American Psychological Association
Society for the Advancement of Psychotherapy
Psychotherapy

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0033-3204/19/$12.00
2019, Vol. 56, No. 1, 11–15
http://dx.doi.org/10.1037/pst0000200

# Therapist Responsivity to Patients' Early Treatment Beliefs and Psychotherapy Process

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As the conceptualization of evidence-based practice expands beyond the phasic application of treatment manuals for specific mental health diagnoses, greater attention is being paid to treatment personalization, including at its very first steps. One approach to such early personalization involves therapist flexible responsivity to patients' presenting *nondiagnostic* characteristics, such as their treatment-related beliefs, that are known to correlate with treatment outcomes. Such tailoring represents one element of the *context-responsive psychotherapy integration* framework that privileges the therapist's use of evidence-informed strategies in response to specific patient characteristics and contextual process markers (Constantino, Boswell, Bernecker, & Castonguay, 2013). In this article, we map context-responsive psychotherapy integration principles onto a psychotherapy case illustration. Namely, we describe Alice E. Coyne's attempt to navigate responsively a patient's early outcome expectation and treatment credibility perception, both of which revealed the need to change course from an original treatment plan (despite that plan making good sense vis-à-vis the patient's diagnoses and initial positive reaction to the explanation of a specific treatment protocol). In addition, the case illustrates the influence that patient treatment beliefs can have on other early therapeutic processes, such as patient change ambivalence and resistance to the therapy, that also require therapist responsivity in the service of personalization.

***Clinical Impact Statement***
***Question:*** Using clinical case material, this article illustrates the use of the *context-responsive psychotherapy integration* framework to tailor treatment to patients' presenting nondiagnostic treatment-related beliefs. ***Findings:*** This case highlights the importance of therapists using empirically derived strategies for assessing, cultivating, and responding to patients' presenting and early treatment beliefs. ***Meaning:*** Responsivity to patients' treatment beliefs from treatment's outset may represent one component of evidence-informed treatment personalization that can help start therapy off on the "right foot." ***Next Steps:*** Future work should test whether the use of the context-responsive psychotherapy integration framework to facilitate belief cultivation and responsivity early in treatment can improve patient outcomes compared with early treatment-as-usual.

*Keywords:* early therapy process, therapist responsivity, outcome expectation, treatment credibility, clinical practice

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Overarching therapist adherence to a specific treatment manual tends to be unrelated to patient improvement (Webb, DeRubeis, & Barber, 2010). Further, perseverative model adherence specifically in the face of negative therapy process can be harmful (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010). Thus, for many, the conceptualization of evidence-based practice has expanded beyond the standardized application of sequenced treatment packages for specific mental health diagnoses. This expansion inherently challenges the notion that starting therapy on the right foot necessarily involves the straightforward prescription of a treatment approach's first phase. Instead, psychotherapy researchers and practitioners are paying greater attention to evidence-informed treatment *personalization*, including at its very first steps.

One approach to such early personalization involves the therapist being flexibly responsive to patients' presenting *nondiagnostic* characteristics that are known to bear on treatment outcomes. Patients' treatment-related beliefs represent one such class of characteristics, with two beliefs being most robustly predictive of outcome. The first is patients' outcome expectation (OE), or their prognostic belief about the efficacy of a given course of treatment. In a meta-analysis, early patient OE was positively and significantly associated with posttreatment improvement, with a small-to-medium effect ($r = .18$, $d = .36$; Constantino, Vîslă, Coyne, & Boswell, 2018). The second belief is perception of treatment

This article was published Online First January 28, 2019.

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credibility, or the extent to which a patient finds a given treatment to be logical, suitable, and efficacious. In a meta-analysis linking this early belief to posttreatment improvement, there was also a small, but significant positive effect ($r = .12$, $d = .24$; Constantino, Coyne, Boswell, Iles, & Vîslă, 2018).

