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A Common Factors Approach to Psychotherapy Training

Louis G. Castonguay[1,2]

This article addresses training in psychotherapy integration from the perspective of common factors. Problems related to this training perspective are first reviewed. As an attempt to deal with such problems, current teaching and supervision efforts by the author are briefly described. Based on a developmental model of clinical learning, a sketch of a more comprehensive program of integrative psychotherapy training is advanced.

KEY WORDS: psychotherapy training; psychotherapy integration; common factors

In the recent past, the exploration and evolution of psychotherapy integration has followed three relatively distinct paths: the development of integrative theories, the identification of prescriptive and eclectic approaches, and the search for common factors (Arkowitz, 1989). The primary goal of individuals interested in common factors (the ''commonians'') is to identify robust mechanisms of change that cut across different orientations in order eventually to develop more effective treatments based on these mechanisms (Grencavage & Norcross, 1990).

Specifically, the commonians are interested in discovering what takes place within the major forms of psychotherapy. Are psychodynamic therapists really abiding by the golden rules of psychoanalytic principles? Are Rogeriens always nondirective? Are they nondirective at all? Is behavior therapy, to use Locke's (1971) provocative words, really behavioristic? The consensus in the field is that there exist significant differences between

[1]Department of Psychology, The Pennsylvania State Universiy, University Park, Pennsylvania.
[2]Correspondence should be directed to Louis G. Castonguay, Ph.D., Department of Psychology, 308 Moore Bldg. Penn State University, University Park, Pennsylvania 16803; e-mail: lgc3@psu.edu.

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what therapists do and what they say they do—or what their treatment manuals prescribe them to do (Castonguay & Goldfried, 1994). The commonians, of course, are also interested in the comparison of different forms of psychotherapy. Process research has provided evidence for similarities among conceptually divergent orientations across many aspects of therapy including, among others, the therapeutic relationship, client expectancies, corrective emotional experience, and values (Weinberger, 1993).

One might expect that training models of integrative psychotherapy could be derived fairly easily from a common factors perspective. In theory, it would be a matter of identifying the variables that cut across orientations (preferably the ones that have been empirically linked with outcome), organizing them into a coherent framework, and teaching these therapeutic elements as the foundation for any helpful psychological treatment. There are, however, several problems related to a common factor strategy for training in psychotherapy integration. The main goal of this paper is to outline some of these difficulties and to present nascent efforts to deal with them within the context of my current clinical teaching. In addition, a developmental model of psychotherapy training is advanced as a potential framework for a comprehensive approach to teaching psychotherapy integration based in part on common factors.

THREE PROBLEMS IN A COMMON FACTORS APPROACH GUIDING PSYCHOTHERAPY TRAINING

The first problem concerns the number and diversity of common factors that have been identified and the fact that these factors have been associated with disparate levels of psychotherapy. Grenvacage and Norcross (1990), for example, reviewed the work of 50 authors, identifying close to 90 common factors and regrouping them into five categories of treatment: client characteristics, therapist qualities, change processes, treatment structure, and relationship elements. Based on a review of research relating process and outcome variables, Orlinsky and Howard (1987) also identified a large number of common factors and integrated them within five dimensions of their generic model of psychotherapy (i.e., therapeutic contract, interventions, bond, states of self-relatedness, and realization). Thus, any attempt to train therapists from a common factors perspective will force one to decide which common factors should be the focus of training and what level or dimensions of the therapeutic intervention should be emphasized in clinical practica and supervision.

A second problem with training clinicians from a common factors perspective is the fact that this strategy is not based on comprehensive

models of psychopathology. Commonians have not developed theories of human functioning from which one can derive links between the etiology of clinical disorders and the therapeutic interventions that are required for attenuating them. As a consequence, it is particularly difficult to develop case formulations and treatment plans strictly based on our knowledge of common factors. For instance, knowing that a therapeutic alliance is an important catalyst of change across different forms of therapy is not particularly illuminating when one is trying to create the most suitable intervention for a client's needs (How helpful would it be for a trainee if his/her supervisor would simply tell him/her: "Well, now go and create a good alliance?!"). For clinicians to know what to do (and what not to do) in order to create a strong alliance at different phases of the treatment, they must rely on an implicit or explicit understanding of the client's problems and how to treat them. Such understanding will be based on case formulation derived from preferred theoretical orientation(s). Thus, the therapist's language and methods related to common factors will be nested within favored theories. Importantly, such favored models can be integrative (e.g., Prochaska & Norcross, 1994; Safran & Segal, 1990; Wachtel, 1977; Wolfe, 1992). A comprehensive model of human functioning and change is required, whether such a model is related to a "pure-form" therapy or an integrative approach.

