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Editorial

Scientific Update and Overview

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Editorial

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Transtheoretical Psychological Therapy – New Perspectives for Clinical Training and Practice

Wolfgang Lutz[1], Winfried Rief[2]

[1] *Clinical Psychology and Psychotherapy, University of Trier, Trier, Germany.* **[2]** *Clinical Psychology and Psychotherapy, Philipps University Marburg, Marburg, Germany.*

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Corresponding Author: Wolfgang Lutz, Clinical Psychology and Psychotherapy, Department of Psychology, University of Trier, D-54286 Trier, Germany. Tel.: +49 (0)6 51 / 2 01 28 83. E-mail: lutzw@uni-trier.de

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In this special issue of Clinical Psychology in Europe on "Transtheoretical Psychological Therapy – New Perspectives for Clinical Training and Practice", we focus on new evidence-based transtheoretical concepts of clinical training and practice. A transtheoretical perspective offers a new framework for integrating evidence-based psychological treatment techniques that can have theoretical roots in different theories. Thus, it represents an umbrella that encourages the consideration of all research results and evidence-based treatment proposals, and a fruitful stimulation of insights *across* traditional orientations. Transtheoretical psychotherapy aims to use findings from mechanisms, outcome, process, and feedback research as conceptual frameworks for clinical practice and training.

The history of psychotherapy (now often referred to as *psychological therapy* to include the various newer theoretical concepts) is characterized by a growing number of clinical theories, approaches, and methods with their psychopathological concepts, psychological models of change, and, as a result, the growth of a heterogeneous landscape of professional therapy associations. The major schools of therapy that have emerged from this development have contributed to the establishment of the field and advances in patient care around the world. However, a scientifically sound and clearly defined causal network between mechanisms of change and treatment outcomes has been lacking (Lutz et al., 2022). In addition, service systems around the world are very heterogeneous in the definition and delivery of psychological therapy, and not all treatment concepts applied in clinical practice are scientifically evaluated (Rief et al., 2022).

Simultaneously, an emphasis on treatment approaches and therapeutic schools resulted in inflexibilities and conflicts among colleagues. This frequently resulted in a constricted view of scientific and clinical perspectives, impeding the dynamic advancement of the field in terms of psychotherapy research and finding common ground (e.g. Goldfried, 1980; Hofmann et al., 2022; Lutz et al., 2023). Furthermore, while for example in Germany the official state-wide guidelines prohibit combining procedures in outpatient practice, such combinations are at the same time prevalent in outpatient and inpatient settings both nationally and internationally (Twomey et al., 2023).

In this special issue, transtheoretical concepts and practical implications that go beyond the boundaries of traditional psychotherapeutic procedures and aim for a broader, scientifically based understanding of psychotherapy are discussed. Transtheoretical is understood here as a broader concept, as originally introduced by Prochaska and Di Clemente (1982).

This includes an orientation towards evidence-based treatment procedures and strategies as well as multimethod and multidimensional diagnostic concepts and data-informed decision tools, which can form the basis for transtheoretical and evidence-based clinical training and practice in the future. From our point of view, it is now time to develop broader transtheoretical and scientifically supported concepts for clinical training and practice of psychological therapy, and this special issue wants to contribute to this process.

The papers cover a wide range of issues in the current debate on transtheoretical and integrative concepts as well as specific interventions, clinical methods, or strategies. Several papers present important new developments in transtheoretical metamodels and provide new research- and process-based conceptual frameworks, such as Babl et al. (2024); Boswell et al. (2024); Caspar and Berger (2024); Flückiger et al. (2024); Hofmann and Hayes (2024); Lutz et al. (2024); McNally (2024); Rafaeli and Rafaeli (2024); Rief et al. (2024) and Taubner and Sharp (2024). In addition, several papers discuss transtheoretical clinical case conceptualization and interventions, competencies, and core processes, such as case conceptualization (Gilboa-Schechtman, 2024), homework (Ryum & Kazantzis, 2024), deliberate practice, marker response sequences, and responsiveness (Babl et al., 2024; Boswell et al., 2024), mentalization (Taubner & Sharp, 2024), alliance ruptures (Zilcha-Mano & Muran, 2024), needs and internal self-states (Rafaeli & Rafaeli, 2024), strength (Flückiger et al., 2024), outcome monitoring (Lutz et al., 2024), central processes (Hofmann & Hayes, 2024); disorder-specific knowledge and dynamic networks (Hofmann & Hayes, 2024; McNally, 2024; Rief et al., 2024). While the authors were mostly trained in traditional approaches such as psychodynamic therapy or CBT, they share the intention to search for the common ground of psychotherapy, the basic mechanisms of change, and to foster the development of a common language of psychological treatments. Our vision is a vibrant scientific and practical discipline, optimizing the surplus of integration and progress of treatments, and overcoming artificial boundaries.

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Twitter Accounts: @LutzPsychRes, @RiefWinfried

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Scientific Update and Overview

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A 21st Century Principle-Based Training Approach to Psychotherapy: A Contribution to the Momentum of Transtheoretical Work

Anna Babl[1], Catherine F. Eubanks[1], Marvin R. Goldfried[2]

[1] *Department of Clinical Psychology, Leiden University, Leiden, The Netherlands.* **[2]** *Department of Psychology, Stony Brook University, New York, NY, USA.*

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Corresponding Author: Anna Babl, Adelphi University, Gordon F. Derner School of Psychology, Hy Weinberg Center, 158 Cambridge Ave, Garden City, New York 11530, United States of America. E-mail: ababl@adelphi.edu

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Abstract

Background: Despite the finding that the majority of psychotherapists adopt a rather process-oriented and integrative stance, it is uncommon that psychotherapy trainings are transtheoretical and transdiagnostic. Considering principles of change that cut across different schools of therapy holds promise for developing truly research-informed psychotherapy trainings. Common principles of change may answer the question what should be trained. Another important question is how to train. In current psychotherapy training programs, transfer of theory into practice relies mainly on role-playing exercises and supervised practice, both of which have their limitations.

Aims: A fantasy for the future would be the development, implementation, and evaluation of a complementary 21st century online principle-based and marker-led psychotherapy training: incorporating the concepts of deliberate practice as well as expert training, the huge potential of technologies, and considering the importance of (context) responsiveness.

Conclusion: To illustrate this idea, we present a training that we are currently developing, an online Alliance-Focused Training.

Keywords

principles of change, psychotherapy training, Alliance-Focused Training, deliberate practice, markers

Highlights

- Considering principles of change that cut across different schools of therapy holds promise for developing truly research-informed psychotherapy trainings.
- A fantasy for the future would be the development, implementation, and evaluation of a complementary 21st century online principle-based and marker-led psychotherapy training.
- We are currently developing, an online Alliance-Focused Training.

For a long period of time it was common for psychotherapists to work exclusively within their own theoretical framework – referred to by Norcross (2005) as an "ideological cold war." Those first-generation approaches to psychotherapy, as developed by their founders, neglected or even suppressed and fought concepts and findings that were not in line with their original stance (Grawe & Caspar, 2011). Despite substantial theoretical and practical differences, and some evidence suggesting some advantages for certain approaches when treating certain conditions (e.g., Marcus et al., 2014), most comparison studies have found that bona fide therapies are equally effective (e.g., Wampold & Imel, 2015). As Saul Rosenzweig (1936) presciently observed when he quoted the Dodo bird from Lewis Carroll's *Alice's Adventures in Wonderland*, "everybody has won, and all must have prizes."

Given the lack of sizable differential treatment effects across psychotherapy orientations, increasingly more attention is being paid to the impact of the therapist on treatment outcome. Stiles and Horvath (2017) proposed that therapists' responsiveness may be a key component of effective therapy: therapists are responsive by flexibly tailoring their relational connection and interventions to support individual patients' needs in that moment (Stiles, 2009) in the context of their transdiagnostic characteristics (Hayes & Hofmann, 2020). Based on a qualitative meta-analytic review on therapist responsiveness, Wu and Levitt (2020) concluded that in order to be responsive, therapists need to develop awareness of and attunement to the process of therapy and to markers of shifts in patients' experience.

Despite the finding that the majority of psychotherapists adopt a rather process-oriented and integrative stance (Norcross & Rogan, 2013), it is uncommon that psychotherapy trainings are transtheoretical and transdiagnostic; rather, the field remains entrenched in a training approach in which different theoretical orientations are siloed and implicitly pitted against one another. Given how much training is based on theoretically specific methods, it is surprising how little evidence there is for its effectiveness, especially comparing different theory-specific approaches (Knox & Hill, 2021).

What to Train

One promising way to advance previous approaches to training is to consider principles of change that cut across different schools of therapy as complementary training modules when aiming for truly research-informed psychotherapy trainings. Transtheoretical and transdiagnostic change principles can help us identify and focus on areas of unity rather than develop new training approaches. In the following, a few key efforts to identify such principles of change are outlined.

An important landmark was Goldfried's (1980) attempt to identify a set of change principles. He argued that change principles are located at an intermediate level of abstraction between the more abstract level of theoretical framework and the more concrete level of specific techniques. At this intermediate level of abstraction, it is possible to grant therapists some freedom with regard to the specific interventions they choose to apply with a specific patient in a specific situation but at the same time ensure that important change processes are facilitated. Drawing on the research literature, Goldfried (1980; Eubanks & Goldfried, 2019) proposed the following 5 principles of change shared across the major theoretical orientations:

- Fostering the patient's hope, positive expectations, and motivation
- Facilitating the therapeutic alliance
- Increasing the patient's awareness and insight (e.g., awareness of connections between thoughts, feelings, needs, actions)
- Encouraging corrective experiences (i.e., encouraging patients to take risks and engage in new behaviors that lead to a shift in cognitions and emotions)
- Emphasizing ongoing reality testing (i.e., helping patients to process corrective experiences and consolidate positive changes by recalibrating their expectations and self-views to be in line with their new reality)

Klaus Grawe and colleagues were also interested in change processes in psychotherapy, with the aim of developing a research-informed psychotherapy that would flexibly use all empirically supported mechanisms of change in psychotherapy (Caspar & grosse Holtforth, 2010). Based on a meta-analysis of approximately 900 comparative outcome studies on the effectiveness of psychotherapy (Grawe et al., 1994), they identified five general change factors:

- Problem mastery/coping (i.e., the patient learns to cope with difficult or anxiety-provoking situations)
- Clarification of meaning (i.e., the patient gains greater understanding of the source of their difficulties)
- Problem actuation (i.e., the patient's emotional experience of the problem is activated during psychotherapy, to provide the optimal opportunity to foster change)

- Resource activation (i.e., the patient's own resources—motivation, skills, strengths—are activated in the service of change)
- Therapeutic relationship

Another effort to identify principles of change with empirical support is the work by Castonguay and Beutler (2006). The five categories of principles they identified are framed in terms of guiding therapists as they predict how therapy will go and determine how best to intervene:

- Patient prognostic principles (i.e., patient characteristics that predict good treatment outcome such as baseline impairment, personality disorder, attachment, expectations, stage of change)
- Treatment/provider moderating principles (i.e., patient characteristics, often present at baseline, that therapists should be responsive to such as patient resistance, ambivalence, coping style)
- Patient process principles (i.e., patient during-treatment behaviors that facilitate or interfere with improvement such as active participation or resistance, respectively)
- Therapy relationship principles (i.e., elements of the patient-therapist exchange that facilitate or interfere with improvement such as alliance quality, alliance rupture repair, therapist empathy, therapist positive regard)
- Therapist intervention principles (i.e., therapist during-treatment behaviors that either facilitate or interfere with improvement such as receiving feedback based on routine outcome monitoring, being flexible, fostering more emotional experiencing and behavior change)

The different attempts to identify transtheoretical principles of change all have agreed on the therapeutic relationship or alliance as a key component of effective therapy. Many original studies and meta-analyses positioned the therapeutic alliance as a robust predictor of psychotherapy outcome across a wide range of patient diagnoses and different treatment types (e.g., Flückiger et al., 2018, 2020). This is true for both between-patient alliance effects (Flückiger et al., 2018) and within-patient early alliance effects on post-treatment outcome (Flückiger et al., 2020). Further, a survey of a diverse pool of 1,998 psychotherapy clinicians on the perceived presence of the five principles of change identified by Goldfried indicated strongest consensus for the therapeutic alliance and when participants estimated whether the principles were common to all schools of therapy, strong consensus was only indicated for the therapeutic alliance (Twomey, O'Reilly, & Goldfried, 2023).

How to Train

Common principles of change may answer the question about what should be trained, but another important question is how change principles can be implemented in psycho-

therapy training. Research has found mixed evidence as to whether standard methods of therapist training are effective (Perlman et al., 2020). In current psychotherapy training programs, transfer of theory into practice with actual patients relies mainly on role-playing exercises and supervised practice. However, both forms of learning have their limitations: role-playing exercises might not be realistic and may thus fail to provide the trainee with useful preparation (Beutler & Harwood, 2004), while supervision usually only follows the trainee's contact with the patient with some time-delay. Immediate feedback, for example in the context of live supervision, can only be realized at high cost and applied to a sub-sample of patients and relevant clinical situations. No satisfactory training procedure is currently in place by which novice psychotherapists can obtain in-vivo hands-on experience in dealing with the range of problems presented by a variety of patients, and in which they get immediate, accurate and consistent feedback (Beutler & Harwood, 2004). For a long time, the field of psychotherapy research has lacked a successful model for therapist skill advancement (Rousmaniere et al., 2017).

The study of expertise in other fields provides a potential model for understanding the key mediating factors involved in the development of top-level performers in psychotherapy. Across a variety of domains, researchers have found that engagement in extended, deliberate practice facilitates incremental development, resulting in superior performance (Chow et al., 2015). According to Ericsson (2006), deliberate practice is defined as individualized training activity especially designed to improve specific aspects of an individual's performance through repetition and successive refinement. Empirical research suggests that deliberate practice can significantly improve the effectiveness and efficiency of psychotherapy education and training (e.g., Rousmaniere et al., 2017). Bailey and Ogles (2023) go as far as making deliberate practice suggestions for rupture and repair interventions, such as video-assisted observation of your work, getting consultant feedback, setting small incremental goals, solo deliberate practice, and feedback-informed treatment. An important next step would be its online application, with the advantages of easy and flexible availability of the training and its time-independent use (Berger, 2015). A meta-analysis of 201 studies has shown that in the health professions, internet-based learning was associated with large positive effects compared with no intervention and with equal effects compared to non-internet instructional methods (Cook et al., 2008). A systematic review synthesized the mental-health training literature published since 2010 to evaluate how different training models affect therapists' knowledge, beliefs, and behaviors (Frank, Becker-Haimes, & Kendall, 2020). With regard to online training (20 studies), there was clear evidence that it can improve therapist knowledge, skills, and use of the intervention after online training (Frank et al., 2020).

One promising framework for guiding therapist responsiveness that has been proposed by Constantino and colleagues (2013) is context-responsive psychotherapy integration (CRPI), a transdiagnostic if-then approach. Based on empirical associations with therapy outcomes, Constantino and colleagues identified several patient characteristics

and treatment processes that therapists will encounter and to which they need to react and be responsive, including low outcome expectations, ambivalence/resistance, patient self-strivings, alliance ruptures, and alarm signals from outcome monitoring (Constantino et al., 2013). Trainees can be taught to recognize markers of these common characteristics and processes and to select from several principle-driven, evidence-based methods to address the markers (*if* this occurs, *then* try one of these responses). CRPI is a promising model that requires more empirical support and further investigation of commonly occurring markers (Constantino et al., 2017). Focusing on *markers* as indicators of problems as well as patients' readiness to work on those problems is a defining feature of Alliance-Focused Training (AFT; Muran & Eubanks, 2020). AFT works with markers of ruptures in the alliance during the psychotherapeutic process as indicators that it is time to pay close attention to the therapeutic relationship and be curious about what is taking place.

A New Vision for Psychotherapy Training

Combining the questions "what to train" and "how to train", the first and second author of this article are developing an online AFT as a concrete example and starting point for our 21st century online principle-based and marker-led psychotherapy training. The online AFT will be modeled after the AFT approach to training and supervision developed by Muran, Safran, and Eubanks, which aims at helping therapists recognize and negotiate ruptures in the therapeutic alliance both through observation of patient and therapist behaviors, as well as attending to the therapists' own internal emotional experience (Muran & Eubanks, 2020). The effects of AFT have been shown to foster rupture repair and patient outcome in six studies (Eubanks et al., 2019), including a randomized controlled trial (Muran et al., 2018).

In psychotherapy research, the alliance is typically conceptualized as consisting of the patient-therapist affective bond, and a purposeful collaboration on the tasks and goals of therapy (Bordin, 1979). It has been shown that during treatment, the alliance is characterized by rupture-repair episodes (e.g., Eubanks, Muran, et al., 2018). Ruptures are defined as moments of weakness or deterioration in the alliance (Eubanks et al., 2015) and they can be organized into two general categories: *confrontation ruptures*, in which patients or therapists move against the other person or the work of therapy, typically showing their concern directly; and *withdrawal ruptures,* in which patients or therapists move away from the other person or the work of therapy, usually having difficulties either recognizing their feelings or directly expressing them. The following three markers are indicators of confrontation ruptures: complaining/criticizing, pushing back, and controlling/pressuring (Eubanks & Muran, 2022); these three markers suggest the occurrence of withdrawal ruptures: shutting down, avoiding, and masking one's own experience (Eubanks & Muran, 2022). Ruptures are common events (Muran & Safran,

2016), which is why it is important that there is a chance to repair them by means of resolution strategies (Eubanks, Muran, et al., 2018). Resolution strategies can include immediate strategies, in which the alliance rupture is immediately addressed and then the dyad returns to the therapy task they were previously engaged in. Examples of immediate strategies include changing the task or goal, illustrating the task or providing a rationale, and redirecting or refocusing on a therapy task (Eubanks & Muran, 2022). Ruptures can also be addressed using expressive repair strategies, which involve exploring the rupture in depth and can include inviting the other to explore the rupture, validating their experience of the rupture, and disclosing one's own experience of the rupture. In addition, therapists and patients can address ruptures by acknowledging their own contribution to the rupture and by linking the rupture to larger interpersonal patterns in the patient's life.

Online AFT will begin with short, introductory theoretical videos (based on the research evidence on rupture and repair) as well as videos of prototypical case examples of confrontation markers and withdrawal markers, which indicate potential ruptures in the alliance, as well as corresponding immediate and expressive resolution strategies. In a second part of the training, therapists will be provided with various patient-therapist video scenarios and will be encouraged to recognize markers of alliance ruptures when they occur as well as corresponding rupture resolution strategies. Exercises will increase in difficulty as therapists move from recognition (e.g., selecting options from a predefined list) to recall. They will receive immediate computer-generated feedback and the possibility to reflect on and refine their responses. Therapists will then practice their skills in recognizing and negotiating alliance ruptures by responding to short video scenarios of withdrawn, confrontational or otherwise interpersonally complex patients. Their responses as therapists will be video recorded and played back to them accompanied by questions designed to foster their curiosity about the therapeutic process as well as access to their own internal experience. Thereby, the online AFT implements deliberate practice for rupture and repair interventions as previously suggested (Bailey & Ogles, 2023). An essential aspect of developing online AFT will be collecting data on its efficacy and based on that data, refining and adapting the training as needed to ensure that it meets the aim of improving therapist skills and treatment outcomes.

A fantasy for the future would be the development, implementation, and testing of additional modules of a *21st century online principle-based and marker-led psychotherapy training*: incorporating the concepts of deliberate practice as well as expert training, the huge potential of technologies, and considering the importance of (context) responsiveness. Such a training could include an online library of a range of clinical markers (e.g., a patient showing vulnerability may best be met with empathy on the side of the therapist. A bodily felt sense or abstract, intellectualized talk about emotions may be encountered with focusing interventions to enable emotional deepening. Self-critical processes may be played out using two-chair dialogue and uncompleted processes with

significant others may be attended to by means of empty-chair dialogue to increase self-compassion and acceptance of emotions and needs) with example patient-therapist videos of how to respond to them (thereby already building a bridge to practice) together with a brief description of relevant basic and applied research. Markers are nested within and can be classified under change principles so that relevant ones can be searched for when needed. In a second step, therapists could be provided with videos of clinical scenarios and corresponding exercises of increasing degree of difficulty (e.g., answers to choose from are given, answers must be generated and written down to meet certain keywords, therapists receive immediate and automated feedback on their choices with the possibility to repeatedly refine their responses, therapists immediately respond to patient scenarios and their responses are video-recorded, the recordings are played back to the therapists together with questions facilitating self-observation and self-reflection, they are then invited to respond again and differently to the same patient scenario). The idea is that therapists can practice their skills in a safe and supportive environment before applying them to their work with actual patients. Such a training could be distributed easily and inexpensively, offers time-independent use, and provides a cost-effective model for therapist skill advancement and ultimately psychotherapy success at the individual patient level. It could complement traditional psychotherapy trainings of different approaches: it could be used by professors in classes, as well as by supervisors who could access resources from the online library while meeting with a trainee in individual or group supervision. Such a training could also facilitate lifelong learning: it could be incorporated into continuing education programs as well as being accessed by practicing therapists when they want to review or learn new skills.

We would like to conclude with some broader ideas for the future of what we are suggesting as a principle-based and marker-led psychotherapy training. To really advance our understanding of how best to practice therapy and train therapists, we need to delineate a full range of principles of change, and we should regard "what works" as an empirical question. One important future direction for principles of change would be to see other principles and common factors enjoy the "success" that the therapeutic alliance has achieved in attracting the interest of researchers, practitioners, and trainers (Eubanks & Babl, in press). As more principles of change are in a position to receive that kind of attention, it will pave the way for more research looking at interactions between them (Norcross & Lambert, 2019). Given that principles of change cut across different approaches to therapy, many practicing clinicians have experience with them and can make valuable contributions by sharing how they understand and employ them. Researchers and clinicians can actively partner with each other in an effort to build an online 21st century principle-based and marker-led psychotherapy training.

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Scientific Update and Overview

Psychotherapy Works – An Inclusive and Affirming View to a Modern Mental Health Treatment

Christoph Flückiger[1], Ulrike Willutzki[2], Martin grosse Holtforth[3,4], Bruce E. Wampold[5]

[1] *Department of Psychology, University of Kassel, Kassel, Germany.* **[2]** *Department of Psychology, Witten/Herdecke University, Witten, Germany.* **[3]** *Department of Psychology, University of Bern, Bern, Switzerland.* **[4]** *Hospital Insel, Bern, Switzerland.* **[5]** *Department of Counseling Psychology, University of Wisconsin-Madison, Madison, WI, USA.*

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Corresponding Author: Christoph Flückiger, University of Kassel, Department of Psychology, Clinical Psychology II, Holländische Straße 36 – 38, DE-34127 Kassel, Germany. E-mail: christoph.fluckiger@uni-kassel.de

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Abstract

Psychotherapy is a highly collaborative and individualized mental health practice developed in (post-) modern societies. The mental health outcomes of psychotherapy cover a broad range of psychological factors including the reduction of suffering/symptoms as well as the promotion of well-being, personal values, and personal strengths. There is extensive meta-analytic evidence that legitimate psychotherapy works remarkably well and robustly for most common mental disorders. In addition, there is a large body of meta-analytic evidence supporting the potential relevance of transdiagnostic relationship principles and transtheoretical psychotherapy factors. Based on this ongoing empirical evidence, we propose four relevant implications for future training and practice in transdiagnostic psychotherapy: 1) the development of a transtheoretical legal framework for psychotherapeutic treatments, 2) the formulation of evidence-based transtheoretical interpersonal skills, 3) an orientation toward transtheoretical therapeutic factors, and 4) the exploration of comprehensive psychotherapy outcomes. We conclude with some more general guidance for future directions.

Keywords

mental health, bona fide psychotherapy, transtheoretical psychotherapy, evidence-based psychotherapy

Highlights

- Legitimate psychotherapy is remarkably effective.
- The evidence-based consolidation process on psychotherapy key principles is progressing continuously.
- There is robust empirical foundation of transtheoretical relationship factors and therapy skills.

There is comprehensive meta-analytic evidence that psychotherapy works across the most common mental health conditions. Surprisingly – and perhaps more controversially – there is robust evidence that various psychotherapy orientations work well, and when intended to be therapeutic (i.e., bona fide therapies) are approximately equally effective. That is, the ongoing controversy between psychotherapy orientations may make the potential differences between orientations appear larger than can be empirically supported, which is particularly true for long-term follow-ups. In this commentary, we provide explicit definitions of psychotherapeutic treatments and their mental health outcomes. Furthermore, we provide evidence-based examples of studies comparing the lasting efficacy at follow-up of particular legitimate psychotherapies vis-à-vis other legitimate psychotherapies. Next, we provide examples of evidence-based psychotherapy principles and skills based on recently conducted meta-analytic summaries. Last, we discuss implications for therapeutic practices and training, and conclude with some more general guidance for future directions.

How Can Legitimate (Bona Fide) Psychotherapy Be Characterized and Why Is It Relevant to Identify Non Bona Fide Psychotherapy Conditions?

Psychotherapy is a highly collaborative and individualized mental health practice developed in (post-) modern societies (e.g., Elias, 1978; Huft, 2022). One of the main characteristics of psychotherapy is its collaborative nature. Furthermore, patients have a proactive role and are engaged in therapy. The key point is that psychotherapy is a socioculturally embedded mental health practice, with patients and society expecting a highly custom-tailored and collaborative talking cure to reduce target complains and fostering well-being and psychosocial functioning to proactively work on the clients´ sufferings.

One of the major challenges in psychotherapy research is that psychotherapy and its minimal standards are often not explicitly defined. We define the minimal standards of legitimate (bona fide) psychotherapy as follow (Wampold et al., 1997; Wampold & Imel, 2015): Psychotherapists with at least a master's degree provided treatment, and two of

the following criteria are required: (a) treatment is generally recognized as legitimate psychotherapy, such as CBT or psychodynamic therapy, and therapists are not prohibited from using recognized therapeutic interventions, such as psychoeducation, empathy, a rationale for treatment, promotion of coping skills, or (b) the description of treatment includes a reference to a psychological mechanism (e.g., operant conditioning), or (c) a manual/guide is used, or (d) the treatment includes an active component that has appeared in the psychological literature. Careful consideration of the minimum standards of legitimate psychotherapy is a prerequisite for including only such trials in meta-analyses of psychotherapy comparisons to minimize research bias and triviality of findings.

With respect to *non bona fide* psychotherapy conditions, such conditions often are constructed to not be fully therapeutic (e.g., Westen et al., 2004; Munder et al., 2019; Flückiger et al., 2022). Non bona fide psychotherapy conditions often can be identified by looking at what interventions are excluded or even "banned". Examples of non bona fide psychotherapy in the above-mentioned sense are: *discussion group* where the leaders were instructed to "not teach skills or differentially reinforce coping strategies" (Wetherell et al., 2003, p. 33), *psychoeducation* where "instructors were asked, as best as they could, not to teach any skills in a way that may enhance mindfulness" (Wong et al., 2016, p. 69), *nondirective therapy* where "direct suggestions, advice or coping methods were prohibited" (Borkovec & Costello, 1993, p. 613), three session *contact control group* to motivate patients "to wait for the start of the treatment" (Linden et al., 2005, p. 37).

In many cases such non bona fide "intent-to-fail"-interventions are used to demonstrate the relevance of specific components of the favored treatment (Westen et al., 2004). However, these conditions are not informative about the efficacy of the approach compared to legitimate psychotherapy and provide little information about specific ingredients.

How Can Psychotherapy Outcomes Be Defined?

WHO defines mental health as follows:

> *Mental health is a comprehensive state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in. (World Health Organization, WHO, 2022, June 17).*

Consistent with the above-mentioned broad definition of the World Health Organization (WHO), we understand mental health as a lifelong process of development and adaptation. Most importantly, mental health has at least two constituents, including the reduction of suffering/symptoms as well as the promotion of well-being, personal values,

and strengths (e.g., Schürmann-Vengels et al., 2022). In psychotherapy, collaborative efforts toward symptom reduction and well-being represent psychotherapeutic outcomes that result from careful therapeutic exploration (grosse Holtforth et al., 2004). The point relevant to this Special Issue on transtheoretical clinical training and practice is that psychotherapy outcomes go beyond the tailored ("primary") outcomes of a particular psychotherapy and should cover the broad spectrum of the WHO definition of mental health.

Does a Particular Bona Fide Psychotherapy Have a More Lasting Effect Than Another?

Although somewhat arbitrary in nature, a threshold for a clinically relevant treatment effect in anxiety and mood disorders has been estimated to be about $d = .25$ (Cuijpers et al., 2014). Comparative meta-analyses report small to negligible relative differences in efficacy if two or more bona fide psychotherapies are compared directly in an RCT design (Wampold & Imel, 2015).

