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Common and Unique Principles of Therapeutic Change: What Do We Know and What Do We Need to Know?

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One of the most salient controversies in the field of psychotherapy is whether client change is primarily due to the therapist's techniques or the quality of the therapeutic relationship. As described earlier (Beutler & Castonguay, this volume), the premise of this book (as well as the Task Force it has emerged from) is that this controversy reflects, more or less implicitly, an "either/or" assumption that is conceptually flawed and empirically untenable. The complexity of the process of change requires, at least in our view, a consideration of both technical and interpersonal factors. Despite the best intention of its proponents, we also believe that by delineating separate lists of "empirically supported treatments" (EST; Chambless & Ollendick, 2001; Nathan and Gorman, 2002) and "empirically supported therapeutic relationships" (ESTR; Norcross, 2002), past APA Task Forces may have inadvertently fueled this controversy.

Of course, very few clinicians or researchers hold an extreme, all-or-none position vis-à-vis these therapeutic factors. None, we assume, would deny that without a minimum of trust and respect from his/her client, a therapist will find it difficult to effectively and successfully implement the techniques required by most treatment manuals—at least for a large number of sessions. Similarly, we would like to think that even for those who are convinced that the therapeutic relationship is healing by and of itself, there are strategies that can foster its impact. In other words, since not all kinds of relationships are likely to bring change, one needs to be aware of interventions (including modes of relating) that should be encouraged or avoided for the relationship to become a corrective experience.

Yet, as we embarked on this project, we felt that something still needed to be done for clinicians and researchers to be fully and simultaneously exposed, within a single volume, to the empirical evidence about the role that relationships and techniques, as well as client and therapist characteristics, play in the treatment of specific clinical disorders. We also felt that the time was ripe to derive from such empirical literature vari-

ous principles of change that are not tied to specific theoretical orientations and that can serve as useful heuristics for day-to-day clinical practice and future research.

A substantial number of such principles were identified in the three initial chapters of each section of this book (12 chapters in total). Four additional chapters have integrated the list of principles for each specific clinical problem. These have provided a survey of what we know in terms of the potential impact of three variable domains (i.e., relationship, techniques, and participant characteristics) in four problem areas (dysphoric disorders, anxiety disorders, personality disorders, and substance use disorders).

The goal of the present chapter is to provide yet another form of integration of therapeutic principles of change. Rather than looking across domain variables within a specific problem area, we will summarize what the empirical literature is telling us for each type of domain variable across the four problem areas covered in this book. This will allow us to identify principles that may be unique to particular disorders, and those that are likely to be common. We hasten to say that by identifying a principle as being unique to one problem area, we do not imply that it is irrelevant to the treatment of other clinical problems. Unique principles are those that have been judged to be particularly salient to one type of disorder and/or have received sufficient empirical attention to draw relevant conclusions for only one clinical problem. As such, future research may suggest that some of the principles currently viewed as "unique" actually cut across different disorders. Furthermore, by identifying some principles as being "common," we do not wish to imply that they are playing a role in the treatment of all psychological disorders. Rather, this suggests that such principles are likely to have an impact in psychological treatment for at least two of the problem areas targeted in this book.[1]

Interestingly, different sets of domain variables have raised particular challenges with regard to the delineation of common and unique principles, which could in turn lead to different contributions to the current state of knowledge about the process of change in psychotherapy. On the one hand, relationship and participant variables have been frequently studied with general clinical populations and the conclusions reached by the ESTR Task Force (Norcross, 2002) did not discriminate among disorders. This is partly based on the assumption that these variables are common to all forms of psychotherapy and should, therefore, be important in the treatment of most psychological problems. Thus, one of the challenges of this Task Force was to determine whether these conclusions are applicable to specific disorders, perhaps even revealing that some are unique to a particular one. On the other hand, most, if not all, studies conducted on technique factors have been done within the context of clinical trials, where the isolation of homogeneous and specific populations is a core feature. The challenge here is to examine whether some of the principles that were derived from the EST studies (Nathan & Gorman, 2002) cut across some disorders, and perhaps reveal themselves to be common to all of the problem areas covered in this book.

PARTICIPANT CHARACTERISTICS

Following the chapter on participant characteristics in the treatment of dysphoric disorders (Beutler, Blatt, Alamohamed, Levy, & Angtuaco, this volume), we have divided these variables into those that are "observed" versus those that are "inferred." For both categories, common and unique principles of therapeutic change have been identified. Also consistent with Beutler et al. (this volume), we have distinguished between prognosis principles (related to a client's likelihood of change irrespective of the type of treatment used) and matching principles (related to the fit of a particular treatment to specific client's characteristics).

Observed Characteristics

Common Principles

Surprisingly, despite the fact that many observable participant characteristics have been investigated, we have identified only three common principles from the current state of this empirical literature—all of them related to client's prognosis.

The first two have been retained from the treatment research on dysphoric disorders, anxiety disorders, and substance use disorders.

1. Clients with a high level of impairment are less likely to benefit from therapy than those with a better level of functioning at pretreatment.

In the treatment of anxiety disorders, the role of impairment is demonstrated by the negative correlation between outcome and numerous variables such as problem severity, problem chronicity, level of distress, interpersonal problems, and Axis I co-morbidity (see Newman, Crits-Christoph, Connolly Gibbons, & Erickson, this volume). In the review of literature on dysphoric disorders (Beutler et al., this volume), the roles of related dimensions of functioning were aggregated within one general construct, and its examination led to the same conclusion. Furthermore, the above principle of change reflects a number of more specific principles delineated for substance use disorders with regard to poly-substance abuse/use, nicotine dependence, psychiatric co-morbidity, and early onset (Haaga, Hall, & Haas, this volume).

2. Clients who have been diagnosed with a personality disorder are less likely to benefit from treatment than those who have not.

For both dysphoric and anxiety disorders, the presence of an Axis II co-morbid condition is an indicator of a worse prognosis. For substance use disorders, however, the reach of this principle may be narrower as the current state of the literature provides only evidence for Antisocial Personality Disorder as a predictor of poor outcome in the treatment of alcohol and drug abuse.