A third problem is that although many common factors have been identified in the literature, they are not the only active ingredients of therapy. One precursur of the integration movement was clinicians' realization that no single form of therapy, with all of the technical repertoire it can offer, is effective for all clinical problems (Norcross & Newman, 1992). Likewise, it would be naive to think that one can effectively work with a variety of clinical problems while restricting him/herself to interventions that are common to all orientations. In other words, not only do the common factors always take a specific form within a particular approach, but they are frequently used in combination with therapeutic methods that are unique to a particular approach (e.g., systematic evocation of feelings, analysis of transference, flooding). As cogently argued by Garfield (1992), the proper use of common factors *and* variables unique to particular orientations will probably be the most effective approach for clients and the most congenial strategy for trainers.

The main implication of the latter two problems is that a training approach based exclusively on a common factors strategy is not a viable option, at least not at this point in time. To provide an appropriate integrative training program, the commonians need to complement their approach by using the conceptual and clinical contributions of some "pure-form" orientations and/or by assimilating the contributions of the two other paths toward psychotherapy integration. As shown below, theoretical

integrationists can provide commonians with conceptual frameworks for understanding and treating clinical problems such as anxiety disorders. Moreover, the prescriptive eclectics can help commonians to determine which methods best fit particular individuals.

CURRENT TRAINING EFFORTS

How can one deal with the aforementioned problems and still effectively train graduate students to become skilled therapists? In this section, I will present my own early attempts toward achieving such a difficult goal. Concretely, my training efforts take place in two different contexts: a graduate seminar on cognitive-behavior therapy and a clinical practicum for doctoral students in clinical psychology. In both contexts, the emphasis is put on common factors and, in an attempt to address the first problem described above (i.e., the large numbers of therapeutic similarities that have been identified across several aspects of therapy), the focus is on a specific level of psychotherapy: the principles of change.

While several clinicians have identified commonalties at this level of psychotherapy (e.g., Beitman, 1987; Grencavage & Norcross, 1990; Prochaska & Norcross, 1994), I have primarily based my training endeavors on the contribution of Goldfried (1980; Goldfried & Padawer, 1982). Goldfried argued that different forms of psychotherapy can be compared within the context of three levels of abstraction. The theoretical models adopted by therapists to understand human functioning and the process of change represent the highest level of abstraction. At the lowest level are the specific techniques used to facilitate clients' improvement. According to Goldfried, very few common factors can be identified at a theoretical level, since conceptual agreement is in fact difficult to establish even within a particular orientation. He also argued that most similarities that exist at a purely technical level (e.g., role-playing) are clinically trivial. Rather, he suggested that meaningful commonalities are more likely to be found at a level of abstraction somewhere between the therapists' conceptual models and their technical tools. At this intermediate level of abstraction, one finds global principles of change, such as the provision of a new view of self, the establishment of a working alliance, or the facilitation of a corrective experience. For Goldfried, many techniques that appear to be unique to a particular form of therapy represent, in large part, different manifestations of these robust change principles or basic intervention strategies.

In both my seminar and practicum, my primary goal is to demonstrate how these principles of change are taking place in the major approaches of psychotherapy, and how each of these approaches can be enhanced by

considering techniques that other orientations have developed to implement the same principles of change. Because of space limitations, the description of my current training program will primarily focus on the graduate seminar.

Graduate Seminar on Cognitive Behavior Therapy (CBT)

My seminar is based on Goldfried's principles of change and Safran and Segal's (1990) integration of contributions of psychodynamic, humanistic, and interpersonal therapy within a cognitive-behavioral framework. Whereas Goldfried's approach allows me to address the first problem associated with a common factors perspective, Safran and Segal's integrative model (which is described in more detail below) gives me the tools to deal with the second problem mentioned earlier: It provides a rich conceptual model of human functioning and change from which case formulations and treatment plans can be anchored, and from which therapeutic procedures from diverse orientations can be integrated in a theoretically cohesive way.

