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METHOD PAPER

Building clinicians-researchers partnerships: Lessons from diverse natural settings and practice-oriented initiatives

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Abstract
In this concluding paper, we identify the type of studies conducted by 11 teams of contributors to a special issue on building clinicians-researchers partnerships. Those studies were conducted across a variety of clinical settings. We also integrate the lessons that have emerged from their collaborative initiatives in terms of obstacles faced, strategies adopted to address these challenges, benefits gained, and general recommendations offered to facilitate studies conducted with or by clinicians. The paper ends with the authors' thoughts about the future success of practice-oriented research in general.

Keywords: practice-oriented research; practice-based evidence; practice-research network; scientific-practitioner model

The wide gap between science and practice is due in part to the one-way direction that has mostly defined the connection between researchers and clinicians (Goldfried et al., 2014); researchers are generating empirical knowledge with the hope that practitioners will implement it in their working environment (Kazdin, 2008). This predominant, top-down approach to the generation and implementation of empirical knowledge has no doubt led to major contributions to our understanding and the efficacy of psychotherapy (Castonguay, 2013). However, since it is primarily guided by the theoretical interest of academicians and frequently conducted in highly controlled settings, this traditional approach to research has not been an optimal strategy to address day-to-day concerns of clinicians or to provide easily generalizable (applicable, actionable, and retainable) practice guidelines in clinical routine.

In contrast to what may be labeled "evidence-based research" (EBR) stands a bottom-up approach that has been referred to as Practice-Oriented Research (POR; Castonguay, Barkham, Lutz, & McAleavey,

2013). POR is characterized by studies that are (1) conducted as part of clinical routine, (2) foster the participation of clinicians in different aspects of the decision, design, implementation, and dissemination of research, and (3) allow for the use of collected data in day-to-day practice. POR thus offers opportunities for clinicians to not only contribute to the advancement of scientific knowledge but to also be involved in setting up the agenda of future research (Zarin, Pincus, West, & McIntyre, 1997). By relying on the unique expertise and resources of practitioners, it represents an antidote to the current state of empirical imperialism in psychotherapy within which full-time researchers have a dominant voice in terms of what should be studied and how it should be studied (Castonguay, 2011). Simultaneously, it offers a remedy for the colander effect that reflects our inattention to clinical knowledge and experience (Kazdin, 2008). Rather than being mutually exclusive, EBR and POR can be viewed as complementary paradigms, whereby the strengths and limitations (in terms of internal and external validity, for instance) of each approach can

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lead to a more comprehensive and robust base of knowledge (Barkham & Margison, 2007; Barkham, Stiles, Lambert, & Mellor-Clark, 2010).

A variety of POR studies have already been conducted (see Castonguay et al., 2013 for a review), but this type of research is still at an early phase of development. In order to generate more interest in and to facilitate future collaboration in studies, 11 groups of contributors who have been involved in POR in different naturalistic settings around the world were invited to share their experience in a special series of papers (Castonguay & Muran, 2014). As a concluding piece, the goal of the current paper is to identify convergences between the clinicians-researchers partnerships featured in this special series in terms of studies conducted, obstacles faced, and strategies used to deal with problems encountered, benefits earned, and general recommendations offered, as well as to highlight some aspects that are only found in particular research programs. We hope that these common and distinct experiences will provide useful lessons and guidelines that could be helpful to all clinicians and researchers interested in conducting future POR, as well as offer new perspectives to current POR investigators working in their own respective naturalistic settings.

Studies

A variety of topics have been investigated in the POR initiatives described in this series. A common focus is the assessment of change using standardized outcome monitoring. This involves tracking or predicting the progress of individual, large groups, or specific types of clients (Adelman, Castonguay, Kraus, & Zack, 2014; Boswell, Kraus, Miller, & Lambert, 2014; Castonguay, Pincus, & McAleavey, 2014; Fernández-Álvarez, Gómez, & García, 2014; Holmqvist, Philips, & Barkham, 2014; Koerner & Castonguay, 2014; McAleavey, Lockard, Castonguay, Hayes, & Locke, 2014; Strauss et al., 2014; West et al., 2014). The use of outcome monitoring in day-to-day practice has allowed some of these programs to investigate a number of issues related to specific patterns of change (such as dose–effect and good enough models, predictors of differential response patterns, sudden changes, deterioration, and therapist–client responsiveness), as well as the impact of providing feedback and clinical tools to therapists based on client change.

Several other types of research have been conducted by a smaller number of partnerships. For example, the effectiveness of psychotherapy has been assessed, whether conducted in psychological services or in private practice (Holmqvist et al., 2014; Koerner & Castonguay, 2014). The outcome of specific types of treatments or interventions for a wide range of clinical problems (e.g., children bed-wetting and adolescents with behavior and drug problems) has also been investigated or compared (Adelman et al., 2014; Fernández-Álvarez et al., 2014; Holmqvist et al., 2014; Szapocznik, Muir, Duff, Schwart, & Brown, 2014). Using different research methodologies (including randomized trials and single-case experimental designs), studies have assessed the impact of specific training programs aimed at fostering relationship skills, behavioral activation techniques, and two-chair techniques associated with emotion focused therapy (Koerner & Castonguay, 2014). The differential effectiveness of therapists has also been a core focus of POR studies (Holmqvist et al., 2014).

Also investigated are a number of characteristics related to the client, such as sociodemographic factors, treatment history, diagnostic variables, pre-treatment severity and family functioning, and attachment (Adelman et al., 2014; Castonguay et al., 2014; Holmqvist et al., 2014; McAleavey et al., 2014; Szapocznik et al, 2014; West et al., 2014); therapist, such as hours per week of direct care and personal style (see Fernández-Álvarez et al., 2014; West et al., 2014); treatment, such as practice settings, referral process, access to, utilization and provision of different types of services (psychotherapy and/or pharmacotherapy), sources of payment and management of care, as well as societal beliefs toward psychotherapy (Fernández-Álvarez et al., 2014; McAleavey et al., 2014; West et al., 2014); and the relationship between some of these variables, such as the congruence between client and therapist's perceptions of symptoms, as well as differences in diagnosis and treatment provided across patients' race and ethnicity (Holmqvist et al., 2014; West et al., 2014).

In addition, diverse POR programs have conducted process studies, focusing on topics such as the use of (or adherence/fidelity to) interventions associated with empirically supported treatments, consistency of routine care with evidence-based practice guidelines, helpful events, therapeutic alliance, and principles of change (Adelman et al., 2014; Castonguay et al., 2014; Fernández-Álvarez et al., 2014; Garland & Brookman-Frazee, 2014; Holmqvist et al., 2014; Koerner & Castonguay, 2014; Strauss et al., 2014; Szapocznik et al., 2014; West et al., 2014). POR studies have also involved the evaluation of assessment measures and DSM-5 diagnostic criteria (McAleavey et al., 2014; West et al., 2014). The development of tools for supervision of evidence-based interventions has also been a focus of a collaborative initiative (Garland & Brookman-Frazee, 2014). Perhaps reflecting, from an

epistemological perspective, an ultimate form of integration of science and practice, efforts have begun to train therapists from different parts of the world in designing feasible and highly rigorous research (single-case experimental studies) to test hypotheses tied to their clinical practice (Koerner & Castonguay, 2014).

Obstacles

A number of obstacles and difficulties are to be expected when building clinicians–researchers partnerships, as well as conducting POR within them. In the following text are some of the problems that the authors in this series have encountered in their collaborative work.

Clinical Concerns: Is it Worthwhile? Is it Dangerous? Is it Feasible?

One of the most serious challenges faced by POR is the fact that the tasks involved can be perceived by therapists as being irrelevant or even detrimental to their clinical work. This is a major issue confronted by the implementation of outcome monitoring systems (Boswell et al., 2014; Fernández-Álvarez et al., 2014; Holmqvist et al., 2014; Strauss et al., 2014). Practitioners are not likely to be fully engaged in data collection if they are concerned that it might generate negative reactions from clients, create difficulties in the therapeutic relationship, or simply fail to provide clinically helpful information. Above and beyond outcome monitoring, Fernández-Álvarez et al. (2014) argued that any research task can force clinicians to shift their attention away from an exclusive focus on the immediate clinical situations, to a consideration of the more distal research implications of the data collected. As they noted, weighting the long-term value of research data can be "a challenge to participants' patience" (p. 8).

Other concerns observed include the fear that outcome data might reveal negative findings or that results could have negative impact on a clinician's practice—or a treatment center—in terms of performance evaluation, referrals, or income (Adelman et al., 2014; Boswell et al., 2014; Strauss et al., 2014). Not knowing who will have access to outcome data and what will be done with it can also be experienced as a major threat to clinicians' autonomy. As evocatively stated by Boswell et al. (2014), clinicians "do not like 'big brother' and perhaps with good reason" (page 7). Rightly so, practitioners have questioned the ability of specific outcome results to accurately capture the clients' change, as well as the appropriateness of interpreting any outcome data without proper context or consideration of other sources of information (e.g.,

how complex the client's problems are, including his/her life circumstances; McAleavey et al., 2014; Strauss et al., 2014).