A third common principle related to an observed characteristic of the client can be drawn from the treatment of anxiety and substance use disorders.

3. Clients who face financial and/or occupational difficulties may benefit less from treatment than those who do not.

This principle is derived from the findings that lower socioeconomic status (SES) is a correlate of worse outcome in the treatment of anxiety disorders and that employment predicts good outcome in the treatment of alcohol and drug abuse. As noted by Newman et al. (this volume), however, the findings related to SES and anxiety disorders should be considered cautiously.

Unique Principles

We have identified 13 principles of therapeutic change related to observed participant characteristics that are unique to one of the particular disorders covered in this book. All but five of these principles are derived from the treatment of dysphoric disorders. The following eight principles unique to the treatment of dysphoric disorders are taken directly from Beutler et al. (this volume). Whereas the first four of them are related to a client's prognosis, the other four reflect matching principles.

1. Age is a negative predictor of a patient's response to general psychotherapy.
2. Patients representing underserved ethnic or racial groups achieve fewer benefits from conventional psychotherapy than Anglo-American groups.
3. If patients and therapists come from the same or similar racial/ethnic backgrounds, dropout rates are positively affected and improvement is enhanced.
4. The most effective treatments are likely to be those that do not induce patient resistance.[2]
5. In dealing with the resistant patient, the therapist's use of directive therapeutic interventions should be planned to inversely correspond with the patient's manifest level of resistant traits and states.
6. Patients with high levels of initial impairment respond better when they are offered long-term, intensive treatment, than when they receive nonintensive and brief treatments, regardless of the particular model and type of treatment assigned. Patients with low impairment seem to do equally well in high and low intensive treatments.
7. 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 de-

signed to facilitate insight and self-awareness.

8. Patients whose personalities are characterized by low levels of impulsivity, indecisiveness, self-inspection, and overcontrol 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.

The majority of the principles here are considered unique to the treatment of dysphoric disorders because insufficient research has been conducted (or mixed results have been obtained) with other clinical populations. The only exceptions are for the principles related to client age and ethnicity (Principles 1 and 2), as these two variables have been investigated in the treatment of anxiety disorders and were found not to predict outcome (see Newman et al., this volume).

It should be mentioned that research has also been conducted with other disorders in relation to two of the principles above (7 and 8). These two principles focus on the moderating role played by coping styles (see Beutler et al., this volume), specifically stating that part of the outcome variance in the treatment of depression can be explained by an interaction between the client's coping style and treatment procedures. Coping, however, has also been investigated as a predictor of change. In the treatment of substance abuse, the client's ability to use coping skills to deal with the temptation to drink has been linked with outcome. In addition, dimensions of externalizing and internalizing, which are consistent with the coping style emphasized in Principles 7 and 8 above, have been investigated as predictors in the treatment of anxiety and have led to the next unique principle of change (taken from Newman et al., this volume). Addressing the client's likelihood of change without regard to the treatment use, this principle can be viewed as a "prognosis" heuristic or guideline. It should be noted, however, that the authors were cautious about drawing firm conclusions with respect to these coping skills, as the variables investigated were not originally intended to capture these constructs.

9. Psychotherapy for anxiety is less likely to be successful if the client has low internal attributions of control or high negative self-attribution. Thus, rigid externalizing or internalizing coping styles are negative prognostic indicators.

Three unique principles of change related to observed participant characteristics were derived from the treatment of substance use disorder (taken from Haaga et al., this volume). The first of them related to client prognosis, while the other two reflected matching guidelines.

10. Therapists with vs. without a history of substance use disorder appear to be equally effective in treating alcohol or illicit drug abuse.
11. High-medical-risk smokers will be especially receptive to individual counseling for smoking cessation only if smoking plausibly contributed to their risk status.
12. Although the evidence is not entirely consistent, cognitive behavior therapy may be differentially effective with depressed smokers relative to comparison conditions. This prescriptive effect may apply especially to those smokers with chronic, recurrent depression.

In addition, one unique principle (related to client prognosis) emerged from the treatment of personality disorders (see Fernández-Alvarez, Clarkin, Carmen Salgueiro, & Critchfield, this volume).

13. Therapists working with a specific personality disorder may increase their effectiveness if they receive specialized training with this population.

Inferred Characteristics

Common Principles

Only two common principles related to inferred characteristics of the participant characteristics were identified, and both of these were related to the client's prognosis (or likelihood of change irrespective of the treatment used). The first of these principles cut across three problem areas: dysphoric, anxiety, and personality disorders.

1. Clients who experienced significant interpersonal problems during their early development may have difficulty responding to psychotherapy.

This principle attempts to capture a number of conceptually related findings. In the treatment of anxiety disorders, the client's perception of negative parenting and attachment difficulties has been linked with worse outcome (see Newman et al., this volume). A client history of positive attachment, parental relationship, and object relations has been identified as a predictor of therapeutic change in the treatment of personality disorders (see Fernández-Alvarez et al., this volume). Attachment difficulties also seem to play a role in the treatment of dysphoric disorders, but the evidence collected so far led Beutler et al. (this volume) to tentatively draw a principle that points to its potential negative impact on the process, rather than the outcome of psychotherapy (see Beutler et al., this volume).

The second common principle was derived from the empirical literature on anxiety and substance use disorders.

2. Client's expectations are likely to play a role in treatment outcome.

In the treatment for anxiety disorders, low expectations for the success of therapy has been associated with worse outcome. Similarly, alcohol outcome expectancies (e.g., alcohol reduces tension) have been negatively associated with abstinence at the end of therapy. In contrast, clients' self-efficacy expectations (for achieving and maintaining abstinence) have also been related to successful smoking cessation (see Haaga et al., this volume). Interestingly, the current state of empirical evidence suggests that clients' expectations (with respect to the success of therapy or the role of each participant) do not appear to be associated with outcome in the treatment of depression (see Beutler et al., this volume).

