Consensus in Psychotherapy: Are We There Yet?

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In any maturing discipline, consensus is generally viewed as a valuable pursuit. Yet, in psychotherapy, one could argue that little such maturation has occurred despite the field being over 100 years old. The current article first reviews one perspective on consensus introduced in 1980, which focuses on the middle level of theoretical abstraction. Next, we present this conceptualization as a sought-after outcome for psychotherapy practice and research; review progress that has been made toward consensus thus far; and offer potential future directions to further move the discipline toward clinically meaningful consensus. We then outline a way to accelerate consensus by leveraging technologies that can augment intradisciplinary and interdisciplinary professional communication. We conclude by discussing the resulting implications for psychotherapy training.

Public Health Significance Statement
This article outlines ways in which psychotherapy stakeholders can work toward building greater scientific consensus in the field. Most notably, we spotlight the as yet unfulfilled promise of practitioners and researchers operating clinically and empirically at a middle level of theoretical abstraction. We also outline technology-based strategies for fostering new lines of communication across, and rapprochement between, typically siloed areas of the discipline. Capitalizing on such efforts, the field may leave behind a history of division and usher in a new era of a more mature science that embodies an agreed-upon core knowledge base.

Consensus has long been identified as a worthwhile goal for psychotherapy practice and research. Some have argued that what distinguishes more mature sciences from our own is an agreed-upon core, the absence of which leaves us forever laboring at the research frontier with little or no consensual foundation on which to ground our empirical and clinical work (Cole, 1992; Goldfried, 2000). Debate at this research frontier is undeniably an important part of scientific development, but when work at the cutting edge does not lead to consensus, it suggests that we have not yet uncovered truths (Goldfried, 2000; Loewer & Laddaga, 1985). Thus, without an agreed-upon core, the psychotherapy discipline remains

in the earliest stage of scientific development (Kuhn, 1970) and lacks a convincing argument to the patients that we serve.

We would be hard pressed to find a colleague who is not in favor of our discipline maturing beyond this relative stage of infancy, especially for a field that is now well over 100 years old. Yet one can reasonably argue that we have made relatively little progress in this regard, likely owing to several prominent and persistent barriers (see Goldfried, 2019 for thorough discussion of these barriers). As a fledgling science, psychotherapy has been understandably focused on developing diverse ideas. While such expansion and lack of agreement is normative during the initial gestation of a discipline, the resulting proliferation of ideas has left us with an assortment of siloed schools of therapy and name-brand treatment protocols, the notorious and long-standing practice–research gap, and an absence of integration between contributions of the past and present. These barriers have inhibited discipline-wide consensus, thereby hindering the advancement of psychotherapy into a mature science.

In this paper, we first revisit a vision for achieving consensus introduced four decades ago and provide a primer on how it can continue to lead the way today by addressing said barriers (Goldfried, 1980, 2000, 2019). Next, for the distinct but overlapping domains of practice and research, we discuss consensus as an integrative, transtheoretical outcome; the progress we have made

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toward consensus thus far; and where we may need to turn next. We then present our view that one crucial mechanism for bringing about consensus lies in reevaluating how we professionally communicate with our colleagues. Finally, we conclude by discussing the implications of these proposed new directions on the future of psychotherapy training.

A Primer on Consensus at a Middle Level of Abstraction

As noted, it was in 1980 that Goldfried first proposed that consensus might be attained at an intermediate level of abstraction, between overarching *theoretical frameworks* (the highest level of abstraction) and specific *techniques or clinical procedures* (the lowest level of abstraction). This middle level was said to consist of "clinical heuristics that implicitly guide our efforts during the course of therapy," which if backed by enough empirical evidence might become core, and potentially transtheoretical, *principles of change* (Goldfried, 1980, p. 994). To Goldfried, if you can identify principles that clinicians of any theoretical ilk might instinctively draw on, you can be confident that they have survived the many biases, assumptions, and distortions tethered to different theoretical viewpoints. In this vein, such clinical heuristics, or *strategies*, hold promise for universality and a remedy for the contention and division that often inherently occupy the high and low levels of theoretical abstraction.

As originally argued, "holding the conversation" at the level of theoretical orientation makes agreement unlikely because theories of change are often self-contained within distinct frameworks for how problems arise, how they are maintained, and how they might be addressed in therapy (Goldfried, 1980). Likewise, we may predict little consensus when focusing on what techniques a clinician should utilize, as these are often tied to school-specific theories of change. For example, if you are a traditional psychoanalytic therapist who conceptualizes mental health symptoms as a defense against undesirable and unconscious conflicts, then you may be strongly inclined to use interpretations as a technique to facilitate insight into one's unconscious—the theory-specific key ingredient for improvement (Wolitzky, 2020). However, if one solely understands change in this way, it might be difficult to appreciate the value in other possible change mechanisms (e.g., behavioral reinforcement) that may be comparably effective in general and, in some cases, better suited to a given patient. If we center the conversation on clinical strategies, we might expect that some agreement can be attained, for example, regarding the benefits of helping to raise patients' consciousness about problematic patterns that are in need of change.

