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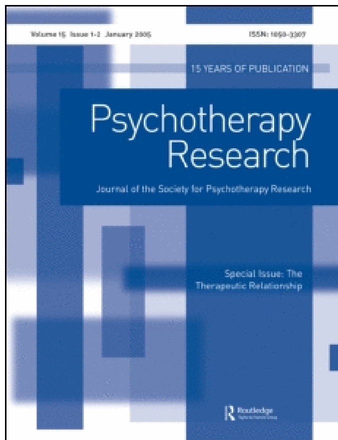

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Psychotherapy, psychopathology, research and practice: Pathways of connections and integration

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Psychotherapy, psychopathology, research and practice: Pathways of connections and integration

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Abstract
This paper describes three pathways of connections between different communities of knowledge seekers: integration of psychotherapeutic approaches, integration of psychotherapy and psychopathology, and integration of science and practice. Some of the issues discussed involve the delineation and investigation of common factors (e.g., principles of change), improvement of major forms of psychotherapy, clinical implications of psychopathology research, as well as current and future directions related to practice-research networks. The aim of this paper is to suggest that building bridges across theoretical orientations, scientific fields, professional experiences, and epistemological views may be a fruitful strategy to improve our understanding and the impact of psychotherapy.

Keywords: psychotherapy integration; psychopathology; research and practice in psychotherapy

Scholars typically work within conceptual, pragmatic, and/or epistemological frameworks or paradigms (Kuhn, 1962). Figuratively speaking, most researchers and practitioners live within fairly distinct or delimited communities of knowledge seekers. As in other scientific and professional fields, distinctive frameworks or paradigms of knowledge have shaped psychotherapy and psychotherapy research (Goldfried, 2000). Theoretical orientations (e.g., cognitive behavioral, humanistic, psychodynamic, systemic), methodological preferences (e.g., quantitative, qualitative), and primary "residence" (e.g., academia, clinical milieu) have an undeniable influence on what one sees as the most relevant source or object of knowledge, as well as the most valid strategy to acquire such knowledge. At various times, the boundaries that separate different knowledge communities have been described as impassable, and the views about psychopathology and therapy prevailing within each of them have been perceived as irreconcilable. Historically, such professional and conceptual divisions have fueled hostile statements and exchanges among respected figures of our field (see Castonguay & Goldfried, 1994). One could also argue that some of these divisions have played a role (and are being reinforced) by dichotomous and divisive positions that are parts of current discussions about the process of change, as well as the practice and training of psychotherapy (e.g., techniques vs. relationship, empirical evidence vs. clinical experience).

However, considering the complexity of psychotherapy, it is unlikely that one theoretical orientation, method of investigation, or one type of knowledge seeker will ever be able to provide the field with a comprehensive view of therapeutic change and a complete set of interventions to alleviate psychological problems. Accordingly, a fruitful way to enrich our understanding and increase the impact of therapy may be to foster connections between communities of knowledge—or to build bridges across different empirical, theoretical, pragmatic, and philosophical quests about understanding suffering and ways to reduce it.

The goal of this paper is to describe three pathways of knowledge connections: Integration of psychotherapeutic approaches, integration of psychotherapy and psychopathology, and integration of

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research and practice. For the most part, these are distinct pathways, except for the fact that each reflects efforts of rapprochement built on convergence and complementarity across communities of knowledge seekers—as well as the fact that they represent meaningful contexts within which I have conducted most of my empirical, conceptual, and clinical work. My intention is not to present a comprehensive or even representative perspective of these pathways of collaboration and plurality. Rather, I will focus on the work that my colleagues, students, and I have conducted within them, as well as some suggestions of the future directions of research that have been derived from this work. By pointing out intrinsic and synergic connections between research and clinical practice that are emerging from these pathways, I also hope to demonstrate that these connections may facilitate the actualization of the scientist-practitioner model.

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Integration of Therapeutic Approaches

Psychotherapy integration has become a leitmotiv in our field. Along with "therapeutic alliance," "therapy integration" may be one of the terms most frequently referred to in current psychotherapy textbooks. There are, of course, numerous factors that can explain such zeitgeist (see Castonguay, Reid, Halperin, & Goldfried, 2003), but one could argue that fundamentally it is a reaction against the orthodox rigidity within and acrimony between traditional schools of therapy that predominated our field up until the 1970s. It can be seen as a response (and by no means the only one) to the theoretical, clinical, and epistemological limitations of modern approaches to psychotherapy: a humble and open response to the unsatisfactory status of our field and one that is based on the assumption that the richness of plurality may be a promising strategy to approach the complexity of human functioning and difficulty of facilitating change.

As cogently stated by Arkowitz (1992), "in its most general sense, psychotherapy integration encourages an attitude of openness and exploration to help understand why people change, how they change, and how to better help them change, unrestrained by the limitations imposed by adherence to one particular approach or theory" (p. 1). The efforts of rapprochement and connection that have emerged from this attitude have taken several forms, such as the construction of new theories of human functioning and/or change (e.g., Prochaska & DiClemente, 1992; Stiles, 2002; Wachtel, 1977; Wolfe, 2005), the prescription and combination of particular interventions for different clients (a.k.a. eclecticism, e.g., Beutler & Consoli, 1992), the delineation of common factors or convergences across different orientations, and the improvement of major systems of psychotherapy based on the assimilation of complementary perspectives from other orientations. Focusing only on the last two of these four themes, I will describe initiatives and a few examples of research (based primarily on the work that my colleagues and I have conducted) that are relevant to the integration movement. I will also present some directions for future research related to these efforts and that, in my opinion, may be relevant to practicing clinicians.

Common Factors

Although current forms of psychotherapy are based on divergent theories and are associated with various types of interventions that are assumed to be unique to each of them, a large number of common factors (see Castonguay, 1987, 2006; Grencavage & Norcross, 1990) have been identified by scholars of different theoretical orientations. In my view, two general types of common factors are of particular conceptual and clinical importance, as they can shed light on the complexity of psychotherapy by challenging simplistic views about therapeutic change (such as technique vs. relationship, common vs. unique variables). These two sets of common factors, principles of change and "faux-unique" variables, are discussed in the next sections.