As for the third problem (i.e., that therapy is generally not restricted to common factors and contains variables that are unique to particular orientations), it is also addressed by the focus on principles of change. Students are first taught techniques developed by cognitive-behavioral therapists that correspond to the principles of change identified by Goldfried. They are then presented with procedures that serve the same principles of change, but that have been developed by different orientations. The goal is to show that some of these techniques may be more appropriate than cognitive-behavioral procedures for certain types of clients. As illustrated below, the work of prescriptive or eclectic therapists is particularly useful in this regard. Like the theoretical integration proposed by Safran and Segal, the contributions of prescriptive therapists are viewed as a necessary complement for the present approach to psychotherapy training.

Specifically, the graduate seminar addresses the strengths and limitations of CBT with regard to the models of psychopathology underlying this approach, principles and methods of assessment, and treatment procedures. In each of these sections, the traditional view of CBT is presented, the limitations of such a view are exposed, and the contribution of other orientations that may enrich CBT are presented. A brief description of how one of the principles of change mentioned above is covered in the treatment section of the seminar will serve as an example.

As noted by Goldfried (1980), therapists of all persuasions attempt to provide the client with a new perspective of self. This principle of change corresponds to what Frank (1961) described as the role of the therapeutic

myth: a rationale that facilitates healing. The procedures most frequently used in CBT that innervate this principle of change fall under the label of cognitive relabeling or restructuring. A number of techniques have been developed, all of them more or less based on the same basic operations: (1) identifying distorted or maladaptive views of self, world, and future, (2) linking such views to negative emotions and symptoms, and (3) challenging and replacing such views.

Accordingly, a significant amount of time is spent in the seminar to learn, via videotape and role plays, how to perform procedures such as exploring meaning and underlying assumptions, recognizing cognitive errors (e.g., ''all or none'' type of thinking), examining the available evidence for distorted thinking, testing beliefs prospectively, and searching for alternative views. Students then learn how to use, within a CBT treatment, methods that therapists associated with other orientations have developed to facilitate the acquisition of a different perspective of self. These methods differ from the way cognitive-behavioral therapists typically provide a healing myth in terms of techniques used, the content of the new perspective offered, and the focus of intervention. The point emphasized is that methods from other orientations can complement or substitute for cognitive restructuring as long as they serve the same therapeutic function.

Techniques

The use of interpretation in psychodynamic therapy is aimed at facilitating the client's discovery of conflictual motivations that have been previously warded off from the client's awareness. Similarly, interventions such as reflection, confrontation, and two-chair techniques are used by humanistic therapists to increase the client's awareness of implicit emotional experiences and unfulfilled needs. By allowing the client to discover or better understand important aspects of self, these techniques essentially provide new perspectives, meanings, or purposes that can guide clients in adopting different ways of treating themselves, coping with difficulties of life, and interacting with others. This, of course, is perfectly consistent with the goals of CBT. The difficulty, however, is to know when (and/or with whom) it is more useful to work with these techniques rather than with cognitive relabeling procedures mentioned above.

Clinical experiences suggest that CBT interventions may not be as helpful when they are perceived by clients as being too directive (Goldfried & Castonguay, 1993). Empirical research has also demonstrated that clients with a high level of reactance (who resist being controlled by others)

benefit less from a directive treatment such as CBT than from a nondirective therapy (Beutler & Clarkin, 1990; Beutler *et al.,* 1991).

Accordingly, I train my students to become aware of potential markers of client reactance and to shift their technical approach from cognitive relabeling to interventions typically used in exploratory therapy. Using a videotape of an expert therapist, for example, I show my students how client-centered therapists can help clients change their perception of self by reflecting particular aspects of the client's experience. Students are taught that rather than systematically and frequently attacking the logic, rationale, or adaptive value of the clients thoughts, cognitive-behavioral therapists can patiently reformulate certain aspects of the client's experience and gradually question the client's perception of self. When working with clients who are highly reactant and are easily invalidated by persistent Socratic dialogue, I frequently spend a substantial amount of time empathizing with the client's experience and later guide their discourse by a very general and empowering statement that may lead them to question their own view of self (e.g., "It makes sense that you are not proud of what you have done. At the same time, there's a part of you that feels that you did the best you could and that it is very unfair that you have to pay with such an amount of guilt and despair. Can you tell me more about this part of you?"). Using humanistic techniques, in other words, I invite the client to become a cognitive therapist, which is the ultimate goal of this skill-oriented approach.