Shifting the field's focus toward clinical strategies or principles can address the aforementioned barriers and provide an opportunity for consensus in multiple ways. First, given that clinical principles are not "owned" by a single school of therapy, they have the potential to be shared across different orientations. If we posit that all schools of therapy deploy techniques that are manifestations of the same core clinical principles, the significance of owning those ideas becomes moot. Consequently, we can evolve beyond the contributions of a single individual or brand-name orientation with recognition or influence (Goldfried, 2000). That is, the field can move away from "*who* is correct" and more toward "*what* is correct" (Goldfried, 1980, p. 991), with substantive value placed on

compiling and integrating findings over time in the service of establishing a consensual knowledge base "owned" by the entire field.

Second, because it is common for distinct schools of therapy to have their own brand-specific terms for concepts that refer to a similar phenomenon (e.g., decentering, mindfulness, observing ego, reflective functioning), there exists a considerable problem for communication and the accumulation of accessible knowledge. If we operate instead at a middle level of abstraction with a more transtheoretical language system, school-specific and technique-specific contributions might more readily feed into a more universal conversation about an agreed-upon strategic core. Of course, even when operating at the middle level of abstraction, there may still be nuanced differences in how we conceptualize consensus in both clinical practice and research. To address this variability, we now turn to these two domains, respectively.

Consensus in Clinical Practice

To illustrate consensus in clinical practice, we might imagine a discipline-wide focus group that is tasked with finding points of agreement about how to intervene with a hypothetical patient in response to certain clinical conditions. We might also imagine that the focus group members would largely formulate their suggestions on how best to respond based on their preferred theoretical model, on their anecdotal clinical experience, and/or potentially on their exposure to orientation-relevant research findings. Perhaps members of the group would agree on the general platitude that "one size does not fit all," or that some approaches are better suited for certain problems more so than others, but there would likely be little agreement on what those approaches are and which specific techniques should be deployed and when. If the focus group instead sought to identify a pool of core clinical strategies (i.e., at the middle level of abstraction) that could be agreed upon as potential candidates for producing change, the conversation would no longer be dominated by how individual orientations conceptualize the origin of problems and their resolution with specific techniques. Instead, the focus would be placed on articulating underlying, transtheoretical change mechanisms, with contributions to such understanding coming from multiple vantage points and contexts. Even with differing inputs, one could imagine the focus group members agreeing on a case conceptualization and preliminary treatment plan that was theoretically agnostic, but no less (and perhaps even more) compelling, evidence-based, and hope-inspiring. We also might envision that such agreement could serve as a catalyst for future research to provide empirical support for transtheoretical mechanisms of change (Castonguay et al., 2019b).

What Have We Accomplished Thus Far?

We may track the origin of our drive for consensus back to a classic publication, "Some Implicit Common Factors in Diverse Methods of Psychotherapy," in which Rosenzweig (1936) proposed a number of processes (e.g., therapeutic relationship, compelling treatment rationale) to explain why various forms of psychotherapy are able to achieve comparable levels of success, on average. This was one of the earliest documented efforts to look beyond theory-specific explanations of change in order to

understand underlying commonalities across approaches; thus, it was also one of the foundations of psychotherapy integration. In more recent years, we have seen a blossoming of interest in the wider psychotherapy integration movement to counter (or bridge) the historical dominance of single-school therapies (Goldfried et al., 2019), with Rosenzweig's work perhaps most realized in the present-day *common factors* pathway to psychotherapy integration.

And yet, whereas modern common factors theorists have argued on behalf of transtheoretical and transdiagnostic mechanisms of change (e.g., promoting patient motivation and positive expectations, building a strong therapeutic alliance, facilitating corrective experiences; Goldfried, 2019), our discipline has largely not unified around such common principles in the practice of psychotherapy. As just one example, the debate between champions of particular theory-specific treatment techniques and those who advocate for the healing capacity of theory-common therapeutic relationship elements (broadly defined) continues. Moreover, clinical improvement is often still conceptualized through the lens of a particular orientation's theory, with some limited acknowledgement of the contribution of common change processes that are often assumed to be a part of any "good therapy." Unfortunately, this characterization continues to predominate clinical practice, despite a lack of empirical evidence that specific factors largely drive the ameliorative effects of psychotherapy (Wampold & Imel, 2015). Nowhere is this more apparent than in graduate training programs, where the content of one's training is more often influenced by the school of therapy to which one's program or clinical supervisor subscribes than by any discipline-wide agreement on essential elements of practice (Constantino et al., 2017).

