Therapeutic Factors in Dysphoric Disorders

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The working group on the treatment of dysphoric disorders focused on ways to integrate variables and qualities that optimize treatment effects for this clinical population. The variables examined represent three aspects or domains of the treatment context that effect positive change. These included aspects of the patient and therapist (participant factors), those relating to the development and role of the therapeutic relationship (relationship factors), and those that defined the application of formal interventions that are implemented by the therapist (techniques factors). The treatment literature on dysphoric populations was reviewed and a variety of relationships was identified, which then were translated into principles that are thought to enhance treatment effects. The principles representing the three domains of this review are then collected, in this article, into a set of cohesive suggestions for treating patients whose problems are characterized by major or minor depression, alone or as a comorbid condition.
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Clinicians operate on the basis of principles, both implicit and explicit, that are designed to help them effect and maintain change among their patients. Some of these principles are common across a variety of disorders and problems, whereas some are relatively unique to effecting change in specific clinical problems such as depression. The dysphoria

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work group of the Task Force on Empirically Based Principles of Therapeutic Change (Castonguay & Beutler, 2006b), initially divided the task of reviewing empirical literature on the treatment of depression among three subgroups. One group (Beutler, Blatt, Alamohamed, Levy, & Angtuaco, 2006) addressed characteristics of the participants that were associated with patient prognosis, as well as those that mediated and interacted with technique factors. A second subgroup (Castonguay et al., 2006) conducted a similar review, but addressed aspects of the therapeutic relationship that were associated with change. A third subgroup (Follette & Greenberg, 2006), repeated once again this process within the constraint of focusing on the nature of the therapeutic procedures and models that have been successfully applied to treating depressive conditions. In all cases, we adopted the vision of the broader task force, addressing ourselves to the uncovering of empirically based principles of change (for a definition of principles as well as the guidelines adopted by the Task Force to delineate them, see Castonguay & Beutler, this issue).

To accomplish our task, the final process was one of reviewing the principles that had been independently extracted by the three subgroups and identifying those that were common with other conditions (i.e., anxiety, personality, and substance use disorders), as well as those that were relatively unique to the treatment of depression. In this latter process, we sought to restate the original principles in ways that both permit and emphasize their integration and cohesiveness with one another. In this article, we address this refined set of principles.

Based on an integrative chapter of the Task Force (i.e., Beutler, Castonguay, & Follette, 2006), we will first summarize very briefly the work of each of the three dysphoria working groups. The principles that were extracted from these three separate groups will then be presented under two headings, respectively, reflecting the common and the unique principles of change that were identified. Finally, we will provide a short description of how these principles seem to interact with one another in the planning and development of a treatment program for patients whose problems are defined by or include depression.

Work Group Findings

The work group that addressed participant factors (Beutler et al., 2006) identified 14 principles that defined the role of either patient factors or patient qualities on outcome at a sufficient level as to be clinically useful. Eight of the 14 defining principles relate to predictors of patient response, or general prognosis. They suggest the importance of patient selection around factors such as level of impairment, background and demographic factors, comorbidity, and level of social attachment. In the area of therapist training, they suggest the need to recognize predisposing qualities of patient functioning and urge therapists to develop means for addressing and/or coping with (among other things) patient needs, difficulties, resistance, and lack of social support.

The remaining six principles define ways to fit and match the treatment to the particular patient needs. They identify certain qualities of patients that can be used for indicating styles of relating or different objectives in treatment. As such, they serve as guides to the discriminative implementation of different treatment procedures, techniques, or strategies.

The Task Force work group who addressed the role of the therapeutic relationship (Castonguay et al., 2006) identified 10 principles on which they believed that sufficient research had been conducted and sufficient consistency had been obtained to support clinical decision making. Six of these emphasized the value of a positive and multifaceted relationship, relying heavily on therapist-conveyed qualities like empathy, congruence, trust, cohesiveness, and caring. The remaining four principles addressed various

ways of implementing interventions to enhance the therapeutic relationship. Thus, the role of therapist nondefensiveness is emphasized in the course of repairing damaged or "ruptured" alliances, the provision of supportive self-disclosure when providing support, and the selective use of relational interpretations were emphasized in these principles.

The third work group (Follette & Greenberg, 2006) addressed aspects of the formal treatment procedures and interventions. They identified six principles that they concluded could and ought to be applied to enhance clinical change. These principles emphasized the role of both cognitive and behavioral change, as well as emotional expression; the role interpersonal relationships and supportive social environments that enhance one's functioning and improve relapse rates; and the importance of using various structuring techniques to keep patients focused and to maximize change.

