Principles of Therapeutic Change: A Task Force on Participants, Relationships, and Techniques Factors

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Louis G. Castonguay
Penn State University

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Larry E. Beutler
Pacific Graduate School of Psychology and Naval Post-Graduate School

The authors present the structure and process of a task force aimed at delineating empirically based principles of change in psychotherapy. Sponsored by Division 12 of the American Psychological Association and the North American Society for Psychotherapy Research, the task force addressed the potential role of participant characteristics, relationship variables, and technical factors in the treatment of dysphoric, anxiety, personality, and substance use disorders. © 2006 Wiley Periodicals, Inc. J Clin Psychol 62: 631–638, 2006.

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Psychotherapy works! This assertion represents a clear consensus in the field of clinical psychology (Lambert & Olges, 2004). More controversial and still a source of debates and controversies, however, are the questions of how well and how it works. To a substantial extent, attempts to address these questions have largely been consolidated as an argument between two perspectives—those who attribute change to specific treatments and those who attribute it to common (or "nonspecific") variables. Indeed, most benefits of psychotherapy have tended to be ascribed to the techniques prescribed by particular approaches (e.g., systematic desentization) or to relationship factors that are assumed to operate similarly in all forms of psychotherapy (see Castonguay, 1993). This dichotomy

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Correspondence concerning this article should be addressed to: Louis G. Castonguay, Department of Psychology, Penn State University, University Park, PA, 16802; e-mail: lgc3@psu.edu

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has pervaded several decades of psychotherapy research and is still the guiding influence that directs the reflections of leading figures in the field about the factors responsible for change (e.g., DeRubeis, Brotman, & Gibbons, 2005). Recently, participant characteristics have received serious consideration as a legitimate candidate in what could be viewed as a "three-horse race" aimed at determining the most important determinant of change. For example, whereas Bohart has defined the client self-healing capacity as "the 'engine' that makes therapy work" (Bohart & Tallman, 1999, p. 91), Wampold (2006) has argued that the psychotherapist "is an important, if not the most important, source of variability in outcomes" (p. 201).

Whether this "horse race" mentality has been explicitly espoused or merely implied, the categorization of therapeutic variables that underlies such thought fails to do justice to the complexity of the factors that are associated with therapeutic change. In fact, there is enough empirical evidence to conclude that each of these three sets of factors play a role in effective therapy. Chronologically, the argument among those who have advocated for technique, participant, or relationship factors to be ascribed the leading role in outcome, first became apparent when the American Psychological Association (APA) Division 12 Task Force made its first report on available empirically supported treatments (EST). This task force provided support for the role of specific techniques (Chambless & Ollendick, 2001; DeRubeis & Crits Christoph, 1998; Nathan & Gorman, 2002). As a response to this initial Task Force, the APA Division of Psychotherapy (Division 29) appointed its own task force whose mission was to demonstrate that relationship factors deserved at least as much credit as treatments in the attributions of psychotherapeutic changes. This latter task force identified *empirically supported therapeutic relationships* (ESTR) as a concept to parallel that of *empirically supported treatments* (ESTs), the rallying label applied by the original Division 12 Task Force.

In addition to demonstrating that relationship variables do account for change, the ESTR Task Force also offered evidence of participant factors in therapeutic effects. This Task Force concluded that client's characteristics predict outcome, and that some of these characteristics can be used to define an optimal or particularly good fit between the patient and the interventions used with particular clients (Norcross, 2002).