Content

Consistent with a common factors perspective, we found that both cognitive-behavioral therapists and psychodynamic-interpersonal (PI) therapists attempt to challenge the client's view of self and others (Castonguay, *et al.,* 1990). We have also found, however, that when they do so, therapists in the two orientations convey different messages. Whereas in CBT, therapists are primarily saying, "You are not responsible for the problems that you are confronted with," PI therapists are primarily saying, "You are mostly responsible for the problems in which you find yourself." Not surprisingly perhaps, this study showed that when therapists used such interventions it was positively linked with outcome in CBT, but negatively associated with a decrease of symptoms in PI.[3]

[3]Although the magnitude of the correlations observed in Castonguay *et al.* (1990) are sizable (0.51 for PI and 0.37 for CBT), the small samples of each treatment condition precluded these correlations from achieving conventional statistical significance (i.e., $p < .05$). Until replicated, therefore, these correlational findings should be considered with caution.

These results suggest that the optimistic message provided in CBT may at times facilitate short-term decreases in anxiety and depression. Consistent with the results of another study (Castonguay, Hayes, Goldfried, & DeRubeis (1995), however, these findings also suggest that in CBT less attention is paid to clients' potential contributions to their difficulties, such as their negative impact on others. Although the therapists' focus on client contributions may temporarily increase client distress, it may ultimately facilitate the modification of longstanding maladaptive relationship patterns.

Cognitive-behavioral therapists may increase the long term effectiveness of their treatment by increasing the client's awareness of their role in interpersonal difficulties. This is in fact consistent with recent contributions in cognitive and cognitive-behaviroal approaches for personality disorders (Beck, Freeman, & Associates 1990; Linehan, 1993). Clients may benefit from becoming more cognizant of their interpersonal needs (e.g., wishes and fears), the unsuccessful strategies that they have used across time and situation to meet them, and the maladaptive patterns of relating with others in which the use of these strategies has resulted.

I also suggest to my students that, although inconsistent with the optimistic messages (e.g., things are not as bad as you think) that are typically predominant in CBT (Messer & Winokur, 1980), the experience of negative feelings (depression, anxiety, anger) during the course of therapy is not necessarily detrimental. When confronted with the difficulty of changing longstanding patterns of coping with life, clients do not always have to be convinced that things are much better than they seem to be. In fact, a study recently conducted with CBT for clients suffering from binge eating disorder indicated that clients who successfully responded to treatment reported more negative affect in the middle of therapy than those who did not improve. Consistent with a psychodynamic picture of the process of change, these results suggest that sometimes things have to get worse before they get better (Castonguay, Pincus, Agras, & Hines, 1998).

Focus

When providing feedback to clients, not only does CBT differ from other approaches in the types of techniques used and the message provided, but the interventions of the therapists also focus on different aspects of the client's experiences. At a theoretical level, case formulations and treatment plans in CBT generally emphasize specific variables that are associated with situational and mostly intrapersonal variables: situation, thought, behavior, consequences (Goldfried & Castonguay, 1993). Empirically, significant dif-

ferences have been shown between CBT and PI, at least when these treatments are conducted within the context of outcome research and confined to the guidelines of specific treatment manuals. For example, we have found that in PI, therapists focus more on the client's emotion, developmental issues, interpersonal functioning, and motivational conflict than do CB therapists (Goldfried, Castonguay, Hayes, Droz, & Shapiro, 1997). In my seminar, a significant amount of time is spent showing how cognitive-behavioral therapists can benefit from emphasizing these four important dimensions of human existence, and how these dimensions are not irreconcilable with the situational and intrapersonal foci generally adopted in CBT.

Contrary to the perspective adopted in the psychodynamic and humanistic models of change, emotion has traditionally been viewed in CBT as an aspect of the human experience that needs to be controlled rather than being experienced or explored (Mahoney, 1980; Messer, 1986). In a study by Wiser and Goldfried (1993), expert therapists were asked to identify the most clinically significant segments of a session they had conducted. Whereas CBT therapists chose segments characterized by low levels of emotional experiencing, PI therapists selected segments with high levels of emotional involvement. Interestingly, however, studies have found a link between emotional involvement and outcome in CT for depression (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996), behavioral therapy for anxiety disorders (Borkovec & Grayson, 1980) and, as mentioned above, binge eating disorders (Castonguay *et al.,* 1998). Thus, although the deepening of emotion is not encouraged by the cognitive-behavioral model and may not be systematically fostered in the consulting room, it may well be an underestimated and underused therapeutic agent.

