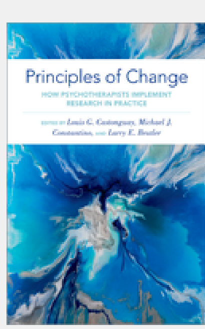

Principles of Change: How Psychotherapists Implement Research in Practice

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Implementing Evidence-Based Principles of Therapeutic Change: A Bidirectional Collaboration between Clinicians and Researchers

Chapter:
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It is well recognized that the links between psychotherapy research and practice are tenuous. This can be attributed, in part, to limited active collaboration and direct communication between researchers and clinicians (Beutler, Williams, Wakefield, & Entwhistle, 1995; Castonguay, Barkham, Lutz, & McAleavey, 2013; McWilliams, 2017). Researchers and practitioners comprise different communities, and their communication pattern largely follows a one-way street (Castonguay, 2011). To avoid perishing, researchers are driven to publish their studies in peer-reviewed scientific journals. Working from the assumption that one function of such journals is to disseminate research results to varied psychotherapy communities, many researchers trust (or at least hope) that clinicians will read these articles and apply the findings to their practice.

However, because of space limitations and an emphasis on methodological details, recommendations about how results can influence practice tend to be brief and unelaborated in most research outlets. Furthermore, because researchers are the ones who, by and large, generate such implications, clinicians may find them as having limited applicability to their practice. Finally, although some data suggest that clinicians find research useful (Beutler et al.,

1995), they also report that empirical journals are not their primary source for guiding their clinical practice (e.g., Cohen, Sargent, & Sechrest, 1986; Morrow-Bradley & Elliott, 1986). This finding holds even for clinicians who also conduct research (Safran, Abreu, Ogilvie, & DeMaria, 2011). Thus, the current system for disseminating and applying evidence to practice remains prone to a wide clinician–researcher chasm.

(p. 4) To address this gap, several efforts have been made to describe how research findings, especially when presented without jargon, can be relevant to day-to-day practice (e.g., Castonguay et al., 2010; Cooper, 2008). Although such efforts likely provide useful information to therapists, they nevertheless represent a type of "empirical imperialism" whereby researchers, who generally treat few clients, try to instruct therapists, who treat many, on issues worthy of scientific attention and on the lessons that can be derived from research findings (Castonguay, 2011). In the extreme, this amounts to researchers telling therapists what they should want to know and what they should do, which is hardly an effective way to reduce the research–practice gap.

This top–down approach to the accumulation and dissemination of research evidence has had negative ramifications for the field. As Garland, Hulburt, and Hawley (2006) argued, "clinicians feel disenfranchised by researchers, believing that research often disregards their realities and invalidates their experience as professionals" (p. 32). This subjective experience of practitioners is not without basis. In a survey of both clinicians and researchers, Beutler et al. (1995) found that clinicians reported research as being important more than researchers reported the clinical literature as being important. By not fully recognizing clinicians' perspectives, the psychotherapy research field may have suffered from developmental delays and/or myopic impairment in its effort to understand and improve therapeutic change. As Kazdin (2008) aptly noted, "we are letting the knowledge from practice drip through the holes of a colander" (p. 155). Far from being intrinsically irreconcilable with research findings, we argue that the ideas and observations of many clinicians about psychotherapy (how change is facilitated or hampered, with whom and by whom) can shed light on how research evidence can best be implemented and on what issues should be studied to increase the effectiveness of psychotherapy. We concur with Beutler et al.: "Scientists may be missing important avenues for identifying critical areas of research. They may do a better scientific job if they were more attentive to the writings and ideas of their clinical colleagues" (pp. 989–990).