Principles of change. Consistent with the seminal contribution of Marvin Goldfried (1980), I define such principles as general guidelines and/or foci of interventions that cut across different approaches, with a number of them underlying many of the specific techniques that are frequently considered to be unique to a particular orientation. In addition to the research that I have conducted with my colleagues and students over many years (for selective reviews, see Castonguay, 2006; Castonguay et al., 2003), I have been involved in two distinct but complementary strategies that led to the delineation of principles of change, in depth examination of some of them, as well as suggestions for future studies.

One of these initiatives was the Task Force sponsored by the North American Society for Psychotherapy Research (NASPR) and the Division of Clinical Psychology of the American Psychological Association (APA, Division 12) that Larry Beutler and I chaired (Castonguay & Beutler, 2005a). The first goal of this task force was to delineate and integrate what we know about numerous variables that contribute to change in psychotherapy, by reviewing the contributions of three sets of variables (i.e., participant characteristics,

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relationship variables, and technical factors) that have not only been shown to be related to outcome but that more than likely operate in constant interaction in clinical practice. The members of the Task Force were respected psychotherapy researchers who worked in pairs, most of which comprised researchers of different theoretical orientations for the sake of fostering connections between different communities of knowledge. Rather than examining the empirical evidence indiscriminately across all disorders, these scholars were asked to review the role of therapeutic variables for four clusters of clinical problems frequently encountered by clinicians: dysphoric, anxiety, personality, and substance use disorders. In addition, these members were asked to translate the research-based evidence into principles of change that could serve as helpful guidelines to clinicians without being tied to particular jargon or theoretical model.

One of the end results of this effort was the identification of 61 "Research Informed Principles" that can be used to help clinicians of different theoretical orientations to plan and deliver treatments that are consistent with contemporary research findings. For example, based on a review of psychotherapies that have received empirical support, Follette and Greenberg (2005) have derived six principles related to techniques for the treatment of depression, including the challenging of cognitive appraisals, increasing positive reinforcements in the client's life, improving client's interpersonal functioning and social environment, as well as fostering emotional awareness, acceptance, and regulation. As a source of clinically relevant information, these heuristics are precise enough to guide the focus of clinicians' interventions without being restricted to a narrow and orientation-specific set of prescribed procedures (there are, for instance, many techniques [e.g., interpretation, cognitive restructuring] that therapists can use to challenge clients, all of them aimed at providing an alternative view of self and others [Goldfried, 1980]). In addition, this list of principles can help therapists to increase their repertoire of interventions if the treatments they typically conduct with their depressed clients do not systematically target dimensions of functioning that may be involved in the cause or maintenance of depression (e.g., interpersonal skills, dysfunctional marital or familial relationships). Furthermore, as described elsewhere, such empirically anchored principles (along with principles of change related to relationship and participant variables) have provided the foundation for training guidelines to prevent or reduce harmful effects in therapy (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010).

Another result of this task force was the identification of recommendations for future research on principles of change (Castonguay & Beutler, 2005b). For each of the clinical disorders addressed, a number of variables were singled out for their need of empirical attention such as the role of client attachment in the treatment of depression, therapist congruence in therapy for anxiety disorders, and the role of group cohesion in substance abuse treatments. Perhaps the two most important directions of future research that were identified are related to (a) personality disorders, which evidence a limited amount of research regarding all three domains of therapy examined, and (b) the interaction between participants, relationship, and technique variables for all disorders investigated. Considering the prevalence of the former and the omnipresence of the latter (let alone the complexity of both of them), these research priorities would no doubt be viewed as highly relevant by many clinicians.

A second initiative that has led to further exploration of principles of change is a continued series of conferences that Clara Hill and I have organized at Penn State University since 2001. Also aimed at fostering connections between different communities of knowledge seekers, these series of conferences are primarily based on open and at times intense (but not hostile) discussions among influential psychotherapy researchers from different orientations and with diverse methodological expertise (quantitative and qualitative). These conferences also serve as a stepping-stone to stimulate new and creative theoretical, clinical, and empirical projects toward specific processes of change. Finally, after the completion of these projects (each of them leading to a book chapter), the last meeting of each series of conferences is set to foster a consensus about four specific questions: what is the nature or definition of the process investigated, what facilitates it, what follows it, and what are the most important questions that future research should address in order to better understand this process.

The first series of conferences was on insight (Castonguay & Hill, 2006) or, using Goldfried's conceptualization of principles of change, the acquisition of a new understanding of self. As an example of the type of innovative and creative ideas that can emerge from active and long term collaboration of researchers typically working within different communities of knowledge, a consensus was achieved on 19 specific (and clinically relevant) directions of future research (e.g., "Does insight need to be true or historically accurate?" "Are insights better if they are client-generated, therapist-generated, or co-constructed?" "Do more complex, emotionally intense, central insights lead to

stronger, and longer lasting changes?"; Hill et al., 2005).

Further reflecting Goldfried's influence, the second series of Penn State Conferences is on another principle of change: corrective experiences. In addition to leading to exciting new research and theoretical contributions, the book that will result for this current series will no doubt lead to a list of directions for future research that will address important clinical questions.

"Faux-unique" variables. Raising doubts about the theoretical boundaries between some of our communities of knowledge, research has suggested that a number of components of therapy that are typically associated with (and used more frequently in) a particular orientation may play a role in the effectiveness of other approaches. I call these "faux-unique" variables.

Consistent with their underlying models of change, for example, research suggests that cognitive-behavioral therapists focus less on client's interpersonal experience than psychodynamic-interpersonal (PI) therapists (Blagys & Hilsenroth, 2000). Moreover, while a preliminary study found that CBT therapists tended to focus more on interpersonal than on intrapersonal aspects of their clients' experience (Kerr, Goldfried, Hayes, Castonguay, and Goldsamt, 1992), two later studies found the opposite (Castonguay, Hayes, Goldfried, & DeRubeis, 1995; Castonguay, Hayes, Goldfried, Drozd, Schut & Shapiro, 1998). Despite this, some process studies have suggested that clients improve more when cognitive behavior therapists focus on interpersonal issues that are associated with psychodynamic treatment. For instance, Hayes, Castonguay, and Goldfried (1996) found that the therapist's focus on early attachment patterns predicted positive outcome CBT. Therapists' connections between the therapeutic relationship and other relationships were also part of a set of psychodynamic techniques correlated with change in CBT (Ablon & Jones, 1998; Jones and Pulos, 1993).