Anxiety and apprehension experienced by clinicians have not been limited to outcome monitoring. The fear, in the eyes of both therapists and clients, of potential breach of confidentiality can be an obstacle to the conduct of any type of research in naturalistic settings (Boswell et al., 2014; Koerner & Castonguay, 2014). As reported by Szapocznik et al. (2014), anxiety can also be raised by videotape observation of sessions (as a means of monitoring therapy adherence), or by the adoption of a treatment manual—especially with highly experienced practitioners. For the less experienced, the idea of having to ask clients to participate in research can trigger intense feelings of impostor syndrome, as some may feel a lack of competence and justification to ask clients to do anything extra for them or for the clinic (Castonguay et al., 2014).

Aside from matters of relevance, immediate value, potential detriment, and anxiety are the issues of feasibility. Research protocols that require too many tasks or intense supervision have been difficult to implement, let alone adopted as part of routine clinical practice after the completion of the study (Koerner & Castonguay, 2014; Szapocznik et al., 2014).

Collaboration and Communication Problems: Can This Really be a Team?

Not surprisingly, various collaboration and communication problems can jeopardize the design, plan, and implementation of any kind of POR. First and foremost, researchers must be constantly vigilant of potential pitfalls of empirical imperialism. These could manifest by subtle errors of omission, as in having innocuous or unplanned conversations about study design without the presence or previous input of practitioners. Or it can take the form of explicit dismissal and exploitation, as when "the researcher determines all aspects of the study, agrees with the clinical director to take advantage of the practice setting's volume of patients, and then the therapist and client participants are roped into additional work that may not align with their goals" (Koerner & Castonguay, 2014, p. 9).

Even when true collaboration and active participation has been sought, communication problems are to be expected. With many stakeholders involved, orchestrating the exchange of information represents a difficult endeavor (McAleavey et al., 2014). It is also important to recognize that stakeholders frequently "talk different languages": Not only do they have their respective jargon, but they can also have discrepant perspectives on the same words. For example, as

pointed out by Garland & Brookman-Frazee (2014), a term such as "evidence" can be interpreted in various ways, evoking very different emotional experiences (threat or approval) in those devoting their professional lives to help clients navigate complex lives, in contrast to those paid to contribute to the advancement of empirical knowledge. Language problems between researchers and administrators have also been observed regarding the translation of research findings. As noted by McAleavey et al. (2014), these problems can be particularly challenging because "questions that seem both critically important and very simple to administrators are among the most complex empirical talks available" (p. 9).

Closely linked to variant languages and perspectives is the fact that the various partners live in different cultures, face different demands and expectations, and pursue different goals (Garland & Brookman-Frazee, 2014; Strauss et al., 2014), all of which may at times reflect or lead to conflictual needs—such as the researchers need to collect publishable data, the clinicians wish to obtain clinically informative data, and the administrators need for actionable data at minimal cost (Boswell et al., 2014). As correctly stated by Garland & Brookman-Frazee (2014), stakeholders can also operate on "different time tables" (p. 11). For example, clinicians who need to figure out quickly how to address issues that emerge on a session-by-session basis can experience frustration by the time that it frequently takes for researchers to present or publish answers to the questions they have investigated together (Castonguay, Nelson et al., 2010). Frustration can also be mutual. As reported by Adelman et al. (2014), the difficulties involved by the implementation of a standardized research protocol within a natural setting can have unfortunate consequences for time-sensitive academic requirements (e.g., dissertation projects).

As in any kind of team enterprise, interpersonal dynamics have been identified as challenges to clinician and researcher partnerships. Garland & Brookman-Frazee (2014) noted that "power differentials" associated with various professional status may influence the way that participants collaborate and communicate. The same authors have also warned against the danger of having a partnership based on a unidirectional exchange of knowledge, as opposed to a reciprocal one. Intentional or not, this power dynamic is akin to or is reflecting the issue of empirical imperialism mentioned earlier. Garland & Brookman-Frazee (2014) have also identified interpersonal problems (personality issues and personal agenda) that, as with any type of group project, can interfere with POR initiatives.

Pragmatics: Being Bugged Down by Reality

The development, implementation, and maintenance of POR also face a number of pragmatic obstacles. For Koerner and Castonguay (2014), practical incompatibilities between research tasks and clinicians' workflow actually represent the primary challenge of POR. Perhaps the most obvious and intractable of these barriers is time, or lack of it. Irrespective of the world that they live in, most POR stakeholders are extremely busy. And although they share an interest in their collaborative endeavor, for many of them such an endeavor represents only a fragment of their professional responsibilities. Put bluntly, POR means extra work. For example, in addition to the training involved in the proper use of a particular measurement system, outcome monitoring requires time to administer and interpret the questionnaire, provide feedback to clients, and keep track of assessment points (Boswell et al., 2014; Holmqvist et al., 2014; McAleavey et al., 2014; Strauss et al., 2014). The more and/or bigger tasks required by a research project, the more its preparation and implementation may compete with the daily demands of all participants involved (Koerner & Castonguay, 2014; Szapocznik et al., 2014; West et al., 2014). As a case in point, the design of a study on helpful and hindering events in therapy required practitioners to meet regularly with researchers for a year. Having to fill out a process measure for each of their private clients after every therapy session over the course of 18-months of implementation also forced therapists to sometimes have to choose between research tasks and bathroom breaks (Koerner & Castonguay, 2014).

Not surprisingly, time for research is particularly difficult to find when participation is on a voluntary basis (West et al., 2014). The lack of financial incentives to clients and therapists has indeed been identified as an obstacle to the successful implementation of POR (Koerner & Castonguay, 2014). When it applies to outcome monitoring in naturalistic settings, the lack of finances, let alone the cost to therapists, reflects an unfair burden. As pointed out by Boswell et al. (2014), whereas physicians do not have to pay for their patient tests, the insurance industry has refused to reimburse the routine collection of behavioral health data. Financial support also represents a major source of challenge and stress for large naturalistic projects and POR infrastructures (Fernández-Álvarez et al., 2014; Garland & Brookman-Frazee, 2014; McAleavey et al., 2014; West et al, 2014). Directly related to the financial needs of these large initiatives are the organizational challenges that come with the collection and management of data across multiple sites, assignment of

responsibilities and distribution of resources across partners, as well as training, management, and retention of staff members (Boswell et al., 2014; Fernández-Álvarez et al., 2014; McAleavey et al., 2014; Strauss et al., 2014; West et al., 2014).

Costs: When Research Interferes with Other Needs

Conducting POR can also be costly for many involved in the partnership. For example, having to remember all tasks required by a research protocol, especially in the early phase of a study, may make it difficult for therapists to allot their full attention to the needs of their clients. Moreover, some procedures, such as getting informed consent during the first session of therapy, can infringe on the therapist's time to conduct a full assessment and/or foster therapeutic bond (Koerner & Castonguay, 2014). Any research-related tasks, big or small, can also impact practitioners' (or a treatment center's) capacity to generate income. By possibly interfering with care delivery and earning potential, the time devoted to research can thus be viewed as an unnecessary luxury by clinicians, clients, and administrators (Adelman et al., 2014). In brief, POR is impeded by a double financial challenge (double whammy): Not only there are often no financial incentive for clients or therapists but it also costs them in terms of time and effort. Researchers also have to struggle with negative consequences that can come along with an engagement in POR, such as the frequent lack of fit between nontraditional research and the priorities of funding agencies (West et al., 2014), the lack of incentives from academic institutions for community-based work (Garland & Brookman-Frazee, 2014), or the incompatibility between the publishing pressure of academia and the slow pace and the demanding efforts of practitioners and researchers collaborations (Koerner & Castonguay, 2014). Accordingly, researchers interested in building POR initiatives should consider inviting others living in their world (such as colleagues and students) and seeking administrative assistance—especially if they are not yet tenured (Castonguay, Nelson et al., 2010; Castonguay et al., 2014).

Fostering Strategies

A number of strategies have been identified by the contributors of this series, both to address the obstacles mentioned earlier, as well as to facilitate POR studies and partnerships in general.

Putting Premium on Clinical Relevance and Beyond

It should be of no surprise to anyone that studies that fail to be directly related to clinical practice are not likely to stimulate therapists' engagement. One of the lessons that emerged from POR collaborations, however, is that in order to generate and maintain practitioners' commitment, such studies have to go beyond the threshold of "clinical relevance" and be more than potentially interesting; they have to suggest ways of improving clinical work. "Clinicians will help with research—if the research helps them clinically" (McAleavey et al., 2014, p. 6) is one of the major conclusions derived from a survey that asked busy counselors what kind of research they would be willing to participate in, knowing that this participation would require additional work and time on their part.