Thus, collectively, the three work groups identified 30 principles that they concluded were applicable to making decisions about the contemporary treatment of depression. Representatives of each work group then participated in a meeting with members of the Task Force representing work groups associated with the other three problem areas (anxiety, personality, and substance use disorders). As described in Castonguay and Beutler (this issue), the main goal of this meeting was to identify principles that appear to cut across two or more of these major problem areas, as well as those that seemed to be relatively specific to enhanced effectiveness in treating a particular problem.

Common Principles of Change

When representatives from all of the sections of the task force met, it became apparent that a number of the principles were applicable to at least two problem areas covered by the Task Force. Of these, 10 principles addressed aspects of participants. We identified these 10 principles as being *common participant principles* (Table 1).

These 10 principles are of three types. The first type identifies contributors to patient prognosis, specifying those variables that seem to predict whether a patient will benefit from treatment. For example, principles #1 and #2 under problem severity predict that severity and comorbidity are negatively related to prognosis; principle #6, under patient psychological factors emphasizes that readiness for change is a prognostic indicator; principle #7, also under Psychological Factors, emphasizes that patient ability to develop a mature attachment is a predictor of positive change; principle #10 under Patient Demographics also emphasizes the impeding effect of low socioeconomic status (SES) among many patients who seek treatment. Low SES is a strong but negative correlate of problem severity and, in turn, is negatively associated with the likelihood and magnitude of beneficial change.

The second type of principle identifies factors that do not contribute to change, despite many speculations that they might do so. Embedded within principle #6 is a reminder to the clinician that efforts to increase patient readiness have not proven their effectiveness; principle #9 reminds the clinician that patient gender is not usually a contributor to outcome. Principle #4 stipulates that the clinician can be effective even if he or she has not had a personal experience with his or her client's presenting problem.

The remaining participant principles may serve as the basis for differential treatment decisions, different treatment strategies being applied depending on various patient and therapist factors. Specifically, they emphasize the importance of staying flexible, especially with patients who present with personality disorders and depression (principle #3); indicate patient qualities that raise the need for taking steps to address patient expectations (principle #5); and serve as reminders of the importance of sustaining a positive level of social support (principle #8).

Table 1
Common Principles of Therapeutic Change Applied to Participant Factors

Severity

1. The more impaired or severe and disruptive the problem, the fewer benefits are noted for time-limited treatments. It is unclear, across disorder/problems, whether longer-term treatments would be better than time-limited ones for these severe problems.
   Chronicity appears to be an index of impairment levels and may follow the same parameters as other indices of impairment.
2. If the patient has a comorbid personality disorder, the gains expected in treatment are weakened.

Therapist characteristics

3. Among patients with personality disorder or who experience depression, therapist flexibility in changing strategies, adapting to patient presentations, tolerance, and creativity are related to improvement. In the treatment of depression, for example, this refers to the importance for the therapist to be open, informed, and tolerant of religious views. There is little data on this cluster of variables among other disorders, but it is logical to suggest that it represents a general phenomenon.
4. The effectiveness of therapy is not substantially benefited by a therapist who has had a personal experience with the same type of problem as the patient. Openness and tolerance on the part of the therapist are more important than shared experience. This has been documented in the treatment of substance use but it is likely that this is a general phenomenon.

Patient psychological factors

5. Among those who have anxiety or who have substance abuse disorders, patient expectations are associated with outcomes. Patient expectations of success are more readily related to outcome than the credibility of treatment. Information is lacking on the effects of patient expectations in the treatment of personality disorder. Interestingly, however, expectations do not appear to be associated with outcome in the treatment of depression.
6. Patient pretreatment readiness for change is a reliable predictor of benefit in substance abuse disorders and likely to be involved in other problem areas, but research is largely absent. However, aside from efforts to address the patients' expectations, there is little evidence to suggest that efforts to alter one's readiness contribute substantially to benefit.
7. Among most problems, especially among patients with depression, anxiety, or personality disorders, the patient's attachment/interpersonal style interfere with the process of change and/or outcome. Prognosis is best among those with social approach or non-avoidant styles.

Patient demographics

8. Perceived levels of social support are positive predictors of treatment benefit. Absence of either actual or perceived social support may be indicative of the severity of the problem and the degree of experienced impairment (e.g., comorbidity and personality disorders). Evidence is inconsistent as to whether efforts to improve social support add benefit to the effects of treatment across problem areas. In depression, improving social support adds some benefit, suggesting that it may be a specific treatment factor.
9. Outcome is not substantially or meaningfully enhanced by variations in patient gender.
10. Among patients who experience either substance abuse or anxiety, low SES is a negative predictor of outcome. The pattern is less clear but still probable among other disorders.