With respect to long-term outcomes, Kivlighan and co-authors (2015) for example examined the long-term follow-ups of bona fide psychodynamic psychotherapies compared with non-psychodynamic bona fide psychotherapies ($k = 25$). They hypothesized that psychodynamic psychotherapies would perform better over time than other treatments (assuming a positive and statistically significant slope effect from assessment post-therapy to follow-up). However, they found an effect of $d_{slope} = .00$ for disorder-specific targeted outcomes, nontargeted outcomes, and personality outcomes. These results suggest that the efficacy of psychodynamic therapies is generally not more sustainable but also not less sustainable after active treatment compared with other bona fide psychotherapies. Several other longitudinal multilevel meta-analyses on interventions for anxiety and depression did not show any significant increase or decrease in relative effects over follow-up time within studies, such as for cognitive interventions versus behavioral interventions (Podina et al., 2019), studies with additive components (Flückiger et al., 2015), and established cognitive behavioral therapy or augmented integrative cognitive behavioral therapy for generalized anxiety disorder under bona fide conditions (Flückiger et al., 2022; for all studies $d_{slope} < .10$). Again, these meta-analytic findings show that differential long-term outcomes for particular bona fide psychotherapy approaches usually are not likely.

The point relevant to the Special Issue for transtheoretical training and practice is that the enormous effort to specify psychotherapeutic effects through very specific approach explains surprisingly little on the long run. Do we therefore face a shambles? No, we think not! On the contrary, as we will show in the following sections there is considerable meta-analytic evidence for the outcome-relevance of multiple transtheoretical principles and skills.

Is There an Evidence Base for Transtheoretical Psychotherapy Principles and Skills?

Psychotherapy represents a cooperative course of action between therapist and patient during and between psychotherapy sessions. One of the most substantiated findings in psychotherapy research is that transtheoretical collaborative qualities are robustly linked to treatment outcomes across many psychotherapy conditions. Based on an international meta-analytic summary of 295 studies representing more than 30,000 psychotherapies, there is a moderate predictive association of 8% explained variance (r = .278; confidence interval .256 ≤ r ≤ .299; Flückiger et al., 2018) between alliance measured mostly once during therapy and therapy outcome (at the end of therapy) in face-to-face and internet-mediated treatments. These statistically significant results confirm those of previous meta-analyses. A comparable predictive power of the working alliance could also be meta-analytically confirmed in therapies with children and adolescents (Karver et al., 2018), in couple and family settings (Friedlander et al., 2018) and groups (Lo Coco et al., 2022).

There seem to be therapists who are comparatively more successful in building working alliances with their patients than others. These differences between therapists are relevant for treatment success, i.e., therapists who on average build better alliances also treat somewhat more successfully. These moderate effects have been meta-analytically confirmed (Del Re et al., 2021).

It is hypothesized that the alliance-outcome relationship manifests itself in particular because of the patients' intake characteristics (e.g., Feeley et al., 1999). However, based on 66 studies reporting both uncontrolled predictor models and predictor models controlled for the intake variables, there is no systematic evidence that the alliance can be fundamentally understood as an epiphenomenon of the intake variables, arguing for the collaborative conception *during* treatment (r = .25 vs. .22; Flückiger, Del Re, et al., 2020). Furthermore, an individual participant data analysis of 17 studies indicated that in the early phase of therapy, symptoms and alliance were reciprocally related to one other, often resulting in a positive upward spiral of higher alliance/lower symptoms that predicted higher alliances/lower symptoms in the subsequent sessions (Flückiger, Rubel, et al., 2020). Overall, the available evidence across hundreds of studies indicates that the above-mentioned sociocultural key principle of psychotherapy as a highly collaborative mental health treatment is robustly linked to psychotherapy outcomes. For other concepts that partly overlap with the alliance concepts comparable correlation patterns have been shown (for example empathy, goal agreement and group cohesion; Norcross & Lambert, 2018).

With respect to particular therapist skills, a recent APA interdivisional effort investigated 27 well-accepted basic psychotherapy skills and methods (Hill & Norcross, 2023). The results of the meta-analytic summaries revealed that some transtheoretical psychotherapy skills such systematic feedback in routine outcome monitoring (Barkham et al.,

2023), emotion-regulation strategies (Iwakabe et al., 2023) or strength-based methods (Flückiger et al., 2023) were evaluated as "demonstrably effective" for post-treatment outcomes (published open access in the journal *Psychotherapy Research;* Hill & Norcross, 2023). Overall, findings from process-outcome research have the potential to moderately improve psychotherapy interventions across psychotherapy orientations.

Clinical and Training Implications for Future Training and Practice in Transtheoretical Psychotherapy

Based on the reviewed literature, the following transtheoretical, transdiagnostic and interdisciplinary implications can be summarized for future clinical practice and training.

Development of a Legal Framework for Transtheoretical Mental Health Treatments and Psychotherapy

We consider it a key societal achievement that legislators have prioritized mental health treatments that have a strong collaborative foundation. Coercive measures are used only in extreme emergencies. Psychotherapy is the best example of how the joint negotiation and decision-making process can be carefully elaborated within mental health systems. The alliance, as one of the most studied collaborative principles, emphasizes the overall meaning of therapy, which includes therapeutic goals, therapeutic tasks, and deeper bonds of trust in the confidentiality of psychotherapy. Legitimate psychotherapy fundamentally requires consensual collaboration between therapist and patient.

The relevant point for training and practice is that psychotherapy provides a socially protected setting where patients are allowed to express their innermost concerns and desires. Psychotherapy is a cultural practice that promotes humane and free society. Psychotherapy does not exclude people and brings individuals, couples, families and groups together. It offers understanding for diversity, cultural sensitivity, psychosocial exclusion and psychological strain.

Evidence-Based Transtheoretical Interpersonal Skills

Building on patients' alliance potential and enhancing their alliance qualities at the beginning of a therapy is, on the one hand, central to ensuring that patients do not immediately discontinue the therapy. On the other hand, the early alliance (among other factors) lays the foundation for patients to engage in tasks of therapy. In the first phase of therapy, it is crucial that the methods of therapy are tailored to the patient's specific expectations, skills and abilities, and needs. The collaborative qualities of psychotherapy are crucial, namely that patients and therapists basically agree independently to the joint therapeutic tasks. The quality of the alliance may fluctuate within sessions. In principle,

central tendency is more relevant to success than a single session. However, critical, negative to hostile reactions from patients are possible during sessions and interruptions of the alliance are not uncommon. Adaptation of procedures to the patients' motives and strengths can enhance the alliance quality. In addition, tears and ruptures in the therapeutic relationship can be explored in a non-catastrophizing way and, if necessary, used therapeutically (Eubanks et al., 2023; also Caspar & grosse Holtforth, 2009; Safran & Muran, 1996).

Navigating Transtheoretical Therapeutic Factors

Navigating and monitoring the patients´ views of psychotherapeutic factors is an important therapist task to ensure that therapists do not take them for granted too quickly or become overly critical of themselves and the therapy. Therapists differ in the quality of how they build and shape custom-tailored treatments. What basically counts is the overall collaborative quality of the therapeutic process and not the adherence to an ostensible therapeutic stereotype.

Broadening Psychotherapy Outcomes

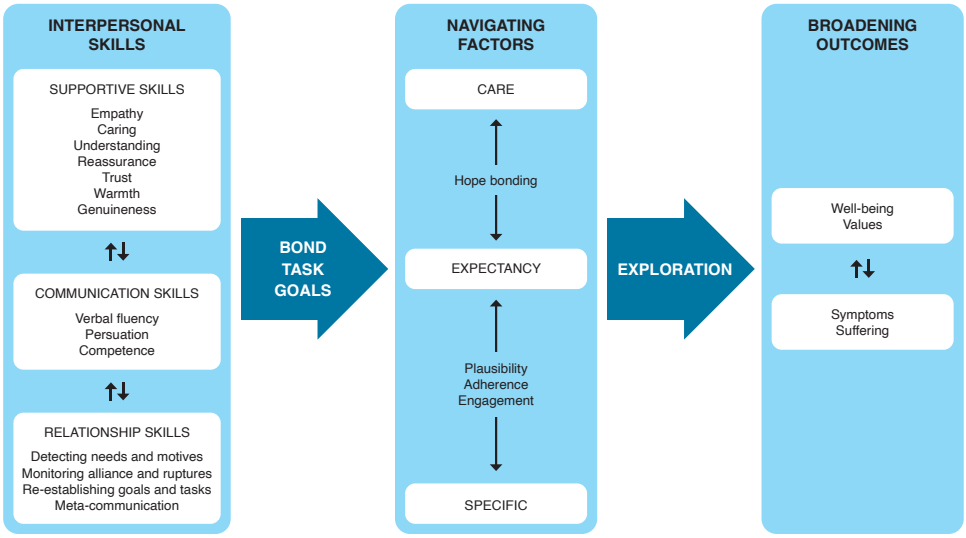
As the above-mentioned health definition exemplifies, mental health is a much more comprehensive condition than the absence of particular symptoms and related disorders. At the same time, well-being is not an exclusive goal for psychotherapeutic treatments. Singing in a choir, sailing with friends, or listening to a punk rock band can similarly contribute to mental health depending on the individuals´ preferences. Clearly, such activities may be highly relevant topics in the consolidation phase of a therapy to explore psychotherapeutic change. The critical point is that a wide range of mental health measures need careful consideration when evaluating mental health treatment.

To promote effective learning and therapy practice, supportive psychotherapy training (e.g., fostering supportive supervision, positive trainee relationships, and group collaboration; Heinonen et al., 2022) as well as structured practice on basic skills (e.g., Anderson et al., 2020; Eells et al., 2005) are essential. We expect a continuing psychotherapy development of therapists over a career that comprises professional and personal progression as well as challenges (Orlinsky et al., 2005). Figure 1 shows an example of how an evidence-based transtheoretical model might be formulated (see Wampold & Flückiger, 2023), which is an extension of Contextual Model (Wampold & Imel, 2015). In the transtheoretical model, there are three pathways to the benefits of all mental health (as well as physical health) service: The CARE pathway (caring, attentive, real, empathic), the Expectation pathway, and the Specific pathway. In a sense, this model integrates the effects of relationship factors and specific ingredients, making it important for all psychotherapists, including those strongly affiliated with a particular treatment, as

well as for various healing domains, including psychotherapy, psychiatry, and medicine. The model is also transcultural as well as transtheoretical.

Figure 1

Exemplification of an Evidence-Based Transtheoretical Model – The CARE-Model of Mental Health Treatments (Adapted From Wampold & Flückiger, 2023)



Concluding Comment for Future Directions

Mental health is a human right and a shared responsibility of societies that cannot be entirely delegated to particular professions nor achieved by certain treatments. At the same time, carefully conducted mental health treatments are cultural achievements. Transtheoretical therapeutic factors such as collaborative qualities are relevant across orientations but also across professions and settings (Wampold & Flückiger, 2023). On the healthy side of mental health, there is openness, individuality, and basic human freedom in how we create our lives. Accepting co-responsibility for psychotherapeutic outcomes is not only a critical interpersonal skill of therapists, but also entails an attitude of trust in joint exploration of what individual well-being means.

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Scientific Update and Overview

Case Conceptualization in Clinical Practice and Training

Eva Gilboa-Schechtman[1]

[1] *Department of Psychology and the Gonda Brain Research Center, Bar-Ilan University, Ramat-Gan, Israel.*

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Corresponding Author: Eva Gilboa-Schechtman, Department of Psychology and the Gonda Brain Science Center, Bar-Ilan University, Ramat-Gan, 52900, Israel. Tel: 972-3-531-8744. E-mail: evagilboa@gmail.com

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Abstract

Case conceptualization is central to the success of the therapeutic process. However, integrative case conceptualization research has lagged behind research on integrating therapeutic intervention techniques. A successful case conceptualization provides (a) a dynamic, context-sensitive, yet parsimonious model of the client's functioning; (b) relevant treatment targets and associated assessment procedures; and (c) a treatment plan including intervention phases and potential obstacles. Success in case conceptualization is a core clinical competency goal for trainees in clinical psychology and a career-long learning goal even for expert clinicians. Emerging technological trends and the formation of adversarial collaborative teams may assist research on the utility of well-constructed case conceptualizations.

Keywords

case conceptualization, case formulation, integration, personalized treatment, supervision

Highlights

- Case conceptualization is central to the success of the therapeutic process.
- A successful case conceptualization promotes effective and personalized interventions.
- Research on integrative case conceptualization is lagging behind treatment by a factor of 1:100.

Case Conceptualization: There Is Nothing More Practical Than a Good Theory

The global burdens associated with many common mental health conditions appear unaffected by diagnosis, prevention, and treatment advances, impacting individuals', families', and societies' quality of life (Bruffaerts et al., 2018). Given this discouraging situation, calls are made to create trans-theoretical and empirically based ways of approaching mental health difficulties, combining elements from diverse treatment orientations to personalize treatments (Lutz & Schwartz, 2021; Schiepek & Pincus, 2023). In the following, I argue that the first step to such an integration is enhanced attention to a clinically central stage of the therapeutic process: case conceptualization.

Our lives are dynamic, and our goals, concerns, behaviors, and aspirations are modified in response to various challenges and opportunities. Our difficulties and strengths are similarly sensitive to various biological, psychological, and sociocultural processes and factors. Thus, there is wide agreement that psychiatric diagnoses are insufficient for clinical practice because they provide only a subset of the information clinicians need to help their patients. Case conceptualization, also known as case formulation, is created to weave a complete understanding of a person, of which diagnosis is only one aspect (McWilliams, 2021). Case conceptualization is a comprehensive and individualized understanding of a client's presenting concerns, psychological symptoms, and interpersonal patterns. It thus integrates information from various sources, such as client interviews, assessment tools, and clinical observations. This information is used to formulate hypotheses regarding the factors responsible for developing (etiology) and maintaining the client's pattern of difficulties. Case conceptualization aims to create a coherent and succinct narrative that provides a plausible framework for understanding the client's difficulties and informs treatment planning (British Psychological Society, Division of Clinical Psychology, 2011; Eells, 2015, 2022a; Johnstone & Dallos, 2014; Persons, 2022; Sperry & Sperry, 2020).

Case conceptualization may serve as a linchpin between initial clinical assessment, personalized treatment development, and the intervention's efficacy evaluation. A comprehensive, well-informed, theoretically rich (and thus, integrative), and source-diverse conceptualization will likely advance the construction of an effective and flexible treatment plan. In contrast, an insufficiently detailed or biased assessment is likely to result in a misguided conceptualization that leads, in turn, to an ill-formed treatment plan. Importantly, case conceptualization is an evolving process: throughout the therapeutic process, case conceptualization is *continually* refined and updated to reflect new information, insights, and responsivity to specific triggers and interventions.

Integrative case conceptualization – case conceptualization informed by multiple interwoven theoretical perspectives – is crucial if a treatment plan is also to be informed by such an integrative perspective. Yet, despite the centrality of case conceptualization for treatment planning, only a few dozen articles have been published in the last decade

concerning case conceptualization (or formulation) and integration[1]. This paucity is striking compared to a few thousand papers concerning treatment integration. This factor of 1:100 favoring the focus on intervention is maintained when we examine the direct comparison of two central research approaches – psychodynamic and cognitive-behavioral.[2]

Case Conceptualization: An Attempt at Theoretical Integration

A case conceptualization needs to integrate diverse and complex information. *First*, it needs to include both nomothetic and idiographic information. The nomothetic information is derived from empirically supported models of individual differences, while the idiographic information contains specific data regarding the individual's idiosyncratic history, concerns, motivations, and aspirations. One of the main goals of case conceptualization is to connect the specific patterns of distress that bring the individual to treatment (idiographic concerns) with this rich database of nomothetic information. For example, it is important to assess which symptoms of distress are specifically significant for this client. Indeed, recent research suggests the need to broaden and refine our definitions of distress even in the most well-known conditions, such as depression, post-traumatic stress disorder, and social anxiety (Gilboa-Schechtman, 2020; Gilboa-Schechtman et al., 2020; Keshet & Gilboa-Schechtman, 2017). Moreover, standard clinical measures of depression have been criticized for measuring domains of limited relevance to patients and leaving out significant areas of concern, such as sick leave, work difficulties, or impaired relationships (Fried & Nesse, 2015). *Second*, a case conceptualization needs to integrate information from several time frames. A macro timescale (decades, years) may include information concerning the client's personal history from early childhood to the present and their aspirations and concerns about the future. The ability of the client to achieve developmental milestones (such as moving to independent living) and handle common stressors (loss of a relationship or a job) is important for the eventual understanding of the person's vulnerabilities and areas of resilience. A meso timescale (weeks, days) may include data concerning their affect, behavior, cognition, and physiological reactions in the period preceding their turn to treatment. Finally, micro timescale (hours, minutes) information may include multi-modal data concerning their response to in-session interactions. This information may be used to examine the way clients experience

1) PSYCHNET for 2013-2023 identified 33 peer-reviewed articles published with "integrat*" and "case conceptualization" or "case formulation" as the keywords. This is compared to 3434 articles with "therap*" OR "treatment*," OR "intervention*," and "integrat*" in keywords.

2) PSYCHNET for 2013-2023 identified 65 articles published with the keywords "case conceptualization" or "case formulation" crossed with "*cognitive-behavioral" or CBT or "psychodynamic"*. This is compared to 9193 peer-reviewed articles with "therapy," "treatment", OR intervention," were crossed with *cognitive-behavioral," OR"psychodynamic."*

their therapists and therapists' responses to their clients. *Third*, case conceptualization needs to consider how culture (communal, individualistic) and societal context (such as social class or sexual orientation) impact our lives. Importantly, culture affects not only our values (e.g., honoring the dead, obedience), beliefs (say, "direct communication is important," "time progresses linearly"), and coping strategies (such as help-seeking from family and friends, prayers, and spiritual practices), but also the emotions that we value and cherish (for example, the value of individualistic pride appears to be higher in Western than non-Western cultures, Kitayama et al., 2006). Social class impacts thoughts, feelings, and behavior (Manstead, 2018; Stephens et al., 2014). Understanding how our identities, shaped by culture and context, intersect offers a greater depth of the client's history and challenges. *Fourth*, the construction of a comprehensive case conceptualization may involve, when possible, information from several perspectives, including the individual's own experiences, as well as input from family members, other healthcare providers, and the therapist's own evaluation of the client's behavior during the assessment and the treatment processes.

Clinically, the development of a case conceptualization involves several steps. *First*, identifying the client's presenting problems, such as the specific symptoms, issues, or difficulties the client is experiencing. These can be emotional, cognitive, behavioral, or interpersonal in nature. *Second*, understanding the client's background and context by exploring their personal history, family dynamics, social environment, and cultural background may contribute to developing or maintaining their difficulties. Indeed, the first two stages offer the opportunity to utilize diverse theoretical orientations, as different orientations emphasize diverse sources of information as significant (e.g., early family dynamics, genetic factors, learning history). *Third*, assessing the client's strengths and resources: social and intellectual skills, coping mechanisms, and social support. *Fourth*, formulating hypotheses about the underlying mechanisms or patterns that contributing to the client's difficulties. Crucially, these hypotheses can be informed by various psychological theories or models, such as cognitive-behavioral (CBT), psychodynamic, humanistic, or trans-theoretical perspectives (e.g., Eubanks & Goldfried, 2019). CBT makes an important distinction between etiological and maintenance factors for disorders. Including diverse factors in the conceptualization (Wong & Rapee, 2016 in the case of social anxiety disorder) may clarify the immediate and long-term treatment targets. *Fifth*, establishing treatment goals. In collaboration with the client, the clinician can set specific, measurable, and achievable goals for therapy, which will address the identified problems and promote overall well-being. Again, such goals may be enriched by inputs from trans-theoretical models of psychotherapy (Bailey & Ogles, 2023) and include, besides, reduction of distress, increase in insight, and in self-efficacy. *Finally*, developing an individually tailored intervention plan that outlines the therapeutic approaches, techniques, and strategies that will be employed to help the client achieve their goals. Thus, case conceptualization serves as a roadmap for both the therapist and the

client, guiding the direction and focus of therapy and helping to monitor progress and outcomes.

Training Implications

Case conceptualization is a widely agreed upon core clinical competency (Eells, 2022a; Page et al., 2008; Rief, 2021; Sperry & Sperry, 2020). This competency is based on theories of personality and psychopathology, coursework on assessment and diagnostics, and the treatment outcome literature learned in lectures and dialogues conducted during clinical supervision. Thus, clinical supervision aims to assist supervisees in shifting from *abstract knowledge about* case conceptualization to the *case-specific clinical implementation* of this knowledge (Page et al., 2008).

Case conceptualization can be thought of as a model of the client's intra- and interpersonal dynamics. Given that models are inherently "wrong" in that they are incomplete approximations of reality, the utility of a model for clinical inference is determined by its ability to provide *actionable insights* for psychotherapy (Fried, 2020). Clinical supervision needs to help trainees find a compromise between simple models and elaborated models by emphasizing that the model is as good as the insights into treatment planning it allows. Whereas most beginner clinicians can identify some presenting problems, strengths, and precipitating factors, elements of the conceptualization concerning etiological and maintaining mechanisms are typically more difficult to articulate. Formulating and testing nuanced hypotheses inherent in each conceptualization is an elusive yet important part of the conceptualization (Ridley et al., 2017). This elusiveness is illustrated in the study by Eells and colleagues, who found that experienced clinicians with decades of professional experience were almost as likely to include a psychological mechanism in their case conceptualization as novices (Eells et al., 2005). Another study with experienced clinicians providing a psychodynamic conceptualization found that many clinicians used a relatively low inference level and an experience-near terminology, again suggesting that many therapists introduce few maintenance mechanisms in their case conceptualizations (Sørbye et al., 2019). Providing a specific structure for the case conceptualization and encouraging trainees to refer to all components of the conceptualization may improve the completeness and quality of their models.

One of the most important tasks of the supervisor is the gentle yet consistent encouragement to construct a "good enough" conceptualization at the *onset* of treatment. There is extensive agreement that an *early* attempt to construct a case conceptualization is an important and necessary foundation for competent practice in several approaches (CBT; Kuyken et al., 2009; Persons, 2008), dynamic therapy (McWilliams, 2011; Shedler, 2022), and interpersonal therapy (Hopwood et al., 2019). Moreover, there is an emergent agreement regarding the clinical importance of the involvement of clients in case conceptualization, goal setting, and treatment planning (Beck et al., 1979; Hopwood et al.,

2019; Kuyken et al., 2009; McFarquhar et al., 2023; Tee & Kazantzis, 2011). Such client involvement is crucial for enhancing the transparency of clinical practice and facilitating the client's understanding of – and, therefore, engagement in – therapy itself.

A competently developed, high-quality conceptualization goes beyond a summary of information about the client (Eells et al., 2005). It is important to enhance the trainees' ability to check their conceptualization for completeness (Eells, 2013). Specifically, the case conceptualization should be (a) *comprehensive* in addressing multiple aspects of a client's functioning; (b) *understandable* to the client and thus use language that is precise and non-technical; (c) *parsimonious* yet not simplistic; (d) *coherent*, providing an internally consistent model of the individual's problems, explaining the presenting complaints by reference to predisposing vulnerabilities and strengths, precipitating events, etiological and maintaining factors; (e) *science-informed,* offering explanatory hypotheses linked to knowledge about personality and psychopathology; (f) *generative*, highlighting the ways in which the treatment plan logically flows from the explanatory hypotheses and predicts measurable outcomes; and finally, (g) *cohesive*, offering a treatment plan that links the hypotheses with a therapeutic course of action.

Ultimately, it is important to stress to trainees that the skill of conceptualizing involves career-long learning. Case conceptualization is a complex process that requires clinicians to draw on a wide range of theoretical and practical knowledge to understand each client's unique needs and challenges. By promoting career-long learning, we can continually expand our knowledge base and develop new skills that can enhance our ability to formulate effective treatment plans for our clients. Additionally, ongoing mentoring and supervision can provide clinicians with feedback and guidance that can help us refine our case formulation skills and approaches. Supervisors who view clinical science as a process of continuous development and who model intellectual humility and healthy skepticism as parts of their professional improvement process are likely to foster up-to-date psychological methods among their supervisees. This, in turn, can lead to more effective treatment outcomes for clients and enhance the overall quality of clinical practice.

Research on Case Conceptualization

Research on case conceptualization traditionally examined questions of validity and reliability (Easden & Kazantzis, 2018; Eells, 2022b). Most studies evaluate the *reliability* of various case conceptualization methods to assess whether different clinicians, using the same case conceptualization approach, arrive at similar or consistent conceptualizations for a given client or case. This line of research typically involves comparing the conceptualizations of multiple clinicians who independently review the same case information (Easden & Kazantzis, 2018; Persons & Hong, 2015).

The *validity* of case conceptualization examines the extent to which different conceptualization methods accurately capture and explain the client's presenting problems, underlying mechanisms, and treatment progress (Easden & Kazantzis, 2018; Horowitz et al., 1995). Validity is typically established when predictions made by a case conceptualization match actual treatment outcome or when different approaches arrive at similar conclusions (Bucci, French, & Berry, 2016; Mumma, 2011; Mumma et al., 2018). Indeed, examining the clinical advantage of case conceptualization involves assessing whether more accurate, thorough, or complete case conceptualizations are associated with better treatment outcomes, such as reduced distress, increased client satisfaction, or enhanced therapeutic alliance, yet only scant research has examined this question (Bucci et al., 2016). To further examine the effectiveness of different case conceptualization approaches, researchers may conduct well-powered randomized controlled trials or comparative studies investigating whether certain case conceptualization approaches lead to better treatment outcomes than others or whether specific approaches are more suitable for particular client populations, problem areas, or therapeutic modalities (see Eells, 2022b for a review of initial attempts in this direction).

Additional important questions involve the role of therapist factors (e.g., training, experience, theoretical orientation) in the comprehensiveness and effectiveness of case conceptualization. Finally, the importance of the timing of case conceptualization may be explored, and the timing of the construction and sharing of case conceptualization with clients may be examined. For example, research may compare sharing a case conceptualization with the client early in treatment (in the first third of the treatment sequence) versus late treatment (in the middle or the final third of the treatment sequence). Such research can use case conceptualization methodologies to translate the idiographic nature of psychotherapy into quantitative research designs (Haynes et al., 2009; Kramer, 2020). For example, when idiosyncratic mechanisms are defined (e.g., over-utilization of cues of social status as opposed to cues of affiliation in social anxiety, Gilboa-Schechtman, 2020), the outcomes of these specific mechanisms can be assessed in a quantitative design.

A Way Forward

An ongoing challenge for reliable, valid, and therapeutically useful clinical case conceptualization is the time constraints for completing this complex task. However, we are witnessing exciting advances promising to assist us in the timely completion of this task. On the methodological side, with the advancement of ecological momentary assessment (EMA, mostly relying on self-report), ambulatory monitoring (which may include physiological data), and routine outcome assessment (e.g., Schaffrath et al., 2022) we can look forward to collecting a wealth of data about a single individual from a variety of intra-personal (including physiology, behavior, passive sensing of a digital footprint, and

expressive signals such as voice, as well as subjective self-report) as well as interpersonal (e.g., family, close friends) sources. With advancing technology, techniques enabling the automated analysis of such intensive data will become increasingly available. Such innovations require a willingness to critically evaluate and adapt one's own clinical practice based on emerging clinical tools, empirical findings, and client feedback.

On the theoretical side, a unified effort to foster adversarial collaborations between representatives of diverse schools of clinical thought in creating a comprehensive scheme for case conceptualization appears to be needed. These collaborations may enhance trans-diagnostic approaches and pluralism by increasing awareness of confirmation biases inherent in any one approach (Doherty et al., 2019). Adversarial collaborations may also help representatives from various schools of thought clarify and refine the assumptions underlying the components needed for a successful case conceptualization. Such collaborations may strengthen the link between research in psychopathology and psychotherapy and foster integration between treatment orientations.

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Four Versions of Transtheoretical Stances, and the Bernese View

Franz Caspar[1], Thomas Berger[1]

[1] *Department of Clinical Psychology and Psychotherapy, University of Bern, Bern, Switzerland.*

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Corresponding Author: Franz Caspar, Department of Clinical Psychology and Psychotherapy, University of Bern, Fabrikstr. 8, CH 3012 Bern, Switzerland. Phone: 0041 31 631 47 31. E-mail: franz.caspar@unibe.ch

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Abstract

A brief characterization of transtheoretical stances to which existing approaches can be allocated is followed by a description of the "Bernese view", that is, what Klaus Grawe and his colleagues, including the authors of this article have developed: the origins, a model of the multiple constraint satisfaction construction of therapist action, a discussion of psychotherapy integration, the crucial role of supervisors in an integrative multiple constraint satisfaction approach, and a discussion of when and how trainees should be introduced to a transtheoretical stance.