One way to increase the helpfulness of research is to integrate it into different aspects of clinical work. For example, Fernández-Álvarez et al. (2014) pointed out that using data within clinical supervision can increase therapists' motivation to collect it. Perhaps the ultimate test of helpfulness is that studies have to be actionable and retainable. To facilitate the clinician's willingness to go along with research tasks and cope with the added stress and anxiety that may come with them, these tasks have to be immediately informative by providing therapists, for example, "here-and-now" guidance about interventions that can be used to best address the clients' needs (Koerner & Castonguay, 2014). Repeating Fernández-Álvarez et al. (2014)'s wise comment, it is testing the therapist's patience to present findings only after completion of a study. As argued elsewhere, research tasks are likely to be performed during the study (and retained in clinical routine after its completion) if they are "clinically syntonic" (Castonguay et al., 2010). Beyond the abstract concept of "clinical relevance," POR investigations will be most successful if they foster a seamless integration of research and practice or, put differently, if the study protocols confound research and practice. As described elsewhere, "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 will lead them to answer these questions by saying, "Perhaps both," may be the most fruitful and exciting pathway to bridge research and practice (Castonguay et al.,

2010, p. 352). Koerner & Castonguay (2014) also use the metaphor of research and practice being woven as a whole cloth to describe POR studies that cause minimal disruption to the clinical workflow and that may "improve clients outcome by meeting therapists' learning needs" (p. 4). It should also be obvious that in many cases confounding research and practice can be a fruitful strategy to protect the limited resource of time. The more infringement on time, the less likely it is to learn empirically from clinical practice.

Also going beyond the concept of relevance, clinicians are more likely to participate in studies and continue to use research procedures in poststudy completion when such procedures do not require drastic changes to their practice (Castonguay, 2013; Koerner & Castonguay, 2014). Most clinicians will be indifferent to or even resentful if they are asked to put aside the way they have been practicing for years and forced to adopt completely new treatment packages (and/or theoretical orientations) in order to test a protocol within their own clinical routine. Rather, they are more likely to join a project and retain what they might learn from it if what they do for research is additive to their clinical repertoires, such as obtaining process and outcome feedback from their clients, using new interventions to address specific clinical issues, or having access to clinical tools that they can use on their own terms and time schedule (see Adelman et al., 2014; Koerner & Castonguay, 2014; McAleavey et al., 2014).

In POR, or any kind of psychotherapy research, clinical relevance is frequently brought up in contrast with scientific rigor—as if clinical utility and internal validity were opposite poles of a continuum, or irreconcilable categories by which one is to judge research quality. It should indeed be recognized that the strengths of POR, such as high external validity, may at times come at a price. As noted in Koerner and Castonguay (2014), some methodological components of psychotherapy research that can increase its internal validity (e.g., multiple observer assessments of pre- and posttreatment outcome) are not likely feasible or desirable in most studies conducted in clinical routine. However, it is also important to avoid false dichotomies. First, naturalistic studies can reach both high levels of clinical helpfulness and validity, internal and external. This has been illustrated by the use of randomized clinical trials and single experimental designs in several studies presented in this series (Boswell et al., 2014; Koerner & Castonguay, 2014; Strauss et al., 2014; Szapocznik et al., 2014). More importantly, rigor and relevance can be seen as complementing and reinforcing of each other (Garland & Brookman-Frazee, 2014). For example, the

more valid an instrument or a finding is, the more confidence we may have that they are truly actionable.

Yet, it is undeniable that a tension frequently exists between making a study both feasible and scientifically rigorous. At least two directions have been suggested in this special series with regard to finding a balance between these crucial issues. The first is to offer some flexibility (or customization) in the way that instruments can be used and data can be collected. For example, in the large practice-research network (PRN) infrastructure of university counseling centers described by McAleavey et al. (2014), specific sites have the ability to change the order and turn on or off individual items of one of the standardized measures used by all participating centers. Another strategy is to explicitly recognize that no study can ever be perfect and that partners have to make an informed choice in terms of level of rigor balanced with the costs entailed (Koerner & Castonguay, 2014).

Addressing Threats and Anxiety

As described earlier, fears of negative impact (e.g., breach of confidentiality, threats of autonomy, risks of negative evaluation, and potential decreases in referrals and revenue) and concerns about the clinical accuracy of empirical data represent major challenges in building up clinicians–researchers partnerships. For many of those involved in POR, a key component to address these understandable apprehensions is transparency (Boswell et al., 2014; Strauss et al., 2014). For example, Boswell et al. (2014) have recommended a full disclosure in writing regarding issues such as confidentiality. Researchers have also found that clinician participation is enhanced not only when they are informed of the complete anonymity of the data collected but also by the explicit reassurance that the data will not be used to control the financing of their practice or to replace clinical judgment (Strauss et al., 2014). POR researchers have clearly voiced that empirical data, even collected in the naturalistic setting where it is used, are not sufficient to guide clinicians about what to do, when to do it, and with whom. In fact, we tend to forget that the philosopher David Hume (1739) had already mentioned a few centuries ago that one cannot get from making descriptive statements ("is") to making prescriptive statements ("ought"). Not only should data be interpreted within the context of the client's life and current situation, but it should also be viewed as complementary to clinicians' judgment and used to point to potential directions for further professional development and training (Castonguay et al., 2013; Holmqvist et al., 2014; McAleavey et al., 2014).

In addition to recognizing the limitations of their instruments, some researchers have also stressed that

one way to address clinicians' concerns about the accuracy and adequacy of empirical data is to continually seek to increase the psychometric quality of measures, improve their utility and predictability (e.g., what types of clients are particular therapists predominantly effective with?), and provide clinical tools (Boswell et al., 2014).

Another apprehension experienced by clinicians is whether the research tasks can be of value to their clients. Data can be helpful in decreasing such fear. A case in point is how outcome data were used to address the imposter syndrome experienced by graduate students which, as mentioned earlier, made them anxious to ask anything of their clients, including filling out pre and posttreatment measures or participating in studies conducted by their peers. Showing students that compared to experienced clinicians in private practice, their interventions had higher impact on serious clinical difficulties such as suicide, and psychosis was a turning point in terms of their sense of self-efficacy and motivation to use and conduct POR studies (Castonguay et al., 2014). Szapocznik et al. (2014) have also observed that the presentation of empirical evidence about the efficacy of a treatment to be tested can facilitate various stakeholders' buy-in.

Yet having clinicians share their experiences with other clinicians might be an even stronger strategy to address apprehensions, as it avoids perceptions of bias, self-serving, or controlling motivation from researchers. As Boswell et al. (2014) have learned from their experience:

> researcher's attempts to impart the "wisdom of routine outcome monitoring" are far less effective than the wisdom imparted by fellow clinicians who have used the particular outcome monitoring system of interest. It is through direct clinical experience and by sharing these experiences (e.g., through vignettes) that other clinicians begin to seriously entertain the potential benefits. (p. 8)

It is also important to note that such direct experience is frequently discordant from previous expectations of clinicians who are being asked to use outcome monitoring. As such, perception of the relevance and value of an instrument is sometimes acquired via a corrective experience (Youn, Kraus, & Castonguay, 2012).

While the strategies mentioned above can and should be used to address clinicians' concerns about their participation in POR, it is, nevertheless, crucial to constantly gather feedback and closely attend to therapists' criticisms about the protocols (assessment, treatment, or otherwise) implemented (McAleavey et al., 2014; Szapocznik et al., 2014). This will not only build a stronger sense of collaboration but is likely to also improve the quality of the research conducted.

Pumping Blood in the Partnership: Enhancing Communication and Collaboration

For it to be worthwhile, a partnership should be based on a diversity of expertise and opinions. True advances in complex fields are rarely achieved by the joint work of individuals who think the same way. As cogently stated by Garland and Brookman-Frazee (2014), partnership members "should possess complementary, but non-redundant knowledge and experiences that can be combined and contextualized to facilitate knowledge creation and innovation" (p. 6). Like any kind of teamwork, however, the success of POR also rests on strong communication and collaboration between individuals who typically live in different professional worlds. Metaphorically, communication and collaboration is the blood that maintains the life in professional partnerships. As described earlier, joint research initiatives face serious challenges, including different languages, perspectives, goals, expectations, demands, as well as wishes and fears of various stakeholders involved. These discrepancies are unavoidable and should be faced with transparency, as well as frequent and open dialogues.