Note. From "Integration of Therapeutic Factors in Dysphoric Disorders" (p. 112), by L.E. Beutler, L.G. Castonguay, & W.C. Follette. (2006). In L.G. Castonguay & L.E. Beutler (Eds.), Principles of Therapeutic Change That Work. New York: Oxford University Press. Copyright 2006 by Oxford University Press. Reprinted with permission.

A second set of nine *common principles* emerged around the focus of the therapeutic relationship. These principles are presented in Table 2. The first six principles emphasize the importance of the quality of the therapist–client interaction and of the relationship enhancing attitudes of the therapist. They emphasize the role of a general working alliance and cohesiveness (principles #1 and #2); the related importance of collaborative engagement (principle #4), and the influence of Rogerian-like interpersonal skills

Table 2
Common Principles Related to the Therapeutic Relationship

1. Effective treatment is enhanced when therapists strive to develop and maintain a positive working alliance with their clients.
2. Group therapy effects are enhanced if therapists successfully foster a strong level of cohesiveness within the group.
3. If the therapist has high levels of empathy, treatment outcomes are improved across a wide range of problem conditions and patient types.
4. Effective treatment is facilitated when therapist and patient share common goals of treatment and are collaborative in seeking to achieve these goals.
5. Therapist positive regard is a probable contributor to patient benefit.
6. Therapist congruence in the expression of feelings or the transmission of knowledge is likely to improve patient outcome.
7. Therapists should be careful not to use relational interpretations excessively.
8. When relational interpretations are used, they are likely to facilitate improvement if they are accurate.
9. Therapists are likely to resolve alliance ruptures when addressing such ruptures in an empathic and flexible way.

Note. From “Integration of Therapeutic Factors in Dysphoric Disorders” (p. 113), by L.E. Beutler, L.G. Castonguay, & W.C. Follette. (2006). In L.G. Castonguay & L.E. Beutler (Eds.), Principles of Therapeutic Change That Work. New York: Oxford University Press. Copyright 2006 by Oxford University Press. Reprinted with permission.

(principles #3, #5, and #6). The last three principles listed in Table 2 provide guidelines to the therapist about ways to work with the therapeutic relationship (i.e., what to do and not to do when providing relational interpretations [principles #7 and #8], and how to repair alliance ruptures [principle #9]).

A final list of 17 common principles emerged from an inspection of the work of authors that addressed treatment that have received empirical support for the disorders included in the Task Force review. These principles are given in Table 3 and guide the application of techniques and procedures. Perhaps the most important of these common technique principles is the reminder that all interventions must be done within the context of a positive working alliance and relationship (principle #1). Beyond this basic point, the other technique principles remind the clinician that treatment is enhanced if it focuses on the client’s most emergent problems (principle #2), provides an explanation for these problems and a rationale about how to address them (principle #8), seeks to set and address clearly defined goals (principle #10), and encourages small and incremental change towards these goals (principle #9). Treatment is also likely to be beneficial if it includes a clear assessment of the patterns in one’s life that cause problems (principles #4 and #5), and if it helps the client to become aware of the relationship between what they do and feel, on one hand, and the environment, on the other (principle #6). Furthermore, these common techniques principles suggest that therapy is likely to be enhanced if the clinician helps the client to modify his or her maladaptive emotional, behavioral and/or physiological response patterns (principle #3) and to acquire new ways of perceiving and thinking (principle #7). In addition, a client is likely to benefit from treatment if the therapist is able to skillfully use “nondirective” (e.g., validating) interventions (principle #11), facilitate the exploration of the patient’s experience (principle #12), and deal appropriately with the patient’s emotions (principles #13 and #14). The last three principles, (#15, #16, and #17), provide guidelines related to the structure of effective therapy (i.e., timeframe, intensity, modality).

In all, 36 principles (Tables 1 through 3) define effective therapeutic guidelines that are common to two or more problem types. These principles address aspects of