Moreover, although "integrative" has become one of the most commonly endorsed orientations by practicing therapists (Norcross & Alexander, 2019), this identification tells us very little about how specific clinicians approach their work. The psychotherapy integration movement as a whole embodies values of flexibility and openness, but it is anything but uniform, as illustrated by the numerous forms of integration described in the latest edition of the *Handbook of Psychotherapy Integration* (Norcross & Goldfried, 2019). In critiquing efforts toward consensus, those who ascribe to a single school of therapy might point to the division among integrationists (e.g., assimilative integration, theoretical integration, technical eclecticism, common factors) as an equally potent impediment to discipline-wide agreement on clinical strategies/principles. Indeed, Goldfried (1980) cautioned against allowing the integration movement to comprise another set of fragmented integrative schools. If achieving consensus for practice would represent a departure from who is right, can we legitimately claim that integrationists have fully left behind the long-standing "horse race?" Is it possible that we have simply recapitulated, through our own multifaceted integration efforts, the very division among single-school therapies we sought to avoid? In actuality, much like the overarching schools of therapy that they draw upon, these seemingly discrete forms of integration also have more areas of commonality than is suggested by their distinct labels. Despite ties to Rosenzweig's (1936) original work, it would seem that the psychotherapy integration movement has not yet been successful in bringing about consensus in clinical practice (at least as we define it here in terms of operating at the unifying middle level of theoretical abstraction).

Where Do We Go From Here?

This continued disagreement in how best to practice psychotherapy suggests that consensus remains in a stage of infancy. Fortunately, the dichotomy between the specific and common factor camps may not be as concrete or as strained as it often seems, as proponents of each side seem to have more points of agreement than is often presumed (Mulder et al., 2017). Surely, in aspiring toward consensus, we might also draw upon the general attitude of collaboration and open-mindedness that is characteristic of the psychotherapy integration movement to reconcile discipline-wide fragmentation.

To address these various forms of division, we propose that consensus in practice may be possible by conceptualizing change through the lens of employing core clinical strategies in response to instances or "markers" of certain clinical conditions/contexts (e.g., declining expectation for good outcomes, alliance ruptures, disengagement from treatment). For instance, if a patient agrees with a therapist's proposal for the session agenda in an unconvincing tone of voice, it may indicate that the patient questions the credibility of the therapist or the treatment approach, or that they have low expectations for how helpful therapy will be. In response, the therapist would want to draw upon consensually derived (and research-informed) strategic guidelines to address this clinically meaningful exchange. Operating by specifying how to respond to frequently occurring situational markers at the middle level of abstraction would both acknowledge the unique contribution of traditional common factors (e.g., promoting therapist credibility and positive patient expectations) and demonstrate how the idiographic, specific factors that are touted by various schools of therapy can be seen as brand-specific instances of more universal clinical strategies (Constantino & Bernecker, 2014). We will return to this issue later in this article when discussing implications for a future model of therapy training.

We argue for a departure from the system in which schools of therapy craft stand-alone narratives about the origin, maintenance, and resolution of problems to inform clinical practice and then look to empirically examine the effectiveness of their presumed theory-specific mechanisms of change. Instead, we need to consider how practice can be informed by findings across the wider research literature that explore transtheoretical clinical responses to markers of common scenarios in therapy. Additionally, we foresee that through clinical observation, practicing clinicians can help to inform researchers of the types of commonly occurring scenarios that necessitate therapist responsivity for which additional empirical investigation on appropriate strategies is needed (Gaines et al., 2021). In essence, this approach to clinical practice would be bottom-up and research-driven, rather than top-down and retrospectively research-supported (Constantino et al., 2013). Such a shift may bring together proponents of various theories, address the often-lamented practice–research gap, and promote unity in our research pursuits (viz., toward elevating theorized core clinical strategies to evidence-based principles of change). We thus envision consensus in the domain of clinical practice as being directly informed by and intertwined with consensus in the domain of research, as we discuss next.

Consensus in Psychotherapy Research

In research, replication denotes scientific agreement. Accordingly, we argue that true research consensus across the psychotherapy discipline would be represented by a collection of generalizable findings that have been thoroughly replicated across the literature and are thus applicable to any practicing psychotherapist. We believe this collection of generalizable findings could be informed by the agreed-upon clinical strategies (deployed in response to commonly occurring clinical scenarios) described previously, once they have accumulated enough empirical evidence to be elevated to principles of change. Moreover, we further believe that the evidence base for these principles of change need not be solely informed by research that explicitly sets out to examine transtheoretical clinical strategies. Indeed, if we shift our perspective to understand previous studies that support the efficacy of school-specific techniques (at the lowest level of abstraction) as methods of implementing core clinical strategies, we can envision how existing research that may seem irrelevant to discussions of consensus can likewise provide support for principles of change. For example, research about the use of thought records (a cognitive–behavioral technique that helps patients to step back and see their problems in a more metacognitive way) can be seen as a reflection of a broader literature on the utility of increasing patient awareness regarding what drives their concerns. It is this transtheoretical evidence base that we feel should imbue the practice of research-informed psychotherapy, rather than only that which corroborates school-specific theories.

