Applied and Preventive Psychology 13 (2009) 32–34

Contents lists available at ScienceDirect

Applied and Preventive Psychology

journal homepage: www.elsevier.com/locate/app

Response to commentaries

Searching for therapy change principles: Are we there yet?

Marvin R. Goldfried*

Department of Psychology, Stony Brook University, Stony Brook, NY 11794-2500, USA

ARTICLE INFO

Keywords:
Empirically supported treatments
Evidence-based practice
Integrative psychotherapy training
Psychotherapeutic process

ABSTRACT

Over the past 30 years, the topic of psychotherapy integration has moved from a latent theme to a clear movement, and the commentaries made in this issue of *Applied and Preventive Psychology* document these changes. More than ever before, the field of psychotherapy has become increasingly interested in achieving a consensus. The question is becoming *what*, not *who* is correct. We are now better able to identify stages of change that cut across different orientations, as well as underlying principles of change. Still, we are not "there yet," and need to confront the limitations stemming from an overvaluation of what is "new," and to develop a common language with which to communicate what we know. It is also suggested that a two-way bridge between research and practice can represent the future of psychotherapy integration.

I would like to begin by thanking David Smith for agreeing to devote this issue of *Applied and Preventive Psychology* to my 1980 article on principles of change (Goldfried, 1980), to Louis Castonguay for making this happen by serving as guest editor, and to all those colleagues who agreed to offer their perspective and commentaries.

I can vividly recall originally working on the manuscript while on sabbatical in the San Francisco Bay area. Sitting in what was a makeshift study in the basement of the house I had rented, I experienced some unusual emotional reactions as I wrote. It was a feeling of great excitement, but also considerable trepidation. Although I felt it important to say what I wanted to say, I fully anticipated that some colleagues might react quite negatively to my thesis. I was not wrong. Although there continue to be colleagues who react negatively to the idea that we need to work toward some rapprochement in the field, there have been a growing number who have come to see the potential benefit of doing so. Indeed, Messer (2009), a psychodynamic colleague who was one of those individuals who believed that psychotherapy integration had little promise, eventually came to be one of its supporters. I like to think that I had conditioned Messer to become more integrative; each time he became more behavioral, I reinforced him by becoming more psychodynamic!

As commented on by some of those who have contributed to this special issue (Benjamin, 2009; Beutler, 2009; Castonguay, 2009; Gelso, 2009; Stricker, 2009), within the past 30 years, what had previously been a latent theme in the field developed into a clearly articulated movement; it is now acceptable to identify oneself as being "integrative." Indeed, an index of this shift in the *zeitgeist* can be seen in the use of "integration" in the title of books that have been published over the past decade. Book publishers, who make it a business of knowing what is "in," have clearly sensed that one of the current themes that runs through the psychotherapy literature is the importance of integration.

1. The need for consensus

One of the motivating forces that prompted me to work on this paper was that the field of psychotherapy seemed to be not only locked into theoretical orientations, but also the originators of these schools of thought. The field had also become differentiated to the point that there were numerous variations with psychodynamic, cognitive–behavioral, and experiential approaches. As I suggested back then, "We have all 'taken up sides,' and have placed far too much emphasis on *who* is correct, not *what* is correct" (Goldfried, 1980, p. 991). Sad to say, this tendency continues to exist some 30 years later—a point that I will return to later in this article. However, alongside this tendency there also exists the recognition that it is important for the field to achieve some consensus. As suggested in the comments by Beitman (2009) and Beutler (2009), one point of consensus can be found in the similarities across orientations with regard to stages of therapeutic change.

In the very broadest sense, it is possible to view the therapy change process as entailing four stages. At stage one, patients arrive with little or no understanding of why they are having problems in their lives. What they do know, however, is that things are not working well for them, and their ineffectiveness or incompetence creates problems for them. We may refer to this initial stage as that of *unconscious incompetence*. Upon entering therapy, and working within the context of a good therapeutic alliance, they gradually

* Tel.: +1 631 632 7823; fax: +1 212 988 4495.
E-mail address: marvin.goldfried@sunysb.edu.