Table 3
Common Principles of Selecting Techniques and Interventions

1. Principles of techniques usage are only of value if carried out within the context of a good therapeutic relationship.
2. Advantageous techniques directly focus on presenting problems and concerns. On the other hand, a laissez-faire approach to therapy, in which the therapist fails to confront the patient, fails to direct the patient's efforts, or avoids raising the patient's distress, has limited effects.
3. Effective treatments directly focus on increasing adaptive ways of feeling, behaving, and/or responding (physiologically).
4. Effective treatments are based on an initial assessment to identify patterns of behaving, feeling, and thinking linked to the maintenance of problems.
5. To maximize treatment gains, an ongoing assessment is valuable to determine whether therapy is meeting the goals set by the therapist and patient.
6. Improvement is enhanced when successful efforts are made to facilitate clients' knowledge and awareness of the relationship between their interpersonal (and physical) environment and the way in which they think, feel, and behave.
7. Effective treatment identifies and challenges specific dysfunctional thoughts and negative core beliefs.
8. Helpful treatments educate the client about the nature of the problem and rationale for treatment.
9. If the therapist works to facilitate incremental change, improvement rates are increased.
10. For optimal treatment to occur, the client and therapist should set clear and explicit goals and structure therapy to achieve those goals.
11. Therapists should be able to use skillfully "nondirective" interventions.
12. Facilitating client self-exploration can be useful.
13. Therapeutic change is likely if the therapist helps clients accept, tolerate, and at times fully experience their emotions.
14. On the other hand, interventions aimed at controlling emotions can also be helpful.
15. Time-limited therapy can be beneficial (except in the treatment of personality disorders).
16. Therapeutic change may be facilitated by, and may even require, intensive therapy.
17. The use of nonindividual interventions (e.g., group and family therapy) can be beneficial.

Note. From "Integration of Therapeutic Factors in Dysphoric Disorders" (p. 114), by L.E. Beutler, L.G. Castonguay, & W.C. Follette. (2006). In L.G. Castonguay & L.E. Beutler (Eds.), Principles of Therapeutic Change That Work. New York: Oxford University Press. Copyright 2006 by Oxford University Press. Reprinted with permission.

three variable domains (participants, relationship, techniques) to which the clinician is encouraged to attend. Thus, adhering to these 36 principles can be viewed as providing an empirical foundation for helping therapists achieve change.[1]

In addition to the *common principles* of change, a number of principles of change seem to apply specifically to the treatment of patients who have depressive symptoms. These empirically defined, *specific principles*, are listed in Table 4.

Specific Principles of Change

Twelve principles of change that are specific to depression were extracted from an inspection of research literature. These specific principles of effective change are of two types: (a) those that have been validated on depressed samples, but have not been found to be valid in anxiety, personality, and substance use disorders, and (b) those that have been found to be valid for treating depression but have not been investigated in the other three clusters of psychiatric populations targeted by the Task Force.

[1]It should be emphasized that by *common principles*, we refer to principles that have been identified for at least two of the problem areas covered by the Task Force (dysphoric, anxiety, personality, and substance use disorders). It should not be implied that these principles are influential in the treatment of all of these disorders or any other clinical problems.

Table 4
Unique Principles for Treating Depression and Dysphoria

Principles related to the participants

1. Age is a negative predictor of a patient's response to general psychotherapy.
2. Patients representing underserved ethnic or racial group achieve fewer benefits than Anglo American groups, from conventional psychotherapy.
3. If patients and therapists come from the same or similar racial/ethnic backgrounds, drop out rates are positively affected and improvement is enhanced.
4. If patients have a preference for religiously oriented psychotherapy, treatment benefit is enhanced when therapists accommodate these preferences.
5. Adding treatment components increases the benefits for severely impaired patients. Specifically, adding longer treatment course may improve benefit for severely impaired depressed patients. It should also be noted that whereas empirical evidence has primarily derived from the treatment of depression, this principle may be also relevant to other forms of disorders. As mentioned by McCrady, Haaga, and Lebow (2006), "About 50% of those with SUDs have another co-morbid Axis I disorder and about one-third have a co-morbid Axis II disorder. Research knowledge about the effective integration of different psychological treatments to manage multiple presenting problems is lacking, but assessment of co-morbid disorders and use of effective treatments for additional presenting problems is appropriate" (p. 348).
6. Benefit may be enhanced when the interventions selected are responsive to and consistent with the patient's level of problem assimilation.
7. Interventions that induce patient's resistance (sometimes measured as collaborative engagement, or lack of thereof) are not likely to enhance outcome. Interventions that activate trait-like resistance include such things as therapist over-control, over-directiveness, and confrontation that exceeds the patient's level of tolerance. These interventions tend to reduce patient level of compliance and lead to reduced outcome. Their negative effects have been most documented in the area of depression. Researchers in the substance abuse field, however, have recognized their importance by suggesting that therapists should "roll with the resistance" as a way to neutralize client's reactance (see McCrady, Haaga, & Lebow, 2006). Furthermore, one potential manifestation of resistance (i.e. noncompliance to homework) has been found to predict outcome in anxiety disorders. Findings related to this variable, however, have been considered under the principle of collaborative engagement (see Newman, Stiles, Woody, & Janeck, 2006)
8. The therapist's use of directive therapeutic interventions should be planned to correspond inversely with the patient's manifest level of resistant traits and states.
9. 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.
10. Patients whose personalities are characterized by low levels of impulsivity, and high levels of 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.
11. A secure attachment pattern in the therapist appears to facilitate the treatment process.