Many papers in this series have emphasized the importance of regular meetings to discuss, understand, validate, and optimally incorporate the needs, concerns, and contributions of diverse collaborators, in addition to remind or inform all parties involved of the goals, tasks, and progress of the joint projects (Boswell et al., 2014; Castonguay et al., 2014; Fernández-Álvarez et al., 2014; Garland & Brookman-Frazee, 2014; Koerner & Castonguay, 2014; McAleavey et al., 2014; Strauss et al., 2014). As noted by Garland & Brookman-Frazee (2014), face-to-face meetings are crucial to build trust and develop a shared language. For these authors, such trust and common language are dependent upon a number of interpersonal processes that are common to many successful relationships, including an openness and responsiveness to others' perspectives, a reciprocal enthusiasm about the collaboration and, interestingly, a willingness "to go above and beyond an agreed upon scope of work" (p 7). Yet, Garland & Brookman-Frazee (2014) have also pointed out that partners should be aware of potential pitfalls that can undermine face-to-face meetings, such as the failure to recognize and adequately process invalidating power differentials, unidirectional sharing of knowledge, and monopolization of control. To prevent or deal with these group processes, they argued it is "important to address members' expected roles and unique contributions, and the distribution of power at the outset, as well as explicitly establishing norms for working together" (p. 8). At the same time, they wisely recommend that input from all members

should not only be attended to but should also contribute to actual changes in collaborative work. Not surprisingly, members of POR have also indicated that interpersonal problems, in the form of conflict and alliance ruptures, are to be expected and should be addressed to foster the development and optimal functioning of collaborative partnerships (Castonguay et al., 2014; Garland & Brookman-Frazee, 2014)

Fundamentally, successful POR requires two things: A strong level of engagement and commitment from each member to the philosophy and tasks of research (Holmqvist et al., 2014; Strauss et al., 2014), as well as a genuine alliance between them. This state of alliance both reflects and fosters a sense of equality and respect, as well as a recognition of diverse ways of understanding and investigating complex realities (Castonguay et al., 2013). The same state of alliance or collaboration has been referred by Garland & Brookman-Frazee (2014) as "egalitarian leadership." This overarching principle of healthy group process, however, does not negate differential skills and the adaptive strategy of matching leading responsibilities with specific knowledge and expertise. But what egalitarian leadership implies, process and outcome wise, is full rights of all participants. For clinicians, this means that they should have access and control over what is frequently in the researchers' exclusive province. As Holmqvist et al. (2014) noted, "a key process that needs to be achieved in practice-based evidence is to ensure a sense of local ownership by practitioners in the data they collect" (p. 8). This includes providing opportunities for clinicians to be involved in the plan (not only with respect to what to analyze but also what not to analyze; see Strauss et al., 2014) and conduct of statistical analyses of data collected, as well as to request data for the investigation of questions related to their own interest (Koerner & Castonguay, 2014; McAleavey et al., 2014). Increasing a sense of ownership can also be achieved by involving practitioners in the selection of instruments to be used for research purposes (Holmqvist et al., 2014) and by giving them the opportunity to modify the way these measures can be used. An example of this is the decision of therapists in training to improve the clinical utility of outcome monitoring by implementing it, as part of their POR infrastructure, after every session rather than at limited assessment points (Castonguay et al., 2014).

As illustrated in several papers in this series, collaboration in POR studies can involve a broad array of stakeholders (e.g., therapists, supervisors, researchers, graduate students, administrators at different levels of management, funders, parents, judges, and policy decision-makers), each of them deserving to have their voices heard and their expertise recognized in the research partnership (see Adelman et al., 2014; Boswell, et al., 2014; Garland & Brookman-Frazee, 2014; Koerner & Castonguay, 2014; McAleavey et al., 2014; Strauss et al., 2014; Szapocznik et al., 2014; West et al., 2014). Building upon such diversity of partners can not only strengthen a study but also help generate "valued research findings that may be more likely to have an impact on clinical practice and policy" (West et al., 2014, p. 12). And while it should be recognized, as we did before, that all stakeholders have different needs, expectations, and demands, it is also important to keep in mind that these diverse goals can be highly complementary. There is, for example, no a priori counterindication between clinicians' desire to get quick and helpful information about the pattern of change of an individual client, researchers' interest in identifying moderators and mediators of change in groups of clients, and administrators and funders' hope of finding ways to efficiently address the needs of all their clients. These are different levels of investigation that can have synergetic impact on each other, where the answer to each particular question can benefit from and contribute to the clarification of other questions.

As illustrated in several papers in this series, partnerships can also be built upon and enhanced by focusing on convergent goals. Academicians and clinicians can actually be pleasantly surprised at the high level of convergence in their interest and research ideas (Adelman et al., 2014; Castonguay in Lampropoulos et al., 2002). Considering how powerful a motivation such shared interest could be, it is not surprising that many authors of this series have emphasized the value of clinicians' full involvement in the selection of the ideas to be examined, design to investigate them, recruitment of participants, implementation of the study, and efforts to disseminate findings (Koerner & Castonguay, 2014; Szapocznik et al., 2014; West et al., 2014). Stakeholders also share general goals, above and beyond the specific focus of a particular study. At least two major ones can be delineated: Many individuals (including, of course, clinicians) are interested in contributing to the advancement of empirical knowledge and the reduction of the gap between science and practice, and most, if not all, professionals in the mental health field are invested in improving the care of clients. Accordingly, one way to foster partnerships is to lead stakeholders to identify themselves, both at a personal and an organizational level, with research projects that are specifically aimed at these far-reaching goals (Fernández-Álvarez et al., 2014). Put differently, successful POR can be fostered by building a "sense of community" (McAleavey et al., 2014) that is guided by the shared ambition to contribute to the advancement of knowledge and reduction of suffering.

Making it Possible: Resources and Pragmatics

McAleavey et al. (2014) have identified two fundamental resources for the development and maintenance of their large PRN infrastructure, and it is fair to say that these supplies are necessary for any kind of POR initiative: "Time (and a lot of it) and people (and a lot of them)" (p. 16). We have already mentioned the large number and variety of stakeholders involved in these partnerships. What has also been emphasized by several authors in this series is the amount of time that collaborative work can require with respect to the preparation, coordination, and implementation of a study (Garland & Brookman-Frazee, 2014; Koerner & Castonguay, 2014; Strauss et al., 2014; Szapocznik et al., 2014; West et al., 2014). For example, the preparation of one of these studies (which included the development of the research design, planning of the management, analysis and publication of the data, and the allocation of funding) took four years (Strauss et al., 2014).

A particular aspect of preparation that has been highly recommended might best be called the "routinization" of a protocol. Routinization begins with thorough planning. Clinicians and researchers have learned that the more time you spend laying down the details of a protocol and anticipating problems that could emerge when implementing it, the more you save in terms of energy, frustration, and time later (Koerner & Castonguay, 2014). Specific strategies have been developed to help practitioners "automatize" (learn, remember, and recall) the research procedures as part of their clinical routine, such as through the use of web technology (e.g., Krug's (2006) "Don't make me think"), or the construction of multiple scripts, each of them including the same research procedures but with differing levels of details. Additional recommendations that have been made to facilitate "routinization" are the inclusion of email and phone consultations, as well as frequent meetings at the beginning of a study to discuss problems that some participants have faced and ways that other partners have devised to prevent and resolve difficulties. It also seems advisable to have clinicians implement the research protocol, or at least parts of it (e.g., core measures), in their clinical routine before the study is launched (Koerner & Castonguay, 2014; Strauss et al., 2014). Such pilot work not only provides opportunities for practice and consultation but also sets up an optimal test for participants to decide whether or not the benefits of research procedures (e.g., in terms of actionable information they can provide during treatment) outweigh their costs (e.g., in terms of disruption of clinical workflow).

Another concrete key to successful POR is to keep things as simple as possible and to avoid imposing unreasonable burden to clinical routine (Boswell et al., 2014; Koerner & Castonguay, 2014; West et al., 2014). Based on their separate experience, Koerner & Castonguay (2014) concluded that "[t]he best strategy we have found in our practice-oriented research designs is to accept the constraints faced by practitioners and design research procedures that map as directly onto clinical care already provided as possible" (p. 9). The clinicians' contribution in the design of feasible studies is critical—as they know best what is possible and impossible to add to their day-to-day work schedule (West et al., 2014). A good example of such wisdom comes from one of the lessons learned in a PRN study conducted in private practice (see Koerner & Castonguay, 2014). In this study, clinicians and researchers had decided that each therapist would be inviting all of their new clients to participate. Because this study required therapists to fill out measures at the end of every therapy session, it became clear that having their entire client caseload as participants was too burdensome. Based on this experience, the subsequent study conducted in the same PRN involved no more than four participating clients for each of the therapist at any given point in the study.

