

## **Synergy Among Research, Practice, and Training in Psychotherapy: An Introduction to the Work of Mikael Thastum and His Students at Aarhus University, Denmark**

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### **ABSTRACT**

While the nature of research, practice, and training in psychotherapy makes it possible for them to be synergistic in advancing best practice and continuous improvement in the field, this potential is just beginning to be mined. In this process, the systematic case study has important roles to play since it captures and analyzes the contextually complex, qualitative and quantitative data that constitute the basic phenomena of the field. This article briefly reviews the dynamics of the research-practice-training synergy and illustrates how they are embodied in the work of Dr. Mikael Thastum at The Anxiety Disorder Clinic for Children and Adolescents (TADCCA) of Aarhus University. As a second example of this synergy and as a comparison to Thastum's Clinic, the parallel work of Brian Chu at the Youth and Depression Clinic (YAD-C) at Rutgers University is reviewed.

*Key words:* synergy in psychotherapy; psychotherapy research; psychotherapy practice; psychotherapy training; cognitive behavior therapy (CBT); youth CBT; case studies; clinical case studies

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It would seem self-evident that there should be synergy among psychotherapy research, practice, and training. Research helps to identify and document "best practice" principles and procedures; practice is most effective when it incorporates these; and training is most effective when the didactics taught to trainees and their clinical practicum experiences are based on the best practices identified with research.

In this context, the systematic case study has important roles to play. First, it's important to note that psychotherapy practice always takes place within the contextual complexities of the individual case. Thus, identifying and richly documenting—both qualitatively and quantitatively—best practice cases is important from a research point of view in identifying the mechanisms and pragmatics leading to good versus poor outcomes in naturalistic, real-world settings. Second, the creation of systematic case studies of best practice can provide guidelines for how practitioners should conduct therapy. Third, systematic case studies can provide explicit models in the clinical training of students who are learning to conduct therapy. Fourth, by learning how to design and write systematic case studies on their own and others' work, students

can enhance their learning by reflecting on and critically analyzing their own clinical work and that of others. And finally, by learning how to write systematic case studies, students are learning a research method that is growing in prominence and popularity (Dattilio, Edwards, & Fishman, 2010; Fishman, 2005; Fishman, 2011; Gelso, Baumann, Chui, & Savelle, 2013; Goldman, Watson, & Greenberg, 2011; Hersen, 2002; Hilsenroth, 2013).

A psychotherapy training program located in the graduate clinical or counseling psychology program of a university would seem to be an ideal setting in which to develop the research-practice-training synergy, since universities are devoted to research and training, and they typically have training clinics that serve the community. However, frequently the research they conduct is limited to the conduct of quantitative group designs, such as randomized clinical trials, and a case focus is reserved for clinical training only. In this arrangement, the impact of the research on clinical training is indirect, providing, at best, therapy manuals that emerge from the clinical trials, but not the qualitative knowledge of how to adapt a manualized approach to the individual case.

Fortunately, there appears to be a growing interest in developing training programs with a research-practice-training synergy. An example at my own university training program, the Graduate School of Applied and Professional Psychology at Rutgers University, is the Youth Anxiety and Depression Clinic (YAD-C), developed and directed by my colleague, Dr. Brian Chu. YAD-C draws from and contributes to the research literature to offer cognitive-behavior therapy (CBT) to youth and their parents in the community. The therapy is provided by graduate students who have received didactic training both in the theoretical foundations of CBT and in the application of CBT to assessing and treating children and adolescents. (For details on the structure and operation of the YAD-C, see Chu, 2009.)