Unique principles related to the therapeutic relationship

1. When working with depressed clients, therapists' use of self-disclosure is likely to be helpful. This may especially be the case for reassuring and supportive self-disclosures, as opposed to challenging self-disclosures.

Note. SUDS, substance abuse disorders.
Note. From "Integration of Therapeutic Factors in Dysphoric Disorders" (p. 115), by L.E. Beutler, L.G. Castonguay, & W.C. Follette. (2006). In L.G. Castonguay & L.E. Beutler (Eds.), Principles of Therapeutic Change That Work. New York: Oxford University Press. Copyright 2006 by Oxford University Press. Reprinted with permission.

Of the 12 principles judged to be specific to the effective treatment of depression, 11 relate to participants' characteristics, and one pertains to the therapeutic relationship. Interestingly, there were no specific principles related to the uniform effect of a given treatment procedure. However, several principles suggested ways to modify treatment approaches as a function of patient qualities and characteristics.

For example, three of the principles were related to how participant characteristics affect prognosis. These three principles stipulated that client's age (principle #1), ethnicity (principle #2), and resistance level (principle # 7) are related to the likelihood of change. The majority of the remaining principles suggest the presence of an advantage when certain patient qualities are matched with compatible therapists or interventions. Thus, ethnic matching (similarity) with the therapist enhances outcomes and reduces drop out rates among depressed patients (principle #3). Similarly, assigning a therapist who can accommodate his or her client's religious beliefs is advantageous (principle #4), and therapeutic benefit is a function of adjusting the length and intensity of treatment in a way that increasingly corresponds with the level of impairment presented (principle #5).

Other matching principles emphasize that therapists are likely to be more effective with depressed patients when their interventions are consistent with the degree to which the client has assimilated problematic experience (principle #6), and when the level of directiveness employed is inversely related to the patient's level of resistance (principle #8).

Other principles observe that impulsive and acting out patients are better candidates for behavioral and symptom-focused interventions than are patients who are ruminative and self-deprecatory (principle #9). In contrast, insight and awareness interventions are suggested for those depressed patients who tend to be ruminative and self-blaming (principle #10).

Only one of these specific principles of change referred to a therapist-related characteristic: The process of change was found to be facilitated when clients work with securely attached therapists (principle #11). Likewise, only one of these principles specified an aspect of the therapeutic relationship that is unique to the treatment of depression—the use of supportive self-disclosure enhances therapeutic change.

Integrating the Use of Common and Specific Principles

Collectively, 48 principles have been identified to guide the treatment of depression. Thirty-six of these principles are shared with the principles that guide treatment among other types of problems and 12 are unique to the treatment of depression. The importance of these various principles, relative to one another, remains unknown. However, there appears to be some common themes within various clusters of principles. One of these themes emphasizes the selection of patients who are most likely to respond to psychotherapy and differentiates them from those who are expected to make slower progress. These prognostic principles may be useful when demand is high and resources are limited and they may be useful for determining what patients might benefit from more-intensive interventions or those that rely on pharmacological effects.

A second cluster of principles emphasizes the salience of a working relationship, as well as guidelines that may be useful in enhancing such therapeutic relationships. Relationship factors, because they are assumed to form the foundation of treatment procedures, may signal that adherence to these principles is a high priority when planning treatments. Developing a positive, working relationship should probably be considered the first task of the clinician. Some principles emphasize the role of therapist factors, such as flexibility, empathy, and focus, in developing an effective relationship. Others focus on the fit between the patient's and therapist's background and culture. All of these qualities are clearly part of the evolving therapeutic alliance and help to develop and form its nature.

A third cluster of variables reflects those that are used to tailor the therapy to the needs of the patient. The discriminative use of directive interventions, procedures that are

adjusted to the level of impairment and assimilation, and those that selectively focus on behavioral change versus insight and awareness, are used for the purposes of tailoring the therapy and making it more compatible to a given patient. A focus on these compatibility and matching factors may form a third level of priority in developing a treatment plan for the depressed patient.

Reflecting the importance of effective techniques or strategies, a final cluster of principles emphasize the value of developing a treatment plan, providing help in evaluating progress and change, and reinforcing changes as they occur. These principles also emphasize the importance of acknowledging negative emotions and of developing positive, adaptive responses to replace maladaptive coping patterns.

Together, by focusing on these four levels of priority in developing and applying interventions, treatment of the depressed patient is likely to be enhanced, regardless of the treatment model used.

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