As compared to psychodynamic therapists, cognitive-behavioral therapists have also been found to focus less on developmental issues, such as the client's relationship with their parents during childhood (Goldfried *et al.,* 1997). Similar to what has been observed with regard to the role of emotion, however, therapist focus on developmental issues was found to be predictive of client improvement in cognitive therapy for depression (Hayes, Castonguay, & Goldfried, 1996). Compared to PI, CBT also tends not to address complex interpersonal issues that cut across different times and situations in the client's life, including relational issues that emerge between the client and therapist (Goldfried *et al.,* 1997). However, this type of intervention, mostly identified with the psychodynamic tradition, has been linked with positive outcome in cognitive therapy for depression (Jones & Pulos, 1993). On the other hand, other studies have found that the way that therapists typically address interpersonal functioning in CBT (i.e., by focusing on the client's cognitions about others, rather that on the interpersonal events per se) has been found to be either unrelated to

therapeutic change (Kerr, Goldfried, Hayes, Castonguay, & Goldsamt, 1992) or negatively related to improvement (Hayes *et al.,* 1996).

We have also found that, as compared to PI, therapists in CBT pay less attention to conflictual elements in the client's life, such as incongruent aspects of self (e.g., conflict between wishes and fears or between different needs) and avoidance of change (i.e., resistance) (Goldfried *et al.,* 1997). However, empirical evidence suggests that focusing on such motivational or conflictual issues may be beneficial for the client. For instance, Greenberg and Webster (1982) found that the use of two-chair techniques, which help clients become aware of and integrate incongruent needs, can lead to a better outcome than problem-solving therapy. Furthermore, the therapist's emphasis on defensive maneuvers, unacceptable feelings, warded-off wishes, feelings, or ideas were parts of psychodynamic interventions found to be positively related to change in CT (Jones & Pulos, 1993).

A focus on the dimensions of the client's experience described above is, as I mentioned previously, not inconsistent with the traditional emphasis on situational and intrapersonal issues in CBT. In fact, the conceptual framework developed by Safran and Segal (1990) provides a coherent and comprehensive integration of these different dimensions. Contrasting with Beck's model, Safran and Segal (1990) posit that an individual's view of self, or schema, is intrinsically interpersonal in nature. At the core of one's definition of self, they argue, is one's view of how he/she relates to others. They also argue that these core interpersonal schema, or role-relationship models, are based on early interactions that an individual has with significant caregivers. Because such relationships are the means by which an individual can fulfill crucial physical and psychological needs, the core schema are also related to intense and frequently conflictual emotions (e.g., wishes of attachment, fears of rejection). Accordingly, the challenge of core schema may require more than Socratic dialogue or the examination of the evidence about current thoughts. It may well require the exploration of early relationships, the identification of emotional needs that have not been fulfilled, and the understanding of views of self and ways of behaving that have prevented the individual from creating and maintaining healthy and satisfactory relationships. The exploration of the therapeutic relationship, especially in an emotionally immediate way, is described by Safran and Segal (1990) as the best way to get access to core schema (or "hot cognitions") and to identify client's interpersonal needs, which can in turn dictate behavioral change. However, because the exploration of emotions and the challenge of longstanding beliefs and interpersonal patterns are by definition threatening, client's resistance is viewed as part of the therapeutic process, not as a detrimental element. Within the context of this conceptual framework, therefore, a focus on emotional, developmental, interpersonal, and conflic-

tual issues allows my students to develop richer case formulations and more comprehensive treatments—case formulations and treatment plans that are consistent with a cognitive-behavioral paradigm, but also benefit from the contributions of other orientations.

Clinical Practicum

This commonian perspective of training is not restricted to my graduate seminar in CBT. The same training philosophy guides my clinical supervision, which covers psychodynamic, humanistic, integrative, as well as cognitive-behavioral orientations. Supervision at Penn State is conducted in group teams with students of different years of training. Rather than imposing a theoretical orientation, I invite each student to select the therapeutic approach(es) in which he/she wants to receive supervision based on their conceptual preference (''pure form'' or integrative) and phase of training. As shown below, the determination of their phases of training is based on a developmental model that I recently developed. As a consequence, most cases supervised on my team are approached from different theoretical frameworks. What prevents chaos and allows us to speak with a common language is that the main focus of the supervision, as for my graduate seminar, is on change principles, rather than on techniques.

