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The Task Force on Empirically Based Principles of Therapeutic Change

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Arising from the creative initiative of David Barlow, the Division 12 (American Psychological Association) Task Force on the Promotion and Dissemination of Psychological Procedures (Chambless, Baker, et al., 1998; Chambless, Sanderson, et al., 1996; Task Force, 1995) has been enormously successful in identifying treatments and methods of treatment that are founded on sound scientific research. Through their efforts, first the term "Empirically Validated Treatments" and later "Empirically Supported Treatments" (Chambless & Hollon, 1998) became part of the lexicon of practicing psychologists. This Task Force, and the standing committee of Division 12 that succeeded it, has published the results of several extensive projects that have led to the identification of treatment models that have been shown by controlled research to be reliably more effective than a no-treatment or a placebo treatment control condition. A compendium based on the work of that Task Force (Nathan & Gorman, 1998, 2002) epitomized the identification of treatments that exhibit specific and important influences on peoples' problems and well-being.

The results of that latter Task Force and the associated book, now in its second edition (Nathan & Gorman, 1998, 2002), were highly debated and severely criticized from many quarters. In particular, many of those in the practice and psychotherapy research communities expressed the belief that the Division 12 Task Force authors and report were too closely aligned with cognitive-behavioral treatments to be objective. Those who shared this belief seemed to feel that the search for Empirically Supported Treatments ignored important aspects of relationship-based therapies, notably the role of the therapeutic or working alliance and the role of patient and therapist factors.

The process and criteria used to define empirically supported treatments had taken a page from the procedural manual of the Federal Drug Administration, which seems a logical place to start, but was perhaps not a sufficient method and criteria with which to continue the search. This cri-

teria identified "proof" of empirical support as the presence of statistically significant findings from two, independently conducted, randomized clinical trials (RCT) in which the targeted treatment was compared with a placebo condition or a no-treatment control group. Unfortunately, RCT designs are not well suited to identifying qualities of the treatment that are either incapable of being randomly assigned or that are nondichotomous and that are embedded both in the treatment relationship and in its participants rather than in the treatment itself.

To address the concern that this criteria ignored participant and relationship factors, a Task Force was constituted by the Division of Psychotherapy (Division 29), under the presidency of John C. Norcross (2002). This latter Task Force was designed to serve as a counterbalance to the original Division 12 Task Force's emphasis on treatment factors. This Division 29 Task Force was aimed at identifying relationship variables that affected treatment outcomes and extended to a consideration of a variety of patient and therapist factors as well. Unfortunately, in doing so, it tended to place all of the emphasis on relationship and participant factors, eschewing the concept of treatment-specific models and manuals. The work of these two Task Forces and the Divisions of APA that sponsored them has frequently come to be viewed as contrasting and contradictory. And, it was in response to this interpretation that we (the Editors) decided to initiate a task force that was specifically designed to serve as a means of integrating the work of the previous two groups.

For Louis Castonguay, this book project was seen as an opportunity to derive from the empirical literature a number of principles of change that are common to a variety of theoretical orientations. Influenced by the work of Goldfried (1980), he believed that many of the procedures assumed to be responsible for the effectiveness of a particular orientation (e.g., challenge of maladaptive thoughts in cognitive therapy and interpretation in psychodynamic therapy) are best viewed as specific manifestations of more global strategies of intervention (e.g., providing a new understanding; Castonguay, 2002, in press). He reasoned that, at the minimum, the delineation of general principles of change would provide clinicians with a set of guidelines (flexible heuristics) that could complement the lists of procedures (more or less prescribed at specific times in therapy) that one frequently finds in treatment manuals and textbooks. Similar to Beutler's view, he believed that principles of change should not only be concerned with treatment procedure but should also encompass factors related to the relationship (e.g., alliance), and client and therapist characteristics (e.g., expectancies).