These previous Task Forces represent laudable and ambitious efforts that should be commended for taking on the tasks of delineating the unique contribution of specific factors involved in the process of change. However, it is important to recognize that all of these techniques, relationship factors, and participant characteristics, when considered independently, do not produce a large impact on client improvement. For example, with the exception of a relatively small number of clinical problems (e.g., obsessive–compulsive disorder, generalized anxiety disorder), it is hard to find one treatment that works better than another. Most estimates from such studies reveal that differences among treatments account for no more than 10% of the variability in change (Luborsky et al., 2001; Wampold, 2001). Moreover, various groups have identified close to 150 different approaches and models to treatment that are effective, each accompanied by a different manual and addressed to a specific type of patient (Chambless & Ollendick, 2001). Together, the evidence that there are only minor differences in effectiveness among treatments combined with the burgeoning number of treatments that identify themselves as being empirically supported has raised doubts for many about whether the benefits of improving practice by developing more manuals is either practical or cost effective (Beutler, 1998, 2002). On the other hand, research has indicated that the most robust of the relationship variables, the therapeutic alliance, typically accounts for no more of the variation among outcomes than the 10% attributed to specific treatments (Beutler et al., 2003; Horvath & Symonds, 1991). Moreover, research on the therapeutic relationship is invariably

correlational in nature; therefore, it has been difficult to demonstrate that relationship quality actually *causes* improvement, rather than vice versa, during treatment.

Hence, the current status of empirical research seems to indicate that the complexity of change should prevent us from focusing on only one type of factor when adopting a scientific–practitioner philosophy to psychological treatment. Thus, as we (the authors), respectively became President of the North American Society for Psychotherapy Research (NASPR) and the Division 12 of APA, we embarked on the creation of a third Task Force, one that would recognize the role of techniques, relationship, and participant characteristics, and foster an integration of their unique but interdependent contribution. In addition, we set up the Task Force to examine the role that these three sets of variables potentially play in the treatment of four clusters of clinical problems frequently encountered in clinical practice: dysphoric disorders, anxiety disorders, personality disorders, and substance use disorders. Finally, with the hope of providing the most clinically helpful recommendations, we decided that the main goal of the Task Force should be to delineate principles of change. Rather than focusing on highly specific techniques or constructs, we believed that it would be more useful to provide general, yet well-articulated guidelines or heuristics about how to most effectively deal with clients. Ideally, we hoped that these principles of change would not be tied to the jargon of particular approaches or theories, and would instead reflect recommendations that could cut across different forms of psychotherapy.

The goal of this series of articles is to summarize the results of this Task Force on empirically based principles of change, which have been described in detail in a book recently published by Oxford University Press (Castonguay & Beutler, 2006a).[1] Reflecting the structure of the Task Force, we divided the book into four sections, each one representing a particular disorder or problem area (dysphoric disorders, anxiety disorders, personality disorders, and substance abuse disorders). Within each of these four problem-focused sections are four chapters. Three chapters within each section are focused on a separate domain or group of variables that are thought to influence treatment: participant factors, relationship factors, and techniques factors. Each of the these domain specific chapters is aimed at identifying a few salient principles that express the things that clinicians can do to optimize the effectiveness of treatment by attending to specific variables within this domain. The fourth chapter in each section is a summary and integration of the principles that are identified in these latter, three chapters. While the 12 individual chapters on participant, relationship, and technique factors were independently written following a general outline and consensus about terminology and scope of work, the integrative chapters, the fourth chapter in each section, were developed at a meeting that took place at the second author's home in Placerville, California. The four articles following this introduction are directly based on these integrative chapters.[2]

The Task Force on Empirically Based Principles of Therapeutic Change

When we formed the task force from which this series derives, we did so with the intent of ensuring that most viable points of view would be represented. Thus, the Task Force members (see Castonguay & Beutler, 2006a, for a complete list of members), including

[1]It is important to note that while the Task Force was sponsored by both APA Division 12 and NASPR, neither the findings presented in the book nor their summarization presented in this series represent the official position of these two organization with regard to what makes psychotherapy work.

[2]For its part, the current article is based on the preface and, more largely, the first chapter of the Task Force report (i.e., Beutler & Castonguay, 2006)

those who wrote the papers in this special series, were initially selected through a process of nomination and discussion. Several criteria were required of the Task Force members: (a) they must be established scholars who have achieved visibility in the scientific community for their empirical research in a given problem area and variable domain; (b) they must be willing and interested in working toward integration and synthesis of research findings; (c) they must be willing to work on a chapter with colleagues who do not share their theoretical perspectives; and (d) they must be willing to work hard for little financial compensation.