Specifically, case formulations are developed within the framework of the preferred orientation of the students, so that a coherent understanding of the etiology and change process can be achieved. The treatment plans, however, are centered around specific parameters of general principles of change. The questions we ask are along the line of: What are the best ways to facilitate the client's revision of his/her harsh view of self? What experience in therapy and/or between sessions would provide support to a more realistic appraisal of his/her skills? How can he/she become aware that the way he/she goes about fulfilling his/her needs for closeness may actually push people away? What could he/she change his/her way of approaching life's commitments and relationships, so that he/she may gain more of a sense of purpose, accomplishment, and attachment with significant others? Although techniques traditionally developed in the orientation chosen by the students are applied, the students remain aware of the limitations of these techniques and the potential complementarity of other orientations.

For example, interpretations and the exploration of the therapeutic relationship are interventions used to facilitate insights by therapists who have decided to be trained in psychodynamic therapy. At the same time, CBT techniques are also used to foster corrective experience and behavioral

changes. This is possible because, as cogently pointed out by Wallerstein and DeWitt (1997), all forms of psychodynamic therapies, from the most supportive to the most expressive (including psychoanalysis), involve supportive and action-oriented strategies. The use of CBT interventions, therefore, does not have to alter the coherence of the treatment; it simply allows a more systematic and potentially more effective use of principles of change that are already active in the therapy.

SKETCH FOR A TRAINING PROGRAM IN PSYCHOTHERAPY INTEGRATION

In this last section, I present an outline of a training model driven by a common factors strategy that might be used to guide clinical psychologists (and potentially other mental health professionals) in their doctoral and postdoctoral training. Only addressed are the psychotherapy components of the training curriculum, without mention of typical academic requirements (e.g., core courses, research training, and comprehensive exams).

It is important to emphasize that although common factors (i.e., principles of change) play a central part, this program is not specifically designed to teach integrative therapy. Rather, the primary goal is to teach clinical practice within an integrative framework. The program would involve training students in ''pure-form'' therapies, and although all students would be minimally exposed to some of the current integrative approaches (see Norcross & Goldfried, 1992; Stricker & Gold, 1993), many trainees would not receive extensive training in any of these approaches. At the end of their training, however, all students would be expected to integrate in their clinical work contributions of different orientations (within the context of an already established integrative theory and/or within their own model of therapy).

The proposed clinical training is based on a developmental model of training, which entails five stages: preparation, exploration, identification, consolidation, and integration. Following is a brief description of these phases and their primary components.

Preparation

Not unlike most current training programs in clinical psychology, the first year of graduate school would be devoted to preparing the students for their role of therapist. Emphasis would be placed on learning basic assessment (e.g., DSM-IV interview and diagnosis) and interpersonal skills

(e.g., empathy, warmth) required for clinical work. Students would not be assigned to clients for the purpose of therapy, but would be exposed to videotapes of higher level students, as well as expert therapists from different theoretical approaches. Students would also review the theoretical assumptions and major constructs of five major orientations: psychodynamic, cognitive-behavioral, humanistic/existential, systemic, and integrative. Furthermore, students would be exposed to the principles of change (such as the ones formulated by Goldfried) that cut across these different orientations, and from which therapeutic convergences and complementarities can be delineated. Finally, students would also be introduced to major findings and issues related to outcome research, such as the pros and cons associated with empirically supported treatment, or the available findings that can guide the prescription of specific forms of therapy for particular clinical problems.

Exploration

Rather than ''forcing'' the student to be trained in one orientation at the expense of others, the proposed program would allow (or ''force'') students to get at least a minimal amount of experience with each of the major approaches to psychotherapy. The rationale of this exploration phase is based on the outcome literature, which indicates that although psychotherapy works, no one orientation has been shown to be superior to all of the others across all forms of disorder. Accordingly, not one approach has yet earned the right to be taught as the single and only (or even most) effective form of therapy. At the same time, since none of the current approaches has been found inadequate for a large variety of clients, there is no empirical justification for preventing students from receiving a systematic training in any of the major orientations.