Feasibility, however, not only refers to how possible it is for clinicians to adopt and adequately implement a research protocol but also how to sustain such implementation. Organizational support has been identified as a critical addition at each of these steps (Koerner & Castonguay, 2014; Szapocznik et al., 2014). For example, Szapocznik et al. (2014) collaborated with treatment agencies to recruit "on-site" supervisors for the training, monitoring, coaching, and provision of feedback to clinicians participating in a psychotherapy effectiveness study. In another study, clinicians greatly benefitted from the help of research assistants (graduate and undergraduate students), who kept a close and timely monitoring of data collected, providing them with rapid feedback about adherence problems observed, and were easily reachable to answer questions regarding the study protocol (Koerner & Castonguay, 2014). Garland & Brookman-Frazee (2014) have argued that, ideally, organizational support should not be tied to one specific stakeholder, and instead, can be shared among various members, such as between administrative staff and university research assistants (Koerner & Castonguay, 2014). In other initiatives, however, the administrative support has been provided primarily by the research stakeholders, via grant funding or university funds (e.g., Garland & Brookman-Frazee, 2014; McAleavey et al., 2014). Irrespective of its

source, POR are likely to be particularly burdensome, in terms of time and energy, if administrative help is not provided to both clinicians and researchers.

The provision of concrete incentives has been recommended, including financial rewards (for both clients and therapists), as well as credits toward professional licenses (Boswell et al., 2014; Koerner & Castonguay, 2014; Strauss et al., 2014; West et al., 2014). Successful conduct of POR, small and large, has also benefited from continued refinement of computer and online technology—to train participants, implement protocols, as well as to collect and manage data (Boswell et al., 2014; Castonguay et al., 2014; Koerner & Castonguay, 2014; McAleavey et al., 2014; Strauss et al., 2014; West et al., 2014). The technical challenges involved for the efficient administration of instruments and management of data has at times been met by integrating software companies as part of the POR partnership (Castonguay et al., 2014; Koerner & Castonguay, 2014; McAleavey et al., 2014). Others have built their own technology to collect data in naturalistic settings (see Fernández-Álvarez et al., 2014; Koerner & Castonguay, 2014).

Technology can, of course, be expensive. Needless to say, this is not the only cost entailed by research. And, of course, the larger a study is, the more substantial are the financial needs. But since it has been observed that monetary incentives can facilitate data collection (Koerner & Castonguay, 2014; West et al., 2014), funding is an important pragmatic issue for any type of POR, small or large. Several investigators have been successful in securing substantial financial support (e.g., Garland & Brookman-Frazee, 2014; Holmqvist et al., 2014; Koerner & Castonguay, 2014; Strauss et al., 2014; Szapocznik et al., 2014; West et al., 2014). However, it is also a fact that for mental health investigators, and perhaps for psychotherapy researchers in particular, external funding is extremely difficult to obtain. Some POR programs have benefitted from support outside of much prized funding sources (mostly governmental), including private foundations, professional associations, and university or treatment center internal funds (e.g., Adelman et al., 2014; Castonguay et al., 2014; Koerner & Castonguay, 2014; McAleavey et al., 2014; West et al., 2014). As a nonprofit research infrastructure, the Center for Collegiate Mental Health (CCMH) has also been able to rely on membership fees from its participating counseling centers, as well as from individuals and companies interested in its intellectual properties (McAleavey et al., 2014).

It may well be, however, that the financial foundation of most POR, especially if partners are interested in long-term sustainability, has to rely in part on the concept of "patching." As defined by Garland & Brookman-Frazee (2014), patching refers to the reorganization of partnership and donation of resources when there is no external funding. In fact, several of the POR initiatives described in this series have operated within a "pre-patching" mode, i.e., without having had any or enough external funding to fully support their research activities. Instead, they have received contributions from business partners (e.g., software companies), donation of time (from therapists, students, and researchers), and even funding from their own members (e.g., Fernández-Álvarez et al., 2014; Koerner & Castonguay, 2014; McAleavey et al., 2014). This level of participatory process clearly demonstrates a strong commitment toward two major goals mentioned above (contribution to the advancement of knowledge and the improvement of mental health care), but it also reflects the synergetic and meaningful contribution that can be generated from a milieu that is characterized by mutual trust and a shared pursuit of professional actualization. As stated by Fernández-Álvarez et al. (2014), clinicians set aside personal resources because they know that the conduct of research fits institutional needs, which in turn "are oriented to meet the individual's professional development" (p. 8).

Though there is no doubt that financial support can be extremely beneficial and even crucial for large POR initiatives, it should also be considered that external funding may, in some circumstances, become a curse. In the current context of "get grants or perish," funding might be the principal motivation for some academicians to establish connections with clinicians. At worst, using clinicians' time and milieu only to please a dean or a chair would be committing a faux pas that is beyond empirical imperialism—it may well be nothing less than "empirical invasion." At best, the search for funding for the sake of funding is likely to guarantee that a research program, including the long-term implementation of its findings, will cease to continue once the grant ends and the researcher will look for other "hot" funding areas. Once the research team begins to pay anybody, it is hard to "go back" to a place where collaborators are not paid. If we want to conduct studies that lead to retainable findings, we should therefore strive to avoid becoming dependent on external findings, at least in some contexts.

Handling Organizational Challenges

As mentioned earlier, true and successful partnership is based on transparent and open communication. In the case of large, including multi-sites, collaborations, however, another layer of communication must be addressed: The orchestration and

dissemination of information to various partners. Different tools have been used to facilitate this crucial aspect of organizational functioning, including email lists to raise and address problems between sites, web-based methods to facilitate communication (e.g., google groups) or to submit research projects to a centralized research team, in-person and video (webinars) training, annual meetings with representatives of local sites, research conferences to present projects conducted across the collaborative infrastructure, and in-print publications (e.g., annual reports) to describe research findings in friendly (for both clinicians and administrators) ways (Garland & Brookman-Frazee, 2014; McAleavey et al., 2014).

Another organizational challenge that must be met by large POR initiatives is the centralization of data, in order to minimize data sources and reduce resources needed to manage it (Strauss et al., 2014). As noted by Strauss et al. (2014), procedures to ensure quality of data have to be systematically assessed and improved upon. A good example of the complexity required for quality control is provided by the standardization and centralization process developed for the CCMH PRN, which aimed at ensuring that:

> the materials reach clients in the same format every time; that the measures are easily administered by and meet the needs of each UCC; that the data from clients are efficiently and accurately recorded, scored, reported to the counselor and transmitted to CCMH; and that any future updates to the standardized materials can be accommodated. (McAleavey et al., 2014, p. 7)

The goal of centralizing data collection is particularly challenging and requires complex technological skills when data is collected and stored using different software packages, as it is the case for CCMH.

Centralized coordination, however, is not restricted to data management. Recommendations for the successful operation of multisite initiatives have also emphasized the coordination of the various aspects related to a study. For example, one of the most baffling tasks of research, for most clinicians and administrators, is the submission of proposals to get ethical approval for conducting a study. In CCMH, for instance, such time-consuming requirement has been handled by having a team of graduate students (themselves part of the centralized research team) to provide examples of and feedback to the various sites in submitting their respective research ethic proposal.

To facilitate the aforementioned tasks of communication, data management, and project coordination, many large POR initiatives have created advisory boards (e.g., McAleavey et al., 2014; Strauss et al., 2014; West et al., 2014), which bear the broader responsibilities of providing recommendations about research agenda and potential sources of funding, as well as ensure that current and future projects are sensitive to the needs of different stakeholders and consistent with ethical standards.

While a centralization process and administrative board structures might be an efficient way to oversee and manage large projects, the implementation of such projects generally takes place at specific sites. To increase the probability of such implementation, some POR programs have recommended the identification of "local champions" (Boswell et al., 2014), "study champions" (Garland & Brookman-Frazee, 2014), or "model managers" (Szapocznik et al., 2014). These are individuals responsible for building trust with stakeholders' on-site, easing the adoption and implementation of research protocols, helping to adjust the project to be consistent with clinical routine, providing training with regard to tasks, expectations, and anticipated benefits, as well as to monitor and facilitate the data collection.

Whether it is accomplished by one specific individual on-site or a group of representatives of different stakeholders, a key organizational task is to preserve a continuity of information regarding goals, procedures, and problems faced in POR (Boswell et al., 2014; Strauss et al., 2014). This is an especially crucial issue when recruitment of new participants and/or turnover of staff members are anticipated. The principle underlying this recommendation is that "you can never communicate too much" (Castonguay et al., 2014, p. 10). As an example, the first author of this paper and his colleagues observed that while the students who had been involved in the development of the PRN within our training clinic were fully cognizant of the purposes and benefits of combining the research and clinical requirements of the doctoral program, this was not always the case for later cohorts of students. Accordingly, many from this latter group felt that procedures implemented by former students were additional burdens imposed on their already hectic clinical responsibilities. To address this obvious obstacle, annual meetings are organized by faculty, clinical staff, and advanced graduate students to describe the origin and goals of our PRN, as well as to inspire a sense of ownership of the data collected at the clinic. As noted in Castonguay et al. (2014), these meetings are aimed at conveying one message: "This is not for us (faculty members), and not imposed by us. It is mostly for you and it has been driven in part by previous and current students" (p. 11)

Building large and long-standing partnerships can also involve organizational tasks or procedures that are foreign to the daily activities of most clinicians and researchers. As noted by McAleavey et al. (2014), for example, "large-scale PRNs are very likely to include the use of intellectual property or

the development of corporate partnerships, and our experience suggests planning for risk-management and legal resources is necessary for success" (p. 10). As another case in point, the transformation of a training clinic into a fully operational PRN required a unique agreement with the office of research protection, which itself involved extensive negotiation with leaders of this office and their attorney (Castonguay et al., 2014).