Unique Principles

A total of 10 unique principles of change related to inferred participant characteristics were identified. In contrast with the unique principles related to observable characteristics, most of them were derived from the treatment of either dysphoric or personality disorders, and more than half are related to therapist variables. The following are four principles unique to the treatment of dysphoric disorders (directly taken from Beutler et al., this volume). It should be noted that the first three have only been retained as suggestive of predictive effects. They are possible contributors whose value is yet to be confirmed. Furthermore, while the first two refer to a client's prognosis, the other two reflect matching principles.

1. If psychotherapists are open, informed, and tolerant of various religious views, treatment effects are likely to be enhanced.
2. A secure attachment pattern in . . . therapist appears to facilitate the treatment process.
3. If patients have a preference for religiously oriented psychotherapy, treatment benefit is enhanced if therapists accommodate this preference.
4. Benefit may be enhanced when the interventions selected are responsive to and consistent with the patient's level of problem assimilation.

Five other unique principles, all related to client prognosis, have emerged from the treatment of personality disorders. As noted by Fernández-Alvarez et al. (this volume), these principles overlap with a number of others related to the therapeutic relationship and treatment procedures (see below). The first of these principles (which obviously relates to the quality of the therapeutic alliance) seems to reflect the emotional cost that psychotherapy especially requires for this clinical population. The other four appear to represent the counterparts of this emotionally and cognitively costly enterprise for therapists.

5. Therapy outcome is likely to be enhanced if the client is willing and able to engage in the treatment process.

6. The therapist is likely to increase his/her effectiveness if he/she demonstrates attitudes of open-mindedness, flexibility, and creativity.
7. The positive impact of therapy is likely to be increased if the therapist is comfortable with long-term, emotionally intense relationships.
8. The benefits of therapy may be enhanced if the therapist is able to tolerate his/her own negative feelings regarding the patient and the treatment process.
9. The therapist is likely to be more effective if he/she is patient.

The last unique principle of change related to inferred participant characteristics was derived from the treatment of substance use. This principle (directly taken from Haaga et al., this volume) reflects yet another dimension associated with a client's prognosis.

10. Smokers in more advanced stages of change, as defined in the transtheoretical model, are more likely to succeed in quitting smoking. Likewise, alcohol abusers reporting increased readiness to change fare better in treatment.

Summary

As specified in the guidelines of the current Task Force (see Beutler & Castonguay, this volume), the reviews of the empirical literature on participant characteristics conducted for this book were primarily based on the previous work accomplished by the Division 29 Task Force on empirically supported therapeutic relationships (Norcross, 2002). As a result of our Task Force, we have been able to derive at least one principle of change (unique to one particular problem area, or common to at least two disorders covered in this book) for each of the variables judged by the Division 29 Task Force to be "demonstrably effective" or "promising and probably effective": resistance, functional impairment, coping styles (externalizing/anaclitic versus internalizing/interjecting), stages of change, expectation, and assimilation of problematic experience.

In addition, by conducting separate reviews for four distinct disorders, the current task force has found support for a number of participant characteristics that were examined by the Division 29 Task Force, but for which insufficient research was found to enable a judgment with regard to their effectiveness. Hence, at least one principle of change was identified for the following client variables: attachment style, ethnicity, religion, and personality disorders. Furthermore, the current Task Force led to principles associated with several participant characteristics that were either not investigated by the Division 29 Task Force or not addressed in its conclusions (Norcross, 2002, pp. 441–442), such as the client's age and socioeconomic status, and the therapist's attachment style, specialized training, and numerous attitudes toward the client and therapy (open-mindedness, flexibility, creativity, patience, tolerance of negative feelings, and comfort with long-term and emotionally intense relationships).

Our reading of the reviews in this book on participant factors led to a relatively small number (five) of common principles, especially compared to the 23 unique principles that we identified. More than half of the unique principles (12) pertained to the treatment of dysphoric disorders. This, obviously, raises questions about whether or not the conclusions reached by the Division 29 Task Force are applicable to most, if not all, psychological problems. However, it should be mentioned that in line with one of the guidelines proposed in the current Task Force (see Beutler & Castonguay, this volume), the authors of the personality disorder chapter on participant characteristics have accepted by default the Division 29 Task Force's conclusions related to each of the variables for which research has yet to be conducted for this population. This involves all of the variables listed above as being "demonstratively effective" or "probably effective". Although we have decided not to do this, one might thus argue that several of the principles identified above as being unique are likely to be shared by two problem areas. In contrast, authors of the chapters on participant characteristics in anxiety and substance use disorders elected not to accept the Division 29 Task Force's conclusions unless sufficient empirical evidence supported them for their particular disorders.

THERAPEUTIC RELATIONSHIP

Adopting the categorization system used in the chapters on dysphoric and personality disorders (see Castonguay et al., this volume; Smith, Barrett, Benjamin, & Barber, this volume), the principles of change associated with relationship variables are divided into three categories: quality of the therapeutic relationship, therapist interpersonal skills, and therapist clinical skills.

Quality of the Therapeutic Relationship

Three variables related to the general quality of the therapeutic relationship were investigated, and each of them led to the delineation of a common principle of therapeutic change. The first of these principles cuts across all four of the problem areas covered in this book.[3]

1. Therapy is likely to be beneficial if a strong working alliance is established and maintained during the course of treatment.

Needless to say, such a statement is hardly surprising considering the considerable amount of research that has been devoted to the therapeutic alliance in the last two decades. It should be mentioned that with respect to the treatment of substance use disorders, this general principle reflects a number of more specific principles of therapeutic change related to the relationship between client and therapist, family and peers, and the relationship that the client develops with the therapeutic program (see Lebow, Kelly, Knobloch-Fedders, & Moos, this volume). The authors of the chapter on personality disorders have also derived a principle of change that is related to the working alliance and emphasizes the importance of the therapist's activity level, provision of structure, and limit setting (see Smith et al., this volume).

The other two common principles of change were derived from the treatment of dysphoric and anxiety disorders, with the first of them also accepted (tentatively) for the treatment of personality disorders.