As an example, one of YAD-C programs specializes in anxious youth and their parents, offering the "Coping Cat" protocol (Kendall & Hedtke, 2006), a 16-20 week CBT intervention which emphasizes affective, cognitive, and exposure-based exercises and which is evidence-based. The Coping Cat therapy is clinically conducted by doctoral graduate students with individual clients in the community under the careful individual supervision of Chu and other senior clinical faculty who specialize in child anxiety. At the same time, a systematic battery of standardized quantitative measures is collected on each client over the course of therapy, and monitoring procedures ensure that the Coping Cat therapy is conducted with fidelity to the manual, so that group quantitative studies can be conducted by collating data across the individual cases. For example, Chu and his students (Chu, Skriner, & Zandberg, 2013) just published an article titled, "Shape of Change in Cognitive Behavioral Therapy for Youth Anxiety: Symptom Trajectory and Predictors of Change." This study included 55 of the Coping Cat cases and their parents and looks at three multilevel growth models in predicting the course of symptom change over time, including "a cubic curve, a log-linear curve plus an exposure covariate, and a linear curve plus exposure covariate" (p. 1). Chu and his students found that by examining the course of symptom change over time for the group, the cubic model best represented the typical growth curve of CBT for anxious youth. They generally concluded that their findings "suggest that the symptom course of CBT, and the effect of between-youth factors on treatment outcomes, is more complex than previously thought. Educating therapists and

clients about findings can aid treatment expectations and dissemination efforts of empirically supported treatments" (p. 1). (For a study that uses the YAD-C data on the Coping Cat cases in a similar manner by doing a trajectory and predictor study of alliance in CBT for youth anxiety, see Chu, Skriner, & Zandberg, 2013)

In addition, the YAD-C clinic serves as an incubator of new approaches, which are then systematically pilot-tested through case studies. For example, Chu and his students created a transdiagnostic Group Behavioral Activation Therapy (GBAT) for anxious and depressed youth (Chu, Colognori, Weisman, & Bannon, 2009). The protocol is designed to "adapt reconceptualized behavioral activation (e.g., Jacobson, Martell, & Dimidjian, 2001) to a group format suitable for young adolescents, plus add a powerful exposure component to accommodate anxiety-related problems" (Chu et al., 2009, p. 408). et al., pilot-tested GBAT by co-leading with one of the advanced clinical psychology doctoral students in the YAD-C a group of five 7th and 8th grade students diagnosed with anxiety and/or depression. The group meetings consisted of 13 weekly sessions confined to the length of a regular academic class period that occurred during the school day, and were held in a group-meeting room housed within the school counseling office.

The write-up of the pilot test (Chu et al., 2009) follows the general format of the disciplined inquiry model (Peterson, 1991; Fishman, 2005) that underlies the systematic case studies in this *PCSP* journal. Specifically, Chu's case study includes the theoretical guiding conception behind GBAT, its research support, and a qualitative and quantitative description of the process and outcome of the therapy with the five individual clients. The write-up also provides data on standardized, child-completed and parent-completed quantitative measures at pre- and post-treatment for each youth and for the group as a whole. These results showed clinically reliable change statistics (Jacobson & Truax, 1991) for three of the five clients (one client did not show change and the other client did not complete post-treatment data). (For the importance of documenting both good-outcome and poor-outcome cases, see Dattilio, Edwards, & Fishman, 2010; Fishman, 2011; Goldman, 2011.)

As mentioned, the write-up provides qualitative descriptions of the nature and course of therapy for each of the five group participants and their parents, including information on the viability of conducting such a group within a naturalistic school setting. In this way, the write-up not only provides (a) a description of the GBAT protocol and standardized quantitative data on the outcomes it can achieve—the type of data needed for determining whether a therapy can be considered by the American Psychological Association as a research-based psychological treatment (see <http://www.psychologicaltreatments.org/>)—but also (b) narrative descriptions of the course of therapy that can help to guide both trainees and established practitioners in adapting the GBAT protocol to different types of clients. As an important follow-up to the pilot case study, the data collected—both quantitative and qualitative—were useful in initiating a wait-list controlled clinical trial of 35 youth in the schools, with 21 assigned to GBAT and 14 to the waitlist. Good diagnostic outcome results have been obtained from this study and it has been submitted for publication (Chu et al., 2013).

As a final note on Chu's work, it is important to reiterate that in each of the two illustrative projects mentioned—the group data "growth curves" study and the GBAT case study—the research data involved included structured clinical training cases conducted by graduate students in naturalistic settings, with supervision and/or modeling through co-leading by Chu as a senior clinician. This structure—which is also contained in the work of Dr. Mikael Thastum, as described below—shows a particular way in which clinical training and psychotherapy research can be synergistic.

