

Change in Psychotherapy: A Plea for No More “Nonspecific” and False Dichotomies

Louis G. Castonguay, Pennsylvania State University
Martin Grosse Holtforth, Pennsylvania State University
and University of Bern

What factors are responsible for change in psychotherapy? We welcome those who question the primacy frequently given to relationship variables in explaining client improvement, as well as the delineation of cognitive-behavioral oriented treatments found to be effective for several disorders. However, we are also concerned about the terminology used (i.e., “nonspecific variables”), as well as with the dichotomy of variables (techniques vs. relationship) that was emphasized. Although such ways of defining and categorizing process variables are predominant in the field, we argue that they may fail to do justice to the complexity of the process of change.

Key words: psychotherapy change, nonspecific variables. [*Clin Psychol Sci Prac* 12: 198–201, 2005]

CHANGE IN PSYCHOTHERAPY: A PLEA FOR NO MORE “NONSPECIFIC” AND FALSE DICHOTOMY

Perhaps the most difficult and elusive question in psychotherapy research and practice is, “What causes change?” DeRubeis, Brotman, and Gibbons addressed this question by challenging the position that client improvement is primarily due to “nonspecific variables.” While doing so, the authors highlight the specific efficacy of cognitive-behavioral oriented treatments for obsessive compulsive disorder, panic disorder, posttraumatic stress disorder, and social phobia. As cognitive-behavioral oriented therapists (Castonguay, Newman, Borkovec, & Grosse Holtforth, 2005), we welcome contributions that provide support to our preferred theoretical orientation. Such contributions increase our confidence in what we are doing clinically, as well as in our training efforts. We have, however,

Address correspondence to Louis G. Castonguay, Department of Psychology, Penn State University, University Park, PA 16803. E-mail: lgc3@psu.edu.

two concerns about the DeRubeis et al. article. The first is related to an issue of terminology, whereas the second is related to a general conceptualization of therapeutic variables.

NONSPECIFIC VARIABLES

Although we believe that the DeRubeis et al. paper will stimulate further reflections and research about the process of change, we also worry that it may encourage the continued use of the term “nonspecific” to refer to variables that cut across different therapeutic approaches. It is certainly the case that for most psychotherapy researchers “nonspecific variables” is a synonym to “common factors.” As previously argued (Castonguay, 1993), however, the term “nonspecific” is also associated with two other meanings that we believe create obstacles for an accurate assessment of the therapeutic role played by variables that are unique to particular approaches, and by those that are common to most, if not all, orientations.

In the field, “nonspecific variables” generally refers to interpersonal, or nontechnical, factors. Regrouping different components or facets of the therapeutic relationship, these variables have been considered for a long time as auxiliary to the technical procedures. Several common factors, of course, appear to be best described as interpersonal in nature. The therapeutic alliance, a variable that DeRubeis et al. gave special attention to when questioning the importance of nonspecific variables, is viewed by most as an interpersonal variable. As described earlier (Castonguay, 1993), however, several technical or procedural factors have been identified as common to many approaches. Among these, one can count a number of intervention strategies, such as providing a new understanding and facilitating corrective experiences (Goldfried, 1980). By equating common factors to nonspecific variables we are thus falsely restricting possible therapeutic commonalities to one type of variable. As researchers, this suggests that when we attempt to rule out the impact of common factors (or to compare the part of outcome variance they explain to that of unique factors), we should be aware that some techniques or intervention procedures are shared by several approaches. As long as we equate them to nonspecific variables, however, the common factors that we are most likely to measure or

control will be interpersonal or nontechnical. This, of course, does not imply that conditions (“attention-placebo,” “supportive-listening”) included in experimental designs designed to control the so-called “nonspecific” variables are useless. It does mean, however, that these conditions can only account for some, but not all, possible common factors.

The term nonspecific also tends to refer to variables for which the nature and/or the impact are not well known. From this perspective, nonspecific means nonspecified (Castonguay, 1993). Although it is certainly the case that some variables that cut across many orientations have not been empirically defined and measured (e.g., therapist attention), this is not the case for all common factors. It is certainly not the case for the alliance. The alliance has been clearly defined, and numerous instruments developed to operationalize this construct have been shown to be reliable and valid (Constantino, Castonguay, & Schut, 2002). And while one can (and should) question how much variance it explains under different circumstances, one would be hard pressed to find a single variable unique to a particular orientation that has been linked to outcome as frequently as the alliance. In fact, more than 1,000 process-outcome findings involving the alliance have been reported (Orlinsky, Grawe, & Parks, 1994). If the alliance is not a specified variable, then we know of no variable that is; which means that under this definition, all therapeutic variables should perhaps be viewed as “nonspecific”!

Although we welcome sophisticated attempts such as DeRubeis et al. to advance our understanding of the factors responsible for change, we feel that by framing these factors within categories of specific and nonspecific variables, the authors adopted a prevalent, but ultimately fallible, set of synonyms where the term “specific” is equated with “unique” (to one approach), “techniques,” and “specified”; and where the term “nonspecific” is equated with “common” (to most if not all approaches), “interpersonal” (or nontechnical), and “nonspecified” (see Castonguay, 1993). The first step in avoiding the unfortunate implications of these false synonyms is to refrain from using the term “nonspecific” and instead use the term “common factor” when referring to variables (such as the alliance) that are assumed to cut across different forms of therapy.