2. Clients are likely to benefit from group therapy if a strong level of group cohesion is developed and maintained during therapy.
3. Therapists should attempt to facilitate a high degree of collaboration with clients during therapy.[4]

Therapist Interpersonal Skills

As for the variables related to the quality of the therapeutic relationship, each of the three factors associated with client-centered interpersonal skills or attitudes led to the identification of a common principle of change. These principles were derived from the treatment of dysphoric, anxiety, and substance use disorders (with the exception of the last one related to congruence for which insufficient evidence appears to have been associated with anxiety disorders). The formulation of the following three principles was directly borrowed from the principles stated in Castonguay et al. (this volume).

1. Therapists should relate to their clients in an empathic way.
2. When adopted by therapists, an attitude of caring, warmth, and acceptance is likely to be helpful in facilitating therapeutic change.
3. Therapists are likely to facilitate change when adopting an attitude of congruence or authenticity.

It should be noted that the principle related to positive regard (therapist's attitude of care, warmth, and acceptance) was suggested only tentatively for the treatment of dysphoric disorders. Interestingly, it should also be mentioned that the principles about congruence and empathy/understanding have received support, at least indirectly, for the treatment of personality disorders. As described below, Linehan, Davison, Lynch, and Sanderson (this volume) have identified these variables as factors enhancing the client's motivation and collaboration.

Therapist Clinical Skills

When working with the therapeutic relationship, only two (out of five) strategies used by therapists led to common principles of change. This is in contrast with the two previous clusters of relationship variables. These common principles appear to be applicable to the treatment of dysphoric and per-

sonality disorders. It should be noted, however, that the first two reflect provisional conclusions for the treatment of personality disorders, while the third one has been adopted only tentatively for the treatment of dysphoric disorders.

1. Therapists should be careful not to use relational interpretations excessively.
2. When relational interpretations are used, they are likely to facilitate improvement if they are accurate.
3. Therapists are likely to resolve alliance ruptures when addressing such ruptures in an empathic and flexible way.

It should be noticed that for the treatment of personality disorders, a broader set of factors were linked to the resolution (and avoidance) of alliance ruptures than those emphasized in the third principle, for example, therapist's benign self-concept and focus on issues of depth during treatment (see Smith et al.).

Only two unique principles of change emerged from the empirical literature on strategies designed to address or manage the therapeutic relationship. The first (stated tentatively) was derived from the treatment of dysphoric disorders and is cited here from Castonguay et al. (this volume).

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.

Indirect support for this principle has also been provided for this principle in the treatment of personality disorders, as Linehan et al. (this volume) have posited that when used strategically, self-disclosure can enhance a client's motivation and collaboration.

The second unique principle is related to the treatment of anxiety disorders.

2. Providing feedback to the client is likely to be beneficial.

Summary

The review conducted within our Task Force has led to the delineation of at least one principle of change that is related to ten of the eleven variables judged by the Division 29 Task Force's report to be either definite or promising general elements of the therapeutic relationship: alliance, cohesion, empathy, collaboration (and goal consensus), positive regard, congruence, repair of alliance ruptures, self-disclosure, feedback, and quality of relational interpretations (see Norcross, 2002). For the management of countertransference (an element identified by the Division 29 Task Force as "promising and probably effective"), however, no evidence was found for any of the four problem areas covered in this book. Thus, no principle (unique or common) was retained in this chapter for this variable.

Compared with participant variables, a larger proportion of the principles that were related to the therapeutic relationship cut across at least two disorders. Specifically, nine out of 11 (82%) of these principles were retained as common, in contrast with 19% (five out of 27) of the principles extracted for the participant variables. Similar to the participant variables, however, more relationship variables appear to have been investigated in the treatment of dysphoric disorders than in other problem areas.

It should also be mentioned that when insufficient research had been conducted for a relationship variable retained as effective or promising by the Division 29 Task Force, the authors of each relevant chapter accepted this conclusion by default. This, one might argue, could increase the number of factors likely to cut across different disorders.

TECHNIQUE FACTORS

In line with the guidelines proposed for the current Task Force (see Beutler & Castonguay, this volume), we have attempted to integrate the technique principles derived from the four problem areas covered in this book within five general dimensions of psychotherapy: (1) directive versus nondirective or self-directive procedures; (2) intensive versus nonintensive/short-term procedures; (3) interpersonal/systemic versus intrapersonal/individual procedures; (4) thematic/insight-oriented versus symptom/skill-building procedures; and (5) abreactive versus emotionally

supportive procedures (Malik, Beutler, Gallagher-Thompson, Thompson, & Alimohamed, 2003).

To ensure that the conclusions reached encompassed a number of related principles, the first two principles that we extracted were reformulated as "therapeutic stance and general interpersonal style" and "framework of intervention," respectively.

Therapeutic Stance and General Interpersonal Style

Two common principles of change related to the therapist's working stance and style can be delineated from the previous chapters on technique factors.

1. Positive change is likely if the therapist provides a structured treatment and remains focused in the application of his/her interventions.

The need for the therapist, at least in some phases of therapy, to be directive (i.e., to guide the process of therapy) is emphasized by the authors of each of the technique chapters. This general principle reflects a number of more specific principles formulated for the treatment of personality disorders, such as the importance of using a theoretically coherent approach, specifying (and agreeing on) the therapy goals, format, modalities, and strategies before the formal beginning of the treatment, as well as organizing the sessions around prioritized targets.

The second common principle has been derived primarily from the treatment of personality and dysphoric disorders.

2. Therapists should be able to skillfully use "nondirective" interventions.

At the core of dialectic-behavior therapy (the most empirically supported treatment for personality disorders) is the therapist's ability to find a balance between the use of change-oriented (directive) and acceptance-oriented (nondirective) interventions. Nondirective techniques also have a prominent place in the early phase of process-experiential therapy, which has received empirical support for the treatment of depression. It should also be mentioned that while most empirically supported treatments for substance abuse have been described as directive, one of them (motivational therapies) emphasizes nondirective components.

In addition, six unique principles of change related to therapist stance and interpersonal style have been identified for the treatment of personality disorders (taken directly from Linehan, Davison, Lynch, & Sanderson, this volume). The first two, point to the importance of adopting a prudent, cautious, perhaps humbling (as opposed to overly optimistic) attitude when working with this difficult population. The other four principles, interestingly, describe ways to foster client engagement and collaboration in treatment. These four "principles of motivation and collaboration" explicitly address relationship variables (i.e., repair of alliance ruptures, genuineness/congruence, self-disclosure, understanding/empathy) and thus overlap with some of the principles previously formulated.