In light of these results, it seems important for therapists to assess patients' OE and credibility perception, as such information would inform treatment personalization. For example, if a patient is highly optimistic about, and finds credible, a treatment that a therapist presents, then the therapist might do well to follow through on that treatment in a fairly standardized manner. However, if a patient has less optimistic OE, or expresses doubt about a treatment's logicality, then a therapist would likely do well to engage in strategies for increasing positive OE or credibility perception, or even to shift gears toward an adapted or different approach that a patient finds more hope-inspiring or credible. Doing so, including right at treatment's outset, would heed the research on OE and credibility, thereby representing an element of evidence-informed tailoring that squares with a treatment framework termed *context-responsive psychotherapy integration* (CRPI; Constantino et al., 2013).

Briefly, CRPI is a pantheoretical and transdiagnostic *if–then* approach to responding to patient characteristics and commonly occurring clinical process markers with modular, contextually localized, and evidence-based strategies in a way that moves beyond simply starting or continuing treatment as it was initially planned. Thus, according to CRPI, patient beliefs would be the *if* markers to which therapists would need to be responsive with evidence-based *then* strategies. Fortunately, several of such evidence-based strategies have been delineated (Constantino, Coyne, et al., 2018; Constantino, Vîslă, et al., 2018). These strategies come in at least two forms: those intended to *cultivate* more positive beliefs, perhaps especially at treatment's outset, and those intended to help therapists *respond* effectively when beliefs wane during treatment.

Regarding belief cultivation, therapists can first assess patient OE and credibility perception (either verbally or with a brief measure) and possible determinants of these beliefs. For example, therapists can elicit patients' past therapy experiences, understanding that lower satisfaction with previous treatment correlates with less optimistic OE for a current treatment (Constantino, Coyne, McVicar, & Ametrano, 2017). The therapist can then use such information to inform treatment selection and adapt her actions to fit the patient's personal beliefs about what is most likely to be helpful. In addition, therapists can attempt to enhance patient OE and credibility perception by using relatively minimal, but impactful, persuasion strategies when delivering a treatment rationale (e.g., describing a particular treatment as prestigious, supported by research, and broad in its effect). Lastly, it may behoove therapists to customize the language of the treatment rationale to align with a given patient's articulation of their problems, strengths, current state of mind, and self-concept.

Regarding belief responsivity, therapists would do well to assess regularly and attend constantly to patients' OE and credibility perceptions *throughout* treatment, as such beliefs can shift or wane. For example, therapists can check in with patients about aspects of the treatment plan that they no longer find logical and compelling. This would afford therapists an important process opportunity to identify and integrate strategies that the patient does find credible, or to switch the treatment approach more fully. Importantly, effective responsivity also requires attending to subtler process markers of waning treatment beliefs. For example, a patient's diminished OE could manifest as resistance to the direction of the treatment or therapist. When this occurs, therapists should consider pausing the current plan and perhaps engaging in motivational interviewing (MI), a person-centered intervention for which the therapist attempts to address patients' resistance and to foster their intrinsic change motivation by being empathic, evocative, and supportive of patient autonomy (Miller & Rollnick, 2013). Notably, when used specifically to address resistance markers, MI has been shown to improve treatment outcomes beyond treatment without this departure module (Westra, Constantino, & Antony, 2016).

In the remainder of this paper, we present a therapy case that underscores the importance of the therapist assessing and attending to patients' presenting and early treatment beliefs. We then draw on the extant belief literature and the CRPI framework when presenting practical recommendations for how therapists can implement the two primary forms of belief strategies outlined earlier—that is, cultivation of more positive beliefs and flexible responsivity to negative beliefs. For the latter, the case specifically prompted the need to use MI when the patient experienced ambivalence about relinquishing his anxiety and related doubts about the treatment.

## Patient Background and Presenting Problem[1]

"John" was a White, middle-aged man who presented for treatment at an outpatient training clinic at a northeastern university. At the time of treatment, John was living with his wife and children, with whom he described having close relationships, and he had recently returned to school full time to complete his bachelor's degree. Socially, John indicated that he had few close friends and that he spent almost all of his time outside of class at home. John met diagnostic criteria for social anxiety disorder and panic disorder. He also reported a history of depression and substance abuse that were in remission.