In their review of the empirical literature, Blagys and Hilsenroth (2000) also demonstrated that CBT therapists focus less on clients' expression of emotion than do PI therapists. In line with a seminal paper written by Stan Messer (1986), a study conducted by Wiser and Goldfried (1993) suggests that, while PI therapists see the exploration and experience of affect as significant in therapeutic episodes, cognitive behavior therapists see the decrease of emotional experiencing as a significant therapeutic event. In a number of studies, however, the client's emotional experience in CBT has been found to relate positively with treatment outcome (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Castonguay, Pincus, Agras, & Hines, 1998; Watson & Bedard, 2006). Processes and techniques related to the experience and exploration of emotions were also components of different sets of factors associated with positive outcome either in CBT (Ablon & Jones, 1998; Jones & Pulos, 1993) or across CBT and interpersonal therapy (Ablon & Jones, 1999; Coombs, Coleman, & Jones, 2002).

Although not all studies have found emotional experience to be predictive of therapeutic change in CBT (Hayes & Strauss, 1998), as a whole, these findings (along with the studies on interpersonal issues mentioned above) suggest that what leads to change may not be restricted to those variables assumed to be mutative in a particular treatment and may involve factors typically associated with other orientations (Barber, 2009; Castonguay et al., 2003). In other words, while our current theories of change are not "wrong" (CBT therapists do focus more on the examination of cognition and less on the exploration of emotion), they may not entirely capture the complexity of the process of change. As described below, these studies on "faux-unique" variables also suggest directions for how to potentially improve the effectiveness of traditional approaches by considering and incorporating processes of change emphasized by other orientations.

In addition to questioning the solidity of conceptual boundaries that separate orientations, as well as the validity or usefulness of dichotomies that prevail in current dialogues about process of change, empirical evidence on common factors also addresses core conceptual and clinical needs of practitioners. Clinicians are likely to be interested in knowing what variables are predictive of or facilitate change, irrespective of the treatment used. Trainers and supervisors will find it helpful to learn more about the relationship and technical interventions that should be considered as foundational pillars of psychotherapy training, even if such factors may take different forms when implemented in different types of therapy (see Castonguay, 2000). In addition, clinicians are likely to be interested in knowing that some variables not typically associated with their preferred approach may nevertheless explain parts of its effectiveness, thereby inviting them to pay more attention to these variables.

Improvement of Major Systems of Psychotherapy

As argued elsewhere (Goldfried & Castonguay, 1992), the "Big Three" (psychodynamic, humanistic, and CBT orientations) are solidly entrenched in our professional landscape. However, a number of

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scholars associated with each of these particular schools have attempted to improve their preferred orientation by integrating constructs and clinical venues developed in other traditions. Aptly defined by Messer (1992, 2001) as "assimilative integration," such efforts refer to "the incorporation of attitudes, perspectives, or techniques from an auxiliary therapy into a therapist's primary, grounding approach" (Messer, 2001, p. 1).

Examples of assimilative integration have been anchored within different theoretical bases. A well-known attempt to do so is Jeremy Safran's expansion of cognitive therapy. Relying on contributions from humanistic, interpersonal, and psychodynamic approaches, Safran (1990a, 1990b, 1998; Safran & Segal, 1990) has offered a revision of the concept of schema that allows for a recognition of dimensions of human functioning (i.e., emotional, developmental, and interpersonal) that have not always received full attention in more traditional CBT models.

A complementary (and, as will be noted, not at all mutually exclusive) way to improve the outcome of psychotherapies may be to modify existing treatments based on research, including process research (see Grawe, 1997). One example of such an effort is the work that my colleagues and I have been involved in exploring the possibility of improving the efficacy of cognitive therapy (CT) based on findings related to common and unique variables in CT.

Integrative therapy for depression. In a process study on CT for depression, Castonguay et al. (1996) found that while the alliance was positively related to outcome, therapists' focus on issues at the core of CT (such as the causal relationship between cognition and emotion) was negatively related to outcome. Content analyses conducted to shed light on this negative finding revealed that when attempting to repair alliance ruptures (e.g., client's reluctance to accept or engage in prescribed procedures) therapists frequently increased their adherence to cognitive interventions sessions either by further emphasizing the validity of the CT rationale or by identifying the client's negative therapeutic reactions as a manifestation of distorted thoughts about the therapist or therapy. These interventions, however, did not appear to repair the alliance problems and may have perpetuated and/or worsened them (interestingly, similar patterns of adherence to prescribed techniques in the context of alliance ruptures have also been observed in psychodynamic therapy, e.g., Piper et al. 1999; Schut et al., 2005)

These findings suggest that one way to increase the effectiveness of CT is to add to its protocol new interventions to address ruptures in the therapeutic alliance. Based on the work of David Burns (1990); Burns & Auerbach, 1996) and Jeremy Safran, I have developed a treatment protocol, called integrative cognitive therapy (ICT), that involves procedures of meta-communication typically associated with or derived from non-CT approaches (i.e., humanistic, interpersonal, and psychodynamic). Specifically, therapists conducting ICT are asked to follow the traditional cognitive therapy protocol (cf., Beck, Rush, Emery, & Shaw, 1979), except when confronted with signs of alliance ruptures. Rather than increasing their adherence to the treatment rationale and/or methods in response to such ruptures (as was observed in cognitive therapy by Castonguay et al., 1996), therapists are instead instructed to use the strategies developed by Burns and Safran: inquiring about the relationship problems, empathizing with the client's experience related to the alliance ruptures, and recognizing the therapist's contribution to these ruptures. Once the relationship problems have been explored and resolved, therapists then resume cognitive therapy, either by continuing to use the procedures they were using prior to the emergence of the alliance rupture or by shifting to other techniques prescribed by traditional CT.