For Larry E. Beutler, the idea for this book arose from a prior effort (Beutler, Clarkin, & Bongar, 2000) to develop guidelines for treating depression. Beutler reasoned that a focus on treatment models, and on their respective manuals, frequently overlooked two important research findings: (1) that procedures drawn from many different treatment models were effective, and (2) most treatments produced a variety of effects, ranging from very positive to negative. Together Beutler, Clarkin, and Bongar shared the view that much more would be accomplished if science could identify the ways in which participant, relationship, and treatment factors and qualities interacted and potentiated one another's effects, and did so without assuming the baggage of an entire model or theory of treatment.

In spite of the stellar work of both the Division 12 presidential (David Barlow) initiative that began the process of identifying "Empirically Supported Treatments" (ESTs) and the more recent Division 29 presidential (John C. Norcross) initiative that defined the nature of "Empirically Supported Relationships," the field remains divided on how best to establish the scientific bases of practice. In fact, these two divisional initiatives exaggerate the schism between the relative value of objective and subjective experience that exists in the field, rather than healing it. Reflected in these two presidential initiatives is a division between those who primarily emphasize the roles of techniques and theory, on one hand (those who rely on objective evidence and EST research), and those who mainly emphasize interpersonal processes as ingredients of change (those who rely on subjective experience and research that identifies correlates of change), on the other. Typically, these two positions are represented by different people with very different values and beliefs about psychotherapy. Accordingly, they frequently interpret *the same body of research* in very different ways.

The models and techniques-oriented groups believe that the best method for ensuring the optimization of practice is to identify treatment models that work for patients who are identified by a particular problem (usually conceptualized as the diagnosis), and to encourage practitioners to learn to use these treatments. Treatments to which those who accept this view adhere and espouse are described via manuals. But, most head-to-head scientific comparisons of different treatments, defined in this way, indicate that they all have similar outcomes. With the exception of a small number of clinical problems (e.g., obsessive-compulsive disorder, generalized anxiety disorder), it is hard to find a treatment that works better than another treatment and all seem to be better than doing nothing. Most estimates from such studies reveal that differences among treatments account for no more than 10% of the variability in change (Luborsky, Rosenthal, et al., 2002; Wampold, 2001). Moreover, various groups have identified over 150 different approaches and models to treatment that are effective, each accompanied by a different manual and addressed to a different type of patient (Chambless & Ollendick, 2001). Together, the evidence that there are only minor differences in effectiveness among treatments, and the burgeoning number of treatments that identify themselves as being "empirically supported," has raised doubts for many about whether the benefits of improving practice by developing more manuals is either practical or cost-effective (Beutler, 1998, 2002).

On the other hand, the interpersonal processes-oriented research and practice groups believe that factors that facilitate the development of a therapeutic relationship, rather than the treatment model used, are the most important contributors to effective therapeutic work. These clinicians and scientists think that effective treatments can best be identified in terms of how patients and therapists interact. That is, improvement is best conceptualized as a product of the qualities that patient and therapist bring to the treatment and the relationship that is developed between them.

So far, however, research has indicated that the most robust of the relationship variables, the alliance, accounts for no more of the variation among outcomes than the 10% attributed to specific treatments (Beutler, Malik, et al., 2003; Horvath & Symonds, 1991) and therapist factors may account for even less of the outcome variance (Beutler, Malik, et al., 2003; Lambert, 1992). Moreover, since research on the therapeutic relationship is invariably correlational in nature, it has been difficult to demonstrate that relationship quality actually *causes* improvement, rather than vice versa, during treatment.

It is time to find a common ground across these perspectives. We must begin to think outside of the narrow view that simply distinguishes between "techniques" and "relationship" qualities, and of one variable versus another, and to begin to look for foundation principles that encompass a variety of therapeutic factors. We think that psychotherapy research has produced enough knowledge to begin to define the basic principles that govern therapeutic change in a way that is not tied to any specific theory, treatment model, or narrowly defined set of concepts.