1. Therapists treating clients diagnosed with PD should be both honest and explicit about their limits.
2. Therapists should not assume that clients diagnosed with PD possess the necessary cognitive or emotional capacities necessary for effective living.
3. The client's motivation for treatment is enhanced, and therapeutic change is most likely, if the therapist can address therapeutic impasses with nonconfrontational strategies.
4. The client's motivation for treatment is enhanced if the therapist is genuine and responsive.
5. The client's motivation for treatment is enhanced when the therapist engages in strategic self-disclosure.
6. The client's motivation for treatment is enhanced when the therapist conveys an understanding of how difficult it is for the client to change.

Framework of Intervention

The framework of intervention refers to a number of structural elements (e.g., contract, setting, phases, or length) within which therapy takes

place (see Castonguay, in press). Two common principles have been retained; the first is derived from the treatment of anxiety disorders, dysphoric disorders, and substance use disorders.

1. Time-limited therapy can be beneficial.

Although the actual length of treatment is varied, the majority of the empirically supported treatments for these three disorders have been conducted within the context of time-limited and relatively short-term interventions. As noted by McCrady & Nathan (this volume), however, therapists working with substance abusers should also "develop a long-term maintenance plan that may or may not include continued formal treatment" (p. 331).

The second common principle is derived primarily from the treatment of anxiety and personality disorders.

2. Therapeutic change may be facilitated by, or even require, intense therapy.

In the treatment of anxiety disorders, this principle is based on the overall, although not robust, findings suggesting that the "massed" delivery of sessions (more than once a week) leads to superior results when compared to "spaced" delivery (Woody & Ollendick, this volume). Although coming from conceptually different models, the two empirically based treatments for personality disorders involve more than one weekly therapeutic contact (Linehan, Davison, Lynch, & Sanderson, this volume). It should also be mentioned that the implementation of some empirically supported treatments for substance use (e.g., community reinforcement approach [see McCrady et al., this volume]) and dysphoric disorders (e.g., cognitive therapy [see Beck, Rush, Shaw, & Emery, 1979]) can involve more than one session per week (at least in the early part of therapy).

We were also able to identify four principles of change unique to a specific disorder. The first three were derived from the treatment of personality disorders (and were taken from Linehan et al., this volume), while the last one pertains to the treatment of substance use disorders (cited here from McCrady & Nathan, this volume). As a whole, these principles may reflect the complexity and particularly demanding nature of treatment for these two particular problem areas.

1. Treatment of BPD takes time. . . . The therapist should plan to consistently apply treatment components over relatively long periods of time.
2. Therapeutic change is most likely if the therapists treating the client in primary and auxiliary modes of therapy receive ongoing consultation and supervision.
3. The client's motivation for treatment is enhanced if the individual therapist is flexible in his or her limits, being more available to the client during a period of crisis.
4. Identify other social service or medical care needs and arrange for attention to these needs.

Interpersonal/Systemic Versus Intrapersonal/Individual Procedures

We delineated three common principles of change related to this general dimension of psychotherapy. The first two cut across the four problem areas (at least to some extent) covered in this book.

1. A therapist may be more effective if he/she does not restrict him/herself to individual procedures: Being with others during treatment can be beneficial for some clients.

In the chapter on technique factors for substance use disorders (McCrady & Nathan, this volume), this principle is expressed both eloquently and pragmatically: Therapists should "provide treatment in an individual, group, or family modality, depending on the individual client and treatment interventions selected" (p. 331). This principle is consistent with the fact that the two empirically based treatments for personality disorders involve both individual and group therapy sessions. In the treatment of dysphoric disorders, this principle is perhaps best demonstrated by the efficacy of behavioral marital therapy and its superior impact on marital discord (a factor robustly related to depression [Joiner, 2002]), as compared to individual cognitive behavior therapy (see Follette & Greenberg, this volume; Craighead, Hart, Wilcoxon-Craighead, & Ilardi, 2002). As noted by Woody and Ollendick (this volume), however, strong support for including others in the treatment of anxiety disorders appears to be restricted to social phobia.

2. Effective therapy may require therapists to address intrapersonal aspects of the client's functioning.

When taken together, the empirically supported treatments suggest that therapists should focus on clients' cognitions, emotions, behaviors, and (in some cases) physiological responses. A number of ways to address these intrapersonal issues are captured in the principles of change included in the next two general dimensions of psychotherapy.

The third common principle of change was derived from the treatment of all the problem areas investigated, with the exception of anxiety disorders. As stated by Woody and Ollendick, even in the treatment of social phobia (where treatments are conducted in group), the intervention strategies used are intrapersonal (see below).

3. Therapy outcome is likely to be enhanced if therapy addresses interpersonal issues related to clinical problems.

This principle refers primarily to the importance of helping the client develop better interpersonal skills and change his/her everyday environment (marital, family, social), so that adaptive behaviors are reinforced and/or maladaptive behaviors are reduced. In addition, helping clients understand their relationship with others is an important aspect of psychodynamic, interpersonal, process-emotional therapies (via exploration and resolution of unfinished business) found to be effective in the treatment of dysphoric disorders. This is also the case, in the early phase of treatment, in psychodynamic therapy for personality disorders. Similarly, some empirically based treatments for substance use disorders (i.e., motivational enhancement therapies and 12-step facilitation treatments) attempt to help clients understand their impact on others.

Thematic/Insight-oriented Versus Symptom/Skill-building Procedures

We have delineated three common principles of therapeutic change related to this general dimension of psychotherapy. The first two are derived from a large number of empirically supported treatments that emphasize symptomatic change and skills acquisition. These two principles cut across all four problems areas covered in this book. The third principle reflects the support received by the thematic, or insight-oriented approach, in the treatment of dysphoric and personality disorders.

