

Should we teach common factors or specific techniques? Why not both?

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The Early Participants in the Debate

- Those who argue for Treatments That Work (Division 12; Nathan & Gorman, 1998; 2002; Chambless & Crits-Christoph, 2005)
- Those that argue for Relationships that work (Division 29; Norcross, 2002; Norcross & Lambert, 2005)
- Those who argue for Participant Factors that work (Bohart, 2005; Wampold, 2001; 2005)

Recognized False Dichotomies

- "It is important to note that the effective practice of evidence-based psychotherapy involves more than the mastery of specific procedures outlined in EST manuals. Almost all ESTs rely on therapists' having good nonspecific therapy skills" Chambless & Ollendick (2001)
 - therapists' competence
 - client's ability to form an alliance
 - client's initial functioning
 - interaction of client characteristics and treatment approaches

Recognized False Dichotomies

- "The therapeutic relationship acts in concert with discrete interventions, patient characteristics, and clinician qualities in determining treatment effectiveness. A comprehensive understanding of effective (and ineffective) psychotherapy will consider all of these determinants and their optimal combinations" (Norcross, 2002)

An Alternative, Integrative Position

- **Division 12 (APA) and North American Society for Psychotherapy Research Joint Task Force on Identifying Therapeutic Principles that Work.**

– Castonguay, L. G., & Beutler, L. E. (Eds)(2005). *Principles of Therapeutic Change that Work*. New York: Oxford University Press.

Mission of Joint Task Force

- To integrate participant, relationship, and treatment factors and consolidate them into working principles that are grounded in research.

Strategy of Joint Task Force

To extract from previous Task Force Reports on Relationship Factors and Treatments that work, common and specific principles of treatment that are “empirically-informed”.

Composition of Task Force

- 24 Senior Scholars who were “assigned” in pairs to work with one another, based on having variable and contrasting viewpoints.
- 21 Associated Scholars picked by chapter authors to assist in the literature reviews and writing.

Task Force Structure

	PD	Dysph	Subs	Anx
Partici-Pants				
Relation-Ships				
Techniques				

Procedure

- Review extant literature cited in relevant chapters of Division 12 and Division 29 task force reports and the *Handbook of Psychotherapy and Behavior Change*, 1994 and 2004 editions
- Summarize results for studies relevant to a specific disorder
- Extract principles that are supported by a “preponderance of evidence”

Seeking Consensus

- Meeting of representatives of all chapters – June, 2003.
 - Common Principles—those that cut across disorders, within a variable domain
 - Unique Principles—The remaining principles that are specific to one disorder, representing each domain (participants, relationships, treatment techniques/models)

Summary of Results

- 26 “Common” and 35 “Unique” Principles
 - Participant Principles
 - 16 on Observed and 12 on Inferred Qualities
 - 5 Common and 23 Unique
 - Relationship Principles
 - 9 Common and 2 Unique Principles
 - Treatment Principles
 - 12 Common and 10 Unique

Conclusions

- When properly applied, principles of change will allow clinicians to operate research-informed practices, to enhance their ability to serve a wider range of patients, and to use an eclectic array of empirically based clinical methods.

Therapeutic principles of change in the treatment of depression.

PRINCIPLES REGARDING PATIENT PROGNOSIS REGARDLESS OF TREATMENT TYPE* ...

1. Patients representing underserved ethnic or racial group achieve fewer benefits than Anglo-American groups, from conventional psychotherapy.
2. If patients and therapists come from the same or similar racial/ethnic backgrounds, drop out rates are positively affected and improvement is enhanced.
3. If psychotherapists are open, informed, and tolerant of various religious views, treatment effects are likely to be enhanced.
4. Co-morbid personality disorders, are negative prognostic indicators in the psychological treatment of depressed patients. (Lewinsohn et al (2005))

**PRINCIPLES REGARDING
PATIENT PROGNOSIS
REGARDLESS OF
TREATMENT TYPE* continued**

5. Age is a negative predictor of a patient's response to general psychotherapy.
6. Patients who enter treatment with high levels of functional impairment, tend to do poorly relative to other patients.
7. A secure attachment pattern in both patient and therapist appears to facilitate the treatment process.
8. The most effective treatments are likely to be those that do not induce patient resistance.

*Beutler et al (2005)

**PRINCIPLES RELATING TO
MATCHING THERAPY TO A
PARTICULAR CHARACTERISTIC
OF THE CLIENT*...**

1. Benefit may be enhanced when the interventions selected are responsive to and consistent with the patient's level of problem assimilation.
2. If patients have a preference for religiously oriented psychotherapy, treatment benefit is enhanced if therapists accommodate this preference.
3. In dealing with the resistant patient, the therapist's use of directive therapeutic interventions should be planned to inversely correspond with the patient's manifest level of resistant traits and states.