Researching Research and Processing Process

Two other strategies, or meta-strategies, have been recommended to foster POR. One is to rely on research that has been conducted on research collaborations. For example, Garland & Brookman-Frazee (2014) have derived lessons from management and implementation sciences, as well as from studies on factors of successful research–practice partnerships in public health, to construct a model of research–community practice partnership; a model which has guided the development of their own researchers and clinicians collaboration. Of course, research directly related to the collection and use of psychotherapy data in naturalistic settings should be highly encouraged. As an example, Boswell et al. (2014) argued that research is sorely "needed on the factors (e.g., participant factors, organizational factors, training factors) that facilitate or inhibit the adoption, implementation, and sustainability of routine outcome monitoring" (p. 11).

Just as the research on research implementation might facilitate the conduct and use of POR, so is the use of conceptual models of psychotherapy process to understand and improve the process of research in psychotherapy. This is a conclusion that can be derived from the experience reported by Szapocznik et al. (2014), who have used their family therapy model to guide the testing of the same model in naturalistic settings. Put in other words, they relied on principles underlying their conceptual framework of therapy to anticipate and deal with organizational difficulties faced in their research program. By addressing difficulties encountered during three different phases of research–practice partnership (adoption, fidelity, and sustainability), their work has not only been consistent with major recommendations of implementation sciences, it has also offered an innovative contribution to this literature. Reflecting an intrinsic integration of science and practice, the recognition of the potential benefits of "using a model to test a model" was facilitated by the fact that the researchers involved in their POR were clinically trained. There is no reason to assume that their model (or any other theoretical frameworks of therapy) could not provide insightful recommendations, process and

content wise, about research on various aspects of psychotherapy in clinical routine.

Benefits

Successfully resolving major challenges that come when building professional partnerships is, of course, intrinsically gratifying. In addition to such transcending reward, POR can have benefits for each of its stakeholders and beyond.

Improving Clients' Outcome

To be viable, ultimately, POR has to be beneficial to clients. As a paradigm of applied science, its credibility rests in part on its ability to have an effect on treatment outcome. Based on a diversity of methodologies, including randomized clinical trials, there is evidence that research collaboration between clinicians and researchers can impact psychotherapy in clinical routine (e.g., Adelman et al., 2014; Szapocznik et al, 2014). Related to the issue of outcome, this partnership can also lead to an increase of treatment retention compared to usual clinical care (Szapocznik et al., 2014). Moreover, POR findings have demonstrated that feedback on progress (as well as the provision of related clinical tools) can significantly reduce the rate of deterioration in psychotherapy (Boswell et al., 2014; Lambert, 2010). While it remains to be seen if it is beneficial across diagnostic groups and settings (e.g., Johnson, 2014), outcome feedback is providing tools for clinicians to meet their most important ethical responsibility, "first do no harm." Outcome monitoring and feedback can also improve the cost effectiveness of psychotherapy; when therapists are receiving feedback on therapeutic change, patients who show early improvement have shorter treatment durations than those who do not (Strauss et al., 2014).

While more traditional research has focused extensively on the impact of particular forms of therapies, POR studies have shown that client outcome are in part due to the individual therapist they are seeing. Specifically, clients seen by particularly effective therapists have a higher probability of being better off at the end of treatment than those who are seen by particularly ineffective therapists (Castonguay et al., 2013). Evidence emerging from POR also suggests that particular therapists may have specific areas of outcome expertise, fostering some types of change (e.g., reduction of depression) more than others (e.g., reduction of substance-abuse symptoms; Kraus, Castonguay, Boswell, Nordberg, & Hayes, 2011). If appropriately used in clinical routine, such findings on outcome variability (between and within therapists) can be a valuable source of feedback about a

practitioner's unique strengths and limitations (Strauss et al., 2014)— which should ultimately be beneficial to their clients.

Enhancing the Therapeutic Process

Empirical data collected by clinicians also has the potential of facilitating the process of therapy. Outcome monitoring, for example, can help case formulation by providing assessment of a range of problems at different phases of treatment (Boswell et al., 2014; McAleavey et al., 2014), at times revealing difficulties that clients are reluctant to share verbally or that therapists may not have thought to ask. Tracking outcome can thus open communication about needs—told or untold, met or unmet. It can also help treatment planning by anticipating patterns of change, with regard to clients who are likely to change, those who are not (Castonguay et al., 2014), and those who are at risk of deterioration (Boswell et al., 2014; Lambert, 2010). Since research indicates that clinicians are generally not good at accurately predicting clients who will deteriorate during treatment, such empirical information can be invaluable to shift the focus of treatment as needed (Boswell et al., 2014; Lambert, 2010). In contrast, as reported by Strauss et al. (2014), clients tend to have a positive view of outcome monitoring, which by itself, can contribute to the quality of the therapeutic relationship, and for those clients who are progressing well, the presentation of data documenting their improvement can reinforce the working alliance (Boswell et al., 2014).

Helpful feedback is not restricted to outcome improvement, or lack of thereof. For example, clients' descriptions of helpful and hindering events during therapy can provide therapists with unique information that might help them adjust their interventions to better address their clients' needs (Koerner & Castonguay, 2014). Interestingly, asking clients to identify such events at the end of every session can provide them with an opportunity to reflect on and process their therapeutic experience. For some of them, writing down positive and negative aspects of treatment is an easier way to provide feedback than verbally expressing them (Koerner & Castonguay, 2014). As described by Fernández-Álvarez et al. (2014), a variety of data collected as part of the clinical routine (e.g., notes, video tapes, and assessment measures) can help detect difficulty in the treatment process and provide guidance for modifications of treatment (e.g., adding family therapy, enhancing involvement of client's social support network, and adjusting frequency of sessions).

At a scientific level, some POR studies have provided findings that contribute to our understanding of the process of change. For example, Szapocznik et al. (2014), found that therapist's adherence to theoretically specific components of their family-based treatment for substance-abuse adolescents was associated with higher retention, greater engagement, as well as better outcome in terms of family functioning and substance use in the adolescent clients. In another study conducted with therapists of different theoretical orientations, interventions intended to increase awareness were perceived, by both clients and therapists, as the most helpful events in therapy sessions (Koerner & Castonguay, 2014). From a clinical standpoint, however, what may be the most important "process" benefit of POR is that it can lead to changes in practice. West et al. (2014) have gathered both empirical and anecdotal evidence indicating that the participation in PRN studies led clinicians to not only modify their clinical practice but also disseminate the use of research findings and procedures.

Professional Development

While motivated by the goal of improving the outcome and process of therapy, POR partners themselves gain from their collaboration. At one basic but important level, such partnership allows for the establishment and growth of connections with others—locally, across different parts of a country, or around the world. Both clinicians and researchers described their exchanges with other stakeholders as stimulating and gratifying, as well as supportive and validating (Adelman et al., 2014; Fernández-Álvarez et al., 2014; Garland & Brookman-Frazee, 2014; Koerner & Castonguay, 2014). As described in Garland & Brookman-Frazee (2014), these exchanges can foster reciprocal learning, as with researchers gaining "greater respect for the immediate and often risky clinical challenges therapists faced" and clinicians having "greater appreciation for the rigor of the research process and the ultimate aim of improving care" (p.9).

Also related to professional development, the participation in POR can provide beneficial training experiences, such as learning strategies to improve the therapeutic relationship and work with particular types of clients (e.g., highly resistant), acquisition of skills prescribed by specific orientations (cognitive-behavioral, psychodynamic, humanistic, and systemic), and increase in awareness of one's own personal style and its impact on clients (Adelman et al., 2014; Castonguay et al., 2014; Fernández-Álvarez et al., 2014; Koerner & Castonguay, 2014; Szapocznik et al., 2014; West et al., 2014). Interestingly, such learning opportunities are not only helpful to trainees but also to experienced clinicians;

as Fernández-Álvarez et al. (2014) learned from their research and practice experience, "[t]eaching and training are the most powerful tools for remaining updated, because they demand contact with new developments and improving training methodology in the communication of knowledge." (p. 2)

Various marks of professional recognition can also result from therapists' (as well as researchers and students) engagement in POR, such as publications, conference presentations, research awards, and requests for consultation (Adelman et al., 2014; Koerner & Castonguay, 2014; Szapocznik et al., 2014). In addition to providing a source of quality control, outcome monitoring can also be used by clinicians to increase reimbursement (Koons, O'Rouke, Carter, & Erhardt, 2013). A less public but perhaps more important form of recognition, some therapists have reported having gained credibility in clients' eyes by their association with scientific projects (Koerner & Castonguay, 2014). Another intangible but, nonetheless, important aspect of professional development reported by therapists through a number of POR partnerships is the sense of purpose and pride gained from contributing to the advancement of science and practice (e.g., Castonguay et al., 2014; McAleavey et al., 2014; West et al., 2014). Interestingly, similar feelings have been reported by clients when agreeing to participate in research conducted by their therapists (Castonguay, Nelson et al., 2010).