Goals of the Book

The present book builds on a previous volume, *Principles of Therapeutic Change that Work* (Castonguay & Beutler, 2006), and represents a new collaboration based on direct, two-way communication between researchers and clinicians that relies on their respective and overlapping knowledge and expertise. To us, this synergy holds promise for increasing our understanding and improving (p. 5) our delivery of psychotherapy. Blending knowledge from these sources, however, requires that we acknowledge that psychotherapy is more complex than applying a standard and sequenced package of interventions to classes of clients, with the assumption that these interventions are, above anything else, the primary factors responsible for therapeutic improvement. This assumption, which underlies the method of studying psychotherapy through randomized clinical trials (RCTs) is dated at best and naïve at worst. Whereas comparative RCTs narrowly privilege the contributions of the client's diagnosis and the therapeutic model, a broader evidence-informed and integrative view of psychotherapy emphasizes client factors beyond diagnoses, therapist factors (including between-therapist effects), dyadic processes, and the need to personalize treatment to individuals and contexts (Constantino, Coyne, & Gomez Penedo, 2017). Guided by such an integrative view, this volume is an attempt to create a new avenue toward evidence-based practice that relies on clinicians as

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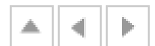
active collaborators, rather than as passive recipients, in understanding and implementing research findings.

Castonguay and Beutler's (2006) first volume integrated, in broad brush strokes, research findings on factors that contribute to client improvement either directly (e.g., predictors) or in interaction (e.g., client trait × treatment effects). Influential psychotherapy scholars worked in teams (most of which comprised researchers of different theoretical orientations) to review research on three variable domains (participant characteristics, relationship variables, technical/intervention factors) as they applied to one particular type of clinical problem (dysphoric disorders, anxiety disorders, personality problems, substance use disorders). In addition, the authors translated the research evidence into principles of change that could serve as helpful clinical guidelines without being tied to particular jargon or theoretical models. The work of these 12 teams led to an aggregated list of 61 principles of change.

Although this initial volume succeeded in delineating change principles that cut across different theoretical orientations, we have since determined that it did not adequately inform clinicians (as stated by a review on amazon.com, as well as in comments made to the editors/authors at various conferences) in how to apply them. Accordingly, we restructured the present follow-up volume. Specifically, we (a) provided detailed descriptions of the ways in which empirically based principles of change might be effectively and efficiently implemented within and across major contemporary psychotherapies, (b) gave a direct voice to practicing clinicians by having them describe how, when, and with whom they apply (or do not apply) these principles in their clinical practice, and (c) sought to provide clinicians and researchers with opportunities to link collaboratively clinical knowledge and the empirical literature.

(p. 6) Structure of the Book



The book contains four major sections. The first section provides a general overview of the book (current chapter) and presents a revised list of the 61 principles of change that were delineated in the first volume (Chapter 2). The second chapter also describes the process that led to the revised list that regroups principles into five conceptually cohesive and clinically relevant clusters: client prognostic principles, treatment/provider moderating principles, client process principles, therapy relationship principles, and therapist interventions principles.

The second and third sections of the book focus on depression and anxiety disorders, respectively. We decided not to have specific sections on personality and substance use disorders (the other two disorders covered in the first volume) because relatively few clients come to treatment primarily for these disorders (at least in most practices). However, we still emphasize these clinical problems in the current volume. Specifically, both sections on depression and anxiety begin with a brief chapter (Chapters 3 and 8, respectively), written by the editors, presenting three cases: one with co-morbid substance abuse, one with co-morbid personality disorder, and one without substance-abuse or personality disorder co-morbidity. The cases also incorporate clinical features frequently associated with depression or anxiety (e.g., marital, occupational, health problems). We created these vignettes to provide a range of clinical situations for practitioners to describe when and how different principles of change may be applicable in their work.

The core of both sections on depression and anxiety are three additional chapters (Chapters 4, 5, and 6, and 9, 10, and 11, respectively) written by the contributing clinicians. The clinicians represent different blends of insight-oriented, or exploratory, and behavior change-oriented approaches. In preparing this book, we decided not to select clinicians representing "pure" forms of therapy, as relatively few therapists define themselves as *exclusively* cognitive-

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behavioral, psychodynamic, humanistic, or systemic. To inform their chapter, the clinicians were provided with the revised list of principles and asked to describe how they might use these principles in their work with each of the three clinical cases in their assigned section (depression or anxiety). As described more fully in the following discussion, we invited the authors to explain in detail how they might apply the principles and to think through (out loud, so to speak) their reasoning behind such implementation (or lack thereof).