TECHNIQUES VERSUS RELATIONSHIP VARIABLES

We are also concerned that DeRubeis et al. may have inadvertently continued to fuel the dichotomy of techniques (or “specific”) versus relationship (or “nonspecific”) that is predominant in the field. As described elsewhere, we find such a dichotomy to be both logically flawed and empirically untenable (Castonguay & Beutler, in press). Put in other words, we believe that there is enough evidence to suggest that both relationship and techniques are important components of change.

It is clear to us that DeRubeis et al. are doing a valuable service to the field by pointing out that cognitive-behavioral procedures appear to have a distinct impact on particular types of anxiety disorders. For us, this suggests that these treatments should be viewed as likely candidates for the “first line of attack” when working with these particular problems (see Castonguay, Schut, Constantino, & Halperin, 1999). This, however, does not mean that one should disregard relationship factors that are common to all therapy when implementing these treatments. In fact, we would venture to guess that a number of the manuals that have been used to test these treatments do recommend the establishment of a good alliance. Recently published books (McGinn & Sanderson, 1999; Rapee and Sanderson, 1998) describing the implementation of cognitive-behavioral based treatments for some of these disorders have certainly done so. With respect to the treatment of social phobia, for instance, Rapee and Sanderson (1998) noted that

All good therapies, empirically based or otherwise, share a number of common, central features. There is ample evidence that all treatments and techniques are more effective when presented by a warm, empathic therapist. It is a common misconception that empirically based, manualized therapies can be presented in a formula-driven mechanistic fashion. Nothing could be further from the truth. The therapist-client relationship is just as important to empirically based therapies as it is to any other form of treatment. (pp. 33–34)

Thus, while it is important to be reminded that techniques do play a role, we also caution against falling into an “either/or” trap. Rather than attempting to

answer whether change is caused primarily by techniques or relationship, the field needs to address issues about change that are conceptually more interesting and clinically relevant. Fortunately, DeRubeis et al. delineated a number of such issues when they emphasized the importance of investigating four possible sources (other than measurement error) of the variation in the alliance and its link with outcome: therapist, client, the client and therapist interaction (in the statistical sense), and symptom change. As the authors explore the potential effect of these sources, they do much more than provide directions to clarify “the specifics versus non-specific debate” (p. 181), as they hope future research will eventually do. Their analysis of therapeutic variables rests on a more comprehensive view of change, as neither the client, nor the therapist characteristics (let alone the statistical interaction of characteristics of these participants), fit neatly in the categorization of “specific” versus “nonspecific.” In other words, these characteristics, in our view, are neither relationship nor technical variables. In addition to opening the debate to other variables, DeRubeis et al. also encouraged the investigation of complex relationships between different factors. We could not agree more with a position that the “one pattern of data that would be the most interesting in the investigation of the connection between the alliance and outcome is one that would support the possibility that therapists determine, to a substantial degree, the quality of the alliance, and that the alliance mediates therapist effects on outcome” (p. 180). We also fully agree with DeRubeis et al. that variables other than the alliance (e.g., treatment adherence) should be examined to explain potential therapist effects on outcome.

Rather than trying to settle the score between conceptually unappealing sets of variables, researchers should take note of some of the concrete lines of research suggested by DeRubeis et al. and investigate how multiple therapeutic factors (e.g., alliance, empathy, technical adherence, therapists’ personal qualities, clients’ level of distress) relate to each other, how they and their complex interaction facilitate or interfere with client improvement, and how client change impacts different aspects of the therapeutic process (see Castonguay et al., *in press*; Castonguay & Beutler, *in press-b*).

It should also be mentioned that the validity of the dichotomy of techniques versus relationship could be

questioned from a purely theoretical point of view. Butler and Strupp (1986), for example, eloquently argued that all technical interventions have relational meaning when applied in psychotherapy, making it impossible to conceptually separate technical and interpersonal factors. Cogently capturing Butler and Strupp’s (1986) arguments, Gelso and Hayes (1998) reminded us that “techniques are offered and have their effectiveness and meaning in the context of a client-therapist relationship” (page 196). Further blurring the conceptual distinction of these variables, the relationship can also be the object of the therapist’s techniques. As we stated elsewhere (Castonguay et al., *in press*), many of the variables investigated by the recent Division 29 Task Force on the therapeutic relationship (Norcross, 2002) can be described as the therapist’s clinical skills geared toward working with the therapeutic techniques. (e.g., repairing alliance ruptures, managing counter-transference, providing relational interpretation). In at least one form of psychodynamic treatment (Strupp & Binder, 1984), the management and therapeutic use of the alliance is viewed as the core technique of intervention. As claimed by Henry and Strupp (1994), the construction of a treatment manual centered on the effective management of the alliance meant that the specific versus nonspecific factors paradigm has been finally discarded.