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

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

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

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

The four groups of authors who wrote the chapters on participant factors were specifically asked to review all of the studies, within their particular problem specialization, on which conclusions of therapeutic efficacy had been identified in the corresponding chapters of the Division 29 report (Norcross, 2002). To complement the studies extracted from these chapters, authors were also asked to examine the relevant reviews of literature offered in Bergin and Garfield's (1994) or Lambert's (2004) texts. Where the literature

warranted, "participants" in psychotherapy included a consideration of family members, spouses, and others whose characteristics and presence provide social context and support to patients in psychotherapy. In each case, we asked authors to consider available research on the role of specific variables in predicting treatment outcomes with an eye especially on factors and variables that may serve as moderators of a patient's response to different treatments.

Likewise, the eight Task Force members who were asked to write the four chapters on relationship factors, were asked to assess the status of research by carefully extracting relevant studies from the chapters on relationship factors contained in the Division 29 Task Force report (Norcross, 2002), and by examining the appropriate reviews of literature in the *Handbook of Psychotherapy and Behavior Change* (4th ed., Bergin & Garfield, 1994; 5th ed., Lambert, 2004). Here, the questions addressed related to the type of relationship the therapist should attempt to foster, as well as the interpersonal skills he or she might want to master to facilitate a client's improvement.

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

The authors of the four chapters on technique variables had a somewhat different task than those who wrote on relationship and participant factors, specifically because the literature in this area was defined by a concentration upon treatment models (e.g., cognitive–behavioral therapy) rather than on specific types of interventions or technical procedures. Thus, these four groups of authors were asked to extract the body of studies pertaining to technique factors both from the chapters contained in the volumes by Nathan and Gorman (1998, 2002) and in the report by Chambless and Ollendick (2001) on the efficacy of ESTs. While authors were encouraged to take the reports in these relevant volumes as evidence of the efficacy of different models of intervention for treating different diagnostic groupings of patients, they were asked to go beyond the simple tabulation of what models work for what patient groups, as done in the original EST reports. Instead, they were encouraged to identify particular classes of intervention that characterized the treatment models employed, for which there was specific evidence of efficacy. Thus, we asked these authors to dismantle the various treatments and to identify the degree to which families, strategies, and characteristics of the intervention, rather than specific techniques, accounted for change. As in the case of the other authors, we asked authors of the technique chapters to extract general principles that identified the role of the variables that comprised effective treatments.

In the penultimate step to the task force's work, we convened a group of 12 authors, with one representative from each of the review chapters of the book. We asked these authors to bring with them to the meeting, the articulated list of the principles that each of

the 12 work groups had distilled from their various reviews, and then we engaged them in a process of distinguishing between principles that were common to two or more of the problem areas and those that were relatively unique to the specific problem types.

Three work groups, representing, respectively, one of the three domains of variables researched (participants, relationships, techniques) identified and clarified common principles. In each of these groups, identified by domain, all four problem areas were represented by one author. The authors shared with one another, the principles that they had derived from their separate reviews and subjected these principles to a discussion. This discussion was aimed at identifying and restating, in a common language, the principles that seemed to cut across some or all of the four different problem areas. This became the list of "common principles."

Once common principles were identified, the work group was reconfigured to identify and refine, through a similar process, from the residual list, a set of principles that were specific to each problem area (dysphoric, anxiety, personality, and substance use disorders). All of the authors within each of these second working groups, represented the same problem area but from the perspective of the three different variable domains addressed by the Task Force. These groups met together, reviewed the principles that had been defined in their various efforts to delineate empirically based principles, but that had not been identified as common across patient groups, and extracted from these, an articulated list of principles that expressed the conclusions reached from the research reviews on each problem area, and that were simple and communicative. The result was a complementary list of principles that are specific for each problem area and that are relevant to each of the domains of variables.

As mentioned above, the discussions that took place during this meeting helped shape the four integrative chapters that serve as the basis of the current series. It should be noted, however, that an additional delineation and articulation of the empirically based principles was undertaken from an integration of the 12 original chapters, at the conclusion of the Task Force's work. This integrated, final review (Castonguay & Beutler, 2006b) constitutes the concluding chapter of the Task Force report.