ICT has currently been investigated in two preliminary studies (Castonguay et al., 2004; Constantino et al., 2008). Although systematic assessment of the therapeutic process has yet to be conducted, observations of a large number of therapy sessions revealed that alliance problems emerged relatively frequently during the application of cognitive techniques and that these problems seemed to be adequately addressed by the use of meta-communication strategies. With regard to outcome, the first study found that ICT led to significantly greater improvement than a wait-list condition, achieving a pre-post effect size of $d = 1.91$ on the BDI (Castonguay et al., 2004), which is more than twice the size of comparable studies of traditional CT. In a second study, Constantino et al. (2008) found ICT to be superior to standard CT with a medium effect size, $d = 0.50$ (also on the BDI). The second study also found higher alliance and therapist empathy ratings were reported in ICT.

Although preliminary, these studies are consistent with other recent investigations that have provided support for the positive effect of alliance-repair strategies (Muran, Safran, Samstag, & Winston, 2005; Safran, Muran, Samstag, & Winston, 2005), as well as the positive impact of training in alliance-fostering interventions (e.g., Crits-Christoph et al., 2006). Considering the relatively high frequency with which alliance ruptures may occur, as well as how challenging such events can be for therapists (see Eubanks-Carter, Muran, Safran, & Hayes, 2010 for a review), more research on alliance rupture and repair

is likely to help researchers, clinicians, and supervisors to prevent or reduce harmful effects in therapy (Castonguay, Boswell, Constantino et al., 2010).

Integrative therapy for generalized anxiety disorder (GAD). With other colleagues, I have also been involved in an assimilative effort aimed at improving CBT for GAD by adding a range of interventions used in humanistic, interpersonal, and psychodynamic therapies (Newman, Castonguay, Borkovec, & Molnar, 2004). As in the case of ICT, the choice of the specific techniques added to CBT was based on research findings. For instance, procedures to deepen emotions (e.g., two chair) have been added to CBT not only because (as mentioned above) emotional experience has been linked to outcome in this treatment but also because several studies have suggested that worry, the central feature of GAD, serves as a cognitive avoidance of painful emotion (Borkovec & Newman, 1998). Therefore, helping the client to become aware of, stay with, and fully experience their emotions may provide them with an exposure to affect that they may be trying to avoid by worrying and ruminating. A large number of applied and basic findings have also led us to add therapeutic intervention addressing several interpersonal issues. As demonstrated by Newman & Erickson (2010), individuals with GAD present with significant past (attachment) and current interpersonal problems. As mentioned above, however, traditional CBT protocols tend to focus more on intrapersonal issues than on interpersonal issues (or at least focus significantly less on interpersonal issues than do psychodynamic treatments). Findings obtained by Borkovec and colleagues indicate that failure to solve interpersonal problems at the end of CBT predicts worse response at follow-up (Borkovec, Newman, Pincus, & Little, 2002). Paradoxically, and also mentioned above, evidence suggests that a focus on past and in-session interpersonal issues is related to outcome in CBT.

Taken together, these findings led my colleagues and me to predict that if we were able to construct a treatment protocol that maintains the coping skills components of effective CBT while also including interventions aimed at directly and systematically processing emotional and interpersonal issues, we would be able to increase the efficacy of the only treatment currently judged to be empirically supported for GAD. As described elsewhere (Castonguay et al., 2005; Newman et al., 2004), the cohesive combination of CBT and non-CBT interventions were anchored in integrative model of human functioning, specifically, Safran & Segal's (1990) expansion of the cognitive model. At a clinical (or procedural) level, our attempt to combine these interventions was structured around Goldfried's principles of change (reflecting what Boswell, Nelson, Nordberg, McAleavey, & Castonguay [2010] refer to as "principle based assimilation"). A first and preliminary (open trial) study revealed that the average within-participant effect sizes obtained for our integrative treatment were superior to those obtained in previous CBT studies (Newman et al., 2008). Clearly suggesting that improvement of an existing approach may be even more complex than what we anticipated, however, a follow-up randomized clinical trial failed to show many significant differences between our integrative treatment (CBT + Interpersonal and Emotional Processing Therapy [I/EP]), and a control condition that added a supportive listening segment (to control for common factors, such as time and therapist attention) to CBT (i.e., CBT + Supportive Listening Therapy [SL]) (Newman et al., in press).

These results warn us of a possible "all-or-none" (and even perhaps a rigid and complacent) attitude that one can sometimes hear expressed, implicitly or explicitly, in the discourse of proponents of psychotherapy integration (the specific type of attitude against which this movement was a reaction), that is, that a combination of techniques (even the best of them) from several approaches will always be superior to a pure form of therapy. The fact of the matter is that we know that there is a substantial percentage of clients who evidence clinically significant change from empirically supported therapies, including CBT for GAD (see Borkovec et al., 2002). For these clients, the addition of non-CBT interventions may be unlikely to lead to further improvement to, and may even interfere with, the therapeutic impact of CBT interventions.

Although comparing integrative treatments with empirically supported therapies is an important scientific step, a more conceptually sophisticated and clinically relevant avenue of research is to investigate which clients are the most likely to benefit from the addition of interventions not already included in treatments that have been shown to be effective. With this question in mind, my colleagues and I are in the process of conducting analyses to test conceptually driven hypotheses regarding the possible moderating role of individual differences in our GAD randomized clinical trial. The same recognition of the complexity of clinical reality should also guide future studies aimed at expanding on the preliminary studies of integrative cognitive therapy (ICT) previously described. Since evidence shows that the quality of the alliance is associated (positively and negatively) with both client and therapist characteristics (Castonguay, Constantino, Boswell, & Kraus, 2010), it is likely that a large scale comparison of ICT with traditional CBT would

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reveal that ICT might be especially beneficial for specific types of clients (e.g., clients high in reactance level), and that the addition of alliance repair techniques to CBT might not be necessary for some (e.g., clients low in reactance level), or sufficient for others (e.g., clients with an extreme level of initial severity). It might also be that specialized training in repairing alliance ruptures would help some therapists to improve their effectiveness more than others.