1. Therapy is likely to be beneficial if a therapist facilitates change in clients' cognitions.

This integrates a number of principles that refer to the therapist's attempt to decrease maladaptive thoughts (by raising the client's awareness toward them, challenging the evidence for them, or setting up experiments to disconfirm them) and increase adaptive cognitions. In the treatment of substance abuse disorders, for example, this principle includes therapists' efforts at raising the clients' awareness of the severity of their problems and their repetitive thought patterns that perpetuate these problems, as well as therapists' attempts to help clients learn new ways to manage dysfunctional thoughts, acquire more accurate perceptions of social norms related to substance use and abstinence, and develop self-efficacy expectations for change (see McCrady & Nathan, this volume).

2. The client is likely to benefit from therapy if the therapist helps him/her modify maladaptive behavioral, emotional, or physiological responses.

Reflecting the clinical utility of learning mechanisms (e.g., classical and operant conditioning), this general principle refers to a large number of more specific principles that emphasize the importance of eliminating maladaptive responses and/or acquiring more adaptive ones. In the treatment of substance use disorders, this involves the consideration of environmental cues (e.g., smell, sight) associated with substance use, assessment

and change of conditioned responses, and the maximizing of contingent reinforcements for abstinence. With respect to the treatment of anxiety disorders, this general principle of change encompassed the reduction of fear by exposure to the feared situation, elimination of avoidance, and the development of skills to handle the feared situation. Also captured is the following principle derived for the treatment of dysphoric disorders: "Increase and diversify the patient's access to contingent positive reinforcement while decreasing reinforcement for depressive and avoidant behaviors" (Follette & Greenberg, p. 94). The same authors also argue that the challenging of the client's behavior (and cognition) with new experiences is another principle of change that reflects "the importance of evaluating and altering the social reinforcing properties of the patient's environment" (p. 94). In addition, we counted eight principles directly related to behavioral change and/or the functional analysis and modification of maladaptive responses for the treatment of personality disorders (see Linehan et al., this volume).

3. Facilitating client self-exploration can be helpful.

Based on the evidence supporting psychodynamic interpersonal and process-experiential therapies, this general principle suggests that therapeutic change can take place when clients are encouraged to arrive at a new understanding of self based on an active and mostly self-directed exploration of meaningful themes and life experiences. It should be mentioned that the related principles derived in the context of the treatment of personality disorders were stated with important caveats (i.e., treatment focus should be present-oriented and the exploration of the past, as well as insight, should not be until the client demonstrates emotional and/or behavioral control). It also seems worthwhile to mention that while insight-oriented procedures are central to none of the empirically supported treatments for substance use, the increase of client awareness about crucial issues related to their problems has been emphasized in one of the principles of change emphasizing the facilitation of cognitive change. Similarly, as cogently described in Woody and Ollendick (this volume), a client's awareness of maladaptive thoughts is an important component of cognitive therapy for anxiety disorders. However, while they recognize that insight should be investigated (as a phenomena that either precedes or follows change), these authors conclude that in the current state of empirical knowledge "effective interventions for the anxiety disorders appear to rely more on behavioral change than on insight" (p. 179).[5]

Abreactive Versus Emotionally Supportive Procedures

Related to this dimension of psychotherapy, we have identified two common principles of therapeutic change that operate, at least to some extent, in all four problem areas covered in this book.

1. Therapeutic change is likely if therapists help clients accept, tolerate, and at times, fully experience their emotions.

The extent to which the experience and expression of emotion is encouraged appears to vary in empirically supported treatments. Nevertheless, a focus on emotion seems to be indicated with all problem areas covered in this book. Therapists working with substance abusers are recommended to attend to the client's affect, and several treatment approaches encourage "the experience of and, at times, the intensification of emotion" (McCrady & Nathan, this volume, p. 328). In the treatment of personality disorder, clients are helped in accepting and tolerating their feelings. Such emotional acceptance is core to a "mindfulness" approach to psychotherapy that has begun to receive support in the treatment of dysphoric disorders. Helping clients to identify, explore, stay with, and/or deepen emotion are important interventions in psychodynamic, interpersonal, and (especially) process-experiential therapies, which have all received support for the treatment of dysphoric disorders.[6] The evocation of intense emotion (fear) is also a cardinal feature of empirically supported treatments for anxiety disorders. Interestingly, the experience of intense feelings (as a means to facilitate exposure to fear structure or deepen emotional experience) appears to be common to cognitive-behavioral therapy and process-experiential therapy, despite their different conceptual roots.[7]

2. Interventions aimed at controlling emotions can be helpful.

While none of the empirically supported treatments encourage the avoidance of emotional experience, some of them are designed to control or regulate feelings. This is the case in treatments for personality disorders (at least for borderline personality disorder), where both empirically based treatments are defined as emotionally supportive and view abreaction (or catharsis) as iatrogenic (see note 4 and Linehan et al., this volume). In the treatment of dysphoric and substance use disorders, cognitive-behavior-oriented treatments are described as methods aimed at helping clients cope with or reduce negative emotion. Although empirically supported (cognitive-behavioral) treatments for anxiety disorders primarily use emotionally evocative procedures, the evocation of emotions is viewed as a by-product of the therapist's attempts to challenge thoughts, reduce avoidance, or decrease anxiety response (Woody & Ollendick, this volume). In exposure-based treatment, for instance, the purpose "is to help the client experience the emotion in a manageable way, not to just experience intense emotion for the sake of experiencing such emotion" (p. 180).

Summary

Taken together, we have been able to identify 22 principles of change related to technique factors, 12 of them (55%) cutting across at least two problem areas. Although not as high as for the relationship variables, this ratio of common over unique principles is substantially higher than that for participant variables. At first glance this could seem surprising. Because most, if not all, controlled clinical trials are conducted with specific and homogeneous clients, one might have expected a greater percentage of technique principles unique to the four distinct problems areas investigated in this book. What our findings may reveal, however, is the prevalence of cognitive-behavioral-oriented therapy among the treatments that have been currently tested in controlled trials. While the particular targets of interventions may vary with different disorders, these conceptually related treatments appear to share several techniques, which in turn allow for the delineation of many underlying principles of change.