The depression and anxiety sections both end with a chapter (Chapters 7 and 12, respectively) co-written by the clinician authors and the editors. The first goal of these chapters is to identify convergences and divergences with (p. 7) respect to how therapists work with empirically based principles. Moreover, these chapters examine therapists' perception of the clinical helpfulness and validity of these principles, as well as their ideas regarding possible combinations of separate principles. Also provided are directions for future research based on principles generated by the clinicians and discrepancies between the current empirical data and some of the therapists' perspectives. Final thoughts are then presented, with an emphasis given to the implications of principles regarding therapist effects (to help understand why some therapists are better than others) and training.

The fourth and final section of the book is a concluding chapter (Chapter 13) written by the editors that summarizes the tasks that were completed, the results that were achieved, and the experience of clinicians and researchers involved in this collaborative project. Suggestions are also offered to enhance our conceptual understanding of principles of change, as well as foster partnerships between clinicians and researchers to examine their validity and impact in day-to-day clinical routine.

Selection of Clinicians

Several criteria guided our selection of the clinical authors who served as proxies for therapists sharing their clinical perspectives and approaches to psychotherapy. First, we invited clinicians who represented a variety of theoretical orientations. To quantify these differences and to ensure diversity, we assessed potential authors' orientation with a brief self-report version of the Therapy Process Rating Scale (TPRS; Kimpara, Regner, Usami, & Beutler, 2015). In addition, the selection criteria included (a) having been trained in accredited graduate or postgraduate mental health programs; (b) having been involved in at least half-time clinical practice for at least two years; (c) recognizing the value of evidence-based and integrative practice, including different types of quantitative and qualitative research; and (d) having previous writing experience, as first author or co-author of professional publications.

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To create a pool of potential authors, we drew on our own knowledge of clinicians and created an advisory board of reputable scholars and/or clinicians in the field. Advisory board members were selected based on the following criteria: (a) being known for their publications on the conduct and/or training of psychotherapy; (b) having trained and supervised many clinicians for several years; (c) having maintained a clinical practice for several years; (d) valuing the contributions of a diversity of theoretical orientations (even if being viewed by many in the field as an influential figure of a particular approach); (p. 8) and (e) recognizing the value not only of evidence-based practice (drawn from both quantitative and qualitative research) but also of other methods of knowledge acquisition. We were fortunate to benefit from the expertise and recommendations of the following advisory board members: Drs. Barry Farber, Charles Gelso, Marvin Goldfried, Gary Groth-Marnat, Laurie Heatherington, Hanna Levenson, Phillip Levendusky, and Heidi Levitt.

Writing Guidelines for the Clinical Chapters

As mentioned, each clinical author was presented with three cases of clients with a primary diagnosis of either depression or anxiety, as well as the list of change principles. As also noted, these principles were clustered in five categories:

1. *Client prognostic principles*: client characteristics that correlate with improvement following treatment.
2. *Client moderating principles:* client characteristics, often present at baseline, that interact with treatment to influence intervention efficacy.
3. *Client process principles:* client during-treatment behaviors that facilitate or interfere with improvement.
4. *Therapy relationship principles:* elements of the client–therapist exchange that facilitate or interfere with improvement.
5. *Therapist intervention principles:* therapist during-treatment behaviors that either facilitate or interfere with improvement.

The main task of the clinical authors was to describe how they may or may not work with these principles if they were to see clients similar to those depicted in their three assigned cases. By consensual decision among the authors and editors, the authors first described their general reactions to the list of principles and their writing task. For example, one author stated that none of the principles are used alone. Another author anticipated that when writing about the principles, he would need to find a way to deal with a tension between his clinical judgment and research results. We believe that these types of gut reactions should be made explicit, as they represent salient knowledge about the clinical relevance of empirically derived principles. We also felt that increasing the authors' awareness of their initial reactions would help them create their own organizational heuristic for discussing the principles vis-à-vis the case material.