It should be mentioned that the integrative treatments described above are not the only ones that have been built with the aim of improving effective therapy while relying on process and basic findings. For example, the treatment for depression developed by Hayes and Harris (2000) (integrating emotional deepening strategies to "destabilize" core schema), the assimilation (based on the work of Klaus Grawe and Franz Caspar) of clients' motivational goals within different therapies (see Grosse Holtfort and Castonguay, 2006 for a review), as well as Constantino's integration of strategies to enhance expectations in cognitive therapy (Constantino, Klein, Smith-Hansen, & Greenberg, 2009), are worth highlighting. More efforts of this type will likely be viewed as relevant by many clinicians—those who base their practice on a preferred approach but who are also open to using interventions associated with other orientations (in theoretically cohesive and/or empirically informed ways), with the goal of developing broader case formulations and treatment plans, and thus better addressing the complexity of therapeutic change. In fact, one might argue that research on all facets of psychotherapy integration is likely to be perceived as relevant to many clinicians.

Future Research on Psychotherapy Integration: Connecting Researchers, Clinicians, and Organizations

At least in the United States, integrative/eclectic has been the modal form of therapy since the 1960s (Norcross, Karpiak, & Santoro, 2005). There are also indications that many psychotherapists identify themselves as integrationists early in their training (Boswell, Castonguay, & Pincus, 2009; Lampropoulos, 2006). Furthermore, a recent survey by Thoma and Cecero (2009) has demonstrated that doctoral level therapists report using interventions that are not in line with the core model of their preferred theoretical orientation. There are, however, signs of discrepancies between such trends in clinical practice and the prevailing issues in psychotherapy research. It is noteworthy that despite the fact that recommendations for future research on psychotherapy integration based on an NIMH sponsored workshop (Wolfe & Goldfried, 1988) were published more than 20 years ago, crucial themes of psychotherapy integration, with the exception of the alliance, do not appear to have received substantial attention by researchers (at least compared to other issues in therapy process and outcome). An informal examination of the psychotherapy grants funded by NIMH between 1990 and 2009 revealed that fewer than 10 included the terms "integrative," "eclectic," or "psychotherapy integration" in their titles. SPR may not have fared much better than the larger community of psychotherapy research, as these terms (again based on an informal examination) appeared in only 20 titles of individual presentations (posters or papers) given at SPR meetings over the last 20 years. Furthermore, with the exception of common factors (such as the alliance) and, to a lesser extent, some theoretical models (e.g., Stiles, 2002) and eclectic matching (e.g., Beutler & Consoli, 1992), the themes of psychotherapy integration have not appeared as prominent foci in the work of influential figures of SPR, which my colleagues and I attempted to capture in a recently published book (Castonguay, Muran, Angus, Hayes, Ladany, & Anderson, 2010).

Considering the way that psychotherapy is practiced and learned today, current and future generations of SPR members may find that research on integration is likely to have direct and immediate relevance to our trainees and clinician colleagues. The timing for such research appears to be particularly appropriate, as one of the founders of the Society for the Exploration of Psychotherapy Integration (SEPI) has recently called for more research to be conducted on integration (Goldfried, Arnkoff, & Glass, 2011), also reminding SEPI members that one of the original goals of this organization was to facilitate the integration of science and practice (Goldfried, 2009). This seems like a meaningful point of connection and convergence between two organizations that have been sharing complementary goals for many years.

Integration of Different Knowledge Domains

Another possible way of increasing our understanding of the complexity of change and improving the effectiveness of different forms of psychotherapy is to establish or solidify connections with groups of researchers who seek knowledge outside our field. As argued by a number of authors, research from different domains of basic psychology is likely to be beneficial for psychotherapy researchers, scholars, and clinicians (Constantino & Castonguay, 2001; Goldfried & Wolfe, 1996). For example, the Penn State University conferences mentioned above illustrated how research and theory from social, cognitive, and developmental psychology can provide

new ways of understanding and investigating insight in psychotherapy (see Castonguay & Hill, 2006). Connections between psychopathology and psychotherapy might be particularly fruitful. As noted by Arkowitz (1989), while psychopathology research can tell us what to change, psychotherapy research can tell us how to change it.

Research in psychopathology has led to a wealth of information related to symptomatology, clinical features, epidemiology, course, co-morbidity, and etiology of disorders frequently seen in outpatient or training clinics. A careful attention to findings from most if not all of these aspects of basic research may help us delineate clinical guidelines in terms of assessment foci, case formulations, and treatment planning. And since these guidelines are drawn from research that is not tied to a particular school of therapy, most if not all of them could potentially be included in the clinical repertoire of therapists from different theoretical orientations.

Using depression as a case in point, psychopathology research suggests, for example, that vegetative symptoms may be crucial to assess (at the beginning and end of therapy). In a study based on the DSM-III criteria, Buchwald and Rudick-Davis (1993) found that the best single predictive symptom of a major depressive episode was psychomotor change, while the worst was "thoughts of death." Numerous empirical studies have shown that interactions between individuals who suffer from depression and other people are frequently characterized by anger, frustration, and lack of cooperation (Joiner, 2002). Such research, addressing issues as basic as symptomatology and clinical features, has helpful clinical implications. Specifically, in assessing the client's needs and the progress of therapy, the therapist should look beyond the psychological symptoms (such as feelings of worthlessness or guilt) that many psychotherapy books or manuals emphasize when referring to the symptoms of depression. Therapists, irrespective of their orientation and level of experience, should also be reminded that negative interpersonal processes are likely to emerge in the therapeutic relationship. Clinical skills are required to discern the extent to which such processes are manifestations of a client's depressive (emotional and interpersonal) reaction patterns, and how much of these are responses to an alliance rupture specifically due to therapy. Irrespective of their sources (and it is not likely to be an all-or-none phenomenon), focusing on such negative processes and their impact on a client's life may lead to important change, perhaps providing unique opportunities for corrective experiences in the safety of the therapeutic relationship.