What Have We Accomplished Thus Far?

Since the call for consensus four decades ago (Goldfried, 1980), we have seen many psychotherapy researchers place a more concerted effort toward compiling evidence for clinical strategies that have elevated them to empirically confirmed principles of change. For instance, the *Psychotherapy Relationships That Work* volumes, first published by Norcross (2002), were born out of an interest in demonstrating the contributions of transtheoretical and transdiagnostic aspects of the therapeutic relationship, and the responsive adaptation of this relationship, to elucidate "what works in general as well as what works in particular" (Norcross & Lambert, 2019a, p. ix). These volumes are now on their third edition (Norcross & Lambert, 2019b; Norcross & Wampold, 2019) and include no less than 24 chapters with meta-analyses and/or systematic reviews looking across the literature, suggesting some degree of consensus on core principles over the last 20 years. Additionally, in 2006, the North American Chapter of the Society for Psychotherapy Research and Division 12 of the American Psychological Association (APA) created a task force that aimed to identify evidence-based therapeutic change principles across the literature that incorporated the role of the therapeutic relationship, the characteristics of patients themselves, and the use of specific techniques (Castonguay & Beutler, 2006a). The findings of this task force culminated in the publication *Principles of Therapeutic Change That Work* (Castonguay & Beutler, 2006b) and its second edition, *Principles of Change: How Psychotherapists Implement Research in Practice* (Castonguay et al., 2019b), representing a profound effort toward consensus as first envisioned in 1980.

Another development leading us toward consensus at the middle level of abstraction can be seen with Chorpita and colleagues' (2005) distillation and matching model. With much of our empirical evidence organized around demonstrating the efficacy and effectiveness of numerous manualized, name-brand treatment packages (see also Chorpita et al., 2007; Chorpita & Daleiden, 2009), the psychotherapy outcome literature remains fragmented. The idea behind the distillation and matching model is that different treatment manuals may actually include some common strategies, suggesting that the literature on empirically supported treatment protocols could be *distilled* to reduce redundancy and facilitate dissemination and implementation efforts. To this end, the model looks to derive the underlying "practice elements" that treatment packages with demonstrated empirical support tend to draw upon, akin to factor analysis. Once distilled, a therapist can then match their patient to particular clinical strategies contained in treatment protocols that have been shown to be effective with other patients who possess similar demographic, clinical, and contextual characteristics. Accordingly, this model shifts the conversation to the middle level of abstraction and highlights current evidence for clinical strategies, while informing treatment selection and personalization.

Where Do We Go From Here?

The aforementioned progress notwithstanding, much of the research literature continues to remain divided across theoretical orientations and, moreover, is unbalanced across the three major research areas that inform clinical practice: basic research, process research, and outcome research (viz., favoring outcome research; Goldfried & Wolfe, 1996). Focusing on principles of change may address this lack of unity and equity by bringing together seemingly disparate research pursuits.

With the goal of elucidating the origins and maintenance mechanisms of transtheoretical and transdiagnostic (rather than school-specific) psychological problems, we could bring together other areas of psychological research (e.g., clinical, social, developmental, personality, cognitive, biological, etc.) and better connect *basic research* to clinical applications. In particular, basic research could focus on highlighting the key markers of clinical characteristics, processes, or scenarios under which a psychotherapist should responsively draw upon a principle of change. As one example, *existential isolation*—which refers to the experience of feeling that no one will ever understand one's perspective—is a social psychological construct that has lately become of interest to clinical psychologists as they seek to better understand the development, manifestation, and treatment of internalizing problems (e.g., Constantino et al., 2019; Pinel et al., 2015). More specifically, researchers have wondered whether patients may benefit from certain kinds of therapeutic strategies that are intended to foster greater connection (e.g., "I-sharing;" Pinel et al., 2015) when they show signs of existential isolation. Beyond patient processes, basic research can also inform our understanding of therapist processes. For instance, from social psychological research on attribution theory, we may posit that therapists' experience of negative emotion in session results in part from their misattribution of patient behavior to dispositional rather than situational factors (Wolf et al., 2013), a hypothesis worthy of examination in clinical settings. Thus, basic research encompassing the clinical, social, developmental, personality, cognitive, and biological literatures (among others) has the potential to contribute to a

consensual knowledge base with utility for psychotherapy practice. Indeed, at least with respect to future cognitively and biologically informed research, the National Institute of Mental Health's Research Domain Criteria initiative may provide the very funding mechanism needed to support this work (Goldfried, 2019).