In contrast with the participant and relationship variables, the list of empirically derived technique principles obtained here cannot be compared to the findings of another Task Force. Our results, however, have provided support for each pole of the five general dimensions of psychotherapy proposed by our Task Force. Across at least two disorders, there is evidence showing support for therapists to be directive (structure the process of change and be focused), use nondirective (validating) procedures, plan time-limited therapy, conduct intensive treatment, make use of nonindividual modalities, focus on interpersonal and intrapersonal issues, facilitate skills acquisition, encourage self-exploration, focus on emotional experience, and to use emotionally supportive interventions. Evidence also supports the use of long-term therapy for the treatment of personality disorders.

FUTURE DIRECTIONS

As a whole, the current Task Force has led to the identification of 61 principles of therapeutic change (albeit a number of them overlapping), 26 (43%) of them derived from the treatment of at least two problem areas. This fairly large number of clinical guidelines reflects a substantial amount of research on the process and/or outcome of psychotherapy for dysphoric, anxiety, personality, and substance disorders. There is still a long way to go, however, in adequately understanding how, as well as the conditions under which, psychotherapy works or fails to be beneficial. The following is a list of suggestions, by no way exhaustive, for future research based on some of the gaps of the current empirical literature revealed by our Task Force.

With respect to participant characteristics, our most glaring lack of empirical knowledge concerns the treatment of personality disorders. In fact, only one of the client and therapist variables retained by the Division 29 Task Force as effective or promising factors has received an acceptable level of at-

tention for this clinical population (i.e., client's history of attachment, interpersonal relationship, or object relations). Even the principles of change about participants that have been identified as unique for the treatment of personality disorders (none of which related to variables investigated by the Division 29 Task Force) need stronger and more direct evidence (see Fernández-Alvarez et al., this volume). It would also be interesting to know whether these principles (linked to several attitudes of the therapists toward the client and therapy, their level of training, and the client's willingness and ability to engage in the process of therapy) are indeed unique or particularly salient to the treatment of personality disorders.

A number of participant variables also deserve more attention in the treatment of both anxiety and substance use disorders. Among them are the client's religiosity or spirituality, preferences, and anaclitic/introjective style; the therapist's attachment style; match between the client's level of resistance and type (more or less directive) of intervention, match between the client's level of impairment and treatment intensity, match between the client's coping style (anaclitic/introjective and/or externalized/internalized) and intervention focus, match between the client's level of assimilation and therapist interventions, and match between the client and therapist's race or ethnicity. More research is also indicated for the treatment of substance use in general with regard to client age, ethnicity, attachment style, and externalizing/internalizing coping style. Furthermore, research on coping skills, personality disorders, and social class is also needed in the treatment of smoking cessation, in particular. Although conclusions were drawn (with various degree of certainty) with respect to SES, parental and attachment issues, externalizing/internalizing style, and ethnicity in the treatment of anxiety disorders, more research appears to be warranted.

While a large number of participant variables have been investigated for the treatment of dysphoric disorders, the principles related to some of them (i.e., client's religiosity and attachment style, therapist's attachment style) have been stated tentatively and/or formulated only with respect to process (and not outcome). As such, these variables should receive more attention from researchers interested in the treatment of dysphoric disorders. In addition, the potential role of the client's social class should be further investigated with this clinical population.

Furthermore, for all the problem areas covered in this book, more studies are needed on the match between a client's stage of change and focus of intervention, as well as on numerous variables related to therapist characteristics and matching therapists and clients.

As with the participant variables, researchers need to pay much more attention to the potential role of relationship variables in the treatment of personality disorders. While five relationship principles were derived for this population, three of them (related to group cohesion and relational interpretations) were adopted as being only suggestive. In fact, only issues related to the alliance (its impact and ways of repairing it) have received noticeable attention. Considering the complexity of relationship factors associated with this difficult-to-treat and heterogeneous population, much more research would be welcome (see Smith et al., this volume).

Gaps of knowledge are again shared across the treatment of anxiety and substance use disorders. More needs to be known for both problem areas about the possible benefit of therapist self-disclosure, relational interpretations, and the repair of alliance ruptures. In addition, researchers should examine the role of collaboration and group cohesion in the treatment of substance use disorders, as well as the potential impact of congruence in the treatment of anxiety disorders.

Similar to the case of participant variables, most of the relationship factors identified by the Division 29 Task Force were investigated, more or less extensively, in the treatment of dysphoric disorders. It should be mentioned, however, that the principles of change related to three of these variables (congruence, self-disclosure, and repair of alliance ruptures) were adopted only tentatively and should therefore be further investigated. More empirical attention should also be given to the management of countertransference and the provision of feedback. The limited evidence supporting the former is not specific to any of the four problem areas covered in the book. Moreover, support for the latter appears to be only applicable to the treatment of anxiety disorders, at least at this point in time.

With respect to technique factors, our Task Force has once again highlighted the paucity of research with respect to personality disorders. The technique principles related to this population were derived from only two treatments (psychodynamic and dialectic behavior therapy [DBT]), for a single type of personality disorder (borderline personality disorder, BPD). As noted by Linehan et al. (this volume) only DBT for BPD currently meets criteria for "well-established" treatment. In light of the prevalence in clinical settings and the heterogeneity of this problem area, more should be done to develop and/or test effective psychosocial interventions. In the meantime, the principles derived highlighted here should be viewed as tentative—less so, however, for DBT for BPD.

Interestingly, it would be worthwhile to determine whether some of the technique principles identified as being unique to personality disorders may actually be relevant to other problem areas (e.g., the value of ongoing supervision and of being flexible about treatment limits).

We also believe that researchers should expand the parameters of typical clinical trials across disorders covered in this book. To begin with, more energy should be spent investigating long-term therapy. Considering the fact that a substantial number of clients do not fully benefit from many of the time-limited protocols that have been tested, it seems indicated to investigate whether some clients with Axis I disorders might need the length of treatment that has been used in empirical trials for Axis II disorders. In addition, more should be done to test the efficacy of treatments that are not exclusively or primarily relying on cognitive-behavioral procedures. There is now enough supporting, or at least promising, evidence for humanistic (e.g., process-experiential), interpersonal, psychodynamic, and mindfulness-based therapies to justify substantial investment, in terms of time and funds, from our scientific community to more solidly and broadly demonstrate their therapeutic impact. More empirical attention should also be given to systemic and integrative approaches.