Clinical guidelines can also be derived from epidemiological research. Such research has demonstrated that the prevalence of depression has been climbing sharply over recent decades (Gotlib & Hammen, 2002; Seligman, 1989). According to Seligman (1989), this increase points to environmental determinants of depression. Contrasting a tenfold increase in prevalence observed in the general population with the rate of depression in some "non-modern" cultures (e.g., Amish), he argued that there is something in contemporary society that causes depression: a focus on individualism rather than the common good. The lack of commitment to common projects, one could suggest, has robbed individuals of buffers against depression when they are confronted with personal difficulties or failures. Our over-involvement in activities aimed at increasing our individualistic accomplishments, wealth, and comfort might well make it more difficult to reach out for and obtain help and support from others when we experience serious difficulties in our lives. What this implies with regard to clinical practice is that irrespective of their orientation, clinicians should help clients renew or create meaningful relationships. They should encourage clients and/or teach them skills to appropriately and safely open themselves to others, as well as to get involved in purposeful and/or pleasurable activities with others.

These clinical implications, emerging from purely basic research, are consistent with some of the principles of change that were mentioned above and that were derived from another domain of research: empirically supported treatments. Such convergence of findings across different communities of knowledge may not be surprising considering the core aspects of human functioning to which they appear to be linked. As argued by MacLean (1985), communication and play are two of the evolutionary developments that differentiate not only humans but all mammals from reptiles. Denying or not attending to such ways of being forces our clients and us to fight a losing evolutionary battle!

Research on the etiology and maintenance of depression can also provide helpful heuristics for treatment planning. Investigations based on cognitive psychology have demonstrated that depressed individuals show information-processing (e.g., memory) biases. In a series of studies, Joorman and her colleagues have showed that such biases can be attributed to deficits in cognitive inhibition (see Joormann, 2009). It is not that depressed people automatically pay more attention to all instances of negative information; rather, they have difficulty disengaging from (and they further elaborate on) such information. Among other things, such a problem of disengagement suggests that while benefits can be derived from focusing on a client's internal experience (e.g., examining distorted

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thoughts, exploring the meaning of such thoughts, or evoking and staying with feelings), therapists may also want to help clients develop strategies to shift their attention, at appropriate times, away from negative emotions and cognitions. Blasting Beethoven's ninth symphony on one's iPod in response to pervasive and recurrent ruminations late at night, for instance, may well be a powerful adjunct to a verbal/insight-oriented form of therapy!

These are just a few examples of basic findings that can help clinicians more comprehensively assess and treat depressive symptoms. This does not mean that we have to reinvent the wheel and create new treatment approaches for different disorders exclusively or primarily based on basic research. What it does mean is that most if not all effective psychotherapy treatments are likely to be enriched by integrating, in a theoretically cohesive way, clinical guidelines that can be derived from the findings emerging from complementary communities of knowledge seekers (as noted by Joiner [2002], even interpersonal psychotherapy has not relied heavily and specifically on basic findings on interpersonal aspects of depression that are complementary to its therapeutic focus).

With the hope of creating new bridges between science and practice, Thomas Oltmanns and I are editing a textbook (for graduate students and experienced clinicians) aimed at weaving together information about basic research on psychopathology and the treatment of mental disorders (Castonguay & Oltmanns, in preparation). Covering psychological disorders most frequently seen in clinical practice, each chapter is written by a pair of experts, most of which include a visible scholar from psychopathology research and an influential treatment researcher (or, for some chapters, researchers who have significantly contributed to both psychopathology and psychotherapy research). Each chapter covers major issues of psychopathology, such as the one mentioned above. Adding a new dimension to the movement toward evidence-based practice, each chapter also provides readers with relevant clinical guidelines, in terms of assessment and treatment planning, derived from basic research in psychopathology. These guidelines are not delineated as a treatment manual, but rather as a way of guiding clinical thinking: for instance, what would be the relevant issues to assess and/or the targets of intervention to consider based on the clinical features and primary determinants typically associated with a particular clinical problem?

By fostering connections between people from different research and/or theoretical backgrounds, this project, like the Task Force on Principles of Change (co-chaired with Larry Beutler) and the Penn State University Conferences (co-chaired with Clara Hill), has been leading to new, fresh, and collaborative ways of thinking about clinical practice. In the case of this book, specifically, the two-way street it aims to build is also likely to be valuable to investigators doing basic research on psychopathology, as it highlights issues from clinical practice that have an important bearing on phenomena and problems that they ought to address. To borrow Arkowitz's (1989) eloquent words, considerable learning about how to treat psychopathology can be derived from the knowledge community of basic researchers, and much can be learned from psychotherapy scholars in terms of how psychopathology manifests itself and is caused or maintained by issues that have been observed or investigated in assessing and treating clinical problems.

Establishing connections between basic research and psychotherapy should not, of course, be solely dependent on active teamwork. Psychotherapy researchers, whether or not they are collaborating with psychopathology researchers (or any other kind of researchers), are likely to gain by being aware of how the richness of basic research can at times guide and/or help understand psychotherapy research. As described above, basic research on GAD led Newman, Borkovec and me to develop an integrative treatment that adds humanistic, interpersonal, and psychodynamic techniques to CBT. Furthermore, basic research (e.g., developmental studies on attachment) is more than likely to provide us with rich conceptual heuristics in our exploration of individual differences that might help us predict who could benefit from adding non-CBT interventions to CBT. Such theoretical and empirical links show that while being distinct, different pathways of knowledge connections (integration of psychotherapy approaches and integration of knowledge domains) are far from being mutually exclusive and can, in fact be complementary to each other.

What About the Therapist?

Basic research on therapists' individual differences (including variables related to psychopathology) is also likely to provide helpful guidelines to improve the effectiveness of therapy. Moreover, such research could directly address one of the paradoxes that we are currently facing in our field today.

Based on the seminal contribution of Bruce Wampold (2001) and his colleagues, we know that a significant proportion of the outcome variance is explained by a therapist effect. Not only do we know that some therapists are more effective than others, data are beginning to show that this effect is specific. Based on an assessment tool measuring a wide range of symptoms and dimensions of functioning (see Kraus & Castonguay, 2010), a recent study suggests

that while a few therapists have superior results with most clinical problems (and a few others demonstrate ineffectiveness at treating most clinical problems), most therapists appear to have superior outcomes with respect to particular problems (e.g., depression, anxiety, suicide, substance abuse) but not with others (Kraus, Castonguay, Boswell, Nordberg, & Hayes, in press). However, our understanding of the variables responsible for these general and specific effects of the therapist appears to be lacking (Wampold, personal communication, 2009).