Keywords

transtheoretical, psychotherapy integration, multiple constraint satisfaction, individualization, supervision

Highlights

- Various understandings of transtheoretical exist.
- Two differences are particularly important: The degree to which theories are integrated, as opposed to conveyed/used as separate approaches, and the striving for "the" right approach vs. emphasizing that we should rather expect and further a never-ending process.
- A concept of satisfying multiple constraints in the moment to moment construction of therapist action is more realistic than adapting standardized procedures.
- Using multiple theoretical concepts is advantageous in the endeavour of offering an optimally fitting psychotherapy.

Your Personal Preference

Let's assume *you* have (or a person you really care about has) a major psychological problem. Your problem may fit into a diagnostic category (such as major depression, or one or the other kind of anxiety disorder) or not, in any case, in the individualized assessment of problems and treatment goals (Goal Attainment Scaling; Kiresuk et al., 2014), the reduction of depression (or anxiety) would appear as secondary or third treatment goal only. More concerned you are about the fact that you have severe conflicts with your adolescent children, or being treated badly at work. The work-related problems you see as a consequence of mobbing.

Let's also assume that as a psychotherapy-interested person, you are informed about the approximative contribution to outcome of a specific approach, the therapist, and the relationship. Still, you are also aware that these are averages, while for the individual patient, a detail may make all the difference. Let's assume that you are also familiar with research showing that professional top performers in general, are contextually oriented. That is, they consider a wealth of circumstances before and while they act (Caspar, 2017), and this is in line with your own professional experience in a different field. What kind of treatment and what kind of therapist would you look for? Let's leave this question open at the moment.

Four Transtheoretical Stances

While many variations are possible, we see four major ways in which a therapist or training program can be transtheoretical:

1. Learn several approaches to psychotherapy (e.g., psychodynamic and behavioral) in parallel or sequentially and practice somehow based on a limited number of pure approaches.

2. Strive towards the one coherent approach that integrates several existing approaches to psychotherapy.
3. Use elements of various origin in an integrative way while maintaining the view that various approaches should maintain differences, as this is a precondition for an ongoing dialectical process in which many therapists and researchers actively participate.
4. Start with a particular, ideally already integrative, approach, then strive for continuous development, integrating further conceptual and practical elements not only from existing approaches to psychotherapy, but also basic science. Not only integrating what appears useful but also dealing with contradictory concepts and evidence.

The first version, while open beyond one single approach, sticks to a view of the world of psychotherapy as divided into approaches. The stance is practiced in institutions seeing themselves as transtheoretical as not one single approach is taught, but if the exchange between these approaches is limited, one might say, it's "transtheoretical light". To the defense of this version, one might say that such a version is based on history, and, after all, somehow complexity needs to be reduced. Critically one might say that in this version, the goal of *integrating* the approaches is not dominating, and the individual therapist is, by and large, left alone with the task of combining conceptual and interventive elements in practice.

The second version is attractive for institutes or individuals intending to provide and "sell" THE integrative approach in general, or use integration in favor of an approach with more limited claims of validity (such as CBASP for chronic depression; McCullough, 2000). The risk of this variation is that unlike versions three and four, there is a considerable chance of petrification and a development to just another approach defending its superiority.

The third version is well represented in the Society for the Exploration of Psychotherapy Integration (SEPI). As a SEPI steering committee member, one of us (FC) has participated in many discussions about whether SEPI should switch to tempting version two and certify therapists as SEPI-proved integrative therapists aiming at the gaining of attractiveness. But always those have won who defended the dialectical version three, which is also signaled by the unwieldy name component "exploration of ...". As Wolfe (2000) states: "... only a minority of SEPI members believes it is even possible to develop an integrative psychotherapy theory. Even if it were possible, such a theory would not be a great idea, some argue, because it would have a chilling effect on therapeutic creativity" (p. 234). Most colleagues would, while acknowledging the importance of guidance coming from theoretical concepts, agree that none of the existing theories satisfies all needs and preferences (Walder, 1993), and that maintaining a variety of approaches may be the best and maybe only antidote against the loss of diversity which may prove useful when it comes to new challenges – analogously to biological diversity and gene pools.

While to some extent compatible with this third version, the fourth version, corresponding to the Bernese view, based on Grawe's *General Psychotherapy*, seems to incorporate most advantages, and will therefore get more space here.

The Origins of the Bernese View

In the mid 1970s, Grawe and colleagues, working at the Hamburg Eppendorf University Psychiatry Hospital, were confronted with patients with mixed diagnoses who were treated in behavioral group therapies. From a technical point of view, therapists did everything right, but some patients did not really engage in therapy and brought various difficulties into the therapeutic relationship. While it was not common at that time to use personality disorder diagnoses, nowadays, many of them would be characterized by such diagnoses. Grawe developed a form of case formulation that focused more on the motivational background of problem behavior and its instrumental function. This overriding of some of the limits of behaviorism allowed the development of individualized "complementary" strategies in the therapeutic relationship. Of influence on his thinking was also the fact that at that time, research on Client Centered Therapy (in which he also had a partial training) showed equally good results as Behavior Therapy, even with anxiety disorders, which many considered to be a domain of Behavior Therapy (Grawe, 1976).

In the early 1980s, Caspar developed Grawe's "Vertical Behavior Analysis" further with particular respect to the role of emotions and the analysis of the patients' problems. These additions led to a replacement of the name "Vertical Behavior Analysis" with "Plan Analysis" (Caspar, 2018b, 2022). In Plan Analysis an instrumental perspective is taken: For conscious and non-conscious, interpersonal and intrapsychic behaviors it is asked what purpose or motives they serve. Plans are the basic unit of analysis: they consist of a motivational component and means serving this motive. The two-dimensional Plan structure represents the whole of inferred strategies of a person, ordered in a hypothetical instrumental hierarchy with concrete behaviors on the bottom and general needs on top. Plan Analysis case formulations serve two major purposes: To understand the functioning of patients in the therapy relationship, and the development and maintenance of psychological problems. These can be a consequence of instrumental strategies (e.g., a depression developing when a person avoids leaving home for two years to avoid agoraphobic anxieties), or they can be means serving the solution of problems (e.g. a depression serving the hypothetical purpose of avoiding the conflict in a difficult pro/con decision related to a potential coming out by a homosexual person in a homophobic environment). Plan Analysis is neutral as far as schools of therapy are concerned, and various approaches to therapy can guide the hypothesis generation: instrumental conditioning: behavior therapy; testing the therapist with challenging behavior in the relationship: psychodynamic control-mastery approach; avoidance of threating emotions

by transformation into emotions that are less threatening on a short by maladaptive on a long range: Emotion Focused Therapy; etc.).

In a major RCT, a Plan Analysis based form of Broad Spectrum Behavior Therapy has been compared to a form of Broad Spectrum Behavior Therapy based on traditional behavior therapy case formulations (Lazarus, 1971), and classical Client Centered Therapy without any explicit form of case formulation (Grawe, Caspar, & Ambühl, 1990). Plan Analysis based therapies fared better in some outcome criteria, but not pervasively, while the process was stunningly more favorable from patient, therapist and observer perspectives.

An important feature of this study was that the three RCT conditions were not defined in a narrow algorithmic but in a rather heuristic way by prescribing three different approaches in terms of case conceptualization while leaving the concrete procedure open as long as it was based on the respective individual case conceptualization. Of course, it was considered necessary to know how therapists proceeded concretely, but this was described retrospectively based on video analyses. These showed by far the most technical and conceptual richness in the Plan Analysis condition, including the reference to psychodynamic and gestalt therapeutic elements. The justification for and advantages of such a heuristic, integration-friendly form of RCTs is described in more detail in Caspar (2018a), for a recent study related to the assimilative integration of Emotion Focused elements see Caspar et al. (2023).

Grawe (1998, 2004) termed the classical therapy orientations *first-generation approaches*. Typical for them is that usually, charismatic founders formulate a coherent approach incorporating theoretical and practical concepts. Typically, they reinforce and defend their approach against competing approaches by (over-) emphasizing its advantages and, more often than not, ignoring or suppressing information incompatible with their assumptions, and fostering group thinking: "we, the good and smart ones, own the best concepts and our patients are blessed that they can profit from this. The others are ignorant, ineffective, not thorough enough, even unethical, etc." *Second-generation approaches*, in contrast, are open to dealing with concepts and findings challenging their existing views, and continually strive to deal with evidence, integrating useful parts not only of alternative existing approaches to psychotherapy, but also of insights from basic and applied science. The ideal of reaching a point of saturation is asymptotic, that is, it is never reached, because approaches of psychotherapy ever evolve further, and so does science. This stance has been denominated *General Psychotherapy*. It is not yet another approach with content and techniques, let alone a transdiagnostic model striving to correspond to the second type (see above), but a model for a continuous process with which a holding on to a particular state in the development would be incompatible. The explicit reference to other concepts and approaches, new and old ones, in a continuous process of change, is a bastion for scientific honesty and appreciation for concepts of others, which is a value considered crucial for further development.

Grawe has compared first generation approaches to "Konfessionen" (German for religious denominations) and entitled a book "Von der Konfession zur Profession" (from religion to profession; Grawe, Donati, & Bernauer, 1998), that is, characterizing the behavior of founders and followers of first generation approaches as unprofessional. The direction of development should, of course, be from confession to profession. It is hard to avoid seeing many developments within the "third wave of Behavior Therapy" going the other way: "From profession to confession" by uncritically following (more or less charismatic) leaders and believers, who don't justify their actions based on a comprehensive individual case formulation but rather do what their approach suggests: "I'm doing this, because I'm an XY-therapist."

For the Bernese approach, a clear emphasis was all along on individual case conceptualizations as a basis for custom-tailoring the therapy to the patient and the concrete situation on the level of relationship as well as working on the problems. Plan Analysis captures the recurrent patterns while being open to systematic variations across situations. The therapist adapts to stable patient characteristics as well as to characteristics and particularities in the moment. Grawe (1988) has entitled one article, arguing for a rather heuristic than algorithmic, process-oriented understanding of therapy with "Der Weg entsteht beim Gehen" (the path develops as one walks it). Such a view of therapy has been grounded for him and FC in training in humanistic therapies.

This corresponds to the idea of "contextual" acting, which is typical for top performers in various professions (Caspar, 2017; see below) and is also seen as a precondition for "responsiveness" in psychotherapy (Stiles, 2021). Responsiveness (overlapping with the terms personalization and precision psychotherapy) is across orientations one of the most topical issues in the current psychotherapy discussion when asking how we can further improve psychotherapy (see, e.g., programs of international psychotherapy conferences).

A Model of Creative Multiple Constraint Satisfaction

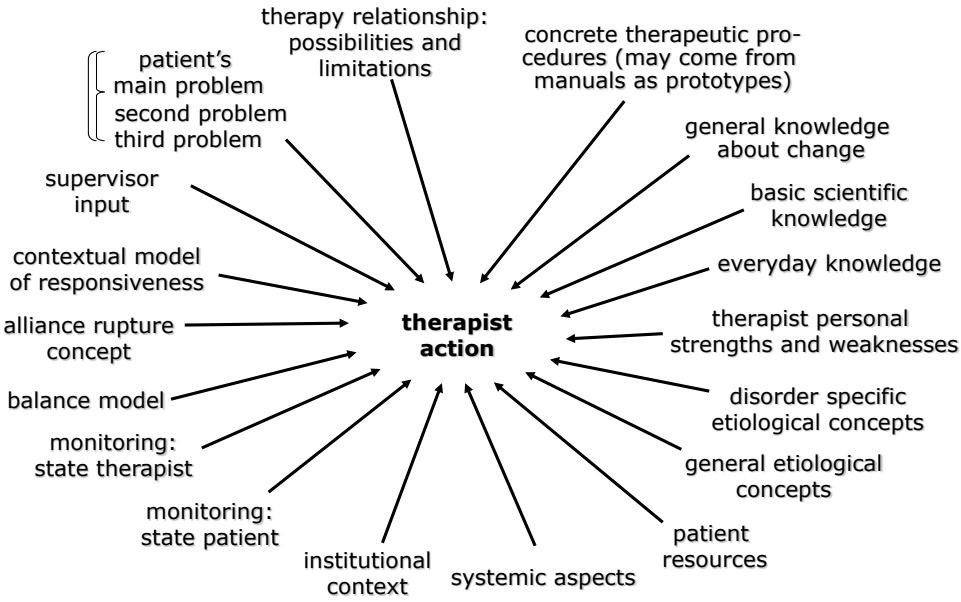
A therapist should be contextual, that is, able to include as many relevant properties of the patient and the situation as possible. A model for this we call “multiple constraint satisfaction model of constructing therapeutic action anew” or “Creative Construction Model” (Figure 1)

The model may appear pretty complex, yet it is assumed to represent what good, experienced therapists include in their construction process. Three assumptions are important:

1. Not all aspects are equally relevant in each case and situation: a patient with a straightforward agoraphobia without instrumental function, easy in the therapeutic relationship, requires less multiple constraint satisfaction than average.
2. Such a multiple constraint satisfaction process is, once a therapist has practiced it several times in a conscious, step-by-step manner, relatively intuitive. The processes become fast and thus workable.
3. Novices can't be expected to master the complexity of all potentially relevant aspects from the outset. It is temporally the supervisor's task to make sure that no crucial aspect gets neglected (see below).

Figure 1

Creative Construction Model



Note. Model of parallel multiple constraint satisfaction in the construction of therapist action. The brackets at the problems indicate that they are typically interconnected. The list of aspects to be considered is not exclusive (adapted from Caspar, 2000, 2022).

The Development of Expertise

Therapist information processing (hypothesis generation, decision making, etc.) and the development of expertise in such processing has been a main working area of both authors of this article, and Cognitive Science is seen as providing models and language suitable for neutral transtheoretical reflection and discussion. The question of when

and how in their development psychotherapists can deal with how much complexity is crucial when advocating the described creative construction model vis a vis psychotherapy trainees. For an answer, it is obvious to look into the literature on the development of professional expertise. There are several phase models for the professional development of therapists. A non-clinical model of high relevance stems from Dreyfus and Dreyfus (1986). According to them in an initial phase, professionals stick to clear, simple when-then rules, and to relatively simple models. This simplicity is appropriate for their beginning level of development, but the results are at the same time considered to be suboptimal. The experience of limitations with individual tasks/cases is seen as the driving force behind a process of enlarging perspectives as well as concrete procedures. According to the Dreyfus and Dreyfus model, the subjective confidence first *decreases* instead of *increasing* as the therapist gains experience. This is due to the awareness that multiple perspectives are possible, and that the responsibility of the therapist is not only to use rules properly, but also to decide on the right perspective or combination of concepts. In the later stages of professional experience psychotherapists develop an ease and efficiency in the form of a good combination of rationally and intuitively knowing what is right, a process which is expected to take about 10 years (Caspar, 2017; Ericsson, Krampe, & Tesch-Römer, 1993), and leads to the ability to and practice of including a big number of aspects, or contextuality.

Psychotherapy Integration

The advantage of psychotherapy integration is obvious from the perspective of a model of continuously constructing therapist action anew:

> Widening the perspective and the tool-box, and breaking free from the limitations of one single approach is supposed to increase the a priori chance of finding the optimal view and procedure in the sense of maximal desired main and positive side effects, accompanied by minimal negative side effects. All possible procedures have negative side effects, sometimes relatively harmless, but often more severe. The more flexibility, the higher the chance to succeed with an optimal main/side effects balance – unless the therapist fails in mastering the complexity. (Caspar, 2010, pp. 18-19)

This chance for optimizing psychotherapy is fertile ground for psychotherapy integration—acknowledging the limitations of each narrow approach when it comes to explaining and treating complex individuals—and for theoretical pluralism (Caspar, 2008, p. 77; Caspar & Grawe, 1989). In Germany, beginning some 35 years ago, when training was still less formalized, there has been a trend among employers to prefer therapists who have had at least partial training in more than one orientation (e.g., behavior therapy

plus gestalt, or plus some psychodynamic elements). Since training has been regulated by law, there seems to be more identification with and concentration on one approach, but trainings usually include some elements from other approaches. Formally, however, integration is forbidden in the strongly approach-oriented regulation of psychotherapy practice in Germany (Caspar, 2008).

In reality, the process of integration begins early: In a poll of 78 trainees undertaken for Caspar (2010) in a convenience sample of participants in postgraduate CBT training in Switzerland and Germany, a majority reported that their supervisors also proposed non-CBT-*concepts*, and even more frequently that they proposed non-CBT *interventions*. "When the supervisees brought in such concepts/interventions they felt strongly supported by their supervisors. The trainees reported furthermore that the inclusion of non-CBT elements was useful for the individual therapies, and they reported with overwhelming clarity that this inclusion increased their therapeutic expertise" (Caspar, 2010, p. 18).

The Crucial Role of Supervisors

In such an opening up, supervisors are of crucial importance, and their tasks are manifold: To help the trainees recognize their development, to encourage and guide the search for appropriate concepts and procedures, to give support in tolerating ambiguity and complexity, to give feedback and guidance with case formulations, to help with procedures the therapist had not originally learned, including role playing with the therapist to teach a technique, to stabilize the therapist when s/he becomes temporarily desperate, but also to challenge when a supervisee avoids relevant interventions due to personal anxieties.

Halgin (1985) has formulated that

> "supervisors play a critical role in escorting beginners through their experiences of artificial security, subsequent confusion, and onward to a process of integration. The supervisor who pushes a beginner into an inappropriate affiliation with a singular model is really colluding with the beginner's simplistic notion that there might indeed be only one correct way of doing therapy. Such a supervisor is not likely to be sensitive to the struggles of the beginner who is trying to make sense of an overwhelming number of theories and techniques. This beginning period in an individual's professional development provides an excellent opportunity for communicating the importance of developing integrated methodologies, for it is during this period that the individual is most malleable" (p. 560; Caspar, 2010, pp. 19-20).

If one assumes

> "that every patient requires a unique combination of concepts and interventions to best fit and treat the case, things become more complex (FC: than in a narrowly manualized procedure)—and possibly more integrative. This has implications for the supervisor's tasks: S/he also needs to supervise the selection and use of these concepts and interventions. Castonguay (2000) recommends that a deliberate decision be made as to whether a supervisee wishes to stay within a single therapeutic approach, or to take an integrative perspective. If supervisee and supervisor decide on an integrative stance, concepts and interventions may be chosen from a wide menu." (Caspar, 2010, p. 19).

If the decision is in favor of "a wide menu", the supervisor's task varies: It "depends on the therapist: It may be to convey concepts a less knowledgeable therapist is unfamiliar with, or it may be to help a therapist overwhelmed by the range of possibilities to sort out, decide, and manage complexity in order to maintain the capacity to act." (Caspar, 2010, p. 19).

A good supervisor helps a therapist take the issue of fit between therapist and procedure seriously, and then to deliberate. This is not a trivial task, as it may be difficult to decide whether the view and procedure a therapist decides on is completely appropriate and in the interest of a patient, or whether the therapist imposes his or her own preferences on a patient at the disadvantage of the latter." The individualization of the psychotherapy training process has long been proposed (Caspar, 1997), but has for a variety of reasons made little progress overall. The extent to which therapists should become integrative as opposed to limiting themselves in the scope of concepts considered is certainly an aspect which can and should be considered explicitly independent of other aspects of individualization: "In any case, the supervisor should also reflect with the therapist on the extent to which the use of an integrative stance is actually advantageous in comparison with a pure approach. In spite of a general preference for flexibility expressed here, it is important that before an integrative approach is chosen, it must be better for each patient and situation." (Caspar, 2010, p. 19).

When and How

The attitude related to *when and how* trainees should be confronted with a transtheoretical stance is clear: One should not spare them from the view that as experience grows, they are expected to gain in transtheoretical knowledge and skills in handling and using this knowledge. Yet the point of departure remains an integrative, but coherent approach (Psychological Therapy, Grawe, 2004), it is communicated that they are not expected to

master unlimited complexity, that it is okay to initially be guided by simple rules which give them security and comfort – absolutely essential when they do their first steps as therapists!

Excellent pre-post effect sizes for novice therapists with patients with a broad range of diagnoses, comorbidity and severity at our outpatient clinic at the University of Bern (grosse Holtforth et al., 2011) illustrate that such a practice is feasible and does not lead to overburdening, although novices certainly struggle with complexity.

Now back to the question "What kind of treatment and what kind of therapist would you look for?" Whatever further details are considered: We truly hope that you would go for a therapist open to a transtheoretical stance and educated in several approaches, or in useful conceptual and technical *elements* of such approaches.

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Scientific Update and Overview

Thinking Transtheoretically About Alliance and Rupture: Implications for Practice and Training

Sigal Zilcha-Mano [1§], J. Christopher Muran [2§]

[1] *Department of Psychology, University of Haifa, Haifa, Israel.* **[2]** *Gordon F. Derner School of Psychology, Adelphi University, New York, NY, USA.*

§ *These authors contributed equally to this work.*

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Corresponding Author: Sigal Zilcha-Mano, Department of Psychology, University of Haifa, Mount Carmel, Haifa 31905, Israel. Telephone: 972-4-8249047. E-mail: sigalzil@gmail.com

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Abstract

Repairing alliance ruptures has the potential to serve as a powerful mechanism of change in psychotherapy. In this article, a transtheoretical individual-specific framework for repairing alliance ruptures is proposed. According to the proposed framework, at the intake session, the therapist evaluates the trait-like tendencies of individual patients to face ruptures in interpersonal relationships. We propose a typology based on which patients are assigned to one of the following therapeutic strategies: (a) a treatment where alliance rupture and repair is the main mechanism of change (Type A), (b) an added module that augments another treatment, focusing on rupture and repair (Type B), or (c) treatment where no rupture resolution work is carried out (Type C). The proposed framework is based on cumulative clinical knowledge, and its validity and utility need to be assessed in future research.

Keywords

rupture and repair, alliance, mechanism of change, trait-like, state-like

Highlights

- Repairing alliance ruptures is considered an important mechanism of change in the psychotherapeutic process.
- A transtheoretical and individual-specific framework for repairing alliance ruptures is proposed.
- Based on an individual's trait-like tendencies to face ruptures in interpersonal settings, the therapist may choose among three different therapeutic approaches.

The alliance used to be an "analytic construct," developed to address the real and practical aspects of the patient-therapist interaction (Greenson, 1967), but it eventually took on transtheoretical relevance. This was in large part due to Bordin's (1979, 1994) reformulation, which defined it as composed of purposeful collaboration (agreement on tasks and goals) and affective bond (mutual trust and respect) between patient and therapist. It is now widely considered an integral "common factor" (Wampold & Imel, 2015), a "principle of change" (Castonguay et al., 2019), and a "quintessential integrative variable" (Wolfe & Goldfried, 1988). In contrast to previous conceptualizations, Bordin placed greater emphasis on mutuality rather than adherence to the therapist's agenda or organizing capacity, and pointed out the inextricable tie between therapist technique and the therapeutic relationship. Bordin's reformulation provided the basis for an "intersubjective elaboration" by Safran and Muran (2000, 2006), which recognized the negotiation between patient and therapist regarding motivational needs for agency and communion. Bordin's definition describes the "explicit collaboration" between patient and therapist; Safran and Muran's describes the "implicit negotiation" (see Muran, 2022).

Decades of empirical research support the importance of the patient-therapist alliance for successful treatment, regardless of theoretical orientation. Four of the most commonly used measures for assessing the alliance are (Flückiger et al., 2018): the California Psychotherapy Alliance Scale (CALPAS; Gaston & Marmar, 1991), the Helping Alliance Questionnaire (HAQ; Luborsky et al., 1996), the Vanderbilt Psychotherapy Process Scale (VPPS; Suh et al., 1989), and the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986). The alliance can be assessed based on patient or therapist reports, or may be rated by an external observer watching videotaped sessions or reading session transcripts.

The various alliance measures developed over the years have been significantly informed by Bordin's conceptualization. A recent meta-analysis suggests that a stronger alliance is significantly associated with better treatment outcome, and a weakened alliance can lead to premature termination of treatment (Flückiger et al., 2018). Indeed, the significant alliance-outcome correlation is among the most replicated findings in psychotherapy research, perhaps in psychology science in general. There is also a growing body of evidence suggesting a potential causal relation of the alliance to outcome, supporting

the consideration of the alliance as a "change mechanism" (e.g., Barber et al., 2000; Zilcha-Mano, 2017; Zilcha-Mano et al., 2019; Zilcha-Mano & Fisher, 2022).

To translate this empirical knowledge into clinical practice methods of improving alliance to achieve better treatment outcome, it is critical to address the question of whether the alliance is a facilitative condition for change or a change mechanism in itself. Correlational research efforts support the former but other work suggests the latter, including mediational, within-individual effects, and task analyses. Change can be understood as involving movement on multiple levels or including multiple processes, and as noted, alliance has been defined as inherently integrated in all change processes of which collaboration and trust are a part. As a change process, the alliance can be understood to involve both skill development and a new relational or corrective experience, that is, how to negotiate one's motivational needs with another and how to be intimate with another (expressive and understood).

One of the most studied and supported perspectives of the alliance as a change mechanism concerns rupture repair. Ruptures have been defined as (a) disagreements about tasks or goals or deterioration in trust or respect (Bordin's formulation) and (b) breakdowns in the negotiation of the patient's and therapist's implicit needs for agency or communion according to Safran and Muran's elaboration (see Safran & Muran, 2000, 2006). More specifically, ruptures have been defined based on patient or therapist markers of withdrawal or confrontation: withdrawal markers are "movements away" from self or the other that can be understood as pursuits of communion at the expense of agency (e.g., shutting down, avoiding, masking experience); confrontation markers are "movements against" the other that can be understood as pursuits of agency at the expense of communion (e.g., complaining about the other, defending the self, controlling the other; Eubanks, Muran, & Samstag, 2023; Muran & Eubanks, 2020a). At the heart of the rupture is the negotiation of individual differences and relationship ambiguities, which result in objectifications to control and feel agentic, but also reflect a struggle to recognize respective subjectivities, define oneself, and feel connected (Muran, 2007; Muran & Eubanks, 2020b).

A recent meta-analysis on rupture repair (Eubanks et al., 2019) that included self-report and observer-based methods demonstrated a similar significant relation between rupture repair episodes and treatment outcome (as ratings of the alliance quality). Several task analytic studies provided empirical support for stage-process models that define rupture repair as a change event: one example defines an exploratory model in which ruptures are acknowledged and explored and implicit needs clarified as expressions of resolution (Safran & Muran, 1996); another defines a renegotiation of tasks or goals, which includes the application of various strategies, such as acknowledging ruptures, explaining rationales, clarifying obstacles, discussing alternatives, redirecting attention, and making modifications (Muran, 2022). Other similar mixed-method efforts (quantitative and qualitative) have sought to elucidate the processes by which alliance ruptures are

repaired (Hill, 2010; Muran, 2019) and to train therapists to better recognize and resolve ruptures (e.g., Muran et al., 2018; see Eubanks et al., 2019, for a meta-analysis).

The present article aims to provide further understanding of how repairing alliance ruptures can be tailored to the individual patient to improve treatment outcome across theoretical orientations. It has been suggested that any change mechanism in treatment, including the alliance, consists of distinct trait-like and state-like components (Zilcha-Mano, 2021). The trait-like component of alliance refers to individual differences between patients in their ability to form satisfying relationships with others, which may translate into an ability to form satisfying alliances with their therapists as well. The state-like component refers to within-individual changes in alliance strength occurring from one moment of the therapy session to the next (Zilcha-Mano, 2017). A synthesis of the available empirical literature disentangling the trait-like and state-like components of alliance suggests that its trait-like component is a product of the patients' and therapists' trait-like characteristics. By contrast, the state-like component of alliance is associated with in-treatment therapeutic processes, such as corrective relational experiences between patients and their therapists (Zilcha-Mano & Fisher, 2022).

