Evidence Based Training Practicum in Context-Responsive Psychotherapy Integration
"CRPI Practicum"

Dr. Constantino will offer in the Psychological Services Center (PSC) an evidenced based training practicum in context responsiveness psychotherapy integration (CRPI) spanning the fall 2013, spring 2014, and summer 2014 semesters. In ongoing development by Dr. Constantino (see Constantino, Boswell, Bernecker, & Castonguay, in press; Constantino, DeGeorge, Dadlani, & Overtree, 2009; Constantino, Overtree, & Bernecker, in press), the CRPI model heeds the psychotherapy research literature, which suggests that common transtheoretical and transdiagnostic treatment factors are instrumental in promoting clinical improvement, likely even more so than theory-specific treatment packages (Duncan, Miller, Wampold, & Hubble, 2010; Norcross, 2011). Common factors in this paradigm are framed as common clinical situations that therapists encounter to which they need to be responsive in some way. Specifically, CRPI proposes an if-then structure for therapists to respond to patients' personal characteristics and emerging clinical scenarios with context-relevant, principle driven, and evidence based therapeutic strategies. Such strategies, and training on them, complement training in a specific, theoretically derived treatment approach; this foundational theoretical orientation provides the coherent conceptual and treatment rationale. The provision of a coherent rationale and rationale consistent-consistent therapeutic actions, which for this practicum will be grounded in *interpersonal reconstructive therapy* (IRT; Benjamin, 2003), have been supported empirically as change ingredients (e.g., Ahmed & Westra, 2009; Frank, 1961); further, a clear treatment rationale lends contextual meaning to common treatment factors (Anderson, Lunnen, & Ogles, 2010), as does the patient's culture, personality, presenting pathology, and so forth.

This practicum will differ from standard clinical teams in several ways. First, the training model will explicitly attempt to confound science and practice; not only will the therapeutic strategies be based on empirical evidence, but practice-based evidence will be generated (and attended to) with each patient being treated. Clinicians, wearing both their researcher and clinician hats, will be constantly guided by the questions: "What is the empirical evidence for what I just did with this patient?" and "How is my patient responding to this treatment?" Second, the weekly "team" meeting will be replaced with intensive trainings, as opposed to informal case discussions; students will be trained first in IRT, during the fall semester, and then in the five common factor responsiveness modules outlined below, starting in the spring semester. (Do note that weekly individual supervision will remain the cornerstone for clinical observation, feedback, and ongoing training.) Third, the practicum will conform to, but also expand on existing PSC procedures, including the collection of expanded clinical data relevant to the modules, and the active use of these data for treatment planning, therapeutic responsiveness, and training effectiveness evaluations. Finally, the practicum will evolve in subsequent iterations based on the advancing extant research base and the clinical outcomes of the cases treated within this practicum structure. The ultimate goal is to maintain a cutting edge training model that reflects a fully integrated clinical and research mission, which embodies the essence of our program's clinical-scientist training model.

The CRPI model currently focuses on five common patient characteristics or treatment processes that therapists need to recognize and to which they need to react clinically, using systematized, flexibly manualized, and empirically tested responsiveness modules. The five modules center on responding to (1) patients' low expectations for change (using expectancy persuasion strategies), (2) therapeutic alliance ruptures (using interpersonal rupture-repair strategies), (3) patient change ambivalence (using motivational interviewing principles), (4) self-strivings (using social psychological interaction principles), and (5) an alarm signal indicating that patient's are "off track" according to predictive analytics (which are superior to clinical judgment) based on Treatment Outcome Package (TOP) assessment and monitoring (using clinical support tools). Dr. Constantino has extensive experience in developing, testing, and applying these modular strategies.