One way to elucidate therapist effects might be to investigate interactions between individual differences and various components (affective, cognitive, and behavioral) of therapists' engagement that have been identified as common factors (Castonguay, 1993, 2006). To build on our current state of knowledge, it may be particularly indicated to study the possible interaction between personal characteristics and advanced therapeutic skills that have shown promising links with outcome, such as meta-communication (Eubanks-Carter et al., 2010), self-disclosure (Hill & Knox, 2002), and management of countertransference (Gelso & Hayes, 2002). From a practical point of view, focusing on who the therapist is and what he/she should do in therapy to facilitate change is likely to be of great interest to clinicians. Furthermore, considering our duty to "First, do no harm," perhaps it is even more urgent that we focus on how these factors may interfere with change (Castonguay, Boswell, Constantino et al., 2010).

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Integration of Research and Practice

It seems fair to say that in the current state of our field, the connection between psychotherapy research and clinical practice is not a strong one. It has been argued that few full-time practitioners are substantially guided by empirical findings, in part because many studies fails to address the concerns and questions that clinicians faced in their day-to-day practice (Beutler, Williams, Wakefield, & Entwistle, 1995; Goldfried & Wolfe, 1996). To a certain extent, this might reflect what I have described elsewhere as "empirical imperialism" (see Castonguay in Lampropoulos et al., 2002), when scientists who often treat very few patients decide what should be studied (and how it should be studied) in order to understand and improve psychotherapy.

As also argued elsewhere (Castonguay in Lampropoulos et al., 2002) a likely antidote to such empirical imperialism is to foster clinicians' full participation in all aspects of empirical studies, from the selection of issues to be investigated, delineation of hypotheses to be tested, construction and implementation of research design, as well as dissemination of the findings. The formation of Practice Research Networks (PRNs), which rests on an active collaboration between researchers and clinicians in the development of clinically relevant and scientifically rigorous studies, has been viewed as a promising vehicle or infrastructure to foster such engagement. Established under the leadership of a full-time academician (Tom Borkovec) and a full-time clinician (Steve Ragusea), the Pennsylvania Psychological Association Practice Research Network (PPA-PRN) is, to my knowledge, the first PRN to be specifically devoted to this type of collaborative research on psychotherapy. The PPA-PRN has now completed two studies. Launched in the mid-1990s, the first was aimed at testing the feasibility of conducting scientifically sound research within the practice setting using a core assessment battery for obtaining pre and post-outcome data within a state-wide infrastructure (Borkovec, Echemendia, Ragusea, & Ruiz, 2001).

The second completed study is the focus of two recently published papers (Castonguay, Boswell, et al., 2010; Castonguay, Nelson, et al., 2010); the first presents the findings obtained in this second study (discussed further below), and the second describes the experiences of clinicians who collaborated with full-time researchers not only in the implementation, but also in the design (which alone required regular meetings for one full year) of this investigation. I want to briefly discuss this study, not by emphasizing its results but by highlighting the level of involvement that clinicians can commit toward research within their own private practices, as well as some of the lessons that can be derived from the active collaboration of knowledge seekers living in different worlds.

The primary goal of the PRN study upon which these papers are based was to assess what clients find helpful and/or hindering during treatment in order to help therapists better address their clients' needs. As described in detail in Castonguay, Boswell, et al. (2010), the research protocol required clients and psychotherapists (or only the psychotherapist, depending on the experimental condition to which a client was assigned) to fill out parts of the Helpful Aspects of Therapy questionnaire (HAT; Elliott et al., 2001) at the end of every session. Specifically, participants were asked to (1) answer two questions on small index cards ("Did anything particularly helpful happen during this session?" and "Did anything happen during this session which might have been hindering?"), (2) briefly describe the event(s) if applicable, and (3) rate these events in terms of the degree to which they were helpful or hindering, respectively.

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Thirteen therapists of varying theoretical orientations participated in the design and implementation of this study. For a period of 18 months, psychotherapists invited all of their new clients (adults, adolescents, and children) to participate in the study (except when psychotherapists judged such participation to be clinically contra-indicated). Combining the child, adolescent, and adult groups, 146 clients participated, and more than 1600 helpful or hindering events were collected. These events were coded by three independent observers, using a therapy content analysis system. Among the findings obtained with the adult and adolescent groups, both clients and therapists perceived the fostering of self-awareness as being particularly helpful. The results also point to the importance of paying careful attention to the therapeutic alliance and other significant interpersonal relationships.

A qualitative analysis of interviews conducted with the participating psychotherapists led to the delineation of several benefits to therapists (e.g., learning information that improved their work with clients and feeling that they were contributing to research that would be useful for psychotherapists), difficulties for them and their clients (e.g., time and effort required to integrate research protocol into routine clinical practice), as well as general recommendations for future PRN studies (Castonguay, Nelson et al., 2010). As we noted,

> Perhaps the most important recommendation for future PRNs is to conduct studies that intrinsically confound research with practice – studies for which it is impossible to fully distinguish whether the nature of the questions investigated, tasks implemented, or the data collected are empirical or clinical. We would venture to guess that psychotherapists and researchers will be most successful in designing and implementing PRN studies when their empirical goals are intertwined with day-to-day clinical tasks and/or concerns (as when clinicians are able to learn about what could facilitate and/or interfere with change as they are involved in the process of collecting data with each individual client). To paraphrase a commonly used term ("ego-syntonic"), research has to be "clinically-syntonic." It could be argued that clinicians truly integrate science and practice every time they perform a task in their clinical practices and are not able to provide an unambiguous answer to questions such as: "Right now, am I gathering clinical information or am I collecting data?" or, "At this moment, am I trying to apply a helpful intervention with my client or am I implementing a research task?" Frequently, setting up rigorous empirical investigations that will lead them to answer these questions by saying, "Perhaps both," may be the most fruitful and exciting pathway to bridge research and practice. (pp. 352–353)

Private practice, of course, should not be viewed as the only anchor for PRNs. Clinic training programs in psychology departments can also be optimal sites for such networks, as they can foster another level of healthy confusion between three goals or tasks that are frequently viewed as mutually exclusive: clinical, research, and training. One might argue that simultaneous, seamless, and repeated integration of science and practice activities as early as possible in a psychotherapist's career might create an intellectual and emotional (hopefully secure) attachment to principles and merits of the Boulder model.