Organizational Gains

POR benefits are not restricted to individuals, whether these are clients or therapists. Organizations can also make gains in terms of recognition, quality of care, and climate. For example, studies based on outcome monitoring can provide evidence of effectiveness, which can be used by administrators and clinicians to increase clients' positive expectations, referrals from other professionals, and credibility in the eyes of funding agencies (Adelman et al., 2014; Holmqvist et al., 2014; Szapocznik et al., 2014). Within a particular center or service, collection of data can also be used to better understand the needs of clients, as well as to guide the refinement of interventions to better address these needs (Adelman et al., 2014; Holmqvist et al., 2014; McAleavey et al., 2014). As described in Adelman et al. (2014), for instance, the initial use of outcome monitoring in a residential center for adolescents with substance-use problems revealed high levels of violence, both before and at the end of treatment. These unexpected findings led members of the administration and a psychologist to organize the training of the entire clinical staff in a treatment approach specifically targeting anger. Continued outcome monitoring

showed gradual decrease of anger at posttreatment during the training period, as well as the maintenance of this improvement after training.

With the same goal of improving the quality of care, large POR partnerships can also provide means to compare data across sites. For example, in the large PRN infrastructure of university counseling centers described in McAleavey et al. (2014), each site receives benchmarked reports allowing administrators to contrast the pre- and posttreatment scores of the clients they serve with others centers. Both good and bad news revealed by such reports can provide lobbying tools for additional funding and/or policy changes at higher levels of university administration.

In the same way that it can foster interpersonal relationships among individuals that work in different worlds (e.g., private practice and university), POR can also have a positive impact on the culture and climate within an organization (Castonguay et al., 2014; Garland & Brookman-Frazee, 2014). As a case in point, the success that students in a PRN training clinic have had in recruiting their colleagues for their masters or doctoral thesis has both relied on and improved the collaborative attitude that is predominant in many doctoral training programs; an attitude that could be expressed by many statements, including, "Graduate school is hell, but we are in together and we should do what we can to help friends get their degree" (a much more eloquent and well-known statement would be "Un pour tous, tous pour un"! Castonguay et al., 2014, p. 9).

Contributing to Health Care System

POR can, and optimally should, also have an impact at a more global level of mental health services, by providing information about current needs and interventions, as well as by pointing out directions for improvement. For example, outcome data collected within the context of health-care management have been able to predict psychiatric and substance-abuse hospitalizations (Boswell et al., 2014). Considering the costs (for the individuals, their family, and the society) of inpatient treatments, it could be beneficial to use this kind of data to provide targeted, immediate, and more efficient care to those who need them the most. Interestingly, findings obtained in PRN studies have already contributed to important changes at the national level, such as the increase of access and continuity of psychiatric treatment in governmental health programs, and a new policy for assessment and treatment of posttraumatic stress disorder in the US Army (West et al., 2014). Needless to say, PRN could be conducted to study the effectiveness of those social and clinical interventions.

POR findings on the effectiveness and process of psychotherapy in general are also available to inform policy-makers and third-party payers in decisions regarding implementation and reimbursement of mental health services. In the current context of evidence-based practice, the empirical support for the effectiveness of psychotherapy in naturalistic settings (see Castonguay et al., 2013) should give it credence as a high priority form of intervention (Barber, 2009). This recommendation should not be restricted to problems like depression or anxiety. For example, results from a PRN study show that the use of psychotherapy as an evidence-based recommendation has yet to be adequately implemented in the day-to-day treatment of schizophrenia (West et al., 2014). Other large POR studies have reported similar levels of effectiveness between different forms of psychotherapy, including cognitive-behavioral, psychodynamic, and humanistic (see Castonguay et al., 2013). Such data should dissuade decision-makers from emphasizing a limited repertoire of interventions in routine clinical practice (Barber, 2009; Stiles, Barkham, Mellor-Clark, & Connell, 2008). POR findings can also be helpful to assess the actual use of evidence-based interventions in naturalistic settings, as well as to provide directions about how to increase their dissemination, which is one obvious way to facilitate the integration of science and practice in routine care (Garland & Brookman-Frazee, 2014; Koerner & Castonguay, 2014).

Advancing Science

Not only do clinicians (and clients) feel, as we mentioned before, that they are contributing to the advancement of science when they participate in POR, they actually do. Some features of this type of research are rarely found in studies conducted in controlled settings; most noteworthy is the access to extremely large samples of therapists (of various theoretical orientations), clients (with wide range of clinical problems), and varying lengths of therapy. With the use of sophisticated statistical analyses that take into account the nested structure of psychotherapy data, these features offer unique conditions (in terms of statistical power and score variance) to investigate participant and treatment characteristics, as well as process and outcome variables (e.g., Barber, 2009). Because of these distinctive features, and since it has been guided in part by clinicians' interests, POR has led to the much-needed knowledge about underinvestigated treatments (other than cognitive-behavioral), service effects, long-term impact, and cost–benefits of therapy, differential effectiveness of therapists, and training (Castonguay et al., 2014;

Holmqvist et al., 2014; Strauss et al., 2014)— just to name a few of the innovative contributions.

At its most general level, POR can provide two major contributions to the advancement of science. First, because of its particular foci, it can complement more traditional forms of research (e.g., randomized studies in controlled settings) and thus broaden the knowledge base in psychotherapy (Barber, 2009; Barkham & Margison, 2007; Barkham et al., 2010). Second, because some of its findings (with regard to the alliance, for example) are convergent with those obtained in academic settings, POR can increase the strength of this knowledge. As argued elsewhere, when similar effects are cross-validated across different methodologies, each with its own strengths and limitations, we can feel more confident about the veracity and generalizability of these effects (Castonguay, 2013).

In addition to these general contributions to the field, POR can also bring local benefits—benefits that have more to do with the process of science than the content of scientific knowledge. Members of different clinicians–researchers partnerships have reported that their experiences have generated new and better research. Garland and Brookman-Frazee (2014)'s first PRN with disruptive children, for example, has served as the basis for later partnerships on autism. For clinicians in another PRN, one primary benefit of conducting research is learning how to do so (Koerner & Castonguay, 2014).

General Recommendations

The contributors of the present series of papers have also delineated general recommendations to facilitate the collaboration of practitioners and researchers in the conduct and use of research in clinical practice. A number of these have already been integrated in the previous section on fostering strategies. Following are a few others, with some of them, as we will highlight, reflecting overarching guidelines that were previously offered for the future of POR.

Technological Advances

To begin with, technological advances should be relied upon. Electronic health records software, for example, has been found helpful, or at least promising, in the collection of long-term clinical data (McAleavey et al., 2014; West et al., 2014). Electronic technologies can and should be made available by researchers and administrators to provide clinicians with easy and immediate tracking and reporting of outcome monitoring (Boswell et al., 2014; Strauss et al., 2014). Yet, not all aspects of research should mandate the use of sophisticated technology. Boswell

et al. (2014), for instance, suggest that alternative methods of data collection (including paper and pencil options) should be available to therapists depending on their preferences.

Instruments Development

In addition to technological developments, instruments related to outcome monitoring could be refined and expanded upon. Boswell et al. (2014) have recommended that feedback based on client's progress should be benchmarked (and if possible risk adjusted) to identify therapists' strengths and limitations across caseloads or with respect to particular types of clients. They also advise that the same feedback be complemented with clinical support tools that can provide guidelines for therapists on how to address difficulties in clients' lives and/or treatment that could interfere with change. Holmqvist et al. (2014) also suggest that service delivery systems and governmental policies provide access to a set of measures from which therapists could choose particular instruments that are best suited to the needs of individual clients. Such a measurement system, they argued, would operate "at a holistic level akin to the practitioner working with the whole person of the patient rather than with fragmented parts determined by diagnosis and dominated by symptom specific measures" (p. 8).

"Just do it!"