### **THE ANXIETY DISORDERS CLINIC FOR CHILDREN AND ADOLESCENTS (TADCCA) AT AARHUS UNIVERSITY IN DENMARK**

This issue of *PCSP* presents an in-depth look at the work at the TADCCA Clinic, which is in the Department of Psychology at Aarhus University in Aarhus, Denmark, directed by the senior clinical psychologist, Dr. Mikael Thastum. Like YADC, TADCCA offers an excellent example of achieving synergy among psychotherapy research, practice, and training. The students involved are primarily masters-level trainees learning to be CBT therapists with children and adolescents. In addition, a few of the members of the TADCCA team are doctoral and post-doctoral students who aid the director, Thastum, in conducting the administrative, clinical and research work of the Clinic.

Thastum and this staff at the Clinic provide group-based CBT therapy to anxious youth and their parents along with collecting large amounts of standardized and other quantitative data, which serve two functions: clinical monitoring and research on the process and outcome of the therapy. The CBT model they use is Rapee's "Cool Kids" program (Rapee, Wignall, Hudson, & Scniering, 2000).

To understand how research, practice, and training are integrated in the TADCCA Clinic, it is helpful to understand the content and structure of the Cool Kids program (see Lundkvist-Houndoumadi & Thastum, 2013a, for more details). The program involves three types of groups: families and children together; children alone; and families alone. The content of these groups involves (a) teaching the children such concepts and skills as cognitive restructuring (called "detective thinking"); self-reward; building hierarchies of anxiety-arousing situations, creating opportunities to be exposed to them, and worry surfing; assertiveness training; and problem-solving skills; (b) teaching the parents the concepts and skills the children are learning; and (c) teaching the parents child management skills. Follow-up interviews are conducted 3 months and 15 months after the conclusion of treatment. Extensive quantitative assessment data—on both standardized and nonstandardized measures—are collected at the beginning of therapy, at each session, and at the two follow-up points.

Each of nine therapy sessions (there is an additional therapy session that consists of a individual family home visit) involves six child clients and their parents; six student therapists, each assigned to one of the families, plus two additional student therapists; a senior psychologist; and the Clinic Director (Thastum). While before participating in the therapy group, the students have had extensive didactic work on topics like CBT, child development, and child psychopathology, the group therapy is generally their first clinical experience. The structure of

the nine therapy sessions is as follows, using a combination of group and individual work and proceeding along the following steps.

1. The families gather in one room and each family speaks with the student therapist assigned to them about what they had accomplished during the previous week, as well as possible problems they may have had while implementing the homework.
2. The senior psychologist and Clinic Director introduce the goal for the overall session. The children and the eight student therapists go to another room, where the psychologist presents the content of each session, such as the "detective thinking" and "stepladder" skills mentioned above, based on the manual of the Cool Kids Program and using the workbook of the Cool Kids program each child has as a supplement.
3. The psychologist and six of the student therapists assigned to a particular family return to the group of parents, while the two additional student therapists stay behind and play with the children. Parents are informed about the principles that had been presented to the children and are taught alternate ways of interacting with their children, using the parent's workbook of the Cool Kids Program.
4. The children and the two additional student therapists come into the room and sit with their parents and the student therapists. Children tell their parents what they have learned. Along with the parents and student therapists, the children help decide on the assignments for the following week.

Within this structure, the student therapists are engaged in six roles:

- (a) collecting the extensive *assessment* data needed for clinical documentation, clinical monitoring, and the research;
- (b) having their first *clinical exposure* to clients in a setting that is both clinically rich and well supervised, with expert models (see below) demonstrating best practice;
- (c) conducting *individual therapeutic work* with the families;
- (d) conducting *group therapeutic work* with the children;
- (e) observing *expert professional models* (the senior psychologist and Clinic Director) as they work with the parents and the families;
- (f) participating in *clinical supervision* after each therapy session; and
- (g) writing a *systematic case study* on one of the children in the group, thus learning clinical and research report-writing skills.