0962-1849/$ – see front matter © 2009 Elsevier Ltd. All rights reserved.
doi:10.1016/j.appsy.2009.10.013

become more aware of those variables/dynamics/forces that are responsible for their incompetence. Having such awareness, they move to the stage of *conscious incompetence*. At this point, they may have an understanding of and insight into why their life is not working, but are not yet clear as to what they need to do in order to improve the situation. Realizing that many of the problems in their current life are reflections of anachronistic thoughts, feelings, and behaviors, they move onto the phase of therapy in which they make attempts to change such problematic patterns. In doing so, they move into the stage of *conscious competence*. New ways of thinking, feeling, and acting are attempted, with an eye toward whether or not things improve for them. However, old patterns do not disappear easily, and a concerted effort to make changes is needed. In those therapeutic cases that are successful, repeated attempts at functioning in a new way can create more effective patterns and, over time, become more automatic and less effortful. In doing so, they reach the final phase of change, namely, *unconscious competence*.

2. Principles of change

The thrust of my 1980 article was that the field was more likely to reach a consensus at a level of abstraction somewhere between observable techniques and more theoretical interpretations of why these techniques might work. Any commonalities found is at this mid-level a level of abstraction would represent strategies or principles of change that cut across these different orientations. As noted in the original article: "*To the extent that clinicians of varying orientations are able to arrive at a common set of strategies, it is likely that what emerges will consist of robust phenomena, as they have managed to survive the distortions imposed by the therapists' varying theoretical biases*" (Goldfried, 1980, p. 996). As noted in Kendall's (2009) commentary, it is important to underscore that any such common principles or strategies that may have been observed clinically are essentially potentially fruitful starting points, and are in need of empirical confirmation. In their invaluable volume *Principles of Therapeutic Change That Work*, Castonguay and Beutler (2006) have reviewed the research literature on transtheoretical principles that have been found to contribute to successful change.

What are we likely to find as common principles of that exist across different theoretical orientations? (1) To begin with, there is the importance of the client's initial *expectations that therapy can be helpful*, as well as the presence of some level of *motivation* to work with the therapist. Without such positive expectations and motivation, even the most effective of therapeutic interventions are likely to fail. (2) Along with the expectations and motivation that clients bring with them when they enter therapy, the nature of *the therapeutic alliance* becomes particularly crucial—not only in enhancing positive expectations and motivation, but also for providing a working agreement on how therapy should perceived. Here, too, the absence of a good alliance can contribute to therapeutic failure. (3) In line with the stages of change model described above, much of therapeutic work involves *having clients become aware* of those factors that contribute to their current life problems. Clearly, much depends on the therapist's clinical formulation, which eventually determines which thoughts, feelings and behavior are the focus of awareness. (4) Having such an awareness sets the stage for making changes in these problematic thoughts, emotions, and behaviors. During this process, clients engage in numerous *corrective experiences*, whereby their cognitive, emotional, and behavioral reactions to current life situations become different. (5) This process of cognitive–affective–behavioral risk taking continues over time, serving to enhance awareness of how new ways of functioning are better than old ways, which in turn helps to facilitate further corrective experiences. This ongoing, iterative synergy between awareness and corrective experiences provides clients with the *ongoing reality testing* that is essential for change.

One of the advantages of having at one's disposal a handful of principles that contribute to the change process is that it can afford a more manageable list of therapeutic guidelines to practicing clinicians, as opposed to the very large array of potential specific treatment interventions that currently exist. Thus at any point in treatment, therapists' wanting to provide corrective experiences for any given client represents a starting point, after which they can consider the specific treatment procedures that may be used to implement this more general principle. As noted in Boswell's (2009) commentary, having this more manageable set of principles can also help beginning clinicians to learn how to proceed therapeutically, so as to make a more reasonable decision on what specific intervention to then select.