Principles are general statements that identify participant characteristics, relational conditions, therapist behaviors, and classes of intervention that are likely to lead to change in psychotherapy. Principles are more general than a description of techniques and they are more specific than theoretical formulations. As cogently described by Goldfried and Padawer (1982), these principles of interventions are generally found at a middle level of abstraction, between techniques and the theoretical models that are used to explain the effectiveness of treatments. We believe that stepping outside of the box that is defined by our theories, in this way, may allow us to begin to better understand and help a wider range of patients.

THE TASK FORCE ON EMPIRICALLY BASED PRINCIPLES OF THERAPEUTIC CHANGE

When we formed the Task Force from which this report derives (see preface), we did so with the intent of ensuring that most viable points of view were represented. Thus, the Task Force members (see list following contents page) were initially selected through a process of nomination and discussion. Several criteria were invoked of the Task Force members: (1) they must be established scholars who have achieved visibility in the scientific community for their empirical research in a

given problem area and variable domain; (2) they must be willing and interested in working toward integration and synthesis of research findings; (3) they must be willing to work on a chapter with colleagues who do not share their theoretical perspectives; and (4) they must be willing to work hard for little financial compensation.

Interestingly, we had little difficulty finding colleagues who fit these criteria. We first independently constructed lists of potential contributors and debated the pros and cons of each until we were able to agree on a pair of authors within each problem area and variable domain who represented contrasting views from one another about the area of study. These authors were approached and recruited to serve on the Task Force and to work with the identified and contrasting colleague.

Each pair of authors was permitted to recruit additional colleagues to help with the tasks of reviewing literature and extracting principles of change. They also were given several primary sources of readings to reduce the need to revisit already reviewed literature (see below). These readings were identified to coincide with each variable domain, and where possible, each problem area. They then reviewed those selected references in order to abstract the general principles of change. Two definitions aided this process:

1. A *principle* defines the conditions under which a concept (participant, relationship quality, or intervention) will be effective. The concepts to be included should not be too general or theory-specific. Thus, a principle that says "Cognitive Therapy is effective" is too general and adds nothing to the Division 12 list of ESTs. A "principle" might be framed as an "If . . . then" statement or may be more general, such as "Therapists should attempt to create and maintain a strong working alliance that reflects a positive bond and an agreement between the participants in terms of the tasks and goals of therapy."
2. An empirically based principle is one that reflects the role of the participant characteristics, relationship qualities, or components of treatment that are found in the treatments identified by the Division 12 or Division 29 Task Force Reports, or that is supported by a "preponderance of the available evidence" (i.e., 50% or more of the studies on that problem area and domain support the relationship that defines the principle).

This latter definition allowed us to rely on widely accepted secondary sources as the basis for identifying the status of research in the field. For purposes of the current Task Force, several key references served as the means of defining what constructs have been empirically supported. From these constructs, the principles were defined. These principles, and the associated constructs from which they derived, were confined to what has been reported in these references, except in unusual circumstances. That is, the principles were deemed to reflect on qualities, characteristics, and interventions (within and across treatments) that derive directly from these references.

The four groups of authors that wrote the four chapters that focused on participant factors were specifically asked to review what is known about the range of patient and therapist characteristics defined in specific chapters of the Division 29 report (Norcross, 2002). To complement these sources of evidence, they were also asked to consider the relevant reviews of literature offered in the Bergin and Garfield (1994; Lambert, 2003) volumes. Where the literature warranted, some of these authors also included in their respective chapters, a review of research on factors that had been associated with the social context in which the problem occurs or is treated (e.g., family and spousal characteristics). In each case, we asked authors to consider available research on the role of specific variables in predicting treatment outcomes with an eye especially on factors and variables that may serve as moderators of a patient's response to different treatments.

