yet, the discrepancy between endorsed values and the realization of such values remains—what McWilliams framed as the point at which the "conversation ends." This is problematic, and we agree with McWilliams that the problem is more urgent than the long-standing divide between theoretical orientations. We would take this argument a step further by positing that the relative urgency of the problem resides not just in its magnitude among professionals but also in its direct impact on patients. To us, the researcher–practitioner divide has more potential to do harm than debates about theoretical orientation. When clinicians argue about their theoretical models, we know that there is really no "winner" given that different bona fide psychological interventions produce largely comparable outcomes (Wampold & Imel, 2015). Thus, although the cost of blind allegiance to a model may be limiting, it is less likely to be harmful to patients than to ignore what researchers and their work have to say about facilitative, harmful, and inert effects. Take, for example, a clinician who eschews compelling research that points to actuarial prediction of clinical course, based on ROM data, being more accurate than clinical judgment (e.g., Hannan et al., 2005). In this case, the science–practice divide is far more than an academic gulf; it could be a patient-level harmful effect.

From Charismatically Framed Disputes to Current Assimilative Practice

McWilliams shares her hope "that the era notable for clashing visions of therapy from charismatic leaders in the field . . . has pretty much played itself out" (2016, p. 1). We, too, certainly hope so. However, we believe that remnants of this era likely remain, as unfounded claims for in-group superiority of full treatment packages (from top-down comparative research programs that tend to compare these packages to something clinically uninteresting like no treatment or non–bona fide treatments) do continue in pockets of the field. Like McWilliams, we can see how this type of research would be viewed as irrelevant, or at least relatively unactionable, for one's personal practice. We hope that the "playing itself out" continues hastily, as we see an urgent need to do away with any remaining thought remnants that empirically supported treatment (EST) packages, and strict adherence to them, are synonymous with evidence-based practice (EBP); they are not (Laska, Gurman, & Wampold, 2014).

McWilliams shows gratitude for the resolution of the American Psychological Association (APA) on the recognition of psychotherapy effectiveness (Campbell, Norcross, Vasquez, & Kaslow, 2013), including empirical support for transtheoretical relationship factors. As common factors researchers, we too appreciate the inclusiveness of pantheoretical factors in the resolution. However, we are also aware that this type of championing of relational factors can also foster a different type of divide in the

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field—between what is relational and what is specific. To us, while this divide is apparent, it is also artificial. Thus, we have attempted an integrative reconciliation, which we call *context-responsive psychotherapy integration* (CRPI; Constantino, Boswell, Bernecker, & Castonguay, 2013). This approach privileges the notion that common and specific factors play on the same psychotherapy field (see also Constantino & Bernecker, 2014).

CRPI reframes common factors as common clinical scenarios (e.g., patient characteristics, momentary dyadic process, ROM feedback) that clinicians encounter in their daily practice, irrespective of their theoretical orientation or preferred top-down treatment plan. CRPI then blends theory-specific and common treatment factors by first proposing a need for a cogent illness conceptualization and treatment rationale, as these specific factors are necessary for patients to perceive a therapy as credible and hopeful (Anderson, Lunnen, & Ogles, 2010). Next, the model also posits an if-then structure for therapists to respond to markers of important contextual scenarios with context-relevant, principle-driven, and empirically backed clinical strategies that will often require a departure (at least temporarily) from the specific foundational approach.

For example, in moments of patient resistance to the direction of the therapist or therapy (the “if” moment), the therapist can temporarily move away from his or her foundational approach to apply research-supported interventions like motivational interviewing (MI; the “then” moment) that have been shown to help resolve resistance and improve clinical outcomes, including in causal research designs (e.g., Westra, Constantino, & Antony, 2016). Alternatively, in “if” moments of alliance rupture, a therapist can use “then” strategies of alliance rupture repair (see Smith-Hansen, 2016). Finally, “when” a common factor marker has been successfully responded to, the therapist could return to the more specific treatment plan. To us, responsively doing an empirically supported “right thing” at the empirically supported “right time” is *the* quintessential integrative notion for effective therapist behavior. Again, it relies on specific *and* common factors and research that contributes to both elements of this artificial dichotomy.