3. The relationship between principles and techniques

In her commentary, Hill (2009) has suggested that in a consideration of general principles, we should not forget the importance of specific techniques. Certainly, her point is well taken. As noted above, however, and as underscored by Arkowitz (2009), principles of change are only the starting point for making therapeutic interventions. One would not merely suggest to a clinical supervise that she or he needs to increase a client's awareness. Clearly, the issue is what the client needs to become aware of, and also the method by which the therapist can provide this awareness. Should the awareness focus on a reattribution of the perceived motive that the patient has for somebody else's actions, or should it be an increased awareness of the impact that the patient may be making on a significant other? Should this be accomplished by reflection, interpretation, self-monitoring, or some other specific technique? Thus the specific content of the awareness and the method by which it is conveyed are most important parameters of the more general principle. It is here where research becomes most crucial, in that the comparative analysis of different clinical formulations for giving clinical problems becomes front and center, as does the most effective method of increasing awareness.

The relationship between principles and specific clinical techniques can best be understood in the context of the early work of Cronbach and Meehl (1955). In their classic article on construct validity, they consider how conceptual variables are measured, the inter-relationship among these conceptual variables, and the inter-relationship among the measures. They refer to this network as the "nomological net," a configuration that empirically links the constructs with each other, together with the links between construct and measures, as well as links among the measures. One may think of principles of change at the construct level, being implemented by various specific techniques. The network would consist of the inter-relationship between the constructs associated with the principle (e.g., impact of increasing awareness on the reduction of stress), as well as the empirical inter-relationship among the specific clinical procedures by which the principle is implemented and the various ways that the indices of change are assessed. For example, if the therapist wishes to implement the principle of increasing client awareness in the context of relevant emotional arousal, with the goal of creating a shift in meaning structure, research on this inter-relationship clearly involves the use of therapy techniques – such as the use of empty chair work in helping clients to reattribute the motive of a significant other who has not met their needs – as well as measures of change in meaning structure.

4. Obstacles to reaching a consensus

Despite the increasing acceptance of psychotherapy integration, Beitman (2009) and Staats (2009) have observed the continuing

resistance within the field for obtaining consensus. Staats, in particular, has observed that the rewards within our field are given for arriving at new information, not integrating what we already have. Kendall (2009) has similarly commented that this somewhat unfortunate tendency to overemphasize the importance of what is "new" at the expense of what we might already know. This has been a longstanding concern of mine; as I have suggested elsewhere: "One's career is made by making history, not knowing it" (Goldfried, 2000, p. 11). Clearly what is required is a change in the system, whereby it needs to be recognized that obtaining a consensus on what we know is just as important as obtaining new findings.

Another barrier that has prevented us from obtaining a consensus is that most of our theoretical systems have their own idiosyncratic jargon. Although this can help to easily communicate with colleagues of a similar orientation, it unfortunately serves to create fragmentation. If you do not know the jargon, you cannot read the literature. As editor of the journal *In Session* – later becoming the *Journal of Clinical Psychology/In Session* – I attempted to deal with this problem by setting an editorial policy that all articles needed to written in ordinary English. As one might imagine, this required considerable editorial oversight. However, when authors writing from different theoretical points of view avoided the use of jargon, it became quite apparent that there were numerous similarities that existed among them. Indeed, Kuhn (1970) once noted members of competing paradigms "... who held incommensurate viewpoints [can] be thought of as members of different language communities and that their communication problems [can] be analyzed as problems of translation" (Kuhn, 1970, p. 175). He then went on to say that in using a common language, "... some members of each community may also begin vicariously to understand how a statement previously opaque could seem an explanation to members of the opposing group" (p. 203).