(p. 9) Following these introductory self-reflections, the authors wrote a case formulation and a general treatment plan for each of the three cases. For the remainder of the chapter, they described how they would or would not implement the principles. For this primary task, we provided the following general guidelines:

> When describing such implementation, we would like you to write as if you were talking to supervisees and/or colleagues about how you conduct therapy. We do not want you to worry about writing a formal, scholarly paper aimed for a peer-review journal. Rather, we urge you to let the elegance, complexity, richness, and rigor of your thinking emerge naturally from making explicit what is implicit in your mind about clinical work (you may even give a try at talking to a voice recorder, as a way to ease the process of bringing alive

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> your ideas about how psychotherapy unfolds with diverse clients). Relatedly, we do not want extensive references to theoretical or empirical literature. Put bluntly, what we want is readers to have access to expertise, knowledge, and wisdom that YOU have acquired and refined over years of extensive clinical work. This is because one of the main goals of the book is to offer a stage to experienced practitioners whose voices, in our opinion, have not received as much attention as those of theoreticians and researchers.
>
> We want you to describe how you would make the principles work, integrating across all domains covered by the list of principles—client characteristics (prognostic predictors, moderators) and experience during sessions, relationship variables, and technical/intervention factors. Three questions should guide the description of your clinical work. For the client prognostic principles, the question is: “When and how do I intervene with these clients?” For the client process principles, the question is: “How do I foster or deal with this?” For the three other sets of principles, the question is: “When and how do I do this?”
>
> Depending on the therapeutic context, we expect that there are many ways that you implement these principles, or choose not to, and we want to hear as many of them as possible! One of the primary reasons that we provided you with three different cases is precisely to provide you with a range of specific clinical situations to illustrate how and under what circumstances principles can be applied to best address the needs, difficulties, and strengths of particular clients. Thus, to help you show your flexible and attuned use of helpful processes of change, as well as to help you bring to life the empirically derived principles, we would like to you to constantly refer to the cases we’ve provided when answering the questions mentioned above.

(p. 10) In providing instructions to the authors and in editing their chapters, we encouraged them to use writing strategies that they, as individual writers, found to be most fruitful in describing their clinical work. Accordingly, some authors structured the main part of their chapter based on the clinical cases presented to them, describing the implementation of the principles one case at a time. Others chose to structure their chapter using the clusters of principles that we derived, describing the implementation of each principle across three cases simultaneously. Stylistically, some authors depicted their work through a fluid integration of the principles, while others elected to describe the principles separately within each of their respective clusters. We felt that providing a degree of freedom in the structure and narrative style used would help the authors to find their voice and bring the principles to life. We also felt that the readers would enjoy, as we did, the various ways of writing about clinical work.

As a concluding piece of their chapter, the authors briefly stated their experience in writing it. Then, they were asked to complete a few final tasks: To read the chapter written by the other authors in their respective section (depression or anxiety disorders) and identify points of convergences and complementarities across their work, and rate the helpfulness of each of the principles that they referenced (plus a few other principles that were not retained in our list because of insufficient empirical evidence). They were also invited to share thoughts that they might have regarding (a) combining separate principles, (b) implementing others beyond the list, (c) seeing some principles as invalid or unhelpful under certain circumstances, as well as (d) using these empirically based principles to improve training and better understand why some therapists are better than others. These tasks served as the foundation for the concluding chapter for each section.

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Moving Beyond a Bridge between Science and Practice

By retaining and updating a list of empirically based change principles, this book maintains the major contributions of the first volume. Building on this work, the present volume not only illustrates how these guidelines can be implemented in day-to-day practice (as well as within and across theoretical orientations), but it also reflects a unique partnership between researchers and practitioners that goes beyond previous attempts to "bridge" science and practice. As noted elsewhere (Castonguay et al., 2013), "rather than trying to connect science and practice, as if they stand on different river banks, we should strive to confound the two activities in order to create a new, unified landscape of knowledge and action" (p. 122). Having researchers and clinicians working **(p. 11)** together to define and demonstrate how research findings can best improve therapy might be an optimal strategy to build such a landscape.

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