Thus, although we agree with McWilliams that most practitioners are assimilative integrators who are trained in one main language but are also motivated toward becoming at least literate in others, our hope is that clinicians might evolve from assimilative integrators to context responders, with literacy coming not only from theory but also from research on and skills in assessing markers and responsive interventions shown to work in the face of these markers. Succeeding in such context responsiveness has been shown to promote improvement directly (e.g., through using MI in moments of patient–therapist disagreement; Aviram, Westra, Constantino, & Antony, 2016) and indirectly (e.g., through being less adherent and more flexible in applying theory-specific techniques; Owen & Hilsenroth, 2014), while failing in it can reflect clinician error (Bugatti & Boswell, 2016). Of course, CRPI is a new model requiring additional empirical support and an ongoing search for relevant, commonly occurring markers to which therapists need to respond by doing something else rather than by forging ahead with an a priori plan.

Contemporary Agency Practice

McWilliams laments the disappearance of quality in-service clinical trainings and notes that psychology interns may have taken on the role of cheap labor more so than apprentices learning from the wisdom of experienced professionals. We had a complex reaction to this point. On the one hand, we would suggest caution in assuming that skill and wisdom best emanate from experienced professionals. The literature on therapist effects warns us that not all therapists are created equal (Baldwin & Imel, 2013), and there is a notorious lack of association between clinician experience and patient improvement (Tracey, Wampold, Lichtenberg, & Goodyear, 2014). Thus, we are in no hurry for in-service clinical trainings to reappear in the form of so-called clinical gurus passing down clinical wisdom to apprentices. Although these trainers will believe that they are at the top of their profession (Walfish, McAlister, O’Donnell, & Lambert, 2012), the statistical reality is that some trainers will be effective in treating their average patient, others relatively ineffective, and others even harmful. Unless these trainers’ empirical outcome track

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records are known, it would be unknown whether beneficial skill and wisdom are being passed down to apprentices. Statistically, some in-services would be training apprentices to do ineffectual or harmful therapy (yet reputation or name recognition might mask this problem).

On the other hand, we agree that in-service training needs to reemerge, but perhaps in a novel way that is efficient enough to counteract the many pulls on people's time and focused enough to capitalize on people's ability to learn and take action in today's clinical environments. To us, brief, modular trainings on evidence-based marker recognition and responsiveness strategies have the potential to be both highly effective and efficient, especially given that the if-then learning paradigm requires less cognitive control (Parks-Stamm & Gollwitzer, 2009). In turn, these principles can be directly implemented without having to graduate to some advanced level of training on a full-package EST. For example, we would imagine that clinical trainees would be very interested in attending a 45-min in-service that outlined markers of a common clinical occurrence, such as a patient articulating low expectation for improvement, as well as practice-friendly, evidence-based strategies for fostering increased patient outcome expectation (Constantino, Ametrano, & Greenberg, 2012). Then, trainees could immediately "try on" these strategies were a patient to reveal the marker. This is a much different form of dissemination than putting in hours of training to become certified to deliver a particular EST for a particular disorder. To us, this newer type of in-service would represent a "disruptive innovation" (Rotheram-Borus, Swendeman, & Chorpita, 2012) necessary to evolve EBP in a way that is time efficient, cost effective, and immediately actionable.

Contemporary Independent Practice

McWilliams references the concept of category mistake, which she applies to clinicians being asked to conduct their treatments as if they were engaging in randomized clinical trials (RCTs). She then notes:

> It is a research requirement to be very specific about the problem to be studied, to take objective measures of reportable symptoms at the beginning of treatment, to manualize what is done, to monitor client adherence and treatment fidelity, to end the trial after a certain number of sessions . . . and to judge progress by reduction of symptoms reported at the beginning of the study (Chalmers et al., 1981). (2016, p. 4)

Although we understand her point, these so-called research requirements seem dated. For example, component control designs can manipulate a principle or treatment component to see if it can improve *any* kind of practice—be it controlled or naturalistic. Moreover, the manipulation does not require excessive control over intervention. For example, our team was recently funded to conduct a RCT that manipulates not treatment but rather the system of case assignment. Specifically, in a double-blind design, we are comparing the efficacy of matching patients to therapists who have an empirically supported track record of successfully treating patients with the same presenting problem versus therapist assignment-as-usual. As we have shown that therapists not only differ between one another on general effectiveness with their cases but also show strengths and weaknesses based on patient outcome domains within their own caseloads (Kraus et al., 2016), this is another contextual marker to which we can be responsive (e.g., via case assignment) and for which we can put this responsivity to experimental test. (We are thrilled, by the way, that McWilliams wants to see this type of research on match or fit.) We suspect that the conclusions of our study will not represent a category mistake because in no way does the design alter what therapists typically do and for how long. However, the findings might isolate a causal positive effect of scientifically matching patients to therapists, something that clinicians, patients, administrators, and (hopefully) insurance companies would want to know.