The Proposed Individual-Specific Framework for Repairing Alliance Ruptures

Integrating the rich theoretical, clinical, and empirical literature on repairing alliance ruptures (Muran & Eubanks, 2020a; Safran & Muran, 2000) with the trait-like state-like model (Zilcha-Mano, 2021), we proposed an individual-specific framework for repairing alliance ruptures. The proposed framework is based on our experience as clinicians, trainee supervisors, and researchers. In the proposed transtheoretical framework, at the intake sessions, the therapist evaluates the trait-like tendencies of the patient to face ruptures in interpersonal relationships. This evaluation process may result in a systematic formulation of the individuals' main interpersonal strengths and weaknesses (Zilcha-Mano, 2024). The resulting formulation can then serve as a guide for selecting whether and how to implement a treatment or a module for repairing alliance ruptures. The evaluation includes the frequency of such ruptures, their nature and intensity, generalizability across types of relationships, as well as the patient's awareness of the ruptures and insight regarding their origins. These trait-like tendencies can be assessed both through the collection of specific relational episodes occurring outside the therapy room, in the individual's daily life, and based on the in-session relational moment-to-moment interactions between patient and therapist in the therapy room. An example of a structured interview that can be used to collect specific relational episodes occurring outside the therapy room is the Self-Understanding of Interpersonal Patterns Scales–Interview (SUIP-I; Gibbons & Crits-Christoph, 2017; Yaffe-Herbst et al., 2023). The SUIP-I is a semi-structured interview, in which patients are asked to share five stories about

relational exchanges with significant others that they view as problematic. Structured questions are used to give patients the opportunity to verbalize their understanding of each interaction without leading them. The interviewer evaluates the patients' ability to recognize, understand, and describe their conflictual pattern. The information collected using the SUIP-I can be used to formulate the trait-like tendencies to show ruptures, their nature, severity, and manifestations, their generalizability across types of relationships and the patient's awareness of the ruptures and insight regarding their origins. Other measures that can be implemented to explore the patients' trait-like tendencies may include structured interviews of personality disorders (e.g., Structured Interview for DSM-IV Personality; Pfohl et al., 1997) and self-report questionnaires of interpersonal problems (e.g., Horowitz et al., 1988).

Following this initial relational-based evaluation, the therapist can develop a therapeutic program tailored to the individual patient's relational needs, difficulties, and capabilities. The key decision about the therapeutic program in this context is whether a rupture and repair manual should be implemented as the recommended treatment (Type A below), a module augmenting another treatment manual should be used (Type B), or no rupture resolution work is needed (Type C).

During the pre-treatment evaluation phase, the therapist seeks to map the trait-like capacities of the patient to negotiate interpersonal needs. Overall, three main "types" of such trait-like abilities can be delineated. *Type C – Mature*: Individuals with mature capabilities to negotiate interpersonal needs are able to form satisfying intimate relationships with others, which balance needs for agency and communion. Across their interpersonal interactions, those individuals form satisfying relationships in which both their needs for agency and for communion are met most of the time. These individuals come to treatment with relational strengths and may not require deep relational therapeutic work. Their therapists can build on those relational strengths and invest in strengthening other mechanisms of changes, such as adaptive cognitive schemas. They can build on the patient's abilities to form a strong helpful alliance early in the course of treatment, and maintain it throughout with little or no direct work on building relational capabilities during treatment. Few ruptures are expected with these patients during the course of treatment, and they are likely to be easily repaired using surface-based repairing techniques (e.g., explaining misunderstanding).

Type B – Functioning but with some struggles: Some patients are able to form satisfying relationships with others but are still struggling to meet their needs for agency or communion. They may either be able to establish and maintain relatedness with others but struggle with self-definition and individualization, or may be able to maintain autonomy but at the cost of relatedness with others. These individuals may form a good enough alliance with their therapist early in treatment with some investment by the therapist in the form of implementing active supportive techniques of alliance formation. Later in the course of treatment, when challenges appear, because of the

patient's frustrations in the process of building a helpful intimate relationship with the therapist, because of other struggles resulting from the therapeutic process, or because of interpersonal struggles outside of the therapy room, a rupture and repair module may be required to augment the treatment. The concrete points in which challenges occur may differ as a function of the type of treatment, treatment duration, patient and therapist characteristics, the fit between them, etc. For example, in short-term supportive-expressive psychodynamic treatment, some patients may face challenges at the end of the treatment, when by definition, the therapists can no longer actualize the patients' interpersonal needs and therefore may be seen as a rejecting other (Ben David-Sela et al., 2020). Such an augmentation module is aimed at facilitating state-like improvements in the individual's ability to negotiate interpersonal needs (e.g., Castonguay et al., 2004). Each episode in which the therapist implements techniques for repairing alliance ruptures results in state-like strengthening of the patients' ability to negotiate their interpersonal needs. Similarly to Fredrickson's (2004) broaden-and-build model of positive emotions, the repetitive state-like improvements in the individual's ability to negotiate their interpersonal needs in the alliance with the therapist result in a gradual improvement in the individual's trait-like ability to negotiate interpersonal needs. Over time, this expanded interpersonal negotiation repertoire builds useful skills and psychological resources that become available for the individual in any interpersonal interaction.

Type A – Major interpersonal struggles: Some patients either come to treatment because of severe interpersonal struggles or the interpersonal struggles are main contributors to their suffering and the mechanisms underlying their anxiety, depression, or other mental health symptoms. Therapists may initially perceive the formation of a strong alliance that can support the work of treatment as an unattainable goal. These patients may distrust the therapist's goodwill or ability to help. Any therapeutic intervention the therapist may wish to implement, such as challenging thoughts or implementing a behavioral hierarchy of goals, may become an interpersonal struggle with the patient. Assigning such patients to treatment containing a mixture of both indirect and direct techniques for repairing alliance ruptures (Safran & Muran, 2000) may be more effective. The implementation of indirect techniques may produce a corrective relational experience in which, during the rupture, the therapist identifies the patient's suffering and distress and uses implicit techniques (e.g., changing therapy tasks) that help the patient feel understood, appreciated, and validated. Through the implementation of direct techniques for negotiating interpersonal needs in the therapist-patient relationship, the patients learn, by direct participation, how interpersonal needs can be expressed and negotiated.

For individuals belonging to Types B and A, the recommended techniques should be based on the therapists' evaluation of whether the trait-like interpersonal difficulties are of the self-definition or relatedness kind. Based on Safran and Muran (2000, 2006), it is suggested that individuals may differ in their trait-like tendencies to cope with the tension between needs for agency and for relatedness. Different trait-like interpersonal

tendencies are expected to be reflected in the tendencies to show withdrawal vs. confrontational ruptures. Safran and Muran (2000) provided elaborated models of how to work with each that can help choose the right approach and technique for repairing ruptures, according to their type. For example, when the needs for agency are generally not being met in the patients' lives, and the patients may tend to respond to the therapists with withdrawal ruptures, a stage of qualified assertion may follow a stage of disembedding and attending to the rupture, which may finally result in an increase in self-assertion.

Summary and Future Research

The proposed individual-specific framework for repairing alliance ruptures is based on theoretical conceptualizations and empirical findings. But it has never been tested directly, therefore clinical trials are needed in which patients are assigned to treatment according to their receptive "type." Although the proposed typology refers to relatively stable trait-like characteristics of individuals, it may also be subject to change as a result of transformative and formative experiences. It is important to take into account that therapists have their own trait-like tendencies toward self-definition vs. relatedness, which can be used to better match patients with therapists (e.g., Constantino et al., 2021). Alternatively, this information can be used to tailor therapists' training to focus on their trait-like interpersonal tendencies and the ways in which those tendencies are reflected in their interactions with their patients and affect them, as may be manifested, for example, in therapist-initiated ruptures or unsuccessful repair efforts.

After being empirically validated, the proposed typology can be further elaborated to account for and be sensitive to the socio-cultural experiences and characteristics of individuals. Its utility should also be evaluated for children, after making the relevant adaptations. For the proposed conceptualization to become useful for clinical practice, after its merit and utility receive empirical support, it should be incorporated into the skill set imparted to trainees in training programs. Given the great consistency in empirical findings showing the importance of a strong alliance for treatment success, many training programs worldwide are already teaching their trainees how to identify ruptures and repair them. Therapists trained in such programs already possess these skills, and the added value of the typology lies in how to integrate these skills into their practice and how to tailor the implementation of the skills to the individual patient's characteristics using the proposed typology. It is recommended that all programs teach these skills, given the cumulative empirical evidence concerning the adverse effects of unrepaired ruptures and the therapeutic effects of those that are repaired. Helpful resources are available to support a large-scale implementation (e.g., Eubanks-Carter et al., 2015; Muran & Eubanks, 2020a; Muran et al., 2010).

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Scientific Update and Overview

From Theory to Practice: A Transtheoretical Treatment and Training Model (4TM)

Wolfgang Lutz[1], Brian Schwartz[1], Anne-Katharina Deisenhofer[1], Jana Schaffrath[1], Steffen T. Eberhardt[1], Jana Bommer[1], Antonia Vehlen[1], Danilo Moggia[1], Kaitlyn Poster[1], Birgit Weinmann-Lutz[1], Julian A. Rubel[2], Miriam I. Hehlmann[1]

[1] *Department of Psychology, Trier University, Trier, Germany.* **[2]** *Department of Psychology, Osnabrück University, Osnabrück, Germany.*

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Corresponding Author: Wolfgang Lutz, Wissenschaftspark 25+27, 54296 Trier, Germany. E-mail: lutzw@uni-trier.de

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Abstract

Background: In this paper, we present the conceptual background and clinical implications of a research-based transtheoretical treatment and training model (4TM).

Method: The model implements findings from psychotherapy outcome, process, and feedback research into a clinical and training framework that is open to future research.

Results: The framework is based on interventions targeting patient processes on a behavioral, cognitive, emotional, motivational, interpersonal, and systemic/socio-cultural level. The 4TM also includes a data-based decision support and feedback system called the Trier Treatment Navigator (TTN).

Conclusion: We discuss important problems associated with clinical orientations solely based on one school of thought. We then contrast these concerns with a clinical and training framework that embraces ongoing research, serving as a guiding structure for process-based transtheoretical interventions. Such research-based psychological therapy can take both traditional and novel clinical developments as well as findings from psychotherapy research into account and be adaptively disseminated to a variety of patient populations.

Keywords

transtheoretical clinical practice and training, psychotherapy outcome research, outcome monitoring, therapist effects, process research, clinical training, precision mental health

Highlights

- We introduce a research-based transtheoretical treatment and training model (4TM).
- The framework can serve as a guiding structure for process-based transtheoretical interventions.
- It is targeting processes on a behavioral, cognitive, emotional, motivational, interpersonal, and systemic/socio-cultural level.
- It includes a data-informed decision support and feedback system (i.e., Trier Treatment Navigator, TTN).

In this paper, our aim is to introduce the conceptual background and clinical implications of a research-based **t**rans**t**heoretical **t**reatment and **t**raining model (4TM). We discuss important problems associated with clinical theoretical orientations solely based on one treatment approach (or school of thought). These challenges are then met with a clinical and training framework that is open to future research as a guide to process-based transdiagnostic and transtheoretical interventions. At the core of this framework is a data-informed decision system designed to facilitate therapists' evidence-based clinical decision making throughout the entire treatment process.

Decades of research on treatment effects have provided substantial evidence for psychotherapy as a (cost-)effective intervention for a wide range of psychological disorders (e.g., Barkham & Lambert, 2021). The widespread acceptance and integration of psychotherapy (now often referred to as *psychological therapy* to include the various newer theoretical concepts) into healthcare systems worldwide has led to the establishment of standardized training and certification requirements for therapists in numerous countries (e.g., Lutz, Castonguay, et al., 2021).

In the introduction to the first edition of Bergin and Garfield's Handbook of Psychotherapy and Behavior Change, Urban and Ford (1971) already noted that the evolution of psychotherapy was not a linear or continuous process. While the field emerged in the late 19th century, its development did not follow a simple linear progression towards ever more refined and effective psychological techniques, strategies, or principles of change. Instead, with the introduction of numerous variations of psychotherapeutic treatments and orientations, progress took several lateral paths. Therefore, it comes as no surprise that even a brief search on Wikipedia using the term "list of psychotherapies" yields 171 variants. However, not all approaches have been empirically studied (Barkham & Lambert, 2021).

Regardless of the presence of an evidence base, a multitude of approaches and therapeutic schools have emerged, each with their own psychopathological and change

concepts and corresponding professional organizations. As a consequence, the landscape of accepted approaches and regulations for clinical training and practice has become highly diverse, both within and between countries. Decisions about which treatment approaches are available within a healthcare system or how many sessions per treatment are funded are often based on a mixture of empirical and political considerations (e.g., Lutz, Castonguay, et al., 2021).

Furthermore, for therapists, the different theories seem to constitute a narrative, which gives them a deep sense of meaning and identity and strong feelings of affiliation to a specific therapeutic orientation. Simultaneously, the strong adherence to specific schools of thought within the different approaches has led to rigidity and ongoing disputes among colleagues, often resulting in a narrowed scientific and clinical perspective. It has been common for proponents of a particular therapy school to mistakenly assume that evidence of therapeutic effectiveness automatically validates the underlying theoretical assumptions pertaining to psychopathology and psychological processes of change. However, Rosenzweig (1938) already pointed out this logical fallacy and the patients' perspective seems to differ. While some patients may find it important to know the theoretical orientation of their therapist, for the majority of patients, their primary concern lies in their improvement through therapy. Patients often recall having engaged in some form of talking therapy but tend not to retain specific details regarding their therapist's treatment model.

Nevertheless, while this strong therapist identification with a single treatment approach is historically understandable, it is somewhat surprising from a scientific point of view. This is because heterogeneity within treatment schools is enormous, making it challenging to establish a unified set of concepts or mechanisms that are coherent across all variants within a specific treatment orientation. Furthermore, none of the therapeutic orientations have yet established a scientifically grounded and clearly defined causal connection between their theoretically proposed mechanisms of change and treatment outcomes (e.g., Crits-Christoph et al., 2021; Kazantzis et al., 2018).

Research Guiding Clinical Practice and Training

In the following, six lines of psychotherapy research are described that can form the backbone of a clinical practice and training framework that is open to future developments: 1) comparative outcome research; 2) patient-focused feedback research; 3) research on therapist effects; 4) research on processes and mediators; 5) research on predictors and moderators; 6) research on dissemination and implementation.

Traditionally, outcome-oriented research in psychotherapy has focused on determining the average effectiveness or average comparative effectiveness of specific psychotherapeutic models for particular disorders. This line of research was essential to fostering a widespread acceptance of psychological interventions worldwide. However, this

approach has limitations as it solely relies on average or comparative average effects between varyingly well-defined treatment models. Categorizing the change processes in different variations or orientations of psychological therapy can be challenging and is often based on arbitrary boundaries rather than well operationalized theoretical distinctions. Furthermore, the emphasis on specific change processes in certain treatment models and the assumptions regarding their prevalence in a model are often not well studied or understood (e.g., Baldwin & Imel, 2020; Cohen et al., 2023).

Regardless of the long-running controversy surrounding the extent of small or nonexistent treatment differences between therapeutic models (e.g., Barkham & Lambert, 2021), for our purpose, two conclusions can be drawn from this line of research: a) Comparative outcome research on treatment procedures and methods does not automatically lead to differentiated clinical knowledge about treatment options for a patient with a particular disorder; b) psychological treatments do not work for all patients and under all circumstances. Negative treatment responses or patients at risk of unfavorable treatment outcomes are usually overlooked in clinical trials and meta-analytic reviews that focus on average effects (Lutz, Schwartz, & Delgadillo, 2022).

Another line of outcome research, patient-focused feedback research, has been an influential research topic in psychotherapy research in the last two decades (e.g., Lutz, Schwartz, & Delgadillo, 2022). Over 50 studies on feedback and routine outcome monitoring (ROM) have been conducted during this period (Barkham et al., 2023). The overall effect of feedback-informed treatments vs. evidence-based treatments without feedback is significant with an effect size of approximately $d = 0.15$ and 8% higher success rates in comparison to treatments not informed by feedback. The application of such a low-cost intervention as continuous measurement and feedback seems to result in improved treatment outcome, reduced dropout, and higher treatment efficiency than standard evidence-based treatments alone. It is important to note that these effects are additional to the effects of well-established evidence-based treatments.

Patients who benefited most from feedback systems were those who, at some point during treatment, indicated a higher risk for treatment failure. The effect can be enhanced when clinical support tools (CSTs) are used to personalize treatment for such "not on track" cases (with an effect size between 0.36 and 0.53 and an average success rate advantage of ~20% to 29%; Barkham et al., 2023). These tools include additional clinical information to adapt treatment specifically to patients at risk for treatment failure by assessing potential problem areas (e.g., motivation, social support, etc.) and then directing therapists to additional interventions for identified risk profiles via a decision tree. New developments include machine learning prediction models and multimedia instruction materials to help therapists provide those interventions, which are the most promising for a particular patient (e.g., Lutz, Deisenhofer, et al., 2022). However, the effects of such systems seem to depend on the extent to which therapists make use of the information provided by feedback systems.

As a summary, this line of research has important implications for clinical practice and training. Feeding psychometric information back to therapists and integrating this procedure into clinical practice via modern technologies seems to have the potential to improve clinical practice, but the effects depend on the quality of its implementation. Therefore, it is important to focus on the use of feedback in clinical training (e.g., Barkham et al., 2023).

Another area of research relevant to transtheoretical interventions is the research on therapist effects, which has shown that therapists' effectiveness differs systematically independent of their theoretical orientation. The impact of therapist effects on therapy outcomes is estimated to be 5–8% (e.g., Wampold & Owen, 2021), while about 1/8 of therapists have significantly better and 1/9 have significantly worse therapy outcomes than the average therapist. Furthermore, therapist effects are particularly high for more distressed patients. Besides outcomes, therapists also differ regarding therapy duration, dropout rates, and sudden gains (e.g., Lutz, de Jong, et al., 2021).

In addition to therapy outcome, change processes and mediators associated with treatment outcome in psychological therapies have been studied (i.e., "process research"). The first empirically based taxonomies summarizing process–outcome research findings and mediators appeared as early as the 1970s. While it is beyond the scope of this paper to provide a comprehensive summary of the findings and challenges spanning five decades of research, for our purpose, it can be concluded that the outcomes of these investigations vary across different theories and treatment approaches. Further, there is no consensus on the importance of specific core processes or mechanisms of change. Moreover, there are measurement problems and the theoretical constructs have yet to be well validated. In summary, process–outcome research in psychological therapy has not yet been able to demonstrate clear causal relationships between specific mediators, mechanisms, or process variables and treatment outcome (e.g., Cohen et al., 2023; Crits-Christoph et al., 2021).

Until a clear causal link or network of interconnected strategies and processes is established, all clinical interventions experience some degree of empirical uncertainty. This also includes situations, in which certain interventions might affect multiple processes, and in which some interventions might lack unique contributions, but could be substituted with others that produce a similar effect (see Figure 1). However, numerous investigations have enabled the identification of a wide array of intensively-studied processes/interventions and change principles. While not firmly established in terms of causal connections, these processes and interventions have demonstrated empirical validity (studied using experimental designs, correlational designs, or Granger causality in time series) and maintain clinical relevance in the treatment of a wide range of disorders. The scope of this statement paper does not permit the description of detailed evidence for each of these processes and interventions. However, this line of research can provide general guidance within a clinical and training framework that remains open to future

investigations into mechanisms and processes (e.g., Caspar, 2019; Cohen et al., 2023; Crits-Christoph et al., 2021; Eubanks & Goldfried, 2019; Grawe, 2004; Hofmann & Hayes, 2019; Kazantzis et al., 2018; Norcross & Lambert, 2019; Rubel et al., 2017; Wolitzky-Taylor et al., 2023). Over the years, several transtheoretical and integrative frameworks have been developed following this line of research (several examples are given in papers within this special issue).

The treatment strategies and clinical processes described in these models are heterogeneous in their conceptualization and application of research findings and do not stem from a fully empirically-defined network of causally linked elements. However, these concepts are all designed to move beyond the traditional view of categorical diagnosis as the sole basis for treatment selection. Such broader conceptualizations can therefore help to unpack traditional treatment packages and understand clinical practice as a framework of scientifically grounded processes, mechanisms, and strategies, which is open to future research findings.

These empirically studied processes and transtheoretical guidelines can also be related to research on predictors and moderators of change (Barkham & Lambert, 2021). Predictor and moderator models that support the assignment of patients to different treatment options have a long history in psychotherapy research. Over the years, such efforts have become increasingly sophisticated, including new statistical tools based on machine learning algorithms that are closely linked to the development of personalized or precision mental health interventions (Delgadillo & Lutz, in press).

Finally, disseminating psychological treatments constitutes a challenge in many areas of the world, especially in low- and middle-income countries where access to mental health treatments is limited. Transtheoretical concepts can be used to design cost-efficient programs aimed to target specific mental health issues. Various programs have been developed, which include low-intensity, single-session, or internet interventions. These treatment approaches are often rooted in transtheoretical concepts, emphasizing activities that foster engagement (e.g., collaboration, empathy, active listening), as well as addressing various domains of behavior, interpersonal relationships, emotions, and cognitions (e.g., Singla et al., 2017).

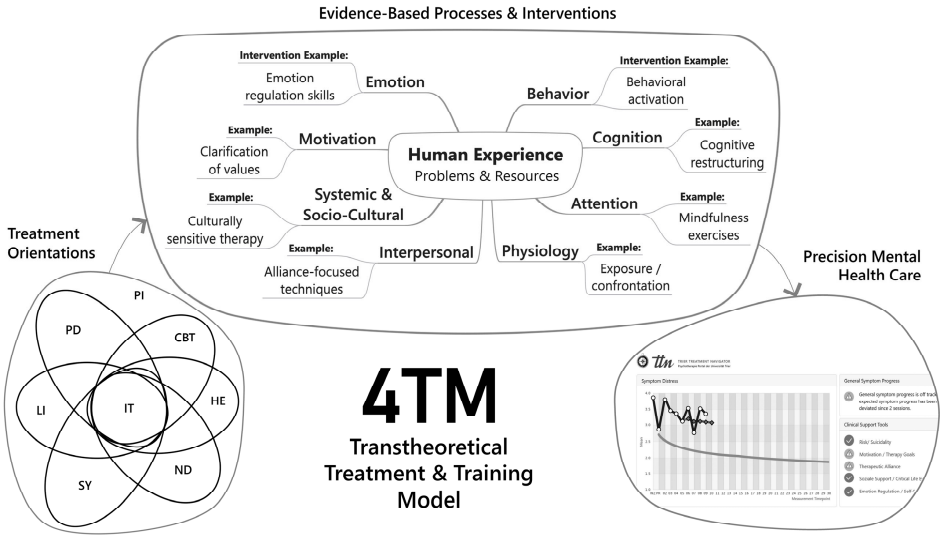
It is important to note that these lines of psychotherapy research, which form the foundation of a transtheoretical framework, are not a rigid set of findings and a corresponding treatment approach, but rather a set of concepts that remains open to future research findings and further verifications. Nonetheless, in our opinion, it provides sufficient guidance to structure clinical training and practice effectively.

What Could Transtheoretical Clinical Practice and Training Look Like?

The open framework introduced above can be built on interventions targeting human experiences that facilitate change processes on a behavioral (e.g., behavioral activation), cognitive (e.g., cognitive restructuring), emotional (e.g., emotion-focused techniques), motivational (e.g., work on life goals), interpersonal (e.g., building a therapeutic relationship), and systemic/socio-cultural level (e.g., strength-based methods, cultural adaptations). Figure 1 illustrates the core elements of such a clinical and training framework that is open to future research, showing the bio-psycho-social network of human experience and the web of associated problems and resources as the targets of evidence-based clinical interventions. Each such intervention might therefore have a broader impact on the entire network (e.g., Fried et al., 2022; Orlinsky & Howard, 1995).

Figure 1

Core Elements of a Transtheoretical Treatment and Training Model (4TM)



Note. PI = psychological interventions; CBT = cognitive behavioral therapies; PD = psychodynamic therapies; SY = systemic therapies; HE = humanistic-experiential therapies; ND = new developments/third wave (e.g., Acceptance and Commitment Therapy, ACT; Mindfulness-Based Stress Reduction, MBSR; Dialectical Behavior Therapy, DBT; Emotion-Focused Therapy; Mentalization; Positive Psychology); IT = integrative treatment models (e.g., Systematic Treatment Selection, STS; Alliance-Focused Therapy, AFT; Schema Therapy; Cognitive Behavioral Analysis System of Psychotherapy, CBASP); LI = low-intensity treatments (e.g., brief treatments, one session treatments, online therapy). TTN = Trier Treatment Navigator.

Figure 1 does not include details of evidence-based processes and interventions (see e.g., Lutz & Rief, 2022; Lutz et al., in press), however this concept can guide research-based psychological therapy, while respecting the traditions of successful clinical developments and research within the specific orientations. It includes clinical skills on the micro level, techniques and strategies on the meso level, as well as principles of change on the macro level. The general clinical practice and training framework comprises several tasks and goals of therapy, such as facilitating the acquisition of cognitive, behavioral, and emotional coping skills, strengthening patients' resources, establishing a therapeutic alliance as a healing context, as well as fostering corrective experiences (on a motivational as well as an interpersonal/cultural/context level) and the acquisition of a more flexible and healthy view of the self and others. A corresponding model of psychological distress posits a transdiagnostic approach to psychopathology. Of course, such a transtheoretical clinical practice and training framework must be continuously updated based on new research findings.

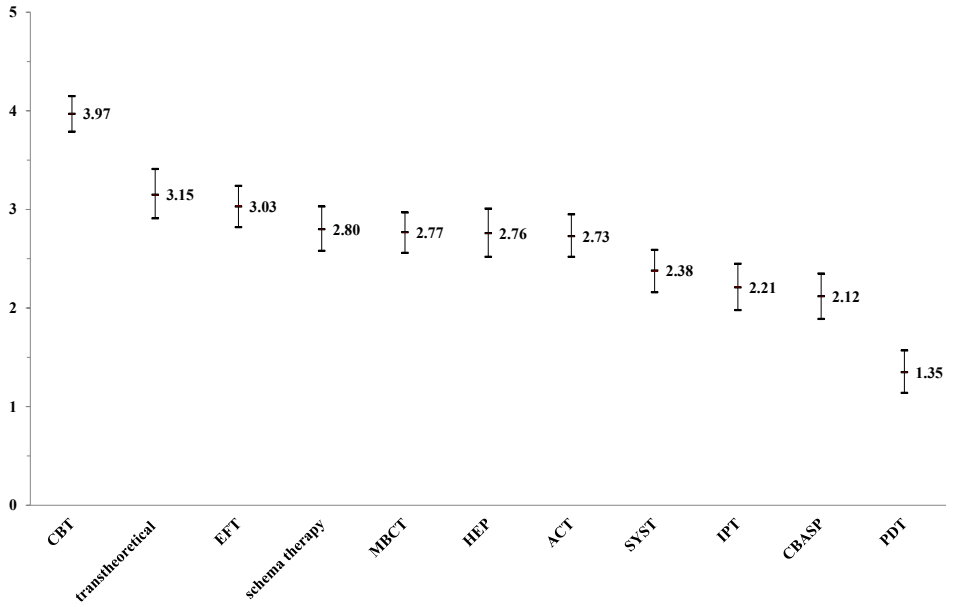
Example of a Transtheoretical Treatment and Training Model (4TM)

Over the last decade, we have tried to implement such a research-based **t**rans**t**heoretical **t**reatment and **t**raining model (4TM) at the outpatient center at the University of Trier. This 4TM aimed to realize one primary objective: integrating psychotherapy research into clinical training and practice on an ongoing basis. This aim has led to the development of the Trier Treatment Navigator (TTN), a tool that supports and enhances research, training, and practice, fostering synergistic effects between the three (right side of Figure 1). The TTN was successfully evaluated in a recently published prospective randomized-controlled trial (Lutz, Deisenhofer, et al., 2022). It enables continuous monitoring of patient progress via psychometric questionnaires and provides therapists with valuable feedback and clinical decision support tools.

Therefore, rather than adhering to a predetermined manualized treatment for a particular diagnosis from the onset of therapy, our approach prioritizes patients' real-time progress and continuously adapts treatment based on their specific needs (Lutz, Schwartz, & Delgadillo, 2022). Therefore, treatments integrate various therapeutic concepts such as cognitive-behavioral, interpersonal, emotion-, motivation-, and alliance-focused as well as mindfulness- and strength-based interventions. As a result, therapists receive training in disorder-specific manuals, clinical guidelines, and transtheoretical concepts. When surveying our trainees ($N = 102$) about their therapeutic practice (see Figure 2), 80.5%[1] identified themselves as transtheoretical with an emphasis on embracing a variety of orientations, while acknowledging that CBT serves as the foundational concept, which, depending on the country, may need to be adapted to different contexts, health care traditions, or legal systems.

Figure 2

Therapeutic Orientation Within N = 102 Postgraduate Trainees at the University of Trier



Note. 0 = not at all; 5 = very much; CBT = cognitive-behavioral therapy; EFT = emotion focused therapy; HEP = humanistic experiental psychotherapy; MBCT = mindfulness-based cognitive therapy; ACT = acceptance and commitment therapy; SYST = systemic therapy; IPT = interpersonal therapy; CBASP = cognitive behavioral analysis system of psychotherapy; PDT = psychodynamic therapy.