5. Conclusion

So, are we there yet? No, but some of us seem to be on the right path. It should be noted that when the Society for the Exploration of Psychotherapy Integration (SEPI) was first formed in 1983, the objective was two-fold: one goal was to create a rapprochement and dialogue across the different theoretical orientations; the second aim was to provide for an integration between research and practice. Most of what has been done over the past few decades in the area of integration has dealt with the former objective. Within more recent years, there have been clear attempts to link research with practice, such as in the formation of empirically supported treatments (ESTs). As observed by Benjamin (2009), however, the research–practice connection has largely consisted of a one-way street. For true integration to occur, it must go both ways.

Wachtel (2009), who commented on my fantasized integration conference of the future, underscored the point that it would involve both clinicians and researchers. It is of particular interest to note of that the current model of using randomized clinical trials (RCTs) to determine which interventions have been empirically supported was adopted from drug research. Yet in that arena, clinicians have a voice in providing information about their clinical experience once a drug has been approved by the FDA. This, in essence, provides a two-way bridge between research and practice, whereby the practice is informed by research, but research experience provides information for future research. As yet, no such mechanism exists within the field of psychotherapy. As of 2009, the Society of Clinical Psychology, Division 12 of the APA, will create such a two-way mechanism (Goldfried, 2009). With increasing demands for accountability, this synergy between research and practice is likely to represent a new and most important stage of psychotherapy integration.

References

Arkowitz, H. (2009). Principles of change vs. therapy techniques or principles of change and therapy techniques: A commentary on Goldfried's 1980 paper. *Applied and Preventive Psychology*, *13*, 5–7.

Beitman, B. D. (2009). Searching for therapeutic change principles. *Applied and Preventive Psychology*, *13*, 8–9.

Beutler, L. E. (2009). Progress in delineating change principles: A comment on Goldfried (1980). *Applied and Preventive Psychology*, *13*, 10–11.

Boswell, J. F. (2009). A young scholar's commentary on Goldfried (1980). *Applied and Preventive Psychology*, *13*, 12–13.

Castonguay, L. G. (2009). Marvin Goldfried's (1980) American Psychologist paper: (Re) Introducing a classic. *Applied and Preventive Psychology*, *13*, 1.

Castonguay, L. G., & Beutler, L. E. (Eds.). (2006). *Principles of therapeutic change that work*. New York: Oxford University Press.

Cronbach, L., & Meehl, P. (1955). Construct validity in psychological tests. *Psychological Bulletin*, *52*, 281–302.

Gelso, C. J. (2009). Confessions of a non-believer: The merits and mythology of integration. *Applied and Preventive Psychology*, *13*, 14–15.

Goldfried, M. R. (1980). Toward the delineation of therapeutic change principles. *American Psychologist*, *35*, 991–999.

Goldfried, M. R. (2000). Consensus in psychotherapy research and practice: Where have all the findings gone? *Psychotherapy Research*, *10*, 1–16.

Goldfried, M. R. (2009). Making evidence-based practice work: The future of psychotherapy integration. *Psychotherapy Bulletin*, *44*, 25–28.

Hill, C. E. (2009). Reaction to Goldfried (1980): What about therapist techniques? *Applied and Preventive Psychology*, *13*, 16–18.

Kendall, P. C. (2009). Principles of therapeutic change circa 2010. *Applied and Preventive Psychology*, *13*, 19–21.

Kuhn, T. S. (1970). *The structure of scientific revolutions* (2nd ed.). Chicago, IL: University of Chicago Press.

Messer, S. B. (2009). Common factors in psychotherapy: Three perspectives. *Applied and Preventive Psychology*, *13*, 22–23.

Smith Benjamin, L. (2009). Goldfried's prophecies: The good outcomes, the bad outcomes, and outcomes yet to come. *Applied and Preventive Psychology*, *13*, 24–25.

Staats, A. W. (2009). Unification in psychotherapy, in clinical, and in psychology. *Applied and Preventive Psychology*, *13*, 26–27.

Stricker, G. (2009). A classic then and now. *Applied and Preventive Psychology*, *13*, 28–29.

Wachtel, P. L. (2009). The evolving investigation of therapeutic change principles. *Applied and Preventive Psychology*, *13*, 30–31.