McWilliams also notes that most therapists work from general principles and deviate as needed from manuals. We think that this is great because research says that this is responsive and can promote better outcomes (Owen & Hilsenroth, 2014; Stiles, 2009). Thus, we agree on the idea that EBP equating to an a priori treatment package with a sequence of events that should be standardly applied to a diagnostic category (for which reliability is typically suspect) seems dated and reductionistic. The research would also support our convergence on this idea. Therefore, whether we arrive at this place of principle-driven, flexible psychotherapy through systematic

research and consumption of it or through clinical common sense, maybe the science–practice "gap" is not always as big as it seems.

Of course, we believe that the principles need to be evidence based (Castonguay & Beutler, 2005). Recall our example of using MI in moments of patient–therapist disagreement; in this study, using MI in these precise moments had a 10 times greater effect on improvement than using MI at any moment (Aviram et al., 2016). This principle, then, can actually be synonymous with, versus orthogonal to, evidence. However, it needs to be a two-way street. It is important that clinicians tell researchers which principles they use need to be tested as well as how things go over when they apply research-informed principles (Goldfried et al., 2014).

What Kinds of Research Would Be Most Helpful to Practicing Therapists?

This section felt like such an important clinician-to-researcher dialogue. Moreover, the fact that McWilliams thinks that it would be helpful for therapists to know more about therapist effects research felt quite validating with regard to our research program on therapist effects (discussed previously to some extent). Also, we agree with McWilliams that research needs to focus even more on nonverbal aspects of therapy, and having a self-defined practitioner telling us researchers this is exactly the type of two-way dialogue that we need to reduce the realities and perceptions of the so-called empirical imperialism. We hope that this series stimulates more of the type of research that McWilliams is calling for; it certainly will in our lab.

That said, we would also pose a friendly challenge to clinicians to go beyond calling for "more research" on areas for which little research exists (McWilliams goes on to cite other areas, such as sadistic personality disorder). It seems that an important premise of McWilliams's article is that only *some* types of research are useful to the practitioner. For example, we would guess that she would not find it terribly useful to conduct an RCT on a tightly controlled sample of people meeting strict criteria for sadistic personality disorder who receive a manualized and time-restricted treatment by uniformly trained therapists being monitored for competence and adherence. If we are correct, the call is not just for *more* research but rather more *meaningful types* of research. It would be useful for researchers to hear ideas on utility and what is most likely to make a disseminable impact. Otherwise, the situation is again ripe for empirical imperialism (even if clinicians had a say in the topic). The main point is that collaboration can, and should, run deeper than topic selection. McWilliams, of course, appreciates this in her praise of practice-research networks (Castonguay, Youn, Xiao, Muran, & Barber, 2015).

Of course, two-way dialogues are not without complexity and challenge. For example, on the surface, it is easy to see the appeal in McWilliams's statement "But if scientists would take seriously the lifelong experience and careful observations of a reputable therapist treating trauma victims in naturalistic settings, many of his claims could be investigated empirically" (2016, p. 8). Yes, *and*, again, we wonder what makes someone reputable if his or her patients' outcomes have never been studied. To us, there might be a different pathway to learning from practice-based evidence in a way that will have the most positive effect on our patients; that is, study therapist effects in the real world and then study what the consistently effective therapists do. The argument is that the tag *reputable* might best come from evidence that a therapist consistently helps his or her patients to a clinically meaningful degree. Even we are not completely comfortable saying that this is the *only* way to reputable, but it seems far more potent than self- or peer nomination and, again, we are seeking disruptive innovations in the field (which require a level of distress tolerance).

As another point of convergence, we, too, agree that psychotherapy integration remains our future. However, integration has also been our past few decades, and one could argue that the four proposed models of, or pathways to, integration have evolved rather little. We believe that the field need to go beyond acknowledging integration as our future and start thinking of integration in innovative ways. Instead of just citing the four established pathways (of which we have been guilty), we see the aforementioned CRPI model as just one attempt at adaptive disruption. We also hope that it will evolve versus just being a static path. In fact, the model's essence suggests that it will have to evolve in a type of metaresponsivity to emerging research.