Finally, it is crucial to highlight that while there is a considerable level of flexibility in the theoretical portion of training, it is complemented by monitoring patient outcomes via feedback provided by the TTN. Clinical training includes courses on psychotherapy research and its relation to clinical practice as well as the TTN. It is important to recognize that TTN recommendations are data-based and provide probabilities. They must be evaluated with care in a case-specific manner (Lutz et al., in press). This combination of decisions based on clinical and empirical knowledge enables trainees to cultivate their own therapist identity, while working within a framework that prioritizes patient outcomes and knowledge accumulated from psychotherapy research.

1) The following item, "To what extent would you assess your therapeutic work as transtheoretical?" was answered on a scale from 0 (not at all) to 5 (very much). The percentage provided reflects the combined number of trainees who answered 4 and 5 on the scale.

Overall, the development of transtheoretical clinical concepts, as illustrated in this paper, holds potential for the future of psychological therapy. By providing an overarching adaptable framework that accommodates both new and traditional schools of thought, along with findings from clinical research, we hope to enable therapists to move beyond the limitations of rigid schoolism and instead embrace a more comprehensive perspective. Aligned with the development of a measurement-based approach to psychological therapy, this framework might improve the accessibility as well as outcome for a broader and more diverse patient population than previously achievable.

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Scientific Update and Overview

Between-Session Homework in Clinical Training and Practice: A Transtheoretical Perspective

Truls Ryum[1], Nikolaos Kazantzis[2,3]

[1] *Department of Psychology, Norwegian University of Science and Technology, Trondheim, Norway.* **[2]** *Cognitive Behavior Therapy Research Unit, Melbourne, Victoria, Australia.* **[3]** *Beck Institute for Cognitive Behavior Therapy and Research, Philadelphia, PA, USA.*

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Corresponding Author: Truls Ryum, Department of Psychology, Norwegian University of Science and Technology, 7491 Trondheim, Norway. E-mail: truls.ryum@ntnu.no

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Abstract

Background: This paper defines and illustrates the ways in which Between-Session Homework (BSH) may be integrated into clinical work with clients across various treatment approaches. In line with the focus of this special issue, we explore how clinical training and supervision can enhance therapist skills and competence in the use of BSH.

Method: After providing a brief historical overview and an integrative perspective on BSH, along with a review of empirical research supporting its efficacy, we delve into the discussion of BSH as a transtheoretical clinical method with heuristic value across different treatment approaches, such as cognitive-behavioral, psychodynamic, and humanistic-experiential therapies.

Results: There exists diversity in how BSH is incorporated into distinct treatment approaches. Furthermore, we emphasize the significance of therapist skills and competence in utilizing BSH to facilitate client engagement and achieve positive treatment outcomes. Finally, we address how clinical training and supervision contribute to the development of these essential skills and competence.

Conclusions: Our findings highlight three main points: (1) substantial empirical support for the integration of BSH within cognitive-behavioral therapies, (2) the potential of BSH as a promising transtheoretical clinical method, even though research beyond cognitive-behavioral therapies remains limited, and (3) the imperative need for further research into how clinical training and supervision can effectively enhance therapist skills and competence in implementing BSH.

Keywords

homework, training, practice, trans-theoretical, evidence-based

Highlights

- Between-session homework (BSH) shows promise as a transtheoretical clinical method for clinical practice and training.
- Therapist skills and competence in utilizing BSH are essential to facilitate client engagement with BSH and treatment outcomes.
- Research into how clinical training and supervision can effectively enhance therapist skills and competence in implementing BSH is needed.

A Brief Historical Overview of Between-Session Homework (BSH)

The utilization of Between-Session Homework (BSH) holds a substantial historical significance within behavioral and cognitive-behavioral therapies (CBT). It was initially introduced as a systematic strategy for promoting and sustaining behavior change in behavior therapy (Shelton & Ackerman, 1974; Shelton & Levy, 1981). As cognitive therapy gained prominence, the significance of between-session assignments in achieving successful outcomes gathered momentum. Notably, Aaron T. Beck and colleagues dedicated a separate chapter to the use of BSH in their seminal clinical guide, "*Cognitive therapy of depression*" (Beck et al., 1979). While there has been a proliferation of training resources (e.g., Beck, 2020) and treatment manuals for specific disorders since then, there has also been a recent shift towards more integrative and transtheoretical models (e.g., Barlow et al., 2017; Barlow et al., 2011). Despite these changes, the importance of BSH remains a defining feature of CBT. This significance is underscored in the recent conceptual model proposed by Kazantzis and Miller (2022). In fact, the literature on homework is most advanced within CBT, with more research supporting its positive impact on outcomes compared to any other treatment component (see reviews in Kazantzis et al., 2018; Ryum et al., 2023a, 2023b).

While BSH is considered a primary driver of change in CBT, it has received relatively less attention within psychodynamic (PDT) and humanistic-experiential therapies (HET). In these approaches, BSH is typically assigned a more supportive role in the therapeutic process and outcome. However, even Freud proposed the incorporation of between-session activities in psychoanalysis (Freud, 1952), and subsequent psychodynamic authors have advocated for integrating BSH into psychodynamic therapy (e.g., McCullough, 2003; Stricker, 2006; Wachtel, 1977). This notion is further supported by surveys of practicing therapists, indicating that BSH is commonly utilized by both cognitive-behavioral and psychodynamic therapists (Fehm & Kazantzis, 2004; Kazantzis & Dattilio, 2010; Kazantzis, Lampropoulos, et al., 2005). Similarly, within humanistic-experiential therapies, the use

of BSH has been endorsed (e.g., Brodley, 2006; Greenberg & Warwar, 2006; Warwar & Ellison, 2019), although a comprehensive survey among practicing therapists is lacking to our knowledge. It is worth noting that the *Journal of Psychotherapy Integration*, Vol. 16, No. 2, featured a dedicated special issue on the topic of homework across various psychotherapeutic models.

We note that there has also been substantial interest in the affiliated concept of "intersession experiences/ processes" (Orlinsky & Geller, 1993; Orlinsky et al., 1993), which builds upon psychodynamic- and transtheoretical theories, and refers to the client's (and therapist's) spontaneous or intentional processing of psychotherapy between session, including thoughts, feelings, memories, and fantasies about the therapy or the therapist (Orlinsky et al., 1993). These experiences are internalized over the course of therapy, forming affect-laden representations, that influence on the therapeutic process and outcome (e.g., Hartmann et al., 2010; Hartmann et al., 2016; Zeeck & Hartmann, 2005). While both intersession processes and BSH concerns between-session activities, and client's intersession experiences may relate to BSH, they differ fundamentally in the sense that BSH is planned, targeted, and negotiated between therapist and client through in-session dialogue, whereas intersession processes are not. We therefore refer interested readers to other sources for recent reviews on intersession processes (Gablonski et al., 2023; Stewart & Schröder, 2015). For similar reasons, we avoid further discussion of between-session activities that are primarily client-initiated (e.g., spontaneous implementation of treatment-related content in stressful situations), although such activities would clearly be considered therapeutic (see discussion in Brodley, 2006).

Furthermore, while our primary focus here centers on individual therapy, it is also imperative to acknowledge the enduring interest in the utilization of BSH within the contexts of couples and family therapies. This enduring interest is evidenced through surveys conducted among practicing therapists and their clinical applications (Dattilio et al., 2011; Kazantzis et al., 2023). The pervasive employment of BSH is thus discernible across various psychotherapeutic approaches, to the extent that it has been posited as a potential 'common factor' (Kazantzis & Ronan, 2006). Nonetheless, disparities persist in the manner by which BSH is assimilated into clinical practices across these treatment approaches—an issue we shall expound upon. It is noteworthy to highlight that substantial endeavors have been undertaken to facilitate conciliation between therapeutic paradigms in the conceptualization of BSH as a transtheoretical method (a forthcoming special issue in the *Journal of Clinical Psychology – In Session*, 2024, delves into this matter). Importantly, an enduring interest in the application of BSH endures, both within the framework of Cognitive Behavioral Therapy (CBT) and across other diverse treatment methodologies (Ryum et al., 2023a, 2023b), with mounting empirical support that substantiates BSH as an evidence-based, transtheoretical method of significance for clinical practice and the training of clinical psychologists.

Between-Session Homework: An Integrative Perspective

Numerous terms and definitions have been proposed to encapsulate the fundamental essence of Between-Session Homework within the context of psychotherapy. These designations, encompassing a range of connotations such as "homework," "extra-therapy assignment," and "home practice activities," among others, do not inherently signify a transformation in the content, nature, or essential essence of BSH. In this paper, we adopt the term "Between-Session Homework," recognizing the absence of a universally established terminology. Nonetheless, it is imperative to underscore that BSH serves as a conduit for fostering therapeutic advancement and ultimate treatment objectives. A comprehensive generic definition of BSH may be formulated as "activities enabling clients to assimilate information and extrapolate newfound insights from the therapeutic milieu into their everyday life contexts, wherein their challenges transpire." This definition encompasses both "insight-oriented" elements such as information and awareness, and "action-oriented" components like new learning and skill acquisition, which have been posited as universal mechanisms for change in psychotherapeutic contexts (e.g., McCullough et al., 2003; Nelson et al., 2007; Ryum et al., 2014; Valen et al., 2011). Furthermore, this elucidation underscores the inherent reality that, for each therapeutic hour dedicated, the remaining 23 hours of the day are lived beyond the counseling environment. Thus, it intuitively follows that this time outside the therapy room should be harnessed to expedite the therapeutic process and advance toward ultimate treatment goals (Kazantzis, Deane, et al., 2005).

Diversity characterizes the content and nature of BSH across distinct treatment methodologies. The timing, inclusion, and modality of BSH in psychotherapy necessitate adaptability, both within and across therapeutic approaches. The specific nature of BSH tasks and the procedural dynamics within a therapeutic session with a given client are contingent upon an array of factors, including the unique requirements of the client, the rationale underpinning the chosen therapeutic approach, the client's stage of change (e.g., precontemplation, contemplation, preparation, action, maintenance; Prochaska & Norcross, 2018) and contextual variables. To elaborate further, BSH might encompass activities such as relaxation training, exposure exercises (in vivo, imaginal, interoceptive), activity scheduling, behavioral activation, integration of newly acquired skills (e.g., experimenting with novel interpersonal strategies or modes of interpersonal engagement), behavioral experiments, and the acquisition of information and heightened awareness (e.g., recording automatic thoughts, attending to dreams or emotional responses). BSH can effectively address behaviors and symptoms linked to specific settings or individuals in the client's daily life beyond the therapeutic encounter, as exemplified in various anxiety disorders (e.g., agoraphobia, obsessive-compulsive disorder) or maladaptive interpersonal patterns or self-other relational dynamics (e.g., personality disorders).

Amid this diversity, a central unifying rationale for BSH is the cultivation of learning in various forms (Kazantzis & L'Abate, 2007). BSH serves to inform, consolidate, expand, and reinforce the clinical work transpiring within the therapy session, enabling the continuation of therapeutic progress into the client's daily life where challenges most persist. The emphasis on BSH accentuates the client's active involvement in the therapeutic journey and may foster a sense of agency and responsibility for effecting positive change in their lives (Dobson, 2022; Dobson & Kazantzis, 2023; Strunk, 2022). Inherent to this endeavor is the promotion of a mindset characterized by curiosity, interest in one's thoughts and emotions, and the cultivation of self-care and self-acceptance.

Diverse perspectives arise when considering the in-session dynamics and therapist behaviors germane to the integration of BSH into psychotherapy. Notably contentious is the question of whether BSH should predominantly emanate from the therapist (Ellis, 1962), be initiated autonomously by the client (Brodley, 2006), or emerge through collaborative negotiation between therapist and client (Kazantzis et al., 2013; Kazantzis et al., 2017). In most cognitive and behavioral therapeutic modalities, the delineation, planning, and review of BSH are explicitly incorporated into the session agenda, ideally arrived at through collaborative empiricism between client and therapist. Homework assignments are meticulously tailored to the individual client, grounded in evidence-based therapeutic strategies and contextual considerations, often accentuating the specificity of the execution of BSH (e.g., how, when, where, duration, frequency, interpersonal involvement), thus augmenting the likelihood of successful outcomes (Hildebrand-Burke et al., 2023; Kazantzis & Miller, 2022).

Conversely, psychodynamic and humanistic-experiential therapies typically do not accord the same explicit prominence to the selection, design, and review of BSH within the session context. These therapeutic paradigms lean historically towards a less specific stance, emphasizing in-session processes such as the client-therapist relationship and the exploration of subjective experiences, emotions, and meaning, in contrast to activities external to the session. Consequently, the introduction of BSH in these approaches is characterized by a more indirect and tentative manner; for instance, a humanistic-experiential therapist might propose BSH as an optional experiment or as a potential avenue for the client's exploration if deemed beneficial (Brodley, 2006), for example, with the use of tasks to increase self-soothing capabilities or the use of a diary to promote emotional awareness. Meanwhile, a psychodynamic therapist might adopt a hypothetical approach to between-session assignments, such as positing, "I wonder what might have transpired had you...", or even suggest more directively that the client tries out new interpersonal behaviors or ways of relating to others (Dimaggio et al., 2015). It is important to highlight that a CBT therapist might also choose to use similar language and express a level of tentativeness. This approach could be prompted by their ongoing case formulation, suggesting that a straightforward expectation regarding BSH may potentially result in an alliance rupture. For instance, this might occur in situations involving an active abuse/

mistrust schema being transferred to the therapist (refer to the discussion in Kazantzis et al., 2017).

As previously alluded to, current trends in the field indicate a burgeoning framework for BSH underscored by integration and assimilation. For instance, BSH may encompass endeavors aimed at heightening client awareness regarding latent thoughts and emotions or promoting self-compassion and self-acceptance (Hayes, 2022). Irrespective of the precise nature of the homework task, it is crucial to underscore that the effective and successful utilization of BSH hinges on the establishment of a reciprocal and collaborative therapeutic relationship, where the therapist's facilitative interpersonal skills are indispensable, and consensus between therapist and client prevails regarding the specific objectives and tasks of the therapeutic process (Kazantzis et al., 2017). These qualities appear to characterize the in-session process of integrating BSH across treatment approaches, as recently demonstrated (Ryum et al., 2024a, 2024b).

In summary, the panorama of BSH in psychotherapy is characterized by a mosaic of perspectives, encompassing diverse terms and definitions, multifaceted modalities, and a rich interplay between therapist and client. Amid this diversity, a common thread of fostering learning and facilitating therapeutic progress emerges, with a recognition of the client's active engagement and empowerment. The process of integrating BSH into psychotherapy is contingent upon the treatment approach, necessitating nuanced considerations, yet grounded in the shared commitment to advancing the client's well-being and progress towards treatment goals.

Empirical Research on the Relations Between BSH and Outcome

Numerous studies have extensively investigated the relationship between BSH and treatment outcomes, and their findings have been synthesized in multiple meta-analyses and reviews (for a recent comprehensive overview, refer to Ryum et al., 2023b). The majority of earlier publications have focused on three primary areas: (a) assessing the causal impact of homework on treatment outcomes by comparing interventions with and without homework (Kazantzis et al., 2000; Kazantzis, Whittington, et al., 2010); (b) examining the correlation between client compliance with homework and treatment outcomes (Kazantzis, Whittington, et al., 2010; Kazantzis et al., 2016; Mausbach et al., 2010); and (c) investigating therapist skills and competence in assigning homework and their connection to engagement with BSH and treatment outcomes (therapist behaviors), see special issue in *Cognitive Therapy and Research* (Vol. 45, No. 2).

Causal effects analysis has reported a medium effect size (d = .53) (Kazantzis et al., 2000; Kazantzis, Whittington, et al., 2010), while a significant linear association (r = .26) has been identified between client compliance with homework and treatment outcomes (Mausbach et al., 2010; see also Kazantzis, Whittington, et al., 2010). Recent meta-anal-

yses have further validated these findings concerning both the quantity and quality of homework engagement in relation to treatment outcomes (Kazantzis et al., 2016), including a specific examination of obsessive-compulsive disorder (Wheaton & Chen, 2021). Collectively, these findings underscore that interventions incorporating BSH yield superior outcomes in contrast to those lacking BSH, and that greater client engagement with homework corresponds to better treatment results.

More recent research has progressively highlighted the pivotal role of therapists' skills and competence in integrating BSH to facilitate client engagement with homework (as explored in research question C above). For instance, investigations have revealed that therapist competence in homework review (Bryant et al., 1999; Weck et al., 2013), as well as homework selection and planning (Conklin et al., 2018; Jungbluth & Shirk, 2013; Ryum et al., 2010), correlates with treatment outcomes. Notably, these effects remain robust even when accounting for confounding variables like the therapeutic alliance (McEvoy et al., 2023; Ryum et al., 2022), and studies have also incorporated client feedback in studies of therapist competence in using homework (Hildebrand-Burke et al., 2023; Yew et al., 2021). These findings indicate that the positive impact of BSH extends beyond mere client compliance, emphasizing therapists' pivotal role in facilitating client engagement with homework. Furthermore, a recent review conducted as part of the interorganizational Task Force on Psychotherapy Skills and Methods That Work (Hill & Norcross, 2023) comprehensively summarized findings on therapist behaviors affecting immediate (in-session) and intermediate (session-to-session) outcomes of BSH. The review observed favorable effects on intermediate outcomes, while results for immediate outcomes were mixed and generally neutral (Ryum et al., 2023b). The Task Force concluded that BSH demonstrates efficacy for ultimate treatment outcomes and likely effectiveness for intermediate outcomes (Hill & Norcross, 2023).

However, amidst largely positive results, research has also illuminated challenges that clients may encounter with BSH, stemming from practical and emotional factors, which could impede therapeutic progress and potentially lead to premature discontinuation. Some clients may exhibit adverse reactions to the term "homework" due to its educational connotations, invoking feelings of apprehension linked to evaluation, control, or failure (Fehm & Kazantzis, 2004; Kazantzis, Arntz, et al., 2010). Consequently, the use of this term in clinical practice is not recommended (Kazantzis, MacEwan, et al., 2005), and an alternative, "action plan," has been proposed within CBT (Kazantzis & Miller, 2022). Additionally, BSH may induce pressure, anxiety, resistance, or exacerbate mood-related issues for various reasons (e.g., lack of comprehension regarding homework rationale, overly demanding assignments due to symptom severity), with some clients identifying it as the foremost challenge in treatment. Consequently, therapists should anticipate potential obstacles, maintain receptivity to client feedback, and establish a collaborative atmosphere where engagement with BSH is discussed through Socratic dialogue and monitored via feedback on session-relevant aspects (Kazantzis et al., 2017).

It should also be recognized that (persistent) non-engagement with BSH may be a way for the client to oppose treatment and/ or the therapist (Okamoto et al., 2019; Okamoto & Kazantzis, 2021; Safran & Muran, 2000; Sijercic et al., 2016). Strong needs for dominance or attachment may be evoked in certain clients, within a therapeutic relationship characterized by giving and receiving help and care, and client non-engagement with BSH may therefore sometimes signal a rupture in the therapeutic alliance (Kazantzis et al., 2023). Although there is little conclusive research in this area, we may speculate if certain client populations are at a higher risk for non-engagement with BSH, for example, as for clients presenting with personality disorders or severe eating disorders. However, in general, we caution against "blaming the client", and rather suggest that therapists should examine their own contribution in the process when accounting for client's non-engagement with BSH.

Notably, empirical investigations and reviews of BSH have mainly been conducted within cognitive and behavioral treatment frameworks, with rare exceptions emerging from psychodynamic (Hilsenroth & Slavin, 2008; Nelson & Castonguay, 2017; Owen et al., 2012) and humanistic-experiential approaches. While research underscores BSH's clinical relevance for training and practice, as we will explore in the subsequent section, the generalizability of these findings to alternative treatment methodologies remains uncertain.

Clinical Practice and Training

Drawing upon theoretical writings and empirical research spanning five decades, our current understanding of the factors that can either facilitate or hinder the effective integration of homework into psychotherapy has become more comprehensive. These factors hold significant relevance for clinical training and practice. A comprehensive practical guide for the utilization of homework already exists in CBT (Kazantzis, MacEwan, et al., 2005). Additionally, an updated and comprehensive model was recently published (Kazantzis & Miller, 2022), which could provide valuable insights for integrating BSH into other therapeutic approaches. In the following sections, we delve into strategies that therapists can employ to enhance client engagement with BSH and discuss how clinical training and supervision can bolster therapist skills and competence in implementing BSH.

Clinical Practice

While the term "homework" is commonly associated with specific tasks assigned to clients, it also encompasses an in-session process reliant on a collaborative client-therapist relationship. Therapist behaviors play a crucial role in helping clients establish realistic expectations about the role of BSH, fostering engagement with homework, and facili-

tating symptom improvement. Drawing from practical guides and empirical research, therapists should: (a) collaboratively design, plan, and review BSH in alignment with the client's goals and values; (b) link BSH with takeaways from the session; (c) provide a compelling rationale for homework; (d) address potential challenges and barriers to task engagement; (e) offer a written BSH summary including instructions and rationale; (f) incorporate client feedback when selecting, planning, and reviewing BSH; and (g) remain responsive to the evolving needs and context of the client (Kazantzis, MacEwan, et al., 2005; Kazantzis & Miller, 2022; Ryum et al., 2023a, 2023b). Feedback here refers primarily to the therapist eliciting reactions and input from the client in the on-going therapeutic dialogue (e.g., beliefs about BSH; barriers to engagement; reactions to in-session practice; degree of skill acquisition or mastery), and not to more formal methods such as "routine outcome monitoring" (Lambert & Shimokawa, 2011).

Although "compliance" or "adherence" have historically been associated with BSH, the concept of "engagement" has been proposed as a more meaningful construct for research and clinical practice (Kazantzis & Miller, 2022). Beyond merely measuring completed BSH tasks, a comprehensive assessment of client engagement should encompass potential practical obstacles, task-related difficulties (or perceived difficulties), activation of personal beliefs, and associated emotional distress (Kazantzis, MacEwan, et al., 2005). For instance, a client might view a homework task as "too challenging" or "irrelevant," leading to negative beliefs about themselves or the therapeutic process. While tracking homework completion remains informative (as compliance is linked to improvement), therapists should also explore client beliefs about BSH benefits, perceived progress contribution, skill acquisition, and encountered obstacles. The Homework Rating Scale-Revised (HRS-II; Kazantzis, Deane, et al., 2005, available from www.cbtru.com) stands as a validated tool towards these goals, and is suitable for research, clinical training, and practice. Regardless of the specific task, BSH should be framed as an opportunity for learning, even when tasks don't proceed as planned.

Therapists might harbor assumptions that hinder the integration of BSH into therapy (Bunnell et al., 2021). Negative attitudes, such as viewing homework as exclusively for distressed clients or fearing it might overstructure the client, should be treated as hypotheses rather than established facts. Integrating BSH should entail Socratic dialogue and feedback solicitation from clients. Moreover, therapists' interpersonal styles or core schemas could impede effective BSH integration, manifesting as "demanding standards" or "excessive self-sacrifice" (Haarhoff & Kazantzis, 2007; Kazantzis et al., 2017).

Clinical Training

Although research supports the efficacy of BSH for treatment outcomes, empirical investigations into how clinical training and supervision enhance therapists' acquisition and proficient use of BSH are lacking. This gap mirrors the broader dearth of evidence-based training research in the field (Callahan & Watkins, 2018), and the need for future

research utilizing controlled, longitudinal designs (see Brattland et al., 2022). We propose recommendations for clinical training based on practice guidelines and insights from process-outcome research (Kazantzis & Miller, 2022; Ryum et al., 2023a, 2023b).

While reading materials and didactic courses grant trainee therapists a conceptual understanding of BSH integration, hands-on practical experiences hold even greater importance. Clinical work necessitates practical skills and competencies, and direct engagement with BSH is pivotal for novice and seasoned therapists alike (see Kazantzis et al., 2017 for competence frameworks for collaborative work in CBT). Competent and skillful BSH utilization hinges on the therapeutic approach, case conceptualization, contextual factors, and in-session dynamics. This complex clinical method defies full standardization but should be informed by practical guidelines. Thus, learning "what works" with various clients and effectively addressing resistance or difficulties requires firsthand experience. Although evaluating how well a therapist sets agendas is relatively straightforward, gauging skilled BSH implementation demands more nuanced expertise.

Role-plays and deliberate practice are effective tools for honing BSH skills in early therapists. Developing standardized stimuli-clips depicting challenging integration scenarios could also enhance training. Nonetheless, supervision of sessions with actual clients, whether through video recordings or direct observation, remains the optimal method for therapists to receive constructive feedback on BSH application. This process can be reinforced using validated measures of therapist behaviors pertinent to BSH, such as the Homework Adherence and Competence Scale (HAACS; Kazantzis, Wedge, et al., 2005, available from www.cbtru.com) or the Homework-Specific Therapist Behaviors Scale (HSTBS; Conklin et al., 2018). These tools aid trainees in identifying and addressing skill gaps related to task selection, planning, review, and overcoming obstacles, and could be used in supervision. Complementing this, a validated measure of client engagement and beliefs, like the HRS-II, could provide insights into client perspectives on BSH, and suggest areas that warrant further attention, exploration, and discussion between therapist and client (e.g., negative beliefs about a specific task; lack of comprehension, rationale, or specificity, etc.), although the scale does not have specific cut-offs.

Conclusions

There has been more research on the use of BSH in CBT compared to that of other therapist interventions/ methods, and sufficient empirical evidence to consider BSH a demonstrable efficacious method for ultimate treatment outcomes. While empirical support is lacking for other treatment approaches, there is diversity in how BSH may be integrated into clinical work within and across treatment approaches, and we propose that BSH should be considered a transtheoretical method with heuristic value also for psychodynamic and humanistic-experiential therapies. For example, BSH may facilitate the treatment process and outcome by promoting experiential awareness, insight, or the

discovery of new meaning; behavior change and the acquisition of new adaptive skills; the generalization of new learning from the counseling room and into the everyday-life of the client; and a sense of agency and confidence in clients that they may play an active role in their own change-process.

Furthermore, empirical evidence highlights specific therapist behaviors linked to skillful BSH utilization, such as presenting a compelling rationale, collaborative planning, addressing challenges, and assigning personalized tasks. These behaviors should be central in clinical practice and training. However, empirical research on how to enhance therapist competence and skill in BSH remains scarce, urging clinicians and researchers to prioritize this vital avenue of inquiry in the future.

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Scientific Update and Overview

Competence-Based Trainings for Psychological Treatments – A Transtheoretical Perspective

Winfried Rief[1], Marcel Wilhelm[1], Gaby Bleichhardt[1], Bernhard Strauss[2], Lisbeth Frostholm[3], Pia von Blanckenburg[1]

[1] *Division of Clinical Psychology and Psychotherapy, University of Marburg, Marburg, Germany.* **[2]** *Institute of Psychosocial Medicine, Psychotherapy and Psychooncology, University Hospital Jena, University of Jena, Jena, Germany.* **[3]** *Department of Clinical Medicine, Aarhus University, Aarhus, Denmark.*

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Corresponding Author: Winfried Rief, Gutenbergstraße 18, 35032 Marburg, Germany. E-mail: rief@uni-marburg.de

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Supplementary Materials: Materials [see Index of Supplementary Materials]

Abstract

Background: Although in most countries psychotherapy trainings focus on one treatment orientation, such an approach is associated with systematic shortcomings. The priorities from teaching one theoretical framework should be moved to a more rigorous orientation in science and evidence-based practice, and to the needs of patients, even if strategies of different theoretical approaches need to be combined.

Method: We discuss whether competence-based trainings in psychological treatments offer a better framework to facilitate the progress of psychological treatments to a professional academic discipline with transtheoretical exchange, and we provide an example of a transtheoretical education in the basic competences of psychological treatments. A transtheoretical education program requires an umbrella model for case formulation and a transtheoretical definition of intervention goals.

Results: We provide an adaptation of the traditional model distinguishing vulnerability/resilience, exacerbation, and maintenance of clinical problems for case conceptualization. Dynamic network models offer a further perspective for developing modern, transtheoretical case formulations. Treatment methods should be better classified according to their transtheoretical goals, which

offers opportunities to better compare or combine them. We report a case example of how to transform a general competence-based approach in the training of psychological treatments in the academic education system, which found exceptional acceptance from participating students.
Conclusion: Thus, a rigorous competence-based approach to training early clinicians in applying psychological treatments helps to bridge the artificial divide between psychotherapeutic traditions. It also supports the evolution of psychological treatments into an academically robust and highly professional, integrative discipline.