While the recommendations above highlight what researchers (as well as administrators and policymakers) can do to facilitate therapists' engagement in the collection and use of data, several papers in the present series clearly demonstrated that therapists do not have to rely on academic researchers to build their own research programs (Adelman et al., 2014; Fernández-Álvarez et al., 2014; Koerner & Castonguay, 2014). For therapists who have the time and energy to combine clinical and empirical work in their own practice, our suggestion is simple: "Just do it!" Although the complementarity of expertise and resources can be of great value, partnership with academicians is not always feasible—it can unfortunately be difficult and frustrating (see Adelman et al., 2014). Full-time clinicians should thus be aware of both benefits and costs that come along with partnering with people living in the world of academia, and decide for what projects, under what conditions, and to what extent they want or need to collaborate with them. Moreover, past experiences suggest that POR is likely to be successful if it allows flexibility at the level of therapist participation. Time, interest, and expertise of each clinician should dictate whether he/she wants to be involved in only one, some, or all aspects of a study, from the selection of the idea to be investigated, the design and implementation of the protocol, and/or the dissemination of the findings (Koerner & Castonguay, 2014).

Graduate Students

For both the short- and long-term viability of POR, it has also been recommended to gather the help of graduate students. Among the many contributions they can offer, students have resources that most professionals, clinicians, and academicians, are short of: Up-to-date knowledge of methodological and statistical advances and, most precious of all, time and energy (Adelman et al., 2014). For students, POR can provide unique opportunities to be involved in projects (including publications and scientific presentations) that combine clinical relevance with scientific rigor at an early phase of their career. Their participation might thus be an optimal way to achieve one of several overarching recommendations that were recently offered for the future of POR: Begin early (Castonguay et al., 2013). As stated elsewhere, "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" (Castonguay, 2011, p. 135). A research partnership that involves students, clinicians, and academicians can also lead to the creation of a pipeline for both archival and prospective data that cohorts of trainees within a university program could have access to (Adelman et al., 2014). Such pipeline, needless to say, can have long-term benefits for all stakeholders involved, let alone the field of mental health. To actualize this beneficial collaboration, universities should perhaps accept a sense of responsibility toward preparing trainees to collect and use data from clinical routine. As argued by Boswell et al. (2014):

> training programs should instill the value of collecting routine data, on both process and outcome, and using this information to inform case conceptualization and treatment planning (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010). In addition, training faculty would do well to encourage an openness to receiving progress feedback (Boswell & Castonguay, 2007), as well as encourage the use of outcomes data to answer clinically relevant research questions early on in training. (p. 11)

Networks of Networks

Seeking the engagement of students is one form of expansion that has been recommended for the growth

of some partnerships. Another one is the creation of networks of networks (Castonguay, 2011). Irrespective of the clinical setting, small research-practice infrastructures will be confronted with limitations in terms of expertise, knowledge, and resources. In particular, small partnerships can be restricted in their ability to recruit large samples of clients and therapists (e.g., Adelman et al., 2014; Koerner & Castonguay, 2014), which can slow down the collection of required data and/or raise serious concerns with regard to the generalizability of research findings. One recommendation that has been offered to address these important issues is for members of specific partnerships to connect with other similar groups of partners (Castonguay et al., 2014; Koerner & Castonguay, 2014). The idea is for multiple groups of clinicians and researchers to work together in the development of a study, or for one group of partners to design an investigation and then invite therapists from other networks to join their project by implementing the protocol in their own setting. As yet another overarching recommendation for future PRNs, this has been referred elsewhere as: "work locally and collaborate globally" (Castonguay, 2011; Castonguay et al., 2013).

This network of networks is in line with Borkovec's (2002) dream of a large infrastructure of psychology training clinics, all of them linked by a shared basic assessment protocol. Interestingly, this infrastructure could provide an avenue to address a problem of "extinction" frequently observed in graduate research. As noted by Castonguay et al. (2014), many students complete graduate school without having the time and resources to fully pursue the creative research program that they began with their masters and/or dissertations. Referring to this problem as the "dusty piles in the lab" effect, they suggest that a large network of training clinics could serve as a forum of knowledge exchange and long-term collaboration, during and after graduate school.

Worldwide Collaboration

The concept of global collaboration can also be applied to connections among solo practitioners. Koerner and Castonguay (2014) have described a training initiative where clinicians from around the world are provided with expert feedback about single-case experiments to test a wide range of hypotheses and interventions in their own clinical practice. As they noted, "[t]his line of research begins to build a network of therapists and a library of open enrollment research designs and protocols that make it feasible to scale single-case designs to make meaningful contributions to the scientific literature" (p. 4). In addition to offering a perfect example of local action

and global collaboration, this training infrastructure also has the potential of fostering three other overarching recommendations for future POR (Castonguay et al., 2013). First, to be most valuable and sustainable, this type of research should address clinicians' concerns and should be designed, at least in part, based on their observations and expertise. Nothing comes closer to this recommendation than helping practitioners test interventions that they are implementing, or want to implement with their own clients. Second, it should add minimally to, or be as confounded as possible with clinical work. In this case, clinicians are simultaneously applying, learning, or refining both therapeutic and empirical skills, thereby reflecting not only a seamless clinical and research integration, but an epistemological one. Third, POR has to count. Findings obtained from naturalistic settings have to be made known to scholars and decision-makers so that the results can be taken into account in practice, training, and funding guidelines. The first step in making POR count is in dissemination, as when researchers and clinicians work together to create an open library of scientific contributions. One might also say that when they do so, they go further than building bridges between science and practice—a metaphor that suggests that clinicians and researchers live on different banks of a river and maintain connections by importing or exporting knowledge that was independently secured. Instead, by blending together their expertise and resources to directly investigate questions emerging from clinical routine, they are creating new landscapes of knowledge and action (Castonguay, 2013).

Conclusion

Building POR partnerships is for those who dream big (McAleavey et al., 2014), not only because of the amount of work required but also for the ambitious goals they embrace: Fostering rapprochements of minds, integrating research and clinical work, and improving our understanding and practice of the mental health field. In their respective pursuit of these goals, the contributors of the present series have shared their experience about the studies they have conducted, challenges they have faced, strategies they have adopted to tackle these obstacles, and benefits that they and their collaborators have gained. They have also offered general suggestions about future POR.

Additional lessons can be derived from research programs in the field of mental health that have not been represented in this series, such as the process and outcome studies by Jacqueline Persons (e.g., Persons, Roberts, Zalecki, & Brechwald, 2006) and

David Burns (e.g., Burns & Nolen-Hoeksema, 1992) in specialized cognitive therapy centers, as well the work that has been conducted within the Healthy Families America Research Practice Network (Galano & Schellenbach, 2007) on the prevention of child maltreatment (see Castonguay et al., 2013; McMillen, Lenze, Hawley, & Osbourne, 2009). Moreover, much can be learned from partnerships of practitioners and researchers in a wide range of health care and medical fields, including nursing, primary care, pediatrics, and family medicine. Nevertheless, it is hoped that the breadth of contributions and recommendations captured in the papers of this series will provide both encouragement and guidance to clinicians and researchers to conduct and use psychotherapy research in clinical routine.

As part of our attempt to integrate core features of the diverse partnerships presented in this series, we have identified a number of characteristics of successful POR. Optimally, each study or project conducted within such paradigm should be aimed at providing actionable findings, while imposing minimal level of extra work, negative consequences, and drastic changes to clinical practice. We would like to end this paper by offering our thoughts about what will make the whole enterprise of POR successful. In a most basic way, research partnerships in naturalistic settings will be judged as worthwhile, at least in our opinion, if they contribute in the reduction of the problem that we identified in the introduction of this series: The fact that research does not significantly and substantially influence practice (Castonguay & Muran, 2014). The best and most stringent way to achieve this is perhaps for POR to deliver retainable findings. Some partnership initiatives have reported that participation in research has led to changes in practice (e.g., West et al., 2014). However, more efforts will be needed to systematically ensure a feedback loop between the generation of findings and their implementation in the setting where they have been obtained (see Castonguay et al., 2014). Studies should be conducted to inform not only the field in general but also to quickly and meaningfully transform the clinical practice that has been investigated.

While research findings should, optimally, be retainable, this does not imply that they have to become the only source for clinical guidance. Clinical experience, theories, supervision, and training workshops will, as they should, remain crucial sources of influence. For example, as mentioned above, monitoring of outcome data should not be viewed as a way to replace clinical judgment, but instead, it should be used as one of several complementary tools. Similarly, the success of POR as a whole should not rest on clinicians' continued involvement in empirical studies—even those who are members of researchers–practitioners partnerships. While many therapists do seek extra training during their career, most of these experiences are time limited. And while these experiences can allow them to acquire new and usable skills, it is safe to assume that they do not lead therapists to abandon their traditional ways of practicing. The same expectations should be attached to POR. Ideally, collaborative research should be perceived as opportunities that are available to clinicians who, at different times in their career, may want to be engaged in and, as in all learning experiences, might lead to some (but by no mean complete) changes of practice. If these experiences also lead them to be more interested in research and find ways to improve their practice through the use of empirical literature then, in our eyes, POR will have fulfilled its potential.

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