With regard to *process research*, the above texts (e.g., Castonguay et al., 2019b; Norcross & Lambert, 2019b; Norcross & Wampold, 2019) are a laudable achievement, but they present predominantly correlational findings, meaning the principles contained therein can only be considered candidate mechanisms of change for the average patient. In order to fully elevate clinical strategies to principles of change, we must move beyond meta-analyses of correlational evidence to instead experimentally test putative change mechanisms. For such principles to have clinical utility for practicing therapists, we must also move beyond what matters for the average patient to understand what in particular works best for whom, and under what clinical conditions certain principles are more or less impactful (i.e., moderators). When we uncover nuance, it should not warrant the demotion of a principle from the status of principle of change, but rather allow us to further qualify the principle to inform therapist responsivity and treatment personalization. For example, transtheoretical meta-analytic evidence supports that insight (or self-understanding or awareness, depending on your preferred terminology) is associated with better outcomes for the average patient (e.g., Jennissen et al., 2018). However, future research may also inform us that some patients find certain types of insight-promoting techniques more beneficial than others, that insight itself is a more potent contributor to outcome for certain patients, or even that certain use insight more therapeutically than others (as has been supported in one study for the therapeutic alliance; Coyne et al., 2021). Thus, potential interactions among demographic, clinical, and contextual characteristics need to be considered when building the evidence base for principles of change. In addition to these future empirical directions, process researchers will also need to further aggregate the existing evidence for principles of change by abstracting common clinical strategies from the literature on theory-specific techniques.

Approaches like the distillation and matching model, which essentially provide a frequency count of effective manuals that reflect common clinical strategies (Chorpita et al., 2005; Chorpita & Daleiden, 2009), may prove useful for leveraging existing *outcome research*. If we see the techniques drawn upon by empirically supported, theory-specific protocols as manifestations of common principles of change, such a model can help to make sense of the scope of the extant outcome literature. Furthermore, given that the distillation and matching model can be used to examine the evidence base for clinical strategies across higher-order interactions of patient demographic, clinical, and contextual characteristics, it may also be useful for highlighting possible clinical strategies in need of further empirical support from process research. As one example, researchers could examine the clinical strategies shown to be effective in manuals tested on older adult patients with anhedonia, and then compare this list of strategies to those shown to be effective for patients with other combinations of characteristics (e.g., college-aged patients with anhedonia). Discrepancies between the lists might point to clinical strategies in need of future investigation with specific populations, or they may inform treatment personalization efforts by helping to formulate

hypotheses about whether certain principles of change work better for some patients or in certain contexts more so than others.

Going forward, we believe psychotherapy researchers need to leave behind the traditional overemphasis on the top-down, school-specific approach to research and adopt more of a bottom-up, data-driven, and patient-centered approach. Although these approaches to research are by no means mutually exclusive, an effective research program needs to draw upon both in order to provide a remedy to the fragmentation that currently characterizes our discipline. Given the historical imbalance between these two approaches, we believe that a more thoughtful shift toward a bottom-up approach would achieve a healthier balance across these research foci, better unify the discipline, and highlight the utility of the research literature for all practicing clinicians, not just those who ascribe to a particular theory that is being examined empirically. As we later discuss, doing so could have major implications for the future of psychotherapy training.

To illustrate what we envision, from clinical observation (Sullivan, 1954) and the accumulation of empirical research (e.g., Constantino et al., 2018), it is evident that patient expectations play an important role in treatment outcomes. In order for therapists to practice in accordance with research-informed psychotherapy, there must be an evidence base of clinical strategies for therapists to draw upon that details how best to respond when patients demonstrate low expectations. Therefore, initially informed by clinical observation, we foresee the field moving toward investigating markers of key clinical conditions (basic research) and flexible, evidence-based therapeutic responses that draw upon transtheoretical principles of change (process and outcome research).

Although therapy-related research has included some of the most fruitful progress in the direction of consensus thus far, it has yet to have a profound impact on changes to practice, research, and training. We believe that this is due, in part, to restricted discipline-wide communication.

Professionally Communicating With Colleagues

In working toward consensus in research and practice, our contributions are filtered by what we have been exposed to, namely through conducting our own clinical and research work within our unique professional communities. When discipline-wide barriers (e.g., division between orientations, practice–research gap) shape these contributions, they influence our ability to communicate with one another—let alone communicate about on what we can agree. Historically, communication barriers have meant that mental health professionals have not spoken the same language or operated in the same spheres. Researchers, as well as clinicians, tend to align with different professional organizations, subscribe to different listservs, attend different theory- or diagnosis-specific conferences, and publish in different theory- or diagnosis-specific journals. This division fosters an in-group/out-group mentality among schools of therapy, which exists alongside the practice–research gap. Researchers have been criticized for decades for ignoring the needs of practicing clinicians, instead directing their work toward the latest funding opportunities (Castonguay et al., 2019a). Therapists who are interested in consuming the research literature may be barred entry to the platforms in which academics often present their findings, especially if they do not have access to peer-reviewed publications. Consequently, psychotherapy researchers and practitioners across schools have essentially spoken *at* one another in different spheres

rather than *with* one another in a shared sphere, hindering progress toward finding common ground.