Likewise, the eight Task Force members who were asked to write the four chapters on relationship factors were asked to assess the status of research by carefully reviewing the relevant chapters in the Division 29 report (Norcross, 2002), and by examining the appropriate reviews of literature in the Bergin and Garfield (1994; Lambert, 2003) volumes. Here, the questions addressed related to the type of relationship the therapist should attempt to foster, as well as the interpersonal skills he/she might want to master in order to facilitate client's improvement.

These first two groups of authors were essentially asked to review the general literature, extract the studies that addressed the problem area that they were reviewing, judge whether the current status of the general literature (as defined by the relevant conclusions reached by the Division 29 Task Force) appeared to be valid for the problem area, and then derive the most relevant principles that fit the problem and the domain of participants or relationship variables. If the Task Force members were not able to extract from the general literature a sufficient number of studies from which to derive principles of change directly related to their problem area, we invited them to accept by default (i.e., pending future research) the relevant conclusion reached by the Division 29 Task Force. Although most authors followed our recommendation, some did not elect to accept any conclusion or to derive any principle of change unless they found an adequate number of studies conducted with samples that were representative of their problem area.

Finally, the authors of the four chapters on technique variables were asked to draw from the volumes by Nathan and Gorman (1998, 2002) on effective treatments and on the report by Chambless and Ollendick (2001) on ESTs. These references have focused on treatment models and procedures that are associated with benefit within different diagnostic groupings of patients. While authors were encouraged to take the reports in these relevant volumes as evidence of technique effects, we asked authors to go beyond a simple recounting of what models work for what patient groups and to specify aspects of the treatment procedures used that seem to account for positive changes. Thus, we asked these authors to dismantle the various treatments and to identify the degree to which families, strategies, and characteristics of the intervention, rather than specific techniques, accounted for change. We suggested that, in making these determinations, that they consider qualities along various dimensions, such as the degree to which the treatment focus was on symptomatic and discrete behaviors versus the development of awareness and insight, the degree that the therapist assumed a leadership and directive role versus one of facilitating exploration, the degree to which interventions focused on intrapersonal versus interpersonal issues, and the degree to which the various models studied worked to enhance and focus emotional experience as opposed to reducing and containing it. As in the case of the other authors, we asked authors of the technique chapters to try to extract general principles that identified the variables that comprised effective treatments, rather than broad models of change.

In the penultimate step to the Task Force's work, we convened a group of 12 authors, representing each chapter. We asked them to bring with them an articulated list of the principles that their work group had distilled from their various reviews, and then we engaged them in a process of distinguishing between principles that were common or virtually the same across multiple problem areas and those that were relatively unique to one or another problem type. Common principles were identified by each of three work groups, representing, respectively, one of the three domains of variables researched (participants, relationship, techniques). Each of these groups was comprised of four authors. Thus, in each of these groups, all four problem areas were represented, but all of the participants had studied the same domain of contributors to outcome. They shared with one another, the principles that they had derived from their separate reviews and subjected these principles to a discussion. This discussion was aimed at identifying and restating, in a common language, the principles that seemed to cut across the four different problem areas. This became the list of "common principles."

Once common principles were identified, the work group was reconfigured in order to identify "specific principles." They were asked to consider the residual principles that had not been duplicated across disorders, and to refine them into a list of principles that were specific to each problem area. The authors within this second set of working groups represented all of the four problem areas, within a particular variable domain. They met together, reviewed the principles that had been defined in their various efforts to define empirically based principles, but that had not been identified as common across patient groups, and extracted from these an articulated list of principles that expressed the conclusions reached from the research reviews and that were simple and communicative. The result was a complementary list of principles

that are specific for each problem area and that are relevant to each of the domains of variables (participants, relationships, treatments). The common and specific principles that have been derived from our Task Force are featured (in slightly different ways) in two integrative chapters (Beutler, Castonguay, & Follette, this volume; Critchfield & Benjamin, this volume) as well as in the final chapter of this book.