As seen, the students' research, practice, and training roles are intertwined: the students learn assessment and therapy (a-d) while contributing to the research done on the groups by

conducting the assessments and participating in providing the therapy. At the same time the quality of the therapy is maintained by having clinical experts participate (b & e), and these experts also provide learning models for the students. In addition, the students' learning and the clinical quality control are maintained through supervision by the clinical experts (f). Finally, the students learn to write systematic case studies (g), which contribute to the research (Dattilio, Edwards, & Fishman, 2010).

These synergistic aspects of the TADCCA's activities are reflected in the work of the Ms. Irene Lundkvist-Houndoumadi, senior author of the two case studies in this issue. Lundkvist-Houndoumadi was a first year student in the TADCCA program when they conducted their first group, and her client in the group was Erik, about whom she wrote a systematic case study. This case study was adapted and edited for publication as the first case study in this *PCSP* issue (Lundkvist-Houndoumadi & Thastum, 2013a). During her second year Lundkvist-Houndoumadi analyzed and wrote up an embedded case study of all six of the clients in the first group as her masters thesis. An adapted and shortened version constitutes the second, "responders versus nonresponders" case study in this *PCSP* issue (Lundkvist-Houndoumadi & Thastum, 2013b).

As described by Thastum (2013) in the first article in this issue, which provides much more detail about TADCCA, after Erik's group and a number of subsequent groups were run, Thastum obtained funds to run a large randomized clinical trial of 110 participants, with half acting as a 3-month, waiting list control. Part of his trial involves individual follow-up therapy with an individualized treatment plan for those 20% or so of cases who—based on past groups—are expected to show a limited or lack of response to the Cool Kids group. Systematic case studies are planned for each of these cases. Lundkvist-Houndoumadi's doctoral dissertation will consist of a study of the non-responders, both quantitatively and in terms of selected systematic case studies.

## **CREATING A "RESEARCH TRAINING ENVIRONMENT" (RTE)**

In a just published article, Gelso and colleagues (Gelso, Baumann, Chui, & Savelle, 2013) discuss the nature of student attitudes in doctoral clinical programs that educate psychotherapists. Typically, "psychotherapy is the draw" (p. 139), and the students naturally increase their positive attitudes towards it as they progress through training. On the other hand, entering graduate students typically are ambivalent in their attitudes and feelings towards the role of research and science in their careers. Gelso et al. have thus developed a model of the "research training environment" (RTE) that can enhance positive attitudes and involvement with research and science in students' subsequent work, be it in conducting research and/or in engaging in practice that is informed by the latest research. Gelso et al. have identified 10 ingredients of an ideal RTE. Six of these are intrinsically designed into programs like Chu's YAD-C and Thastum's TADCCA, and a number of them highlight the integration of research, practice, and training. They include:

- "faculty modeling of scientific behavior,"
- "early and minimally threatening involvement in research,"
- "emphasizing science as a partly social-interpersonal experience [e.g., by having clinical work as part of research projects],"
- "the wedding of science and practice,"
- "relevant statistics and the logic of design [e.g., the use of standardized quantitative measures in systematic case studies and their statistical analysis by such measures as the Reliable Change Index (Jacobson & Truax, 1991)]," and
- "teaching how research can be done in practice settings" (Gelso et al., 2013, pp. 141-144).

Before closing, it is important to note that even though the Chu and Thastum clinics focus on CBT with youth anxiety, the logic of their programs apply across theoretical orientation, client age, and presenting problems. This logic involves using faculty to model and supervise clinical practice as new psychotherapists are trained by following structured assessment and therapy models in working with clients—clients who constitute the subjects in research projects, both at the systematic case study level and/or at the quantitative group data level.

The articles to follow by Thastum and Lundkvist-Houndoumadi in this issue of *PCSP* provide details of both the structural context and setting in which their synergy of research, practice, and training take place, and details of the systematic case studies that emerge from this setting. Overall, clinics like Chu's and Thastum's provide attractive models for other training programs striving to create positive RTEs and to contribute simultaneously to high quality training, effective practice, and best-practice training of psychology graduate students.

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