What Have We Accomplished Thus Far?

To combat these communication challenges, there have been multiple efforts to connect psychotherapy researchers and practitioners of various backgrounds and orientations, foster community, and open up new dialogues (Goldfried, 2019). For instance, the Society for Psychotherapy Research (SPR; https://www.psychotherapyresearch.org) was founded in 1970 to bring together psychotherapy researchers of various theoretical orientations and disseminate research-supported psychotherapy to practitioners. Another high-profile example of such community-building is the Society for the Exploration of Psychotherapy Integration (SEPI; https://www.sepiweb.org), which was founded in 1983 to provide a home not just for academics, but also for practicing clinicians across orientations who are interested in psychotherapy integration. Over the last three and a half decades, SEPI has worked to engage practitioners and researchers of varying schools through the creation of the *Journal of Psychotherapy Integration* (JPI), the quarterly newsletter *The Integrative Therapist*, and a special recurring JPI series—"Practice-Oriented Evidence Reviews."

Additionally, the growth of patient-centered and practice-oriented research in recent years illustrates an attempt to move beyond a history of so-called empirical imperialism, where researchers unidirectionally report their findings to clinicians (Castonguay, 2011). To address the practice–research gap, there has been an increased effort to involve practicing clinicians in both research study design (e.g., practice research networks) and dissemination of findings (Castonguay et al., 2013). With regard to the latter, the latest edition of *Principles of Change: How Psychotherapists Implement Research in Practice* (Castonguay et al., 2019b) gives practicing clinicians a platform to voice how they choose to implement (or when they choose not to use) various principles of change in their work, helping to demystify the clinical applicability of the research literature. In addition, the collaboration of APA's Division 12 and Division 29 in the Two-Way Bridge Between Research & Practice initiative (Goldfried et al., 2014; https://www.stonybrook.edu/commcms/two-way-bridge/) represents an attempt to foster a bidirectional dialogue between researchers and clinicians regarding empirical findings. Namely, this initiative was designed to elicit feedback from practitioners on how empirically supported treatments fair in their work. Through this exchange, practicing clinicians can highlight, for example, the limitations of treatments tested in clinical trials, thereby helping to direct future research and make it more clinically actionable for practicing psychotherapists.

Despite some notable progress, a division nonetheless persists between researchers and clinicians of different schools, inhibiting consensus. Those outwardly interested in finding common ground tend to be the researchers and practitioners who have already shown interest in psychotherapy integration (e.g., SPR and SEPI members). We maintain that obtaining consensus across a discipline with interests as diverse as ours inherently necessitates participation beyond like-minded peers. Accordingly, we believe that existing efforts have not produced consensus because they have failed to consistently engage a wide enough audience to prove

fruitful. Moreover, contributing to consensus requires that one demonstrate a willingness to question one's habits of thought and practice, which are deeply entrenched and difficult to change. When careers depend on receiving recognition for one's ideas and when it is habitual to think in terms of carving out one's niche, it is easy to see how even well-intentioned efforts to bring about unity can devolve into another horse race. Thus, we also believe that the existing work toward consensus reviewed above has fallen short because these efforts have understandably become another arena in which competition outweighs unity, given the clear lack of incentivization for the latter. To resolve these issues, we may need to increase our exposure to other disciplines, clinical schools of thought, and less familiar areas of the literature; expand our professional circles and foster new lines of communication; and engage the next generation of psychotherapy professionals committed to changing the status quo.

Where Do We Go From Here?

We believe the next step toward actualizing consensus in research and practice requires enabling unfettered communication with a shared language in a shared sphere through the creation of an "invisible college" consisting of individuals interested in pursuing a common professional goal (Wagner, 2008). Social media may provide a facilitative platform for realizing this step. Technology-driven applications that allow for consuming novel content and interfacing with broader communities are now ubiquitous. Importantly, the success of online social media and content-dissemination technologies is often predicated on using common, accessible language. Should the psychotherapy discipline choose to prioritize this aim, we are poised to usher in a new era of unencumbered professional exchange by drawing on these instruments of social connectedness.