Keywords

psychological treatments, psychotherapy, training, competence, transtheoretical

Highlights

- Effective psychotherapy depends on basic transtheoretical competences of the clinician.
- A competence-based approach helps to overcome barriers caused by the artificial separation of different treatment schools and stimulates better, research-based exchange of findings and intervention effects.
- A case example of training in psychological treatment exemplifies the potential of a transtheoretical training approach and is supported by the exceptional satisfaction ratings of participating students.

In most countries, the training of early career clinicians in providing psychological treatments is highly linked to one treatment tradition (e.g. psychodynamic, cognitive-behavioral therapy CBT) or one newer development in psychotherapy (e.g., Acceptance and Commitment Therapy ACT). Thus, the typical education goal is to become an expert in one of these theoretical frameworks and its practical applications. However, defining psychotherapy as the application of one specific treatment orientation is associated with a series of problems and shortcomings. First, this is in sharp contrast with medical specializations, which have the goal of training upcoming specialists to be able to provide best evidence guideline-oriented treatments for most clinical conditions in the specific field, instead of limiting the training to one specific theory. Such a system, like in medicine, is transparent for cooperating health care providers with other specializations and allows adaptation of training programs according to changes that are based on new evidence, even if other theoretical orientations are necessary to understand and use the new guidelines. As long as psychotherapy is defined through separated theoretical orientations, the transtheoretical stimulation and inspiration of treatment experiences are hampered, and a consequent transition of scientific evidence to clinical application (and back) is limited. Even for the blockbuster of scientific evaluation in psychological treatments, CBT, an exclusive perspective on its own concepts hinders dynamic progress that would allow for benefits from other experiences outside its own theoretical world.

Defining psychological treatments as a family of non-linked theoretical orientations is also in opposition to research results that highlight that successful treatments and successful therapists have shared features that are not limited to one single theory (Norcross & Lambert, 2019). Common factors explain major parts of the variance of outcome (Wampold et al., 2017). Further, there seems to be a benefit if therapists have options to switch to interventions from other theoretical backgrounds, or, as Fonagy has pointed out: "Recent studies indeed suggest that adherence flexibility ([...] using interventions from other treatment approaches and modalities) may be associated with superior outcomes" (p. 270, Fonagy & Luyten, 2019). However, the typical trainings of early career clinicians do not sufficiently address this full potential of scientifically based knowledge about the delivery of effective treatments, and improved education in transtheoretical competences can provide a pathway to more successful treatments in clinical practice.

The lack of a common language for psychological treatments further hinders fruitful exchanges between representatives of different treatment approaches. Overcoming these restrictions offers new potential for improving training for psychological intervention and for shaping the personal competence profiles of upcoming psychotherapists. In addition, this leads to more transparency in what patients can expect from an expert providing psychological treatments. It seems barely acceptable that patients have to inform themselves before they choose psychological treatments about whether the treatment provider has a good training, is able to offer guideline-oriented treatments, or has some specialization that does not fit the patient`s problem. Like in other fields of healthcare specialization, patients have a right to expect that experts providing treatments for mental health should be qualified to address most clinical problems in this field with the best evidence intervention.

Competence-Based Training as a New Framework for Education in Psychological Treatments

What are the competencies that patients can expect if they search for an expert offering psychological treatments? It is surprising that many groups trying to define basic competences for clinical psychologists came up with a list of general competences that are not linked to one specific orientation but rather take into consideration the clinical needs and experiences with patients suffering from mental and behavioral disorders. The University College of London has done impressive work in defining competence profiles, some of them being linked to clinical conditions (such as psychosis), and some of them being linked to providing specific treatment approaches (UCL, 2020). The problem-specific definitions of competences needed to professionally treat this condition summarize a long list of general factors before defining the specific competences that are necessary

to provide a specific treatment approach (see example for persistent physical symptoms; Supplementary Materials, Figure S1). The European Association of Clinical Psychology and Psychological Treatments (EACLIPT) also provided a list of general competences of professional clinical psychologists (EACLIPT Task Force on "Competences of Clinical Psychologists", 2019) that was the result of a discussion group with members representing different treatment orientations (for an excerpt, see Supplementary Materials, Table S1).

We can use such competence profiles as a starting point for the systematic development of a self-learning system (Rief, 2021): Trainings for therapists can better focus on these competences, and the consequences for patients and other involved people can be evaluated. The results of this evaluation can be fed back into the competence list, leading to refinements and changes. Therefore, comparable to the English "talking therapies" program (Clark, 2018), such a living system can lead to the detection of weaknesses in current mental health care, and the ability to respond with methods to improve the system.

A competence-based approach typically indicates that people providing professional psychological treatments need to have general academic knowledge that is relevant for understanding the clinical condition (e.g., from basic psychology or neuroscience), mainly to have a basic understanding of evidence-based change processes during treatments, and they need the personal competences to apply this knowledge in the current patient-clinician-interaction.

However, moving from a theory-specific training of clinicians to a transtheoretical, competence-based training has some requirements. First, we need a general, transtheoretical framework for case conceptualization. Second, we need some agreement about the necessary competences and how interventions from different treatment orientations can contribute to the training of these competences.

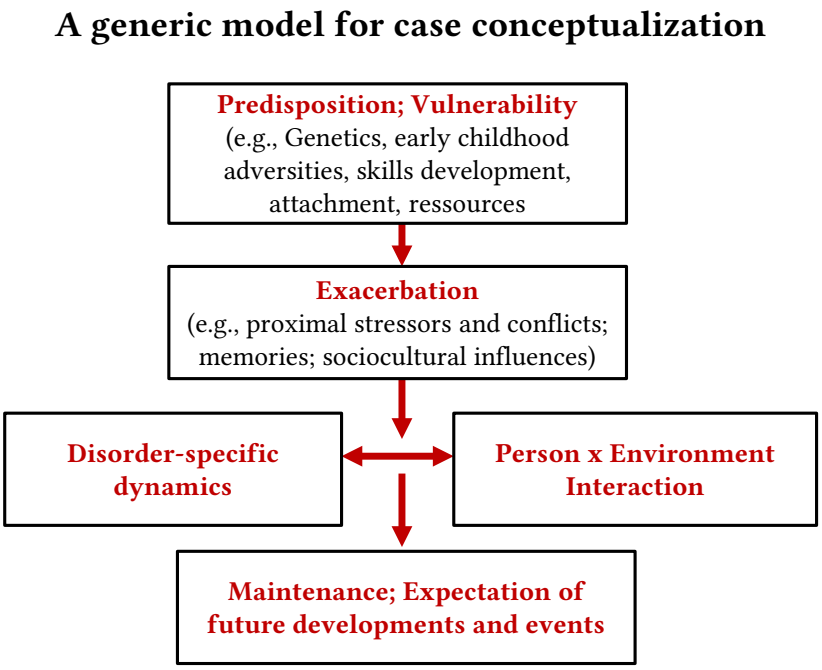
Transtheoretical Case Conceptualization

Transtheoretical case conceptualizations are necessary to provide a framework for understanding mental disorders and to identify foci for personalized treatment decisions. One of the oldest transtheoretical concepts for case conceptualization is the diathesis-stress model which distinguishes vulnerability/resilience factors (distal factors) from factors that led to symptom exacerbation (proximal factors), while symptom persistence and chronicity is closer linked to maintaining factors. This model has been modified by Rief and Strauß (2018; Figure 1) to better integrate person-environment interactions, the self-perpetuating capacity of mental disorders (disorder-specific dynamics), and the specific role of patient expectations as a maintaining factor (Rief & Glombiewski, 2017). Problems in social interaction are a scientifically proven risk factor for the development of mental disorders (starting from attachment experiences in early life; see predisposition

box in Figure 1), but social interaction problems can also develop or intensify after the establishment of mental disorders, thereby contributing to maintaining mechanisms (see person x environment interaction and maintenance boxes in Figure 1).

Figure 1

Transtheoretical Case Conceptualization (Adapted From Rief & Strauß, 2018)



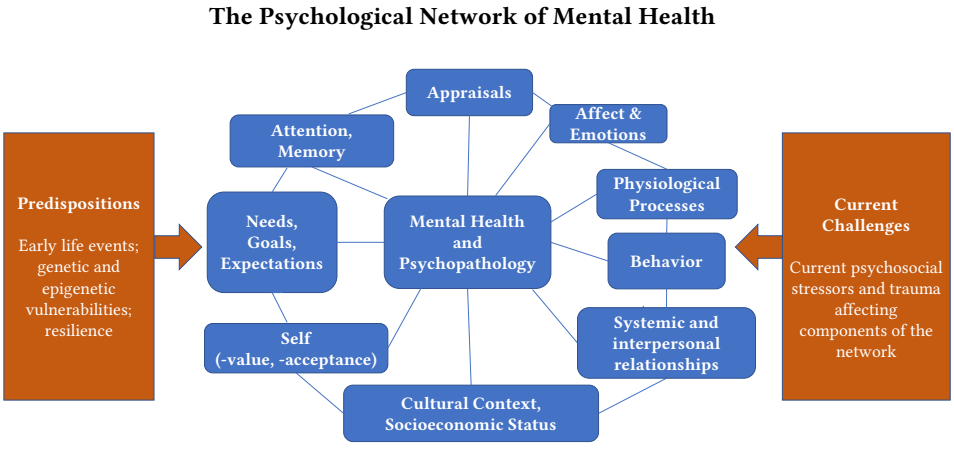
The model presented in Figure 1 offers a guidance for designing training programs for psychotherapists: they need to acquire competences to address problems of every single box, and they have to decide which box requires most attention according to the individual case conceptualization. It also highlights that mental disorders can have their own intrinsic dynamics, and typically this needs to be addressed directly. Although the classification of mental disorders is under discussion (Rief et al., 2023), therapists need specific competencies to address different mental disorders (disorder-specific dynamics).

While models such as the one in Figure 1 are still mainly static, dynamic network models for understanding mental disorders have been published to overcome the limitations of our traditional case conceptualizations (see Figure 2). These models identify "nodes" with high centrality to understand the clinical condition, and these nodes can vary from patient to patient. Therefore, network models do not only overcome the

gap between group-oriented (nomothetic) concepts and person-oriented (idiographic) conceptualizations, but they also explain why sometimes different treatments can lead to the same results, while in other cases the same treatments can lead to very different results (depending on the network status of the patient). Further, such a network approach rejects the illusion of separated clinical disorders, takes it as given that symptoms and clinical problems can be highly interlinked and that mental disorders do not represent isolated entities. While applying network models to clinical decisions and treatments is just at its beginning, first attempts show highly promising results, open the view to a more transtheoretical understanding, and enable us to define new pathways for treatment planning (Betz et al., 2020; Fried & Robinaugh, 2020). Of note, clinical information can be integrated into data-driven developments of individual network models (Burger et al., 2022; Scholten et al., 2022).

Figure 2

A Network Approach as a Common Framework for Transtheoretical Treatments (Lutz & Rief, 2022)



To ensure a comprehensive competence-based training, clinicians are trained to integrate both the traditional diathesis-stress model and the evolving network models, recognizing the unique contributions and insights each brings to understanding and treating mental disorders. Trainings of clinicians should qualify to address every single node (see boxes in blue, Figure 2) if it is considered a critical part of the network.

Transtheoretical Categorization of Psychological Interventions

Instead of describing treatment goals with the words of one specific treatment approach, we recommend categorizing treatment techniques according to more general aims using the basic concepts of psychology and neuroscience. This helps to bundle treatments from different treatment theories, thereby indicating the potential for comparing, stimulating and evaluating similar approaches and accelerating their developments to better achieve the common goal. The selection of these treatment goals is grounded in a transtheoretical framework, emphasizing the importance of versatile skills that transcend specific theoretical orientations, thereby ensuring clinicians are well-equipped to address the complex needs of their patients. Beyond integrating academic knowledge into clinical work and considering disorder-specific recommendations, clinicians providing professional psychological treatments should be trained to develop the competencies according to the following treatment goals.

Establishing a Therapeutic Relationship

It is not only common sense that the quality of the therapeutic relationship is able to predict treatment outcome, but it is also an everyday experience in the context of clinical encounters that the trustworthiness of the clinician is a major predictor of a patient's behavior and whether a patient accepts and complies with a therapist´s recommendation. While this is not part of the case conceptualizations in Figure 1 and Figure 2, nearly all general models of psychotherapy emphasize the role of a therapeutic relationship as a precondition for treatment success, although much of its evidence goes back to correlational analysis (Grawe, 2004; Norcross & Lambert, 2019; Wampold & Imel, 2015). There is ambiguity regarding how to define the relevant features of therapeutic relationship. In social psychology, one of the most prominent concepts on social perception is the model of Fiske and others (Fiske et al., 2007; Fiske et al., 2002), summarizing that the major features of social perception can be grouped into the two factors of warmth and competence. In one of the few studies using an experimental approach to investigate the role of therapeutic relationships, we were able to show that both warmth and competence determine whether participants make use of new information provided by a therapist (Seewald & Rief, 2023). This does not only determine explicit change processes but also implicit attitudes (Seewald et al., 2023). This means that the new experiences triggered during treatment sessions can only be integrated if patients consider the therapist as someone with warmth (empathy, perspective taking, non-aggressive) and competence (e.g., well-trained, providing convincing explanations, structuring treatment sessions). A first step in training early career clinicians should be how to establish a relationship with a patient that leads to the patient's perception of a therapist as being warm and competent.

Consideration of Patient´s Goals and Values

In the past, motivation for psychotherapy and motivation for change have been typically considered as preconditions for treatment. This has substantially changed over the last two decades, and working with motivation is considered a part of the psychological treatment process, in particular if the motivation for treatment and for change is fragile, ambiguous, or varies because of conflicting needs. Therapists need the competence to reflect the patient´s motivation and needs, and to consider the patient´s life goals during the treatment process, to finally arrive at shared treatment goals to select intervention techniques that are in accordance with the patient's general values. Acceptance and commitment therapy (ACT; Hayes et al., 2006) has reinvented the consideration of existential life goals to establish commitment as part of the treatment process, but the tradition of working with patient´s life goals and values is much older (e.g., Frankl, 1955). Psychodynamic treatments often focus on the conflict between different motives of patients. But also Roger´s non directive intervention aims to clarify patient´s needs, help to find solutions in conflicts, and to increase the motivation to follow them. Thus, people offering professional psychological treatments need the competence to analyze, reflect and work with the patient´s motives, taking into consideration general life goals and values of patients, to clarify different aspects of conflicts, and to improve patient´s motivation for change. Motivational interviewing is just one of the examples of how to directly focus on aspects of motivation (Miller & Rollnick, 2002); originally developed for people with addiction problems, it can be used for nearly all decision problems, as a tool to improve motivation for change in particular with patients with stable, dysfunctional states (e.g., a patient with anorexia suffering from chronic underweight; long-year persisting depressive states; dysfunctional aggressive and impulsive behavior). This strategy can be easily combined with other treatment techniques.

Improving Tolerance for Unpleasant Sensations and Feelings

Emotion regulation refers to the process of understanding, managing, and effectively coping with feelings and sensations. It involves developing skills to identify and respond to emotions in a healthy manner. This can include recognizing triggers, understanding the intra- and interpersonal context of feelings, and implementing strategies to manage intense feelings. The rise of concepts on emotion regulation and their relevance in psychological treatments also brought another insight into the field that has its roots in the Buddhist wisdom "Living is suffering". Every person needs competence in tolerating aversive states and not to change strategies because of single unpleasant disruptions. People suffering from chronic aversive states (e.g., chronic pain) need to develop acceptance strategies, if they want to improve their quality of life. Therefore, clinicians should be able to support patients how to better tolerate unpleasant feelings.

Improving Skills

The counterpart of accepting aversive situations and memories is trying to change them. This often requires the improvement of skills, and improving skills is a major component of nearly all treatments. The history of training how to improve communication skills started before behavior therapy was officially introduced (Salter, 1949), and psychodynamic treatments wanted to overcome "structural deficits" (e.g., deficits in emotion regulation, communication of needs, self-concepts) by working with the patient´s psychological skills during the therapeutic encounter. Other skills were added to the portfolio of skills improvements in psychological treatments: Improving problem solving skills, relaxation skills, emotion regulation, and mentalization competence (reflection of motives and emotions of others and self). These interventions focusing on improving skills have some specific characteristics in common. They typically follow a step by step approach, trying to induce some smaller successful changes as soon as possible, before aiming for broader goals. They typically follow a communicable rationale and are rooted in the principles of learning.

Exposing to New and Feared Situations

Although exposure is often defined as a pure CBT intervention, the overall goal is broader: how to expose a patient to a new situation, a feared situation, or an aversive inner stressful experience if this is necessary to achieve the treatment goals? With such a definition, it is obvious that every psychological treatment will arrive at such a point because either implicitly or explicitly most patients have to face the fact that exposure is a prerequisite for change. Most treatment frameworks require exposure to new situations and/or behaviors (Foa & McLean, 2016). Further, there are few psychological interventions with as much scientific evidence and scientifically based principles as exposure. Therefore, knowing about the basic principles of exposure interventions and being able to motivate and guide patients through such a process is a basic requirement for all therapists.

Working With the Therapeutic Relationship as an Example of Interactions

For many years, psychodynamic treatments focused exclusively on working with the therapeutic relationship, considering aspects such as transference and counter-transference. Even if this exclusiveness could be questioned and was modified in many subsequent psychodynamic developments, the work with the therapeutic relationship still offers a splendid option to reflect on and modify interaction patterns and problems in social relationships. One could argue that as long as warmth and competence are established in therapeutic relationships, there is no need for further relationship-oriented interventions. However, other experts brought attention to the fact that ruptures in

the therapeutic alliance are a common phenomenon (Eubanks, Muran, & Safran, 2018), and trying to repair these ruptures can be a helpful experience not only to establish a pre-condition for a successful treatment, but also as an example of how to deal with interaction problems in everyday life (Eubanks, Muran, & Safran, 2018). A consensus between different therapists was reached on how typical ruptures during the therapeutic interaction can be categorized (Eubanks, Burckell, & Goldfried, 2018), and a portfolio on how to intervene when ruptures occur was put together (Eubanks, Muran, & Safran, 2019). Detecting and reflecting on these ruptures, and being able to use strategies from a broad portfolio how to deal with them can help further to professionalize psychotherapy.

Reattribution and Mentalization

Reattribution takes place in all forms of successful psychological treatments. It starts with providing a new framework for understanding the clinical problem, continues with changing cognitive evaluations of one's own feelings and behaviors, of motives of other's behavior, and also includes reformulations of the self-concept and self-esteem. In recent years, it has been emphasized that the overall goal of all psychological treatment is to improve psychological and cognitive flexibility (Doorley et al., 2020). Psychotherapists should be sensitive and even able to trigger these reattributions. Also, models of affect regulation and its connection to psychopathology (Gross et al., 2019) emphasize the crucial role of appraisal processes. Supporting patients to be able not only to consider one explanation for problems but to choose between different views is a major step in problem solving. Cognitive therapy offers a broad spectrum of ways to deal with this topic, but it can be enriched with other approaches as well. Mentalization-based treatments (Bateman & Fonagy, 2010) also address improved perspective-taking, more variety in interpreting the motives of others and oneself, and a better understanding of emotional reactions through new appraisals.

Working in Multi-Person Settings

For many interventions, it is necessary to work with several people together. Often, the inclusion of significant others who might play a role in maintaining the problems is necessary. But also providing group therapy (which may be more economical than individual treatments) or even working with communities belongs to the competence profile of clinical psychologists. All professional psychotherapists should be aware that the single patient always lives in a social environment with other people who interact and can either support or hamper successful changes. Therefore, working in multi-person settings is also a precondition for the broad competence profiles of psychotherapists. Systemic therapies have suggested multi-person interventions (Pinquart et al., 2016; Riedinger et al., 2017), but nearly all other major traditions of psychotherapies have developed ways to deal with it.

Personal Competences of the Therapist

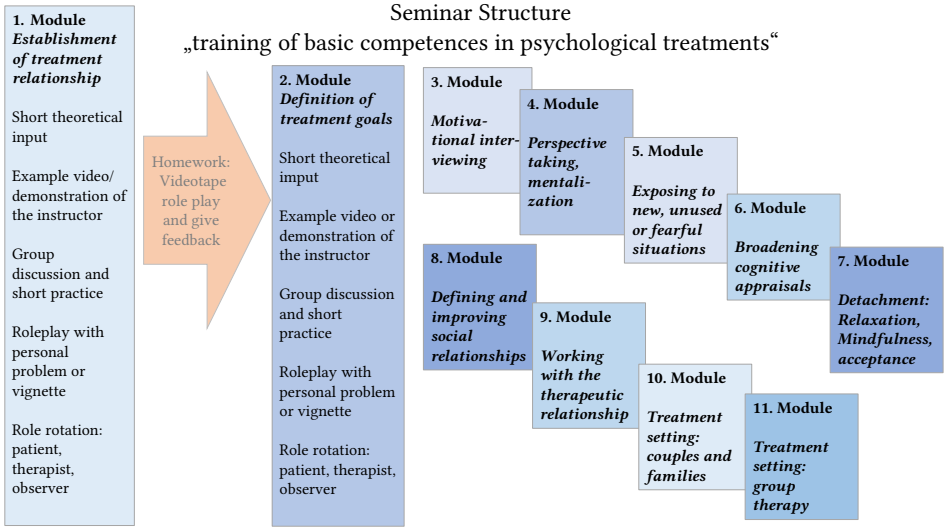
During the last decade, more emphasis has been put on the role of the persons offering psychological treatments and their personal competences. Therapist's personality characteristics can predict parts of the treatment outcome (Norcross & Lambert, 2019). Still, there is no good and broadly accepted framework for self-reflection and self-experience and how to achieve these personality features. While the evidence for this field does not allow well-proven recommendations, there is some clinical agreement at least about one position: It is helpful if psychotherapists have the abilities they want to teach their patients (emotion regulation, communication, problem solving, self-reflection, mentalization, psychological flexibility, and even humor; Ziede & Norcross, 2020).

An Example of Training Basic Competencies for Psychological Treatments in a University Setting

After legal regulations for providing psychological treatments in Germany changed in 2019, more practice-oriented master programs were introduced, and the University of Marburg established an example of training in basic and transtheoretical competences for psychological treatments. Hereby, the ideas of subchapter 2-4 were the basis for planning the program. In a block seminar attended by a maximum of 15 students, various modules covering basic competencies are taught (see Figure 3). Each module begins with a brief theoretical overview and repetition about one basic competence and watching an example video or a demonstration of the instructor. This is followed by a short exercise in the group and a discussion about possible difficulties and pitfalls. The main part is on role plays featuring different vignettes or personal experiences. During the first sessions, all students are required to provide a personal problem, while later, written clinical examples are the basis for the role plays. They take place in groups of three: one acting as the patient, one as the therapist, and one as the observer who provides feedback using a structured feedback form. The instructor, a licensed psychotherapist, also gives feedback. Afterwards, students rotate roles to ensure that every student has the opportunity to learn each role. Students are tasked with a homework assignment in regard to the last competence learned. They are required to create and film another role play, which is then submitted via the university's secure platform. Two randomized fellow students subsequently provide feedback on the performance and demonstrated competences of these videos.

Figure 3

Seminar Structure



The modules encompass a range of essential topics, including:

1. Initial establishment of a treatment relationship: In this module, students learn how to create a treatment relationship. This involves active listening, empathetic understanding, and creating a safe, non-judgmental space, allowing the patient to feel heard and supported.
2. Definition of treatment goals: Students should proactively assess both explicit treatment goals and personal objectives (life goals and values). Treatment goals should be attainable, clear, and congruent with the patient's emotional preferences. Additionally, a hierarchical approach, distinguishing between general goals (such as overall well-being and personal growth) and specific goals (like overcoming specific challenges or behaviors), allows for a comprehensive approach, addressing both immediate concerns and the broader context of the patient's life (e.g., Michalak & Holtforth, 2006).
3. Treatment motivation, motivational interviewing: The module “Motivational interviewing” employs a guiding approach to engage with patients, elicit their motivations for behavior change, and foster autonomy in decision-making; it can be learned through practicing “change talk” and “confidence talk” (e.g., Rollnick et al., 2010), and can be applied in addiction problems, but also all other ambivalence conflicts.

4. Perspective taking, mentalization: In this module, students learn to get a deeper understanding of mentalization. It refers to the capacity to understand and interpret one's own and others' thoughts, feelings, and intentions, particularly in emotionally significant interpersonal relationships, and is viewed as a learnable skill crucial for maintaining stable relationships (e.g., Bateman & Fonagy, 2010).
5. Exposing to new, unused, or fearful situations: This module provides students with specific strategies, such as expectancy violation and deepened extinction, to optimize the exposition to new situations, adding these strategies to traditional cognitive-behavioral approaches like 'fear habituation' and 'belief disconfirmation' (e.g., Craske et al., 2014).
6. Broadening cognitive appraisals: In this module, students learn how to expand the patients´ perspective and how to consider alternative interpretations of situations to gain more balanced perspectives and constructive thinking patterns. Developing psychological flexibility is a major goal.
7. Detachment: This module trains the integration of detachment, encompassing relaxation, mindfulness, and acceptance, as an important aspect of psychological treatments with a focus on emotion regulation (Shapiro et al., 2006). Techniques such as progressive muscle relaxation, mindfulness meditation, and self-compassion practices are employed to help patients cultivate detachment from thoughts and emotions (Wells, 2005).
8. Defining and improving social relationships: In this module, understanding and improving social behavior is trained with the help of the Interpersonal Circumplex model (Kiesler, 1983). This framework visualizes interpersonal behavior along two axes: agency (ranging from dominance to submissiveness) and communion (ranging from friendliness to hostility), creating a circular space. This model categorizes behavior into eight segments, providing a comprehensive representation of an individual's interpersonal profile and serving as a valuable tool for understanding psychopathology within social contexts (Guhn et al., 2019).
9. Working with the therapeutic relationship; complimentary relationship expectations; ruptures and repair: In this module, the students learn the concept of complementary therapeutic relationship, in which therapists should offer each patient a customized relationship tailored to their most significant goals, as determined through plan analysis and case conceptualizations. This approach suggests that a therapist's behavior should align with and complement the patient's needs and objectives in therapy (e.g., Caspar et al., 2005). Moreover, students train to recognize and effectively address ruptures in therapy (e.g., Eubanks et al., 2019).
10. Treatment setting - couples and families: This module stresses the importance of integrating the partners and children into the psychological treatments. It offers strategies for enhancing positive interactions and components for communication, and it also trains the therapist in multi-perspectivity and impartiality. Additionally, it

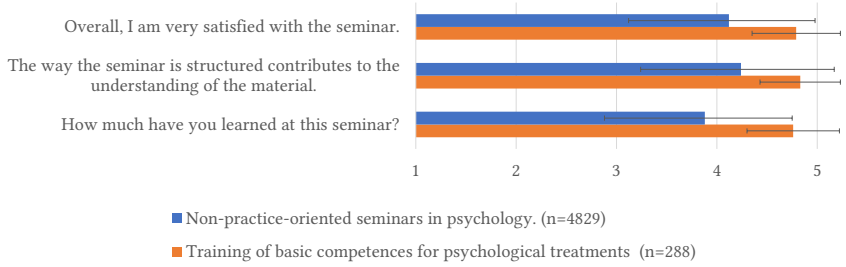
outlines therapeutic approaches for various psychological disorders within the framework of couple and family therapy (e.g., Hahlweg & Baucom, 2008).

11. Treatment setting - group interventions: In this module, students learn to conduct different types of group therapy (e.g., psychoeducational, disorder-specific, individual case-oriented). The main focus of the module is on individual case-oriented group therapy addressing the specific psychological issues or predetermined theme of a protagonist. The selection of the topic is tailored to the individual's personal situation and life history, with the assumption that most group participants may have similar problems or life situations (Sipos & Schweiger, 2019). The goal is to work on the individual situation of the protagonist, while other group members serve as sources of information, experiences, feedback, and practice partners for role-playing exercises. All of the students get different vignettes about their role as trainer or participant, and large role plays follow (see Supplementary Materials, Table S2 for an example vignette).

The described seminar is evaluated regularly, using standardized questions that are similar in most German universities. The evaluations consistently show that students rate the quality of the seminar very high. Figure 4 shows the students' assessment regarding the three most relevant items for evaluating seminar quality (satisfaction, understanding of the material, increase of learned content). The results of the training of basic competences for psychological treatments include 15 teaching evaluations (2012-2023) from six different instructors. For comparison, n = 4,829 teaching evaluations from non-practical events in psychology from the same years are depicted.