One word of caution should be expressed with regard to the empirical status of the principles of change, common and specific, identified in this book. It is indeed important to state that very few of them, if any, have been measured directly or found to be causally related to client's improvement in definitive, experimental studies. To our knowledge, none of these principles have been systematically manipulated within experimental studies or sufficiently investigated as potential mediators of change. Thus, rather than referring to them as being "empirically supported," it might be more appropriate to define these principles as "empirically derived" or "empirically grounded." For the same reason, and until they receive more direct support, it would be wise to view these clinical guidelines as hypotheses, rather than as established or factual processes of change.

CONSTRUCTS AND SOURCES

Participant factors, for the purposes of this book, are those characteristics of the patient or therapist that (1) exist solely within the person of the therapist or patient, and (2) represent qualities that are manifest in life beyond psychotherapy. From the Division 29 Task Force report, there were two sets of client or patient variables from which principles should be derived.

Those that represent prognostic factors in outcome include:

Attachment Style
Gender
Ethnicity
Religion and Spirituality
Preferences
Personality Disorders

Those that are identified as moderating variables, that have been found to be demonstrably or probably effective as a means of customizing therapy, include:

Resistance
Functional Impairment
Coping Style
Stages of Change
Anaclitic/Sociotropic and Introjective/Autonomous Styles
Expectations
Assimilation of Problematic Experiences

Relationship factors refer to general qualities of the therapeutic interaction and therapist's interpersonal skills that serve to enhance or impede the process of change and client's improvement. The Division 29 report listed the following factors that we believe are best defined as relationship factors:

Therapeutic Alliance
Cohesion in Group Therapy
Empathy
Goal Consensus and Collaboration
Positive Regard
Congruence/Genuineness
Feedback
Repair of Alliance Ruptures
Self-Disclosure
Management of Countertransference
Quality of Relational Interpretations

Technique factors, as we use this term in this volume, are the specific procedures that comprise the models of psychotherapy that are identified as "probably" and "possibly" efficacious treatments in the Division 12 reports. These lists served as the criteria of what treatments to be inspected to derive principles of change. To determine the nature of the interventions and to extract their underlying principles, authors were asked to inspect the specific manuals listed by the Division 12 reports. Authors were also provided with categories of intervention principles that could be used to regroup techniques from different orientations, based on the presence of similar goals, functions, or demand characteristics. These include: (1) level of therapist directiveness; (2) level of insight versus symptom and behavior change focus; (3) treatment intensity (e.g., length, frequency, multi-modal, etc.); (4) intrapersonal and/or interpersonal focus of intervention; and (5) interventions that were designed to be emotion enhancing versus supportive.

In all three sections (participants, relationship, technique factors), authors were instructed not to consider findings that pertained exclusively to biological treatments. Thus, the principles of change that have been derived are only relevant to psychosocial therapies. The efforts of the Task Force have also been focused on the adult population and, as such, its conclusions may not be applicable to psychotherapy with children and adolescents, or for that matter, to psychological treatment for adult disorders not covered (e.g., eating disorders, psychotic disorders).

THE PROCESS

As noted, in the foregoing, the various chapters and authors were encouraged to rely, in defining what variables to consider, upon a list of established, secondary sources. But, authors were also encouraged to supplement these references and findings by going to specific studies and studies published after the secondary sources appeared, in order to extract more detail about what was done. Authors were allowed to add factors, qualities, or interventions only if the additions were accompanied by clear and persuasive evidence for efficacy or effectiveness, and only if the authors could convince others that adding some constructs is consistent with the preponderance of available evidence. Thus, while we encouraged authors to introduce new concepts and point to promising directions in research and practice, we did not want this volume to simply be a means for any or all of us to present our own research findings and favorite concepts, no matter how important. We wanted this book to represent the state of the art, while reflecting the creative processes of each group of authors—with the hope that what would result could have an influence on the field for years to come.

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Part II

DYSPHORIC DISORDERS