## Therapist Information and Theoretical Model

At the time of John's treatment, the therapist was a White, 20-something woman who was a fourth-year clinical trainee (Alice E. Coyne). Throughout treatment, a licensed clinical psychologist led weekly individual and group supervision, which consisted of didactics, case discussion, and video review. The therapist and her supervisor approached this case from a CRPI framework, with the unified protocol (UP; Barlow et al., 2017) serving as the "home" orientation (based on a belief-inspired selection process described in the following text). Namely, the plan was to follow the UP until relevant patient characteristics or clinical process markers indicated the need for therapist responsivity. In such times, the therapist's plan was to use, when possible, evidence-informed interventions designed to address the markers. Therapy began with (a) an assessment of the patient's presenting difficulties, past therapy experiences, and relevant treatment beliefs, and (b) a presentation of the integrative treatment rationale. Although we will focus exclusively on the early phase, treatment lasted 12 sessions, with a mutually agreed upon termination.

[1] Consistent with the American Psychological Association Ethics Code Standard 4.07, Use of Confidential Information for Didactic or Other Purposes, the case material was disguised to be unidentifiable (American Psychological Association, 2010).

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## Therapy Process and Practical Recommendations

### Assessing and Attending to Early Treatment Beliefs

In the first session, the therapist verbally assessed John's treatment beliefs and the potential determinants of them, to which he expressed low OE for the present therapy. Such outcome pessimism appeared to stem, at least in part, from negative experiences in previous therapies. John also revealed that his low OE and doubts about provider or treatment credibility often went unaddressed, which resulted in relationship tensions with previous therapists that in turn prompted premature termination.

Therapist (T): *Can you tell me a little bit about what your previous therapy was like? Were there aspects you found really helpful, or parts that you didn't like?*

Patient (P): *I don't really know. I mean I've gone to a bunch of therapists before, but I don't really know that I'd describe anything as particularly helpful. The last time, I only went a couple of times. Honestly, it just didn't seem like it was going anywhere.*

T: *What about the other times you went? Were any of those helpful?*

P: *It's been kind of the same for all of them. After a while, it's like what's the point?*

T: *So, you would start feeling like therapy was not working and you'd stop going?*

P: *Yeah. I never really said anything. A lot of the time they would make a suggestion or something that just didn't make sense. Like it would make me think that they didn't know what the hell they're doing, and it was not going to work for me.*

T: *I'm really glad you brought that up. You know, it's possible that as we start working together there will be times where you start to feel like that with me. You know, therapy involves a relationship and just like any other relationship, there may be times when we disagree about something or feel like we're not on the same page. I know that it can feel odd or even a bit awkward to bring those things up, but I'd like to really encourage you to do so. It's really helpful for me to know when you're feeling like that so that we can get back on the same page and revise what we're doing so that it's more helpful for you.*

P: *Yeah, I mean, I can see what you're saying about it being a little awkward to talk about it. What you're saying makes sense though. That was part of the problem with what happened before. I didn't want to hurt my therapist's feelings, so I didn't really say anything when things weren't working. It was easier to just stop going.*

T: *Mhmm.*

P: *Actually, it feels better just to be able to tell you that I have some doubts about therapy and whether it's going to actually help me feel better. I mean I've been this way for my whole life, you know? Before I sort of felt like they would just be so positive and tell me that I'm doing great, and that's nice and all, but it made me feel like they didn't really get it.*

John's description of past therapy relationships was consistent with research indicating that pessimism about a treatment's effectiveness can be relationally toxic (Westra, Constantino, & Aviram, 2011), perhaps *especially* when it goes unaddressed. Consistent with CRPI, the therapist responded to this risk factor for negative process by preparing John for possible alliance tensions and inviting an explicit discussion of any future ruptures and the beliefs that might underlie them (Constantino, Vîslă, et al., 2018). After the abovementioned discussion, the therapist persisted in assessing John's previous treatment experiences and their influence on his current forecasts. The therapist also considered both the empirical literature and John's own statement about previous therapists being too "positive," by being careful to not outpace John's current level of hope by promising more improvement than he was ready to accept (Constantino, Vîslă, et al., 2018).

### Cultivation of Credibility Perception and Positive OE

In the same initial session, the therapist also elicited John's own beliefs about the etiology and maintenance of his anxiety. Consistent with CRPI's approach of tailoring treatment to patients' nondiagnostic characteristics, this information was then used to guide the selection of a "home" orientation that matched John's own understanding of, and language around, anxiety and change. This approach is one immediate attempt to cultivate a patient's perception that a given provider and her treatment are credible and suitable. Following treatment selection, the therapist then attempted to cultivate positive OE by using evidence-backed persuasion strategies connected to the selected approach.