Figure 4

Teaching Evaluation of the Training of Basic Competences for Psychological Treatments



Note. Legend: The items are rated on a five-point response scale ranging from 'strongly disagree' = 1 to 'strongly agree' = 5, or 'very little' = 1 to 'very much' = 5.

Taken together, the seminar integrates theoretical knowledge with hands-on practice. It empowers students to apply basic competences in practical settings and receive feedback from both instructors and peers. Such active learning strategies equip students for real-world applications of their psychological treatment skills.

Shortcomings of This Approach

The competence-based training approach in psychotherapy, while valuable in many respects, is not without its limitations. It is important to acknowledge that this approach is not intended to replace comprehensive postgraduate trainings in psychotherapy, but it is meant to offer an alternative to current trainings in particular as a starting approach early in the career, e.g., offering a "common trunk" before specialization takes place. Here are some of the key shortcomings associated with this approach:

Lack of Disorder-Specific Approaches: One significant limitation is its generalist nature. It may not sufficiently cater to the unique needs and nuances of specific psychological disorders and problems. Tailoring interventions to address specific conditions like depression, anxiety, or trauma requires additional training and expertise.

Incomplete Coverage of Competences: While the competence-based approach covers important therapeutic skills, it may not encompass the full spectrum of competences that could be beneficial in psychotherapy, and it will always represent a selection. Factors such as cultural sensitivity, advanced assessment techniques, or specialized interventions for severe psychopathologies might not receive adequate attention. The complexities of transference and countertransference, which are crucial aspects of the therapeutic relationship, may not be fully addressed in a competence-based framework, similar as some other specific approaches (such as schema therapy or specialized exposures). Emotion regulation training could be strengthened compared to this proposal. There are limitations in a transtheoretical approach to integrating highly specialized abilities from all different approaches. However, we want to understand our approach as a dynamic model that invites modifications, adaptations, and improvements and also allows variations. In contrast to being bound to one single approach, a strength of our approach is that it can be flexibly adapted to improve identified shortcomings and integrate new evidence-based acknowledgements stemming from different fields.

In summary, while the competence-based approach provides a valuable foundation for psychotherapists, it should be viewed as a starting point rather than a final comprehensive training in itself. Supplementing this approach with specialized knowledge, disorder-specific techniques, and a nuanced understanding of complex therapeutic dynamics is essential for providing high-quality, tailored care to clients with diverse needs.

Concluding Remarks

Many early career clinicians using psychological treatments receive training that focuses on one of the traditional or current frameworks, such as psychodynamic, CBT, or ACT. Focusing on one of these approaches, often accompanied by developing a strong identification for it, typically neglects other experiences, new developments in other contexts, and/or basic findings on disorders or treatment mechanisms. Overcoming these limitations requires a transtheoretical approach for case conceptualization and treatment. This can create a platform for a true academic and scientific field of psychological treatment. We provide such transtheoretical frameworks for case conceptualization, and we suggest a competence-based framework for training early career clinicians in how to use psychological treatments. These concepts should not be understood as fixed or new truth, but as a flexible framework that can be continuously adapted according to new scientific or practical experiences and local needs. We established a basic training of competences for upcoming psychotherapists that integrated treatment approaches of different theoretical orientations. Students' satisfaction was very high, and negative aspects (e.g., being confused; not being able to integrate the different approaches to an overall understanding) were not observed. Broadening the science of psychological treatments to a transtheoretical approach helps to overcome artificial differences and improves the integration of our knowledge and experiences into an overall transtheoretical framework.

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Twitter Accounts: @WRief1

Supplementary Materials

The Supplementary Materials include the following items (for access, see Rief et al., 2024):

- The first supplemental material outlines a framework detailing essential competencies for psychological interventions with individuals facing persistent physical health conditions. These include professional stance, values, and assumptions; core knowledge about the illness; a good assessment and planning ability; generic therapeutic competences such as the ability to foster and maintain a good therapeutic alliance; knowledge about specific interventions; and meta-competences.

- The second supplement provides an excerpt of a competence list, as outlined by the EACLIPT Task Force on "Competences of Clinical Psychologists" in 2019. Meta-competences for clinical psychologists encompass proficiency in providing interventions aligned with treatment aims and scientific knowledge. Moreover, meta-competences include the ability to motivate patients, explain interventions to stakeholders, demonstrate perspective-taking and empathy, regulate their own emotions, and address treatment and therapeutic relationship issues.
- The third supplemental material introduces a case vignette illustrating therapeutic objectives aimed at addressing relationship ruptures and understanding patient motives to enhance therapeutic engagement and flexibility. This case features a patient with an affective disorder and can be used in the training of clinical psychologists.

Index of Supplementary Materials

Rief, W., Wilhelm, M., Bleichhardt, G., Strauss, B., Frostholm, L., & von Blanckenburg, P. (2024). *Supplementary materials to "Competence-based trainings for psychological treatments – A transtheoretical perspective"* [Additional information]. PsychOpen GOLD. https://doi.org/10.23668/psycharchives.14202

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Needs, Modes, and Stances: Three Cardinal Questions for Psychotherapy Practice and Training

Eshkol Rafaeli [1], Alexandra K. Rafaeli [2]

[1] *Department of Psychology and Gonda Center for Neuroscience, Bar-Ilan University, Ramat-Gan, Israel.* **[2]** *Unit for Psychological Services, Ben-Gurion University, Beer-Sheva, Israel.*

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Corresponding Author: Eshkol Rafaeli, Department of Psychology, Bar-Ilan University, Ramat-Gan, 5290002 Israel. Phone: +972-3-531-8582. E-mail: eshkol@biu.ac.il

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Abstract

Background: Advances in motivational science (Dweck, 2017), personality dynamics (Lazarus & Rafaeli, 2023), and process-based psychotherapy (Hofmann & Hayes, 2019) converge into a pragmatic, integrative, and transtheoretical model of practice and training.

Method: The model comprises three elements: a formulation centered on clients' psychological needs which provides guidance regarding the goals and processes most profitable to pursue; a recognition that such pursuit frequently requires contending with a multiplicity of clients' internal self-states (i.e., modes); and an enumeration of pragmatic therapeutic stances likely to help address clients' need-related goals in light of their modes.

Results: We distill these elements into three cardinal questions: What needs does this client have that are not currently met, and what are the most profitable ways of remedying that frustration? What mode or modes does this client manifest – both generally and at this very moment? and What stance should I adopt in response to the client's current mode? We suggest that clinicians should be trained to continually pose these questions and seek to answer them collaboratively with their clients.

Conclusion: This model – illustrated here using schema therapy terms – offers a process-based approach which serves as a theoretically integrative starting point but is general enough to provide an assimilative integration roadmap for therapists anchored in most primary orientations. Integrative or assimilative therapists trained to attend to needs, modes, and stances are likely to be

(and be perceived as) particularly responsive, and thus, to enact "common factor" practices known to be conducive to therapeutic alliance and gains.

Keywords

process-based therapy, universal psychological needs, modes/self-states, therapeutic stances, psychotherapy integration

Highlights

- We present three crucial tasks for facilitating effective clinical training and practice.
- First, identify core psychological needs to set therapy goals and effective interventions.
- Second, recognize the multiplicity of clients' different self-states (or modes).
- Third, flexibly adopt specific stances to respond well to clients' needs and modes.

People seek and enter psychotherapy because something is amiss. It is the role of psychotherapists to help formulate what that "something" is, translate it into identifiable goals for change, present possible pathways towards these goals, collaborate with their clients as they try out these pathways, respond to unforeseen obstacles and turns-of-events along the way, and ultimately help their clients get their frustrated or thwarted needs more adequately addressed.

In this article, we will argue for a model of practice (and thus, of training) that can help psychotherapists embody and enact this role well. This model emphasizes three key elements. The first element is a formulation of a client's story (or their presenting complaints) in terms drawn from *a universal taxonomy of psychological needs*, which provide guidance regarding the goals and processes that would be most profitable to pursue in therapy. The second element is the recognition that such pursuit does not always follow a straight path, and often involves grappling with *a multiplicity of clients' internal self-states* (or *modes*). The third element, which builds on these first two, is an enumeration of pragmatic *therapeutic stances* which help address the client's need-related goals in light of their modes. In concluding, we will put forward the idea that therapists trained to attend to *needs*, *modes*, and *stances* and to make implicit – or better yet, explicit – use of these elements are likely to be (and to be perceived as) particularly responsive, and thus, to enact "common factor" practices known to be conducive to therapeutic alliance and gains.

One note: the model we present is drawn from schema therapy (Rafaeli et al., 2010; Young et al., 2003), a theoretically integrative approach rooted in cognitive behavioral, psychodynamic, and experiential thinking. Indeed, throughout the paper, we use schema therapy terms to illustrate the three elements discussed. However, as we hope to show, the key points presented here do not require one to subscribe to schema therapy per

se, or even to favor *theoretical integration*. Instead, they may provide a roadmap for *assimilative integration* for therapists anchored in most primary orientations.

Let's begin with the first element. Recent years have brought a growing understanding that empirically supported treatments have probably gained much of what there is to gain from categorical identification of syndromes and from the development of syndrome-specific protocols or interventions (Hofmann & Hayes, 2019; Insel, 2022). In their stead, the time seems ripe for process-based therapy – interventions that eschew diagnostic labels and focus instead on procedures most likely to change underlying biopsychosocial processes or mechanisms tied to desirable treatment outcomes or goals across diagnostic boundaries.

But how should these processes or mechanisms be identified? We would argue that a straightforward taxonomy of change mechanisms, one that is most likely to make intuitive appeal to clients as well, is ***a taxonomy of universal psychological needs***. After all, as our opening paragraph illustrated, the logical transition from saying that people enter therapy "because something is amiss" to viewing it as an issue of addressing "frustrated or thwarted needs" is quite seamless.

In a way, most schools of psychotherapy have an explicit or implicit model of *motives* or *needs* at their core. Some base this core, explicitly, on Darwinian evolutionary principles (Gilbert, 2019; Hayes et al., 2020) and note the centrality of the broad needs for *survival* and *reproduction*, from which they draw more specific goals (e.g., social safeness; Gilbert et al., 2008). Others adopt the principles of Bowlby's attachment theory (e.g., Davila & Levy, 2006; Goodwin, 2003; Slade & Holmes, 2019), itself strongly influenced by Darwinian thinking, and focus on specific biobehavioral drives towards *pair-bonding*, *care-giving*, and (centrally) the formation and maintenance of *attachment* bonds. (Notably, a wide range of approaches use the term "attachment" in their title, or identify it explicitly as a key part of their model; e.g., Diamond et al., 2003; Hughes, 2004; Johnson, 2019; Milrod et al., 2016; it's interesting to consider why the same credit hasn't been given to Darwinian theory). And of course, many approaches to psychotherapy – especially those that gained prominence in the mid 20th century – place particular (explicit) premia on needs that may be more uniquely human: e.g., the need for authenticity (Perls et al., 1951), meaning (Frankl, 1959), self-actualization (Rogers, 1963), and creativity (May, 1969).

For various reasons (probably similar that those recognized in adjacent fields, like personality psychology; e.g., Del Giudice, 2018; Zeigler-Hill et al., 2019), motivational accounts within psychotherapy fell out of favor in the height of the cognitive revolution of the 1970s-1990s. A possible consequence has been that evidence-based psychotherapy approaches which came of age in those decades – including ones with which we strongly identify (e.g., cognitive behavioral therapy; Barlow, 2021; Beck, 1970; interpersonal psychotherapy, Markowitz & Weissman, 2004) have stayed rather silent when it comes to discussing needs or other motivational constructs. This does not mean that motives

or needs – e.g., for safety, connection, competence, or even simply for a world that can be adequately understood – aren't implicitly present in these therapeutic models. It just means that they are not seen as key concepts within these approaches. **Thus, our first proposed element is that the practice of psychotherapy – and training in it – should adopt an explicit and transtheoretical language to describe psychological needs so as to help therapies achieve their most basic goal of addressing these needs.**

What should this language be? Rather than pitting one theoretical school (say, humanism) against another (say, attachment-based or evolutionary-based approaches), we would argue that psychotherapists should instead follow the lead of pioneers such as Grawe (1997) in turning to vibrant work being done in the broader field of psychology. Grawe turned to Miller et al.'s (1960) work on Plans to develop his Consistency Theory, which emphasized the role of need fulfillment in promoting well-being and facilitating positive therapeutic change. Today, we can build on more modern motivational work, in which recently developed frameworks (e.g., Del Giudice, 2018; Dweck, 2017; Schaller et al., 2017) still lead to remarkably similar clinical conclusions.

We'll illustrate this with one particularly comprehensive framework – Carol Dweck's (2017) recently-proposed model linking motivation, personality, and development. Dweck's model synthesizes extensive literature on psychological needs from both basic and clinical research to provide a broad and inclusive taxonomy of needs, including three basic ones and 4 compound ones. The three basic needs – for *acceptance/belonging, competence,* and *optimal predictability* (i.e., sufficient order and stability) – are thought to be universal, present at birth, and non-derivative. The compound needs for *control* (or *autonomy*), *trust*, and *status/self-esteem,* though also universal, are thought to each emerge a bit later in development from the conjunction of two basic needs (e.g., *trust* integrating *acceptance* and *optimal predictability*) and to require meta-cognitive capacities not present at birth (e.g., self-awareness). Finally, the ultimate compound need for *self-coherence,* encompassing meaning and identity, is thought to be fed by all other compound as well as basic needs and to serve as the "master sensor" of whether things are as they should be.

Dweck (2017) argues that needs give rise to goals, and that as people pursue these goals, they develop representations (which she refers to as BEATS: Beliefs, representations of Emotions and representations of Action Tendencies). Understanding these needs and the ensuing BEATS is key to understanding human development, motivation, and personality. Importantly, it is also key to understanding human distress and it's amelioration. Specifically, thwarted or frustrated needs and their down-stream consequences (namely, ineffective or maladaptive goals or representations) are key determinants of poor psychological well-being and should therefore be the focus of psychotherapy.

Most clinicians find this basic idea of putting *needs* at the forefront entirely consonant with the underlying assumptions driving their clinical work. Yet, with few

exceptions (e.g., Consistency Theory: Grawe, 1997; motivational interviewing: Miller & Rollnick, 2002; Ryan et al., 2011; schema therapy: Rafaeli et al., 2010; Young et al., 2003), these assumptions typically remain silent, even when the therapy is guided by an otherwise explicit case conceptualization (see Gilboa-Schechtman, 2024, this issue). We argue that by offering (or at least attempting to develop) a comprehensive model of psychological needs, Dweck's (2017) framework provides us with an approach for organizing any therapeutic work we do. This would be relevant in relatively straight-forward situations, in which one of the basic needs (for optimal predictability, belonging/acceptance, or competence) is unmet. And it would be even more relevant when later-appearing compound needs (for control/autonomy, trust, self-esteem/status, or self-coherence [i.e., meaning and identity]) are frustrated, or when multiple needs compete or become intertwined.

Indirect evidence that good therapy helps clients meet their needs, and thus, improve their ability to live meaningful, satisfying lives full of love and work (cf. Freud, 1930) abounds. But despite the intuitive appeal of this model, and despite calls for the actual assessment of need satisfaction or frustration (e.g., Vansteenkiste & Sheldon, 2006), limited empirical work to date has explored need-satisfaction directly. Even schema therapy, which expressly speaks about the recognition and importance of needs, rarely uses measures to directly assess need satisfaction or frustration.

Once needs are identified, understood, and explored, the *ends* (or "targets") of therapy become much clearer. But what about the *means* to reach these therapeutic ends? With respect to this pragmatic question, the psychotherapy field is full of many effective/efficacious therapeutic interventions, drawn from diverse orientations that can help clients satisfy specific needs. For example, a frustrated need for competence is often profitably addressed using behavioral interventions such as graded task assignment; a frustrated need for relatedness is often addressed with interpersonal therapy interventions such as communication analysis; and a frustrated need for self-worth or self-esteem, likely to be accompanied by harsh self-criticism, may be most amenable to techniques such as two-chair dialogues, drawn from Greenberg's (2004) emotion-focused therapy, as well as to self-affirmation tools taken from Gilbert's (2014) self-compassion therapy.

The training implications of focusing on needs are clear: trainees should become familiar with need models and should be provided with at least a basic toolset of therapeutic interventions that could serve as "first-line" choices once a client's core needs are identified. If we had to pare this entire element down to one supervisory point, it is that clinicians (and trainees) should strive to answer this first cardinal question: "*What need or needs does this client have that are not currently met, and what are the most profitable ways of remedying that frustration?*".

Based on this logic, we (the first author together with Aaron Fisher at UC Berkeley and Gal Lazarus at the Hebrew University) are currently implementing a randomized clinical trial comparing brief intervention protocols that are personalized (or not) with respect to the client's most glaring frustrated need. To do so, we adopted specific em-

pirically-supported techniques from a variety of models deemed to be good first-line need-focused interventions (see Table 1 for our choice interventions). Whether these will indeed prove efficacious with respect to need fulfillment is of course an empirical question; if they do not, others will.

Table 1

A Listing of Psychological Needs, Characteristic Distress Tied to Their Frustration, and Suggested First-Line Intervention Tools for Each

The need	***The characteristic distress (and most prominent schemas)***	***High-likelihood first-line interventions (and the approaches from which they are drawn)***
Optimal Predictability	Worried, anxious (*Vulnerability to harm*)	Acceptance and commitment (ACT) or mindfulness tools for emotion regulation
Acceptance/Belonging	Lonely, rejected, isolated (*Social isolation, Abandonment*)	Interpersonal Psychotherapy (IPT) tools to create change in the interpersonal sphere
Competence	Dependent, incompetent (*Dependence, Failure, Insufficient self-control*)	Behavior therapy (BT) techniques to improve performance
Trust	Mistrustful, hurt (*Mistrust/abuse, Emotion deprivation*)	Schema therapy (ST) tools, such as imagery work on trust violations
Autonomy/Control	Outwardly focused or unmotivated (*Subjugation, Enmeshment, Undeveloped self, Approval seeking*)	Assertiveness training tools, decisional balance chair-work, motivational interviewing tools
Self-esteem/Status	Ashamed, self-critical (*Defectiveness/shame, Unrelenting standards, Punitiveness*)	Self-compassion therapy (SCT) tools, emotion focused (EFT) tools for combatting the self-critic
Self-coherence (meaning, identity)	Lost, identity-less, nihilistic (*Self-sacrifice, Entitlement/ Grandiosity*)	Values (commitment) work from ACT

Which brings us to the second element. As many clinicians, including novice ones, quickly learn, the picture of clearly defined aims (whether they be *fulfillment of frustrated needs* or *removal of diagnostic symptoms*) achieved through clearly defined means (including evidence-based ones, known to be effective on average), is an overly idealized version of many therapeutic processes. Even when clinicians ask the first cardinal question noted above and reach well-founded answers for it, they often run up against substantial obstacles which require attention to the here-and-now of therapy.

One example of these obstacles can be observed within the context of the therapeutic alliance. Extensive research on alliance (see Flückiger et al., 2018) attests to how important but non-trivial it is to establish therapeutic bonds, and to develop shared understanding of the goals to which therapy should aspire and the tasks that could lead there. But alliance fluctuates across therapists, clients, sessions, or even moments (Zilcha-Mano, 2021), and alliance ruptures, impasses, and interpersonal enactments are ubiquitous in therapy (Safran & Kraus, 2014). Why do these occur?

The state-like nature of alliance (and alliance ruptures, enactments, etc.) points to a likely culprit: namely, the fact that people themselves (including clients and therapists) are not fixed actors or agents, but rather a collection of multiple selves (Markus & Wurf, 1987), parts (Bromberg, 1996), "I-positions" (Hermans, 2001), modes (Rafaeli et al., 2016), or as Bill Stiles poetically noted – "a community of internal voices" (Stiles, 2011).

As this (very partial) list of terms illustrates, many clinical models (and increasingly, social, developmental, and personality research findings) seem to converge on a similar idea: that humans move around between different "modes" (our preferred term) – cohesive, experientially distinct, state-like manifestations of personality characterized by specific profiles of affects, behaviors, cognitions, and desires (Lazarus & Rafaeli, 2023). Explicit attention to these modes in theory and research – but also in clinical practice (Rafaeli et al., 2014; Ryle & Fawkes, 2007; Stiles, 2011) – can provide an organizing framework for understanding both "typical" personality and all (or at least most) forms of psychopathology. And as we'll show in a minute, they also play an outsized role in the here-and-now of therapy. **Thus, our second proposed element is that practice and training of psychotherapy must prepare clinicians to see *multiplicity* within their clients (and themselves).**

The idea that modes are present to some degree in every person's phenomenology is easily intelligible to most people, who know, viscerally, how different it feels to be hurt, angry, self-critical, detached, reflective, playful, and so on. But therapists and trainees who become attuned to such modes (or voices, or selves, or parts, etc.) can use this attunement to facilitate therapist-client communication, practice more effective empathy, and repair alliance ruptures more effectively. They can also have (and share with their clients) an experience-near understanding of the clients' varying and often distressing psychological states.

Not every client requires mode-based work. Certainly, some clients enter therapy with sufficient reflectiveness and self-compassion (referred to, in schema therapy, as a "healthy adult mode"; Young et al., 2003) and/or with sufficient playfulness and creativity, so that even if they do manifest some vulnerable modes (marked by pain or distress), they are relatively unencumbered by introjected voices (marked by self-criticism or self-punishment) or maladaptive coping parts (marked by avoidance, surrender, or overcompensation). With such clients, answering the first cardinal question posed earlier could suffice; after the focal needs are correctly identified, and a well-suited targeted

response implemented, we should see their pain or distress abate. For example, a client with a relatively simple dilemma regarding a specific life decision may be accurately seen as lacking in (say) *autonomy* or *internal motivation;* these could probably be augmented by using (say) *assertiveness training, decisional balance,* or *acceptance-and-commitment tasks*.

Often, however, broad personality traits and/or more specific pernicious modes (which may reflect such traits) are so prominent that therapy invariably must address them or at least take them into account. For example, trait *perfectionism* (e.g., Zinbarg et al., 2008), as well as state or trait *self-criticism* (e.g., Löw et al., 2020; Werner et al., 2019) have been tied to poorer treatment response; the same is true for *avoidance* (e.g., grosse Holtforth, 2008). To address these, therapists should be prepared to ask a second cardinal question: "*What mode or modes does this client manifest – both generally and at this very moment?*".

Answering this question helps conceptualize the client's presentation in mode terms and brings this awareness of modes into clinical work. Mode-aware clinical work (e.g., Rafaeli et al., 2014; Ryle & Fawkes, 2007; Stiles, 2006) aims to achieve better integration among modes through three broad processes: identifying and labeling individuals' notable or recurrent modes; giving voice to adaptive and vulnerable modes over maladaptive or introjected ones; and creating adaptive boundaries between modes in ways that alter the relative dominance or power of specific modes. These processes frequently involve psychoeducation about the universality of modes coupled with cognitive, behavioral, and experiential methods. Quite often, though, the best way to advance these processes is by implementing **the third element of our model – the idea that mode-aware clinical work calls for the flexible adoption of different *therapeutic stances* depending on the client's active mode.**

Explicit or implicit *therapeutic stances* are present in many clinical approaches, and function as general rules for how therapists using *that* particular approach should engage with their clients. Examples include using an open/accepting stance in acceptance and commitment therapy (e.g., O'Neill et al., 2019), engaging in collaborative empiricism in CBT (Tee & Kazantzis, 2011), maintaining neutrality in transference-focused therapy (e.g., Clarkin et al., 2021), experiencing and expressing empathy in self-psychology (e.g., Kohut, 1981/2010), etc.

Though each of these stances may have its merits, they are often contradictory (e.g., acceptance vs. change, neutrality vs. empathy); moreover, there's little reason to think that any one stance necessarily fits all clinical circumstances. Rather than adhering to a single therapeutic stance, therapists attentive to modes have the opportunity to address their clients differentially – i.e., to ask themselves the third cardinal question: *"what stance should I adopt in response to the client's current mode?"*

To illustrate this idea, we consider the recommendations made within schema therapy (e.g., Rafaeli et al., 2014) regarding the stances that would be most effective vis-à-vis

different categories of client modes (see Table 2). We use these schema therapy categories because we see them as striking a good balance between optimal distinctiveness (i.e., minimizing definitional overlap among modes) and parsimony (i.e., limiting the number of modes as much as possible); for more discussion on adjudicating the number and identity of modes or mode categories, see Lazarus and Rafaeli (2023).

Table 2

Mode Categories, Relevant Example Modes, and Suggested Therapeutic Stances

Mode Category	***Relevant Mode(s) in Schema Therapy***	***Suggested Therapeutic Stance***
Reflective and Self-compassionate Mode	Healthy Adult	*Joining* and mirroring this mode's behavior when it is present. *Modeling* such behavior when it needs strengthening.
Child Modes (i.e., basic emotional need states)	Distressed Mode, Vulnerable Child, Angry Child	Using *limited reparenting* to directly meet client emotional needs (e.g., appropriate nurturance, protection, limit-setting, encouragement, playful joining).
Maladaptive Coping Modes	Detached/Avoidant Protector, Hopeless Surrenderer, Perfectionistic Over-controller, etc.	Using the dialectic stance of *empathic confrontation* (empathy plus confrontation of maladaptive behaviors).
Dysfunctional Introjected Voices	Self-critic, Punitive Parent Mode, etc.	Using straightforward *confrontation* to make the voice ego-dystonic; Siding with the Healthy Adult against it; Providing *psychoeducation* in less severe instances.

Let's begin with the simplest stance, relevant to moments in which clients present with a strong, reflective ("Healthy Adult") mode. In such moments, therapists are free to employ various evidence-based tools (and possibly adopt therapeutic stances such as CBT's collaborative empiricism or ACT's openness and acceptance). In broader terms, the therapeutic stance can be thought of as *joining* and as *modeling* of adaptive problem solving.

In other moments, clients' activated modes clearly reflect basic emotional need states: *distress* of various sorts (which schema therapy refers to as the "Vulnerable Child"), *anger* over unmet needs ("Angry Child"), *impulsivity* ("Impulsive Child"), but also *contentment/play* ("Content/Happy Child"). Schema therapy's reference to these as "child

modes" is meant to evoke the idea that when clients (of whatever age) are in such modes, the most viable and appropriate response is often to try and meet the emotional needs directly – within the ethical boundaries of therapy – in ways that simulate a good-enough parent or attachment figure. Thus, activated modes marked by intense primary emotions occasion a therapeutic stance referred to as *limited reparenting*, which aims to address the client's hyper-arousal, help soothe them back into a window of tolerance (Ogden & Minton, 2000), and (ultimately) serve as a model for healthy self-care. Intriguing evidence in support of this idea comes from recent work (Fisher et al., 2023) showing that therapists' oxytocin responses (a marker of caregiving system activation) following genuine displays of client distress mediate the association between client negative emotion activation and symptomatic change.

Quite often, clients manifest maladaptive coping modes, in which they attempt – knowingly or not – to avoid the distress of unmet needs using coping behaviors (e.g., avoidance, over-compliance, over-compensation) and/or cognitions (e.g., detachment, surrender, self-aggrandizement). These may bring short-term relief, but come with a hefty long-term cost: coping modes impede both raw emotional need states (i.e., the Vulnerable Child mode which evokes limited reparenting) and healthy (i.e., reflective, compassionate) states that would permit real engagement. To address coping modes, ST calls for a third therapeutic stance, a dialectic balance of empathy and confrontation referred to as *empathic confrontation.* In this stance, therapists strive for *empathy* (or at least curiosity) for the need itself, for the distress that accompanies its frustration, and for the short-term relief brought about by the coping behaviors/cognitions; at the same time, they directly *confront* the specific behaviors or cognitions which are deemed maladaptive, and help clients develop healthier alternative behaviors/cognitions.

Finally, therapists may come face-to-face with clients' introjected voices (e.g., voices of parents, other significant others, peers, or the society at large) that are a root cause of distress. These include punitive, self-critical, neglectful, and self-denigrating voices, and they call for yet another stance: one in which the therapist sets limits or directly confronts the introjects to help clarify their ego-dystonic nature and thus weaken them.

The terminology and clinical guidelines above are drawn from schema therapy (e.g., Rafaeli et al., 2016), an approach documented by a growing body of research to offer effective treatment for a range of relatively complex and chronic conditions (e.g., Peeters et al., 2022; Zhang et al., 2023). Other mode-aware approaches may delineate the modes somewhat differently (e.g., Stiles, 2006) or offer somewhat different guidelines for choosing differential stances to address them (e.g., Fosha, 2000; Gilbert, 2019; Greenberg, 2004). Arbitrating which of these stances would work best remains an open empirical issue.