Of course, some students are so committed to one particular orientation that they would gladly be exposed to this approach for the duration of their graduate training. In my view, however, the exclusive choice of an orientation by students early in their training may reveal an unjustifiable bias, a bias which most likely reflects the ideology of previous (undergraduate) mentors and/or a limited exposure to the literature. This should by no means suggest that it is inappropriate for students to have developed early in graduate school or during their undergraduate training a preference for a particular theoretical orientation. Before they can make an informed choice about what works for them and their clients, however, they have to apply different forms of therapy within the context of clinically and conceptually sound supervision. Since process research has repeatedly

shown that there are considerable differences between what therapists say they do and what they actually do in therapy (Cyr & Lecomte, 1983), trainees should be informed that the way a specific form of therapy is practiced and the type of impact it can have on a client is more than likely to be different from what has been conveyed to them in their undergraduate textbooks. Reciprocally, the exclusive choice of a single approach by a training program indicates that those who are responsible for clinical supervision are blind to the obvious fact that although most major forms of therapy have received some form of support, the effectiveness of all of them can be substantially improved. As we noted elsewhere, denying the current state of affairs in the outcome literature is either a sign of ignorance or ideological arrogance (Castonguay & Goldfried, 1997).

Ideally, the exploration phase should take place during the second and third years of graduate school. Students would be expected to apply treatment protocols associated with each major orientation with at least one or two clients. They would also be required to read treatment manuals associated with these approaches. To avoid unnecessary confusion that can emerge while thinking and practicing within the context of different theoretical frameworks, emphasis would be put on principles of change rather than on techniques. Technical interventions would of course be taught during supervision, but they would be presented as specific examples of global strategies of change that cut across different orientations.

Identification

Based on their experience with different approaches during the exploration phase, students would be expected, sometime during their third or fourth year of graduate school, to identify the therapeutic orientation they feel most comfortable with, conceptually and clinically. This is based on the assumption that before leaving graduate school and starting internship, students should be able to independently develop comprehensive and coherent case formulations and treatment plans for a variety of clinical problems. Whereas the commitment to a theoretical model before receiving any formal psychotherapy training may reflect unjustified bias and/or unfortunate myopia, a superficial understanding of numerous approaches at a later stage of training may either reflect or lead to a lack of clinical focus.

To achieve a significant level of expertise in any major orientation, students should have the opportunity to gain a substantial amount of experience in one of them as well as the opportunity to acquire a broad and deep source of knowledge of the conceptual foundations of this particular approach. In an effort to go beyond the reading of textbooks and treatment

manuals, students would be expected to read a number of classics and recent innovations associated with one preferred approach. Students would also need to familiarize themselves with the empirical literature about the process and outcome of their orientations. More importantly, students would be assigned a number of clients judged by the supervisor to be appropriate for the use of the preferred orientation of each student.

Consolidation

In this proposed training program, the last year of the doctoral curriculum as well as most of the internship would be devoted to the students' consolidation, refinement, and expansion of their knowledge related to the particular orientation with which they have chosen to identify themselves. At the end of this stage, students should be able to clearly articulate the therapeutic stance that they typically adopt in a session (i.e., their role and the responsibilities they expect from their client), the type of therapeutic relationship that they strive to establish (with a clear understanding of how to handle complex interpersonal issues such as the alliance, transference, and therapeutic boundaries), and their intervention philosophy (their way of thinking about the therapy, its goals, and process of change). Students should also be able to demonstrate a flexible and competent use of a rich repertoire of techniques, as well as a clear understanding of the limitations of their preferred orientation.

To facilitate this process of consolidation, students would be encouraged to use their preferred therapeutic interventions in several settings (e.g., inpatient, community-outpatient facility), within the context of different tasks (e.g., as a co-therapist, supervision of less experienced trainee), and/or different treatment modalities (e.g., couples therapy, group therapy).

Integration

In this proposed training program, it is only when students have demonstrated significant experience in, and substantial knowledge of, one orientation that a systematic integration with other perspectives would be encouraged. Because of the level of expertise required, it would not be realistic to expect this last training phase to take place, at least for most students, before the internship and even during postdoctoral supervision. Based on my personal training experience, such integration may take place in two phases that are reminiscent of Piaget's developmental model: assimilation and accommodation.

Assimilation

Once well-versed in the use of case formulation and treatment planning within one approach, students would be invited to renew their exploration of other orientations. They would be encouraged to experiment with new procedures or to pay attention to mechanisms of change that are assumed to be responsible for the effectiveness of other approaches. At first, such clinical experimention and theoretical exploration might be anchored (or assimilated) within the frameworks that have guided students since the end of their exploration phase. Revisiting new forms of therapy, therefore, would not need to lead to an abandonment of a well-articulated understanding of psychopathology and psychological change.