My colleagues and I at Penn State have transformed our psychology clinic into such a PRN by creating and/or incorporating four major components into our training program (see Castonguay et al., 2004; Parry et al., 2010): a core outcome battery, standardized diagnostic assessment procedures, a selection committee for the evaluation of research proposals (including representatives from the faculty, clinical staff, students, and practitioners from the community), and an innovative agreement with the office of research protection to efficiently streamline the Institutional Review Board (IRB) assessment process. This infrastructure has allowed several of our students to find themselves in a situation in which they are seeing clients, meeting their clinical hour requirements, and collecting their masters and/or dissertation data, while at the same time discovering, for example, that the trajectory of change of their clients can be predicted by their initial severity level on assessment (Nordberg, Boswell, Castonguay, & Kraus, 2008) or that cognitive-behavioral interventions can have a negative impact on particular clients, especially when used by particular therapists (Boswell, Castonguay, & Wasserman, 2010). Many students, employed as a clinical assistant, even get paid while learning how to do therapy, as well as collecting and thinking about information that is intrinsically relevant to case formulations and treatment planning. Not a bad way to get addicted, from the get-go, to the scientific-practitioner model!

However, while such PRN initiatives can lead to fruitful investigations, individually each particular site or network will be restricted in terms of the sample it can provide, the expertise it can represent, and thus the connections of knowledge it can foster. Hence, I believe that an important next step for the future growth of the integration of science and practice is the creation of large infrastructures where

clinicians (of different level of training) and researchers (in applied and basic sciences) will design and conduct descriptive (including single-cases), correlational, and experimental studies based on the same assessment tools. Examples of such infrastructures include the Network of Practice-Research Networks that my colleague David Kraus and I are in the process of building with groups of researchers and clinicians working together in different regions of North America, a similar type of infrastructure (proposed by Tom Borkovec [2002]), that would connect a large number of training clinics across clinical and counseling masters and doctoral degree programs, and the major infrastructure developed by Ben Locke (Locke, Crane, Chun-Kennedy, & Edens, 2010; Locke et al., 2011) that now includes more than 120 counseling centers providing clinical services to college students in the USA (and which has recently led to a number of "preliminary" studies involving 28,000 clients (see Castonguay, Locke, & Hayes, in press; Hayes, Locke, & Castonguay, in press).

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Concluding Words and Wishes

Psychotherapy research is at least 60 years old. These decades of empirical efforts have led to important and exciting findings, which in turn have firmly established the scientific credibility of psychosocial interventions, as well as confirmed, advanced and sometimes challenged some of our views of therapeutic change. To a large extent, these contributions, including those by many leaders of the SPR (see Castonguay, Muran, et al., 2010), have been facilitated by (and have fostered the growth of) diverse theoretical, methodological, and professional communities. At various times, however, myopic or rigid adherence to a preferred tradition has led to dismissing views about the potential contributions of others, and/or to restrictive and divisive perspectives about what treatments work, how they work, and how we should train future therapists. The aim of this paper is to suggest that one way, and by no means the only one, to challenge such perspectives (and potentially improve our understanding of and the impact of psychotherapy) is by fostering and deepening connections within and between communities of knowledge seekers.

It should be recognized, of course, that building and maintaining such connections is not an easy task. It is difficult to find time to read outside (led alone within) our field of expertise, and our already demanding professional responsibilities impose serious impediments to the possibility of collaborating with people who live in different worlds (practice, academia, various fields of research) or different cultures with the same world (e.g., Association of Behavior and Cognitive Therapy [ABCT], SPR). Although daunting, such pragmatic obstacles may not be the most difficult challenge confronting current and future integrative efforts. It has long been recognized that different theoretical orientations are based on different definitions of what is valid knowledge (subjective experience, interpretation, logical analysis, observation) and what are valid methods to acquire it. Sophisticated scholars (Messer & Winokur, 1980) have eloquently argued that these epistemological bases impose serious limitations to psychotherapy integration.

I would like to suggest, however, that it is too early to be closed to the possibility that such different knowledge tools and lenses may be complementary or that they may even lead to convergent information about important and meaningful phenomena. Perhaps pushing the frontiers of integrative efforts in psychotherapy, I want to end this paper by raising the possibility of one more pathway of connection. Specifically, I would like to suggest that the field of psychotherapy might benefit (both in terms of answers it might provide and questions it would be sure to raise) if many experts espousing diverse epistemological orientations (e.g., logical positivism, hermeneutic, phenomenological), across and within theoretical approaches, were to meet (as we have done at the NASPR/APA Task Force, PPA PRN, and at the Penn State University Conferences) to design and then implement a major investigation of a core process of change (such as insight and corrective experience). Needless to say, such an investigation would involve different assessment foci, perspectives, and procedures, as well as various methods of analyses. Rather than being mutually exclusive, I would predict that out of this diversity of assessment and analyses would emerge convergent and complementary information. Although this is not a new idea (Castonguay, 1987, 1993; Lecomte, 1987), I believe that such exploration of epistemological integration, or at least epistemological plurality, would provide fertile pathways for exciting and unexplored connections of knowledge.

As mentioned above, we have so many difficult and important responsibilities (preventing harmful effects being one of them), that it behooves us to explore and hopefully establish synergetic connections between different research methods, theoretical approaches, research domains, and world views/experiences. Although they will no doubt continue to evolve on their own distinct paths, the crossings of communities of knowledge seekers will likely provide scholars and/or clinicians with unique opportunities to enrich their view of complex realities, such as psychotherapy and psychopathology.

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