*Beutler et al (2005)

**PRINCIPLES RELATING TO MATCHING
THERAPY TO A PARTICULAR
CHARACTERISTIC OF THE CLIENT*
continued**

4. Patients with high levels of initial impairment respond better when offered long term, intensive treatment, than when they receive non-intensive and brief treatments, regardless of the particular model and type of treatment assigned. Patients with low impairment, seem to do equally well in high and low intensive treatments
5. Patients whose personalities are characterized by impulsivity, social gregariousness, and external blame for problems, benefit more from direct behavioral change and symptom reduction efforts, including building new skills, and managing impulses, than they do from procedures that are designed to facilitate insight and self-awareness.
6. Patients whose personalities are characterized by low levels of impulsivity, indecisiveness, self-inspection, and over control, tend to benefit more from procedures that foster self-understanding, insight, interpersonal attachments, and self-esteem, than they do from procedures that aim at directly altering symptoms and building new social skills

*Beutler et al (2005)

PRINCIPLES RELATED TO THERAPEUTIC RELATIONSHIP*...

1. When working with clients with dysphoric disorders, therapists should strive to develop and maintain a positive working alliance with their clients.
2. When conducting group therapy with depressed individuals, therapists should foster a strong level of cohesiveness within the group.
3. Therapists working with depressed individuals should attempt to facilitate their engagement during and between sessions.
4. When working with depressed individuals, therapists should relate to their clients in an empathic way.
5. When adopted by therapists, an attitude of caring, warmth, and acceptance is likely to be helpful in facilitating therapeutic change in depressed clients.

*Castonguay et al (2005)

PRINCIPLES RELATED TO THERAPEUTIC RELATIONSHIP* continued

6. When working with individuals suffering from depressive symptoms, therapists are likely to facilitate change when adopting an attitude of congruence or authenticity.
7. Therapists working with depressed individuals may find it helpful to adopt an empathic and nondefensive (or nonrigid) attitude when attempting to repair alliance ruptures.
8. When working with depressed clients, therapists' use of self-disclosure is likely to be helpful. This may be especially the case for reassuring and supportive self-disclosures, as opposed to challenging self-disclosures.
9. When working with depressed clients, therapists should avoid high levels of relational interpretations.
10. When making relational interpretations, therapists should strive to accurately address client's central interpersonal themes, as a high level of accuracy (or quality) with regard to these interpretations is likely to be beneficial for the client.

*Castonguay et al (2005)

PRINCIPLES RELATED TO THERAPEUTIC TECHNIQUES*

1. Challenge cognitive appraisals and behavior with new experience.
2. Increase and diversify the patient's access to contingent positive reinforcement for depressive and avoidant behaviors.
3. Improve the patient's interpersonal social functioning.
4. Improve marital, family, and social environment to reduce the establishment, maintenance, or recurrence of depressive behaviors.
5. Improve awareness, acceptance, and regulation of emotion and promote change in maladaptive emotional responses.

TENTATIVE PRINCIPLES REGARDING PARTICIPANT FACTORS*

1. Research on gender effects is insufficient for a clear judgment of effects on treatment of depressed patients to be made.
2. Principles related to preference and expectance are not sufficiently well defined to be applied to the clinical treatment of depressed patients.
3. **Insufficient research has been conducted on SES to determine if it is a contributor to treatment outcome for depressed patients.**
4. Patient stage of change is a promising (but not proven) variable for fitting patient and treatment and for predicting the level of intervention in which to engage the patient.

TENTATIVE PRINCIPLES RELATED TO THERAPEUTIC RELATIONSHIP*

1. Repairing alliance ruptures that emerge during treatment is likely to be helpful when working with depressed clients.
2. Depressed clients are likely to benefit from receiving feedback from their therapists.
3. **When working with depressed clients, therapists are likely to be more effective when they adequately manage their countertransference reactions toward their clients.**

**Psychotherapy Training:
An integrative perspective**

- Structure
- Focus
- Components
- Issues

Structure

- From a personal pathways to a training model
 - Hero Worshiping
 - Participant/observer: Full exposure and reflexivity
 - Expanding cohesively

Structure

- Preparation
- Exploration
- Identification
- Consolidation
- Integration

Focus

1. Expectation that therapy will help.
2. Presence of an optimal therapeutic alliance.
3. Helping patients become better aware of themselves and their world / Insight
4. Encouraging corrective experiences.
5. Facilitating ongoing reality testing.

(Goldfried & Padawer, 1982)

Components

- Classical works
- Applied (process and outcome) and basic research (psychopathology)
- Experiential forms of training
- Self reflection
- Multi-cultural competencies

Issues

- Integration: From the get go, as the ultimate goal, or as you go along?
- Myths and misconceptions
- Basic skills: Naked or embedded?
- Supervision: Who should it be?
- Harmful effect: The true common foe