One word of caution should be expressed with regard to the empirical status of the principles of change delineated by the Task Force. It is indeed important to state that most, if not all, of these principles lack research of the type that allows clear assessment of their causal role in evoking therapeutic change. For the most part, they reflect the presence of correlates of change and were derived from research that only permits the conclusion that each principle is *consistent with* causal inferences. Thus, rather than referring to them as being *empirically supported*, it seems more appropriate to describe these principles as *empirically derived* or *empirically grounded*. For the same reason, and until they receive the kind of empirical support that will allow a firm, causal inference to be made, it would be wise to view these clinical guidelines as hypotheses, rather than as established or factual processes of change.

Constructs and Sources

Participant factors, for the purposes of this special series of articles are characteristics of the patient or therapist that (a) exist solely within the person of the therapist or patient and extend to the participant's life beyond the particular situation of psychotherapy, and (b) are representative of qualities that are indwelling to the person but that are manifest mainly within psychotherapy itself. From the Division 29 Task Force report, these variables reflected one of two types of relationships to outcome: those that predict the like-

lihood of change and those that moderate the effects of psychotherapy and that can be applied to the process of tailoring treatment to patients. Included in either or both types of variables are resistance, functional impairment, coping style, stages of change, anaclitic/sociotropic and introjective/autonomous styles, expectations, assimilation of problematic experiences, attachment style, gender, ethnicity, religion and spirituality, preferences, and personality disorders.

Relationship factors refer to general qualities of the interaction between patient and therapist, as well as therapists' skills that allows them to be attuned to their clients and work with the therapeutic relationship. The Division 29 report listed the following factors that we believe are best defined as relationship factors: therapeutic alliance, cohesion in group therapy, empathy, goal consensus and collaboration, positive regard, congruence/genuineness, feedback, repair of alliance ruptures, self-disclosure, management of countertransference, and quality of relational interpretations.

Technique factors, as these terms were used within the context of the Task Force, are the specific procedures that comprise the models of psychotherapy that are identified as empirically supported treatments in the Division 12 reports. These lists served as the criteria of what treatments were inspected to derive principles of change. To determine the nature of the interventions and to extract their underlying principles, authors were asked to inspect the specific manuals listed by the Division 12 reports. Authors were also provided with categories of intervention principles that could be used to regroup techniques from different orientations, based on the presence of similar goals, functions, or demand characteristics. These include (a) the ability of the therapist to provide directiveness, (b) level of insight versus symptom and behavior change focus, (c) treatment intensity (e.g., length, frequency), (d) intrapersonal and/or interpersonal focus of intervention, and (e) interventions that were designed to be emotion enhancing versus supportive.

In all three sections (participants, relationship, technique factors), authors were instructed to exclude from consideration and review, findings that pertained exclusively to biological treatments and those that exclusively pertained to the treatment of children. Thus, the principles of change that have been derived are only relevant to psychosocial therapies as received by adults. Of course, the Task Force conclusions are also restricted to those patient problems reviewed. One cannot generalize the principles to treatments of adult disorders (e.g., eating disorders, psychotic disorders) when dysphoria, anxiety, personality disorder, or substance use are not prominent features.

The Process

As noted, in defining the variables to consider in the various chapters, authors were asked to extract all relevant studies from a predefined list of established, secondary sources. However, they were also free to supplement these references and findings by going to specific studies as well as adding more recently published studies to strengthen their conclusions and to extract relevant detail about samples and treatments. Authors were allowed to add factors, qualities, or interventions to those discussed in the predefined sources only if the additions were accompanied by clear and persuasive evidence for efficacy or effectiveness or if the authors could convince others that adding some constructs is consistent with the preponderance of available evidence. Thus, while we encouraged authors to introduce new concepts and point to promising directions in research and practice, we did not want the Task Force to simply be a means for any or all of us to present our own research findings and favorite concepts, no matter how important. We wanted this Task Force to represent the state of the art, while reflecting the creative

processes of each group of authors—with the hope that what would result could have an influence on the field for years to come.

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