CONCLUSION

Any serious attempt at improving our understanding of the process of change, such as the one presented by DeRubeis et al., deserves much credit. We applaud them for reminding the field that relationship variables cannot account for everything and that techniques do have an impact on outcome. However, although it reflects predominant views in the field, their general conceptualization and categorization of therapeutic variables may not do justice to some of the complexities of the therapeutic process, nor does it do justice to their own sophisticated analysis of possible sources and mechanisms of change. Although a number of variables can be categorized, more or less accurately, as “technical” or “relational,” one should consider that within each of these global categories some variables are unique to (or most representative of) a particular approach, while others are common to most approaches; and that within each of these two categories, some variables are more

specified (clearly defined and empirically measured) than others (see Castonguay, 1993). Using the term “nonspecific” unfortunately confounds many dimensions and qualities of the therapeutic processes. It should also be recognized that technical and relationship variables are not the only types of factors influencing outcome. As demonstrated in a recent task force of therapeutic principles of change (Castonguay and Beutler, in press-a), and in line with the DeRubeis et al. arguments, client and therapist characteristics (qualities of the therapy participants that are identifiable outside of what takes place during therapy, e.g., ethnicity) also need to be taken into account. Some of these variables appear to predict outcome irrespective of the treatment orientation used (e.g., a comorbid condition involving a personality disorder), whereas others seem to have a differential impact on particular forms of treatment (e.g., client’s level of impulsivity; Beutler et al., in press). In addition, variables related to client and therapist experience during therapy (e.g., level emotional experiencing) that do not fit the participant characteristics identified in the Task Force mentioned above have also been linked with outcome. If one assumes that these multiple factors are in constant interaction and interdependence in ways that sometimes enhance and sometimes hinder change, one is indeed forced to recognize that the complexity of the psychotherapy process goes beyond a debate between “specific versus nonspecific” or “techniques versus relationship.”

REFERENCES

- Beutler, L. B., Blatt, S. J., Alamoahmed, S., Levy, K. N., & Angtuaco, L. A. (in press). Participant factors in treating dysphoric disorders. In L. G. Castonguay & L. E. Beutler (Eds.), *Principles of therapeutic change that work*. Oxford University Press.
- Butler, S. F., & Strupp, H. H. (1986). Specific and nonspecific factors in psychotherapy: A problematic paradigm for psychotherapy researchers. *Psychotherapy, 23*, 30–40.
- Castonguay, L. G. (1993). “Common factors” and “nonspecific variables”: Clarification of the two concepts and recommendations for research. *Journal of Psychotherapy Integration, 3*, 267–286.
- Castonguay, L. G., & Beutler, L. E. (Eds.). (in press). *Principles of therapeutic change that work*. Oxford University Press.
- Castonguay, L. G., Grosse Holtforth, M., Coombs, M. M., Beberman, R. A., Kakouros, A. A., Boswell, J. F., et al. (in press). Relationship factors in treating dysphoric disorders. In L. G. Castonguay & L. E. Beutler (Eds.), *Principles of therapeutic change that work*. Oxford University Press.
- Castonguay, L. G., Newman, M. G., Borkovec, T. D., & Grosse Holtforth, M. (2005). Cognitive-behavior assimilative integration. In J. C. Norcross and M. R. Goldfried (Eds.), *The handbook of psychotherapy integration* (2nd ed.). New York: Oxford University Press.
- Castonguay, L. G., Schut, A. J., Constantino, M. J., & Halperin, G. S. (1999). Assessing the role of treatment manuals: Have they become necessary but non-sufficient ingredients of change? *Clinical Psychology: Science and Practice, 6*, 449–455.
- Constantino, M. J., Castonguay, L. G., & Schut, A. J. (2002). The working alliance: A flagship for the scientific-practitioner model in psychotherapy. In G. Shick Tryon (Ed.), *Counseling Based on Process Research*. New York: Allyn & Bacon.
- DeRubeis, R. J., Brotman, M. A., & Gibbons, C. J. (2005). A conceptual and methodological analysis of the nonspecifics argument. *Clinical Psychology: Science and Practice, 12*, 174–183.
- Gelso, C. J., & Hayes, J. A. (1998). *The psychotherapy relationship: Theory, research, and practice*. New York: Wiley.
- Goldfried, M. R. (1980). Toward the delineation of therapeutic change principles. *American Psychologist, 35*, 991–999.
- Henry, W. P., & Strupp, H. H. (1994). The therapeutic alliance as interpersonal process. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice*. New York: Wiley.
- McGinn, L. T., & Sanderson, W. C. (1999). *Treatment of obsessive compulsive disorder*. Northvale, NJ: Jason Aronson.
- Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work*. New York: Oxford University Press.
- Orlinsky, D. E., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy—Noch einmal. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 270–376). New York: Wiley.
- Rapee, R. M., & Sanderson, W. C. (1998). *Social phobia: Clinical application of evidence-based psychotherapy*. Northvale, NJ: Jason Aronson.
- Strupp, H. H., & Binder, J. L. (1984). *Psychotherapy in a new key*. New York: Basic Books.

Received March 28, 2005; accepted March 30, 2005.