P: *I feel like I've spent a lot of time dealing with my childhood. I just do not know that I want to open up that can of worms again. I mean, what's the point? It happened. I cannot change it. Talking about it is probably good and all, but it just makes me feel depressed. It's like, okay I had a tough time as a kid, am I doomed then? Is it always just going to keep coming back to that? At some point I just need to be able to move forward.*

T: *So it sounds like a lot of the work you've done in the past has been focused on your experiences during childhood and how that might be affecting you now, and you're feeling like what's the point of that? How is that helping me move forward?*

P: *Exactly. So, you can see why I'm not so sure about digging into all these issues again.*

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T: *That makes total sense. Now I can see why you were saying before that you were feeling worried about starting therapy again.*

P: *Right, I get that it's probably ultimately good for me to deal with my issues, but I just do not know if I can handle that right now. I'm trying to finish my degree. I do not know if I can handle rehashing a bunch of stuff that I've talked about a million times before. I feel like I've actually gotten a lot better at not letting that stuff affect me, so talking about it just makes me feel like you people think I'm doomed. No offense.* [laughing]

T: *No offense taken* [smiling]. *I'm actually glad that you brought this up. One of the reasons we've spent time discussing your past experiences in therapy is that I take a sort of person-centered approach to treatment. And what I mean by that is that each person is an expert on themselves and every person is different. What might be helpful for one person, might not make sense at all for someone else. So, I absolutely want to hear your beliefs about what might be helpful. There are many effective approaches to treatment. I think that together we can find the right one for you. It sounds like an approach that focuses on the here-and-now rather than your childhood makes sense. I think you also told me that you used to meditate, right? So, I was thinking that an approach that incorporates mindfulness might be a good fit for you.*

P: *Actually, that sounds really good. I've been wanting to get back into meditation for a long time but I just cannot seem to do it. I was also thinking that it would be helpful to learn what strategies are out there for reducing anxiety.*

T: *That's great. One treatment that comes to mind is called the unified protocol. It's a cognitive–behavioral treatment that was created specifically to help people who have multiple anxiety and mood disorders, and it's been shown in research studies that over 70% of people who complete this treatment see broad improvements in their anxiety, depression, and quality of life. It's a skills-based treatment that focuses on the here-and-now rather than on childhood experiences. Mindfulness is a key aspect in the strategies you'll be learning for reducing your anxiety, so I think that we'll be able to build on many of the skills you already have. Does it seem like something that could be helpful for you?*

When delivering the UP rationale, the therapist used a number of the aforementioned persuasion strategies, that is, providing a nontechnical review of the research support, describing the treatment as broad in its focus and effects, and describing why the UP seemed especially well-suited for John based on both the problems he was experiencing and his personal strengths. These tactics appeared to be effective; John stated that the approach "really made sense" to him, suggesting a strong perception of treatment credibility. He also expressed feeling "hopeful" that this approach could finally help him feel better. Accordingly, in the next session, the therapist started the UP, with the first session focused on psychoeducation, goal-setting, and using MI strategies to increase intrinsic motivation for change (Barlow et al., 2017).

## Therapist Responsivity to Waning OE and Treatment Credibility Beliefs

Following the first UP session, John initially expressed a strong desire to "jump right in" and learn anxiety-focused coping skills. However, soon after the therapist began implementing such strategies, John expressed both doubts about treatment, first indirectly and then more explicitly, and related ambivalence about letting go of his anxiety (which he saw as possessing some positive aspects). Following the CRPI model, when John exhibited these markers of diminished hope, change ambivalence, and related treatment resistance (all "if" contexts), the therapist shifted out of the UP and into the evidence-informed "then" strategy of MI—a localized module that can help address change ambivalence/resistance and restore more positive treatment beliefs.