For example, after being extensively trained in cognitive-behavioral interventions during graduate school, I arranged to receive psychodymically oriented supervision during internship. This led to my increased recognition of the role of clinical phenomena typically disregarded in CBT treatment manuals, such as the importance of emotional experience. Although not emphasized clinically, the importance of affect is not inconsistent with recent theoretical advances in behavioral therapy (e.g., Foa & Kozak, 1986). Thus, I was able to assimilate my increased awareness of emotion as a potential mechanism of change within the cognitive-behavioral framework.

Accommodation

With more experience in different approaches, assimilating changes in the existing model may progressively lead to more radical shifts in theoretical orientation. For example, as I gained more experience in psychodynamic therapy, greater incongruity became apparent between traditional cognitive-behavioral models and what I observed clinically. Alliance ruptures, transference, resistance, and attachment with early caregivers were taking a more prevalent role in my practice, even in my application of CBT. In addition, these issues were also emerging as significant predictors of change in my research on CBT (Castonguay *et al.,* 1996; Hayes *et al.,* 1996). Assimilation of new experiments into traditional CBT models proved to be more difficult. What resulted from this training experiment and theoretical discrepancies was a search for a more comprehensive model of human functioning. As I mentioned above, Safran and Segal (1990) has provided me with a rich conceptual model which, although anchored in the cognitive-behavioral tradition, allows for the integration of mechanisms of change identified by other orientations.

Contrary to my personal experience, students in this proposed program

would not have to wait until their last phase of training before identifying themselves with an integrative approach. As mentioned above, such approaches would be covered in the exploration phase and could be selected by students in their identification and consolidation phases. It is predicted, however, that even these models, which aspire to be more comprehensive than ''pure-form'' therapies, would be found to be limited by students as they gained more exposure to clinical work. Assimilation and integration of clinical experience would most likely lead to significant shifts in these integrative models.

It is also likely that most of the phases described above are not limited to therapists' training in graduate school. It might be appropriate to construct them as sequences in cycles of training/learning that repeat themselves over and over again. Within that context, psychotherapy integration, with various degrees of articulation, can be seen as a step in a continuous cycling process of change in psychotherapy practice.

CONCLUSION

Although one has to deal with serious practical and conceptual difficulties, it is possible to train therapists from a common factors approach. Presented only as one example of such an approach, my training effort is based on the implementation of general principles of change. By centering my teaching around a single dimension of psychotherapy, as opposed to all possible aspects of the therapeutic interaction (e.g., therapist's characteristics, treatment structure), I have been able to focus on a relatively small number of therapeutic elements that have a substantial heuristic value for clinical work. In addition, by focusing on principles of change, it has been possible to teach common factors without disregarding the importance of variables unique to different ''pure forms'' of therapy. When one recognizes that several techniques serve the same therapeutic principle, it becomes possible to identify specific procedures that might be more effective for particular clients. As suggested by the work of pragmatic eclectics, for example, therapists should use different techniques (e.g., reflection or cognitive relabeling) when attempting to provide a new view of self to clients who are more or less resistant to the influence of others. As for any type of common factors, however, these principles of change do not by themselves allow therapists to develop comprehensive case formulations and treatment plans. To determine how and when to use specific techniques or parameters of any principles of change for a particular client, therapists need to rely on a model of human functioning and change associated with

a pure-form approach or, as presented above, an integrative theory of psychopathology.

What I hoped to illustrated in this article is how a commonian perspective has already led to concrete, albeit limited, training endeavors. It was also my goal to show that a more comprehensive training program centered in part around common principles of change could be proposed. However, whereas it has been possible to build a graduate seminar and clinical practicum based on these principles, it remains to be demonstrated that the integrative program outlined above is both feasible and viable. Would the developmental model upon which this program is based be a helpful and valid heuristic for trainee and trainers? Would the program provide enough opportunity and structure for the students to achieve a solid grasp of at least one psychotherapy approach and a minimal competence in other major orientations? Would the doctoral students trained in this program be perceived as good candidates by well-respected internship and postdoctoral programs? These, like most issues related to training, are difficult questions that may have serious implications for future psychotherapists.

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