The utility of online networking platforms has been demonstrated beyond mere leisure activity to encompass scholarly applications, including content sharing, creation, and discussion. Journals and publishing websites now have "share" buttons to allow for seamless circulation of articles via email, Facebook, Twitter, LinkedIn, Reddit, and WeChat. Additionally, smartphone apps like Researcher allow users to easily peruse abstracts and sync peer-reviewed articles of interest to citation manager services (e.g., Zotero, Mendeley) or share them to social media. Content creation and sharing platforms like YouTube and Vimeo present a unique opportunity to disseminate creative educational and training resources that can speak to a broader audience in a user-friendly, digestible format. Psychotherapists have already capitalized on some of these platforms. For example, the "Teaching and Learning Evidence-Based Relationships: Interviews with the Experts" YouTube video accompaniments to the *Psychotherapy Relationships That Work* chapters (Norcross & Lambert, 2019b; Norcross & Wampold, 2019) created by Division 29 of APA allow new audiences to learn about meta-analytic findings directly from the study authors (https://www.societyforpsychotherapy.org/teaching-learning-evidence-based-relationships/). Moreover, we have seen a growth in the demand for and use of video conferencing technologies, online workshops, and webinars to facilitate discourse amidst social distancing guidelines (e.g., *Telepsychotherapy in the Age of COVID-19* and *An Overview of Psychotherapy Integration: History and Current Issues* webinars put on by SEPI; https://www.sepiweb.org/page/webinar_recordings). These resources may improve the flow of

scholarly exchange across traditional impediments by engaging researchers and clinicians in both content and methods of communication they may not otherwise access. Thus, the advantage of such platforms for actualizing consensus lies in their potential to curate novel content, so long as they are used in earnest to increase exposure beyond one's area of expertise. Reaching consensus in psychotherapy will require broadly disseminating different areas of the literature to new audiences and engaging them in a conversation about what constitutes our core.

Beyond content-sharing and creation applications, social media websites can be tools for engaging a wider audience and conversing with those beyond our immediate social and professional circles. For example, there are social platforms (e.g., Research-Gate, Academia.edu) that allow for intra-academic exchange in addition to content sharing, but networking among psychotherapy professionals need not be—and arguably, should not be—confined to these sites. Perhaps the best example of the permeation of social media culture into academia can be seen with the growth of "academic Twitter" as a teaching, learning, networking, and professional development tool (Malik et al., 2019). There are now resources to assist academics with cultivating a presence on Twitter, complete with step-by-step directions for creating threads to discuss recent publications (Quintana, 2020), and there is some preliminary evidence that tweeting is positively associated with dissemination of findings (e.g., h-index; Coret et al., 2020) and subsequent citation of scholarly work (Luc et al., 2021; Quintana & Doan, 2016). The durable impact of this activity on traditional metrics of productivity calls into question the common depiction of social media as a "fleeting" medium for academic exchange (Han, 2021). Furthermore, the increased use of 'altmetrics' (which capture online engagement with scholarly work; Priem, 2010) suggests unique scholarly influence of social media and academic interest in operationalizing such engagement. To see the permeation of social media culture into the academic realm, one only need turn to the latest editions of the *Publication Manual of the American Psychological Association* (American Psychological Association, 2020) and the *AMA Manual of Style* (The JAMA Network Editors, 2019), which include guidance surrounding the citing of tweets, Facebook posts, and YouTube videos (not to mention, they recommend following @APAStyle and @AMAManual on social media platforms).

Although the value of social media for professionals has often been viewed through the lens of self-promotion, academics also report using Twitter for sharing scholarly literature and opening a dialogue with colleagues (Priem & Costello, 2010; Stewart, 2015). Beyond merely curating a feed of the latest work in one's field, "open networks" may prove to be particularly useful for facilitating an exchange across areas of expertise and providing new opportunities for intradisciplinary and interdisciplinary collaboration that may not otherwise occur through traditional means (Collins et al., 2016; Priem & Costello, 2010; Stewart, 2015; Veletsianos, 2012). Of course, given that these platforms are merely tools for fostering connection across traditional barriers, individual users must commit to expanding their social and professional circles in order for such platforms to help bring about progress. Admittedly, without this commitment, it is easy to envision how segregation within psychotherapy camps could be recapitulated across social media. Considering the prominence of these platforms, we will need to explore how best to leverage them to find common ground while mitigating further fragmentation. The next generation of psychotherapy professionals who have grown up with this technology are well-equipped to tackle such a challenge. Although it is likely to represent a difficult-to-comprehend perspective for some (including the second author of this article), it is nonetheless our professional future.

As other fields advocate for the use of these platforms for professional and academic purposes (e.g., Gómez Rivas et al., 2019; Han, 2021; Osterrieder, 2013), perhaps we should more thoughtfully consider the utility of these technologies for the psychotherapy discipline, especially given our history of division. Importantly, one key feature of many social media and content-sharing platforms is that they are free to use by all. This low barrier to entry means that practicing clinicians, who may be particularly interested in fostering communication with other mental health care professionals, can feasibly engage with academics in conversations about our agree-upon core. Free usage has implications for engagement not only among psychotherapy researchers and practitioners (intradisciplinary) and within academia (interdisciplinary), but also beyond professional circles, which some have argued may be an important place for the discipline to turn its attention (e.g., Aafjes-van Doorn, 2017). With the relatively unchecked rise of the antiscience movement on some social media platforms in other fields, interaction with the wider public may be of utmost importance going forward, although such outreach may need to be more adequately incentivized for academics and clinicians (Hotez, 2020). To be sure, patients are already using social media to converse about mental health and psychotherapy, and psychotherapy researchers and practitioners have valuable perspectives to contribute to this conversation.