In line with an integrative perspective, we also believe that effective interventions should build on each other to increase their respective impact. The combination of behavioral and humanistic strategies in dialectic behavior therapy is a prefect example of this kind of integrative therapy. We suspect that a similar balance of directive (change or action-oriented) and nondirective (accepting and validating) procedures would lead to better outcome than some of the primarily directive (e.g., traditional CBT) treatments developed for dysphoric, anxiety, and substance use disorders. This is also consistent with Woody and Ollendick's (this volume) suggestion to explore the potential merit of adding interpersonal strategies to the currently supported treatments for anxiety disorders. Although preliminary, promising results have indeed been obtained by adding such interpersonal strategies (along with humanistic procedures aimed at deepening emotions) to cognitive behavioral therapy for generalized anxiety disorder (Newman, Castonguay, Borkovec, & Molnar, 2004). In addition to building on the complementary contributions of different approaches, this type of additive strategy and methodological design avoids major internal validity pitfalls associated with comparative designs that are typically used in clinical trials (see Borkovec & Castonguay, 1998).

In closing, two more general recommendations for future research should be made, or as a matter of fact, repeated. As stated at the onset of this book (see Beutler & Castonguay, this volume), it would be premature to assume, at this point in time, that the principles delineated in this Task Force are empirically supported. It seems more appropriate to refer to them as being "empirically based" (or derived), since they have inferred determinants of change from correlational analyses and/or from the inspection of supported treatment manuals. It, therefore, behooves the field to test the causal effect that these principles may have on therapeutic change via means such as mediator analyses and dismantling, additive, catalytic, or parametric designs (Behar & Borkovec, 2003).

Finally, as stated in differing ways by several authors in this book (e.g., Beutler et al., this volume; Castonguay et al., this volume; Stiles & Wolfe, this volume) each principle should be investigated within the context it takes place. Participant, relationship, and technique principles do not operate in isolation. For example, representatives of each problem area have recognized, to a greater or lesser extent, that the successful implementation of effective techniques is based on, or facilitated by, a collaborative process, well-established rela-

tionship, or empathic and genuine attitude of the therapist (Beutler, Castonguay, & Follette, this volume; Linehan et al., this volume; McCrady, Haaga, & Lebow, this volume; Woody & Ollendick, this volume). Perhaps the most difficult and exciting challenge in psychotherapy research resides in the fact that principles that are related to these three domains are in a constant flux of interaction and interdependence. While some research has begun to delineate such complex relationships, much more needs to be done before we achieve an adequate understanding of how these factors work with, against, and within one another to enhance change.

As an initial step toward this lofty goal, however, it was imperative to show that none of the three sets of therapeutic factors can be upheld as sufficient for the explanation of change. Au contraire, it was necessary to demonstrate that each of these domains plays a role in the treatment of several problem areas. This was the goal of our Task Force, and by looking at the previous and current chapters, we like to think that it was met.

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Notes

1. It should be noted common factors have also been identified in two integrative chapters of this book (Beutler, Castonguay, & Follette, this volume; Critchfield & Benjamin, this volume). They have, however, been worded and organized in slightly different ways. While the current chapter derived common principles uniquely from the 12 original chapters of this book, the authors of these integrative chapters also relied on a group discussion that took place between members of our Task Force (see Beutler & Castonguay, this volume).

2. The lack of compliance with homework, which can be viewed as resistance, has been found to predict worst outcome in the treatment of anxiety disorder. As described in a note below, however, homework compliance has also been defined as a manifestation of "collaborative engagement." Because the authors representing the anxiety disorders area have integrated the findings about homework compliance under the construct of collaboration, the principle of resistance stands as one unique to the treatment of depression. This, however, is clearly an arbitrary classification, since both constructs are overlapping.

3. With regard to anxiety disorders, the conclusions reached in this section are based on the integrative chapter written for this problem area (Newman, Stiles, Woody, & Janeck, this volume). While the authors of the chapter on relationship variables for anxiety disorders (Stiles & Wolfe, this volume) have listed several studies supporting the importance of such variables, they have elected, mainly for conceptual reasons, to adopt by default the relevant conclusions reached by the Division 29 Task Force rather than specifying which of these conclusions have received direct empirical support and which have not. However, evidence for specific relationship variables has been presented in the integrative chapter of the anxiety disorders section.

4. In the Division 29 Task Force, the variable of "collaboration" was investigated along with "goal consensus." As stated in Castonguay et al. (this volume), however, goal consensus is a component of the therapeutic alliance. The principle formulated here refers only to elements considered in the Division 29 Task Force as part of the client collaborative engagement, such as homework compliance (see Tryon & Winograd, 2002). It should also be noted that some elements assumed to reflect a client's collaboration (including, as mentioned in a note above, homework compliance) were also defined in the Division 29 Task Force as manifestations of resistance (or lack of thereof) (Beutler, Moleiro & Talebi, 2002). As such, the principle about collaboration overlaps with one of the previously formulated principles (i.e., "The most effective treatments are likely to be those that do not induce patient resistance").

5. Needless to say, the last two principles of change overlap with a previous one, that is, "Therapists should address interpersonal issues related to clinical problems." At least for the treatment of dysphoric, personality, and substance use disorders, the responses that therapists attempt to modify often involve ways of relating with others. Similarly, the exploratory interventions used in treatment supported for the same disorders focus in various degrees on interpersonal issues.

6. When applied to personality disorder, psychodynamic therapy seems to place less emphasis on the exploration or deepening of emotion. As noted in Linehan et al. (this volume), "therapists attempt to identify patients affects, their interpersonal context followed by their intrapsychic meaning and consider abreaction to be iatrogenic" (p. 248).

7. It should be mentioned, however, that fostering emotional experience within certain circumstances and/or specific time frames may not be effective. Research has suggested that psychological debriefing conducted immediately after the experience of a traumatic event fails to prevent long-term symptoms and may even be detrimental for the recovery of some individuals (see Litz, Gray, Bryant, & Adler, 2002).

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