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Finally, as McWilliams notes the ominous propensity to view therapists as unethical when they work with patients outside of EST parameters established in controlled, lab-based research, we suspect that she too might see unethical behavior like we do; that is, continuing to work in the same way when the aggregated data tell us that *rigid* adherence to a manual (without responsivity) rarely works, and that personalized data might also predict harm (which some therapists shockingly continue to ignore as irrelevant outcome data despite their clear clinical relevance and their statistical superiority in prediction). We hope to soon hear clinicians, supervisors, supervisees, and even patients referencing things like responsivity and ROM data as simply clinical practice. If science and practice are appropriately confounded, there would be no gulf over which to build a bridge (Castonguay, Barkham, Lutz, & McAleavey, 2013).

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La integración contextualizada como un campo de juego común para los clínicos e investigadores: comentarios sobre McWilliams

Comentamos en respeto al artículo de McWilliams, 'La investigación integrativa para la práctica integrativa: La petición para una colaboración respetuosa a través de los oficios de clínicos e investigadores.' Sobre todo, apreciamos el argumento bien entonado de McWilliams para la colaboración cuidadosa entre los investigadores e clínicos. También apreciamos que los obstáculos han hecho difícil por un tiempo a reducir significativamente la grieta entre los científicos y practicantes, y McWilliams astutamente destaca como unos obstáculos se están volviendo aún más desalentados a travesar. En general, acordamos con la mayoría de las ideas de McWilliams. También proporcionamos unos desafíos respetuosos o aun unas extensiones o reebolaraciones. Por ejemplo, para nosotros, la grieta entre los investigadores y clínicos es más que un problema de conversación urgente; más bien, tiene la potencial de hacer daño a los clientes. Asimismo, aunque también apreciamos los factores relacionales en la base de evidencia en la psicoterapia, parece más importante a refrenar de contribuir a la dicotomía del factor relacional-específico artificial. Presentamos una resolución de esta grieta, que llamamos integración de la psicoterapia sensible al contenido (Constantino, Boswell, Bernecker, Castonguay, 2013). Además, ofrecemos versiones posibles de eficiente e inmediato formaciones traslacional, argumentando contra el continuado auto-o pares nominado-expertos transmitiendo la sabiduría en forma larga en los servicios. Similarmente, mientras nosotros campeamos oyendo de clínicos 'acreditados' sobre temas de investigación importantes, creemos que la determinación de las necesidades fundadas en los datos de resultados personales de clínicos. También discutimos que es importante ir más allá de las 4 vías de integración establecidas, empujando por innovaciones integradoras y disruptivas. Por último, nuestra meta es ayudar a localizar un campo de juego común para los investigadores e clínicos, y las maneras eficientes para jugar juntos.

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Integración de ciencia e práctica, practica basada en evidencia, evidencia basada en la práctica, integración de la psicoterapia contextual

语境化整合作为临床医师和研究人员的共同环境：对McWilliams的评论

我们对McWilliams（2016）标题为"综合研究为综合实践：为临床医师和研究人员角色之间尊重性合作的請求"的文章发表了评论。首先，我们感谢McWilliams对研究人员和临床医师之间认真合作的辩护。我们也明白，这些障碍长期以来使得有意义地减少科学家-临床医师之间的鸿沟变得困难，麦克威廉姆斯精明地强调了为什么一些障碍越来越难以穿越。总体来讲，我们同意McWilliams的大部分观点。我们还提供一些尊重的挑战，或至少一些扩展或重构。例如，对我们来说，研究者-临床医师的分歧不仅仅是一个紧急的的对话问题；更確切的說，它有可能对病人造成伤害的潜力。此外，尽管我们也很欣赏心理治疗实证基础中的关系因素，但是，似乎重要的是避免对人为关系特定因素二分法做出贡献。我们提出了对这一分歧的解决方案，我们称之为内容反应性心理治疗整合（Constantino，Boswell，Bernecker，＆Castonguay，2013）。我们还提供高效并可立即转化的培训的可能版本，以此反對持续性的自己或者同业提名的专家在长期的在职服务中传下的智慧。同样，虽然我们倡导倾听"有名的"的临床医师以获取重要的研究课题，我们认为判断声誉需以临床医生的个人成果数据为基础的。我们还认为，通过推动破坏性的整合创新，超越4个已建立的整合途径是重要的。最终，我们的目标是帮助找到研究人员和临床医师的共争环境，并最有效地共同合作。

科学-实践整合, 证据为基础的实践, 实践为基础的证据, 内容反映性心理治疗整合

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