We argue that work toward consensus in clinical practice and research is particularly well-suited to benefit from the sort of open informational exchange within an invisible college. Much as the rise of the internet has increased our global connectivity, social media platforms can open new dialogues across a wide range of professionals with different orientations, specialties, degrees, and training backgrounds, when such discussions may have previously been limited to annual meetings or existing collaborations. We believe that enabling these new conversations can provide greater unity and communication regarding ongoing work across the discipline, thereby accelerating the timeline for actualizing consensus in practice and research. Although the idea of creating invisible colleges dates back to the 17th century (Wagner, 2008), our current technology has now made it an exciting and most workable reality.

Conclusion

In this article, we have provided an introduction to conceptualizing consensus in the distinct but overlapping domains of psychotherapy practice and research. In practice, we view consensus as the agreement on core clinical strategies that transcend theoretical orientations. In research, we view consensus as the evolving collection of empirically replicated therapeutic change principles. We believe that rooting our work at the middle level of abstraction between theories and techniques of therapy provides the best means for transcending perennial fragmentation between psychotherapy practitioners and researchers across schools that is perpetuated by operating at the levels of theory (highest level of

abstraction) and clinical techniques (lowest level of abstraction). Although there has certainly been progress in this manner, the psychotherapy discipline remains a relatively immature science and practice, no doubt influenced by our continued division and dedication to our own personal and professional interests.

To truly achieve consensus, the field of psychotherapy needs to move toward bottom-up, evidence-driven approaches to psychotherapy practice and research (and all of their complexities), consistent with what Skinner (1950) once argued. Clinical practice need not be influenced predominantly by self-contained, school-specific theory systems. Rather, psychotherapists need to make sense of and thoroughly draw upon the wider research literature (i.e., beyond that which supports their own school), and they can play a crucial role in helping to highlight clinically significant and high-frequency transdiagnostic and transtheoretical phenomena that necessitate therapist responsivity. With such clinical observation, empirical attention by basic, process, and outcome researchers can be directed toward investigating these clinical incidents and studying how best to respond to them as a means of promoting research-informed practice. Even with this progress, however, consensus in the field of psychotherapy will ultimately depend on how we choose to professionally communicate with colleagues as we work toward these goals. Although the landscape of social media will undoubtedly evolve in unpredictable ways, these platforms have the potential for optimizing collaborative interaction. As generations adept at using social media continue to matriculate into the psychotherapy discipline, leveraging these platforms to enhance the flow of information may prove invaluable for developing an invisible college among professionals interested in furthering the field of psychotherapy toward mature-science consensus, as opposed to the division that characterizes fledgling sciences.

As we have previewed, our arguments raise questions about training the next generation of psychotherapists. Taken with growing evidence supporting therapist flexibility (Owen & Hilsenroth, 2014), we believe that an effective, transtheoretical training paradigm must involve teaching therapists to attune to clinically meaningful scenarios and respond to them using evidence-based strategies that draw upon consensually derived principles of change (Gaines et al., 2021). If we expect practice and research to move toward evidence-based, data-driven approaches, there is no question our training practices need to follow suit.

Answering this call, Constantino and colleagues present an "if-then" responsive framework that proposes clinical training and practice be guided by a compendium of research-supported responses to clinically observed markers of key challenges in therapy (Boswell et al., 2020; Constantino et al., 2013; Constantino et al., 2020). Importantly, this is an approach to psychotherapy training and practice that is patient-centered, transdiagnostic and transtheoretical, clinically relevant and observable, and research-driven, subsuming all relevant findings. Moreover, it seeks to compile a collection—and perhaps a taxonomy—of "if" markers of key clinical events that can "then" be addressed using consensual, evidence-based responses. For example, *if* there are signs of decreasing motivation, *then* one should consider implementing an evidence-based, motivation-enhancing intervention. The key would be to learn an armamentarium of consensual, evidence-based responsiveness strategies that are more concerned with effectively addressing common clinical scenarios and meeting patients' personal needs than with adhering to specific brands of treatment. To us, a shift toward a modular, responsive, and transtheoretical training paradigm—accompanied by research evidence, clinical guidelines, and video illustrations—would be revolutionary in its ability to unify divided camps, and it would be poised to inform, as well as benefit from, a movement toward consensus. We direct readers interested in helping the field to adopt transtheoretical, principle-based, and modular training practices to the works of Boswell, Constantino, Eubanks-Carter, and colleagues (e.g., Boswell et al., 2020; Constantino et al., 2013; Constantino et al., 2020; Eubanks-Carter et al., 2015).

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