P: *I thought that I should tell you, I stopped that new diet I was on this week.*

T: *Oh, I'm surprised to hear you say that. Last week you told me you were feeling like eating a healthy diet was helping you feel better and you seemed really excited about it.*

P: *Yeah. It's just that I've been thinking that maybe it's not the right time for me to start it. I've got a lot going on with the semester and all that. I'm barely hanging on as it is.*

T: *It sounds like you're feeling really overwhelmed right now and you're wondering if trying to make changes will be way too much.*

P: *Yeah.*

T: *I'm wondering if you're also questioning whether now is the right time to be in therapy.*

P: *No, I wouldn't say that. This is more important than my diet. Maybe we should just talk about the things you had planned for today* [gestures to the worksheets sitting on the table]. *You said that there are strategies that help people be less anxious. I want to get to that, or I just do not see how this is going to be helpful.*

T: *We certainly can talk about strategies for managing anxiety, but I'm wondering if I'd be missing something important about how you're feeling right now. It sounds like you're having some doubts about how helpful treatment will be. You told me that you've noticed that in the past you stopped going to therapy after a couple sessions because it doesn't feel helpful, so I'm wondering if you might be having those concerns now.*

P: [sighs] *I mean, yeah. I guess I've just been thinking that maybe this isn't the right time for me to be here. I mean, you've seen me. I'm crazy now. What will I be like if I try to do all of this new stuff? Maybe I should just try to get through the semester.*

T: *So, it sounds like you're feeling really stuck because you're worried that you might fall apart if you try to make changes in your life now when you're already so busy.*

P: *Yes, exactly. I feel like if I keep going the way I have been, I can probably tough it out and get through the semester without dying. Then I can worry about my health after the semester is over when I have more time.*

T: *Right. I know that getting through the semester is really important to you, so it makes sense that that's your priority right now and that you're reluctant to do anything that might mess that up.*

P: *Yeah. . . I know myself. If I do not hold myself to high standards, pretty soon I'll be down at the bar drinking.*

T: *Okay, can you tell me what you mean by holding yourself to high standards?*

P: *I guess it's like, if I do not constantly stay on top of everything, then everything just completely falls apart. I have to stay on my guard, or I just let everything go and I know what that looks like. I've been there before in my life.*

This vignette highlights the importance of therapist responsivity to subtle markers of diminished hope (in this case, John sharing that he had quit his diet due to a belief that it would not work) and change ambivalence (John expressing a belief that he might fall apart if he tried to change). Although the therapist initially saw the UP as a good match based on her assessment of John's treatment history and beliefs, it ultimately appeared to be more of an *intellectual* versus *emotional* match. That is, the generic notion of here-and-now, change-oriented focus may have made good conceptual sense to John; however, when he encountered the corresponding strategies, there was a misalignment between the UP and John's ambivalence about leaving what is familiar during a time of high school stress (and perhaps about letting go of positive aspects of his anxiety *at any time*). In short, the UP became threatening to John's own sense of helpful change or change pace, which in turn prompted waning belief in treatment efficacy or credibility.

Recognizing this, the therapist drew on the CRPI framework to depart from the UP (at least temporarily), and instead shift to MI strategies known empirically to have a greater chance of promoting change vis-à-vis ambivalence, resistance, and pessimism about the current approach. In this case, the therapist got alongside the resistance and "rolled with it." Instead of doubling her efforts to tout the UP, she supported the patient's autonomy to change or not. This departure seemed to represent a now responsive personalization that led to the patient arguing for his own change, with treatment then taking the shape of a more generic cognitive-behavioral therapy integrated with person-centered principles that ultimately led to clinically significant change in fairly short order (again, the therapy lasted 12 total sessions).

## Conclusions

This case highlights the importance of responding to patients' nondiagnostic treatment beliefs as one evidence-based strategy for starting therapy off on the personalized right foot (DeFife & Hilsenroth, 2011). Such personalization can involve treatment selection that heeds a given patient's OE and credibility perception. It can also involve tailoring "on the fly," either in the form of straightforward attempts to cultivate more positive beliefs or via complex and necessarily bidirectional navigation of intersecting beliefs, motivations, and processes as treatment unfolds. Whatever the pathway, beliefs appear to be at the center of getting off on the right foot *and* indicating when to swift to the "left" foot.

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Received July 28, 2018
Accepted September 17, 2018 ■

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