Conclusion. We presented a model of practice and training containing three elements, translated into the three cardinal questions: "What *unmet needs* are most prominent for this client and how could they be addressed?", "What *mode* is the client in right now?", and "What *stance* would work best to address this client's needs while in this

mode?". These elements distill integrative ideas from schema therapy (Rafaeli et al., 2010; Young et al., 2003), but we believe they are general enough to serve as a starting point for a unifying language for most, if not all, therapists – and for clients. Specifically, though cognitive-behavioral, emotion-focused, and psychodynamic therapists may quibble about the etiology of distress, the pros and cons of alleviating distress through direct intervention (i.e., meeting vs. frustrating needs), or the merits of adopting flexible therapeutic stances, they are less likely to find cause for disagreement regarding the existence – and importance – of the first two elements discussed: *needs* and *modes*.

Establishing a formulation based on needs and (when needed) on modes as an explicit starting point, and using intuitive and experience-near terms to share this formulation with one's client, empowers the client to have greater agency within their therapy. It also sets the stage for therapeutic work that harnesses contemporary understanding about both specific and common/nonspecific factors that exert beneficial therapeutic effects (see Hofmann & Barlow, 2014). Specifically, therapists attentive to the three elements described here are likely to be implementing transtheoretical "common factors" known to be conducive to therapeutic gains.

Consider the widely-studied common factor of therapeutic alliance, responsible for a substantial portion of therapy's benefits (e.g., Flückiger et al., 2018). Two strong (though understudied) predictors of alliance are responsiveness (Reis & Gable, 2015) and high-quality listening (Itzchakov et al., 2022). Both involve getting a clear picture of the client's real as well as perceived needs (Refoua & Rafaeli, 2023), and being attuned to their present "mode". Therapeutic alliance, and repair of ruptures in this alliance, require such responsiveness. Specifically, in addressing clients' core needs, a responsive therapist needs to identify whether, at the moment, they are mostly overwhelmed with pain/sadness/fear and can (at most) absorb some comfort (i.e., limited reparenting); too defended (detached, avoidant, compliant, argumentative, over-controlling, etc. – i.e., in a coping mode) to do any productive work and need to be coaxed away from these coping modes into more productive modes; truly toxic towards themselves (i.e., in an introjected negative mode) and need some limit-setting; or else are present, reflective, integrative, and self-compassionate enough (i.e., in a healthy adult mode) and thus able to work, shoulder-to-shoulder, towards their goals.

Interestingly, transtheoretical work on rupture resolution (e.g., Safran et al., 2011) touches on these three elements as well. In particular, it recognizes that different *needs* (e.g., for communion vs. agency) may underlie disagreements regarding tasks or goals, and/or deterioration in the therapeutic bond. Additionally, it adopts a similar "what to do when" approach, and thus calls for specific *stances* in response to different *states*. Interestingly, whereas rupture repair work focuses on alliance states and views them predominantly intersubjectively, our model allows for, but does not assume, such intersubjectivity.

Of course, as the reviewers of an earlier draft correctly noted, even if we as clinicians and supervisors converge on this universal starting point of needs, modes, and stances, many questions remain to be explored: What instruments or procedures should be used to assess these? Should interventions to address specific needs be selected primarily based on empirical evidence or guided by theoretical principles? Should these choices be made uniformly across all therapeutic schools, or should we expect variation in the selection process within these schools? And would prospective trainees be expected to develop expertise in all distinct first-line interventions and/or in all the approaches from which they are drawn?

Coda. The approach outlined here is decidedly integrative in several respects (Castonguay et al., 2015). It can serve as a *theoretically integrative* starting point; it adopts *technical eclecticism* in addressing specific needs (see Table 1); it speaks (as we've shown) to the issue of *common/nonspecific factors*; and it is general enough to provide those clinicians who choose to remain anchored in a primary orientation (be it CBT, experiential, dynamic, or systemic therapy) a roadmap for *assimilative integration* of concepts that may not be endemic to their approach, but are also not likely to be too foreign. After all, the elements presented here tend to be consistent with most people's (including clinicians') lay understanding of what distress is about (i.e., unmet needs) and of what phenomenology is about (i.e., "parts" or "selves" or "modes"). The model includes a healthy dose of therapist humility and is deliberately jargon-free. Consequently, it can help engage clients in collaboratively posing and answering the cardinal questions presented, developing a shared language for talking about their needs, goals, and modes, and ultimately reaching desired outcomes.

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Twitter Accounts: @ArlabBiu

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Mental Flexibility and Epistemic Trust Through Implicit Social Learning – A Meta-Model of Change Processes in Psychotherapy With Personality Disorders

Svenja Taubner[1], Carla Sharp[2,3]

[1] *Institut für Psychosoziale Prävention, Universitätsklinikum Heidelberg, Heidelberg, Gemany.* **[2]** *University of Houston, Houston, TX, USA.* **[3]** *University of the Free State, Bloemfontein, South Africa.*

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Corresponding Author: Svenja Taubner, Institut für Psychosoziale Prävention, Universitätsklinikum Heidelberg, Bergheimer Str. 54, 69115 Heidelberg, Germany. Tel.: 06221-56-4700. E-mail: Svenja.Taubner@med.uni-heidelberg.de

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Abstract

This position paper follows the call for transtheoretical meta-models of general clinical change by concentrating on severe mental illness such as Personality Disorders (PDs). We have identified a core process of change related to mental flexibility through implicit learning and propose recommendations for stance and technique that are informed by research on Mentalization-Based-Treatment (MBT) and the learning components as represented in the Mediational Intervention for Sensitizing Caregivers (MISC). While the idea of corrective emotional experience as a general change mechanism involves discriminating between an old and new relationship to update relationship knowledge, the capacity to understand and process corrective emotional experiences may be limited and even iatrogenic in patients with PDs. By integrating MBT and MISC, a meta-model of change is created that allows training in and observation of the granular-level, behaviorally anchored, actions taken by the therapist to open up social learning. Here, social learning is conceptualized as epistemic trust, increasing the client's reflective functioning during sessions to ultimately enhance cognitive flexibility outside the therapy room. This opens the possibility to implement and observe micro changes in what should be termed now implicit cognitive and emotional corrective experiences. Thus, we propose to shift towards implicit learning within professional relationships; that is, internalizing a new way of thinking about any life-event

that requires adaption thereby creating adaptive capacities via mental flexibility as the general change mechanism of Personality Disorder (PD) treatment.

Keywords

mentalization, mediated learning experiences, micro-process, corrective emotional experience, implicit learning

Highlights

- The paper provides a transtheoretical change mechanism for the treatment of Personality Disorders such as mental flexibility.
- Mediational learning experiences translate the model of corrective emotional experience in psychotherapy into a clearly defined process of implicit learning.
- Using the model of mental flexibility and mediated learning enables helping professions to establish new competences in managing helping relationships.
- For research on changes process, the model offers ways to investigate micro process in psychotherapy and helping professions.

The treatment of Personality Disorders (PDs) in the past two decades has been strongly influenced by three parallel developments. First, new expert treatment models have been established like Mentalization-Based Treatment (MBT) (Bateman et al., 2023), Dialectic Behavioral Treatment (DBT) (Linehan, 1993), Transference-Focused-Psychotherapy (TFP) (Kernberg et al., 2008) and Schema Therapy (ST) (Kellogg & Young, 2006) that by now are regarded as evidence-based (Storebø et al., 2020) and are commonly summarized as the "big 4" (Rameckers et al., 2021) bearing in mind that there are other effective treatments for PDs available. As stated in the respective treatment manuals, most of these treatments (MBT, DBT, ST, TFP) have integrated techniques from different therapeutic traditions (psychodynamic, cognitive-behavioral, humanistic and systemic) and have further expanded ideas about the developmental pathways of personality problems and how best to address them.

Second, because specialized treatments are often time- and resource-intensive, a need was identified to also establish effective therapy for PDs reflected in treatment protocols that address mental health problems related to impaired personality functioning (Hutsebaut et al., 2020). To this end, treatment approaches like Good Psychiatric Management (Choi-Kain & Sharp, 2021; Gunderson & Links, 2014) have identified the common features that make PD treatment work and have packaged these features in a generalist approach that can be used in clinical practice.

Third, in parallel to these developments, the new classification systems of DSM-5 and ICD-11 identified personality functioning as the common core of personality disorders, characterized by problems in self (identity and self-direction) and in interpersonal (empathy and intimacy) functioning. Interestingly, all "big 4" in the expert-treatments of PDs address personality functioning in general while privileging different facets of disturbed

personality functioning: TFP (identity), ST (self-representation) and DBT (self-direction) focus on the functioning of the self, MBT concentrates on self with others (empathy, and self-and other understanding). All approaches work on intimacy problems by offering a secure attachment with the therapist and by working with varying degrees of directiveness and with the therapeutic relationship; from a more coach-stance in DBT to interpreting transference (enactment of dysfunctional relationship expectations) in TFP. Despite these differences, none of the "big 4" appear to be superior to another in terms of treatment effectiveness (Storebø et al., 2020). However, they have rarely been compared directly to each other and empirical proof for the exact mechanisms of change associated with each approach remains largely unknown. However, this is true for all specific and common factors in psychotherapy (Cuijpers et al., 2019). Furthermore, recent reviews on change mechanisms has revealed the non-specificity of change mechanism so that they are neither treatment-, nor disorder-specific. (Lemmens et al., 2016; Taubner et al., 2023). Strikingly, there is almost no agreement in the research field which mediators should be assessed and which measures should be used. Focusing on psychotherapy with adolescents, Taubner et al. (2023) identified 106 mediator RCTs using 252 different mediator variables (grouped in cognitive, emotional, behavioral, family, therapy or peer-related domains) that were assessed with 181 different measures. For mechanisms of change in PD, Keefe and Derubeis (2019) evaluated changes in attachment-representations, mentalization, core beliefs and defense-mechanisms as potential mediators. Only changes in defense-mechanisms obtained enough empirical support to be regarded a mediator of change in PD treatment. In a recent systematic review on mediators of change in PD treatment, Volkert et al. (2021b) identified 22 RCTS in which the majority (k = 15) focused on the therapeutic alliance as the most important mechanism of change. However, inconclusive results were detected for specific mechanisms, e.g. change of schemas did not explain changes in symptoms whereas changes in mentalizing, defensive functioning and use of skills explained changes at least partially (Volkert et al., 2021a, 2021b). Furthermore, mentalization appears to be a general mechanism of change in psychotherapy – not limited to the treatment of PD – based on a systematic review that included 29 studies on this question (Luyten et al., 2024).

Against this background, recent treatment developments are characterized by more modular, personalized and integrative interventions in the general field of psychotherapy (Lutz et al., 2022) calling for meta-models of general clinical change (Eubanks & Goldfried, 2019). Meta-models of change can serve the purpose of overcoming conceptual inconsistencies in traditional psychotherapy traditions (Lutz et al., 2021). Meta-models of change also provide a framework to study transtheoretical change processes if a certain agreement can be reached in the field. This is consistent with the call from Lancet Psychiatry Commission to move the field of psychotherapy to the level of mechanisms, starting with conceptual clarity, followed by experimental methods to isolate mediator candidates that should be rigorously tested in isolated treatment interventions (Holmes

et al., 2018). Therefore, with this statement we will argue for a meta-model in the treatment of PDs (and psychopathology writ-large) that is transdiagnostic across PDs and transtheoretical across different therapeutic orientations. We have identified a core process of change related to mental flexibility through implicit social learning and will propose recommendations for stance and technique that are informed by research on MBT and the learning components as represented in the Mediational Intervention for Sensitizing Caregivers (MISC; Klein, 1996; Sharp & Marais, 2022; Sharp et al., 2020).

Evidence From Developmental Psychopathology

Conclusions from longitudinal research in developmental psychopathology (Caspi et al., 2014) and large clinical samples (Fonagy et al., 2017; Sharp et al., 2015) established the idea of a general p-factor in psychopathology, meaning that instead of focusing on distinct categorical sets of mental disorders, we can model mental problems on a shared continuum of severity. Although, the p-factor model has been challenged in the field (Watts et al., 2022), we agree with Caspi et al. (2024) that these concerns may be unwarranted. Moreover, Fonagy et al. (2017) among others suggested that psychopathology can be conceptualized by the degree of absence of resilience, drawing our attention away from symptoms towards protective resources and mental capabilities or skills that evolve during childhood and adolescence. As such, developmental psychopathology serves as a strong foundation for meta-models of change in psychotherapy that shifts attention from current presentation of mental problems to etiologies of mental disorders that embrace complexity within a transactional, developmental and culturally sensitive frame. To facilitate resilience as a new goal in psychotherapy means to also shift therapeutic goals from adjustment to a certain cultural norm or definition of mental health to a more open way of creating mental flexibility in individuals. Such flexibility is conditional not only for adaptation in adult role function as adolescents age into adulthood, but also in the pursuit of wellbeing, bearing in mind constantly changing socio-political circumstances and contexts. As such, mental (or cognitive) flexibility becomes that which reduces psychopathology while enhancing resilience. This has particular relevance for personality pathology which is characterized by rigid and maladaptive patterns of relating to self-and others and an inability to flexibly respond to the stochastic nature of interactions and relationships (Sharp & Bevington, 2022; Sharp et al., 2012).

Central to the capacity for the flexible response and adaptation to a constantly changing environment is the ability to learn. Learning takes place in all kinds of contexts (including psychotherapy), the first (and arguably the most potent) of which is within the serve-and-return with primary caregivers. It is within this context that the transmission of cultural knowledge first takes place. And it is within this context that epistemic trust is established in the child – that is, the notion that learning from others is worthwhile and in a person's best interest. Defined as "an individual's willingness to consider com-

munication conveying the knowledge from someone as trustworthy, generalizable and relevant to the self" (Fonagy et al., 2017, p. 766), epistemic trust develops in the context of secure attachment relationships (Harris & Corriveau, 2011). Through repeated exchanges with the caregiver, the infant or child learns that their caregiver is a trusted source of knowledge enabling learning about the self, others and the world. The mechanics of how this learning takes place is not explained by attachment theory, but rather cognitive developmental theory. Grounded in Vygotsky's (1978) theory of social learning, Feuerstein's (1979) theory of cognitive modifiability and Klein's (1996) extension thereof, the mechanics of learning rely on a set of prerequisites that allows the caregiver to create a mediated learning experience (MLE) for a child. Put differently, learning is enhanced when the environment or subjective experience of the child is intentionally, actively and non-intrusively mediated for the child. While intentionality is central to creating an MLE, the learning that takes place is implicit in the sense that the caregiver is not actively teaching; rather, shared knowledge that is relevant to the unique characteristics and experiences of the child develops within the serve-and-return between caregiver and child. Elsewhere we have argued that this implicit form of learning that takes place within the serve-and-return is essential for optimal learning – whether that learning takes place in the context of the caregiver-child interaction or the interaction between psychotherapist and client (Sharp et al., 2020) – a thesis that we further elaborate here.

Explicit Learning, Corrective Emotional Experiences and Micro-Process

Many psychotherapies use psychoeducation and explicitly link behavior with thoughts and feelings to create new knowledge and perspectives to change symptoms. Psychodynamic approaches, for example, aim for insight into one's wishes, anxieties and defenses to find better solutions for intra- and interpersonal conflicts and use the therapeutic relationship as a stage to observe and interpret these phenomena. Therefore, psychotherapy may use explicit learning by either teaching (e.g. psychoeducation, exercise, worksheets) or by explicitly interpreting ways of behaving in relationships (e.g. transference interpretations). In contrast to specific techniques, the contextual model of psychotherapy has emphasized the role of common factors to explain variance in outcome such as therapeutic alliance, empathy, responsiveness, repairing ruptures, etc. (Norcross & Lambert, 2011; Wampold, 2015). However, the general meta-models of change as proposed by Grawe (1997) as well as Orlinsky and Howard (1987) remained too descriptive or not explaining the actual change process thereby still leaving unresolved the question as to what micro-processes between patient and therapist happen within and from session to session. Following the convincing evidence about the impact of common factors, instead of explicit learning via psychoeducation and insight, we propose to consider implicit learning with the therapist as the starting-point to understand psychotherapeutic impact.

Opposed to more instructional, interpretative learning or skill-based learning, implicit change involves the facilitation of a schema for reflection, a move from content (what) to process (how). Implicit learning serves to create a mental capacity to learn how to resolve any life challenge in the future and thus leads to autonomy, agency and independence from teachers, experts and therapists to discover own solutions.

Therefore, in contrast to classic change models of explicit learning, this approach suggests implicit learning as groundwork to create new resources to adapt to life challenges. Alexander and French (1946) described the development of the psychodynamic technique from cathartic hypnosis, suggestion, free association to unlock the unconscious, working through transference neurosis until the emotional reeducation which can be seen as a meta-model of common factors and implicit learning. The authors emphasized that the classic psychoanalytic technique is to stress the repetition of the old conflict in the therapeutic relationship and to emphasize the similarity of the old conflict situation to the current transference situation. The therapeutic significance of the differences between the original conflict situation and the present therapeutic situation is often overlooked. However, it is in this difference that the value of the therapeutic procedure lies. Because the therapist's stance and role are different from that of the caregiving person of the past, the patient is given the opportunity to face again and again, under more favorable circumstances, those emotional situations which were formerly unbearable and to deal with them in a manner different from the old (Alexander & French, 1946). This idea of discriminating between the old and the new relationship to update relationship knowledge, create more mental flexibility and leave behind rigid maladaptive relationship patterns has been further developed in the control-mastery theory (Silberschatz, 2005) discriminative exercises (McCullough, 2000), limited reparenting (Kellogg & Young, 2006) and the plan-based therapeutic relationship (Caspar & Goldfried, 2018). However, the capacity to understand and process corrective emotional experiences may be limited in patients with PDs (Fonagy & Luyten, 2009). In PD treatment, clinicians are faced with a patient that appears unwilling or unable to learn from new relationships and also from the therapeutic relationship as negative expectations and low reflective functioning hinder the perception and internalization of new experiences. Furthermore, mistrust in interpersonally transmitted knowledge is highly prevalent (termed as epistemic hypervigilance). Some patients with PD may also over-identify with the therapist and the method, bearing the risk of pretend mode and credulity which does not generalize to other relationships outside the consulting room as they simply adjust to or idealize the therapist. In this case, therapists may be perceived as the better or ideal parent which can lead to further alienation within families, loyalty conflicts, devaluation of parents, parent blaming as well as a dependency on the therapist. Here, we propose that mistrust, credulity and low mentalizing within corrective emotional experiences can be helpfully addressed by using interventions and stance that rely on implicit learning such as MBT and MISC.

Lessons Learned From MBT

Mentalization-based treatment has reconsidered the role of insight and transference in the therapeutic work with PD patients as their vulnerability in mentalizing is often triggered by the therapeutic relationship itself via attachment anxieties. Thus, the two main functions of psychotherapy, getting support and having new perspectives by a helpful professional, are severely limited in PDs. Furthermore, epistemic trust is compromised for the same reason that mentalizing and attachment fail to be a resource, based on real or perceived histories of abuse and neglect in patients with PD. To facilitate mentalizing and epistemic trust, the MBT therapist adheres to a strict not-knowing stance and adjust all interventions to the current level of the ability to reflect upon self and others. Mentalization which is related to mental flexibility is trained within the therapeutic relationship starting from mental exploration, clarification and challenging beliefs while sensitively keeping an eye on anxiety and arousal levels. If the anxiety/arousal increases, the MBT-therapist is asked to switch strategies from prompting mentalizing to supportive co-regulation and kick-starting mentalizing again by stop-and-rewind techniques as well as specific interventions for specific pre-mentalizing modes of thinking.

Mentalizing the relationship with the client is seen as a key component especially when the so-called "elephant in the room" is addressed – that is, affects in relation to the current session and the therapist. In contrast to classic psychodynamic therapies, the therapist engages in the "real" felt relationship with the patient instead of concentrating on the transference, i.e. the relationship as repetition of former relationships and tries to stay close to the patient's current representation of the self (trying to see the world through their eyes). In so doing, the therapist discloses their own thoughts and feelings if this is helpful. In so doing, the patient learns new or other perspectives on relationships and perception of self and others, making explicit what normally stays hidden. As such, the MBT therapist models effective mentalizing and engages with curiosity and interest in the current, real therapeutic relationship with the patient, i.e. owning and actively repairing all misunderstandings, conflicts and lapses in empathy (maybe enactments) that are typical for real (authentic) relationships. All in all, this way of relating and intervening is thought to train the "mentalizing-muscle" instead of reaching a certain insight into motivations for feelings, and thus serves a more implicit corrective emotional experience. The therapeutic goal is indeed to help patients learn to mentalize effectively through implicit learning instead of mentalizing *for* them, e.g. explaining behavior to them (which would be explicit learning). However, as MBT-training is mainly acquired through experts during supervision, it was recently criticized for being too abstract, too complex and not fine-grained enough in the planning (or evaluation) of minute-by-minute interventions or micro-processes. Furthermore, sensitizing therapists to the implicit learning potential of the MBT-interactions may lead to an even stronger impact and may help therapists to better navigate the micro-processes involved. Lastly, easier programs that enable changes in mental flexibility in patients and caregivers are needed to be

implemented for non-expert therapy in GPM models and for non-psychotherapeutic staff such as nurses, social workers as well as pedagogical (e.g. teachers) and early care professionals (Georg et al., 2022).

Lessons Learned From MISC

Sharp et al. (2020) proposed that the MISC offers the very minute-to-minute micro-processes that culminate in social learning, and by extension, results in the recipient feeling mentalized. The starting point for the development of MISC was Klein's (1996, 2001) observation that, notwithstanding significant differences between cultures, flexibility of mind and the capacity to learn from experience are evident in all cultures. Klein identified the caregiver as pivotal in creating a predisposition for learning in taking on the role of the "mediator" who is responsible for the transmission of cultural knowledge (Klein, 1996, 2001; Klein & Rye, 2004). To create a mediated learning experience (MLE), an interaction must be intentional and reciprocal, must transcend the satisfaction of an immediate need, and must focus on conveying meaning, matching it to the child's responses.

The overlap with the concept of mentalizing is clear; however, MISC extends the concept of mentalizing by describing concrete, behaviorally operationalized emotional and cognitive (learning/mediational) components that helps the caregiver take an inquiring and curious not-knowing stance slowing down the interaction to ensure mutual understanding and learning. As displayed in Figure 1 (the MISC tree), the emotional components of the MISC are the roots of facilitating learning in others. These components are already part of the relational basis of all psychotherapies and include eye contact, smiles, vocalization, touch, physical closeness, turn-taking, sharing of joy, expression of positive affect, synchrony, length of communication chains, and excitement expressed toward things, people and experiences in the environment. However, the emotional components are necessary, but not sufficient, for learning to take place. For learning to take place, cognitive components (also referred to as learning or mediational components) are necessary. These form the trunk of the MISC tree (Figure 1). Here we describe the five mediational (learning/cognitive) components while providing examples of how they would be applied in psychotherapy: *Focusing:* An act or sequence of acts that is directed toward gaining the client's full attention ("Wait… let's pause for a minute – this seems really important"). Through focusing, the therapist is communicating intention to teach. (2) *Providing/requesting meaning):* The therapist names, describes, and gives meaning (without interpretation) to the client's experience ("I see you are upset"). Here, affect is important to convey additional meaning ("Wow… this is tough…. he said that he wants to leave you?". (3) *Expanding (Transcendence):* A therapist's behavior directed toward broadening of the client's cognitive awareness extending the client's understanding of what is in front of him/her by explaining, clarifying, comparing, or adding new experiences

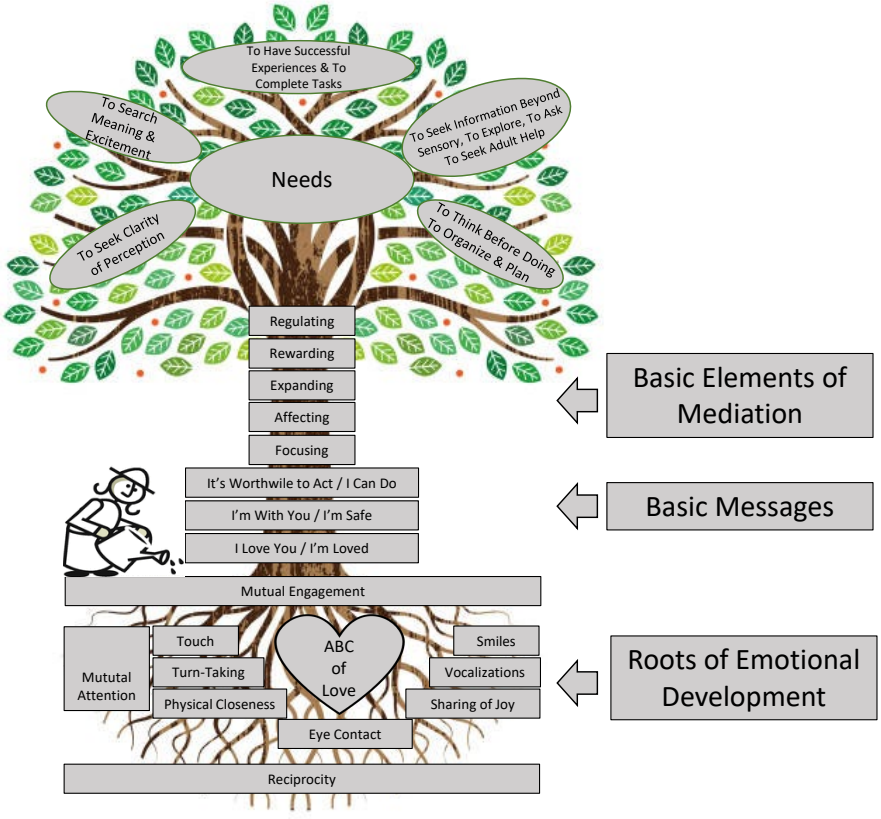
that go beyond the immediate content ("Can we just pause for a moment to unpack this a bit… it sounds very much to me like a conversation we had two weeks ago… can you remember?"). (4) *Rewarding (mediated feelings of competence with explanation)*: Any verbal or nonverbal behavior of the therapist that identifies specific components of the client's behavior that the therapist considers successful ("You did very well in slowing down so we could talk about this in more detail….it helped me a lot to understand you better"). (5) *Regulating behavior (helping the client to plan before acting).* The therapist brings to the client's awareness the possibility of "thinking" before doing, of planning steps of behavior toward attaining a goal by modelling, demonstrating, or scheduling events in time and space, thereby regulating the pace and reducing the client's impulsiveness in perception, elaboration, and expression (e.g. "This is a very difficult topic to bring up with your mom… let's first think together about how that might work out? What would be a good situation to set this up?"). As evident in the examples, the therapist is not explicitly teaching the MISC components but instead use them to slow down the interaction in service of mutual understanding. Over time, these processes are internalized and applied outside of the therapy room.

Evident in Figure 1 are also the leaves of the MISC tree. These are the outcomes for a person who was fortunate enough to experience emotional and cognitive components applied by someone interested in their wellbeing. If applied, the MISC roots and trunk stimulate an individual's needs system – the need to seek clarity of perception, to search for meaning and excitement, to have successful experiences and complete tasks, to seek information and to think before doing – in short, agency. These too are the outcomes that we want for our clients in psychotherapy. Whereas the therapist's role is to mediate the subjective experience for the client at the start of therapy, the end goal is for the client to foster that reflective capacity herself enabling her agency, independence and empowerment.

In summary, the MISC components represent the granular-level, behaviorally anchored, and therefore observable actions taken by the therapist to open up the epistemic highway, flexing the client's reflective mentalizing muscles during sessions to ultimately enhance cognitive flexibility outside the therapy room. These components can be coded frame-by-frame and moment-by-moment using the Observing Mediational Interaction tool (OMI; Kerr et al., 2023; Klein, 1996), thereby operationalizing the mechanisms of change in any psychotherapy assuming that we are correct in our thesis that learning and cognitive flexibility are inherent to all effective psychotherapy. Because MISC's evidence base is grounded in work with laypersons as MISC trainers (e.g. Bass et al., 2017; Boivin et al., 2013a, 2013b; Boivin et al., 2017; Sharp et al., 2022), its components can be learnt by paraprofessionals in healthcare thereby providing a much more scalable option to track, evaluate and teach this core and common feature of psychotherapy.

Figure 1

The MISC Tree



Note. © Paina S. Klein, full copy right was granted for Carla Sharp to use this figure.

Future Outline: Fusion of MBT and MISC

To include MISC in therapeutic processes, professionals would need to be sensitized to the emotional and cognitive components of the MISC first and learn to observe and understand their micro-interactions with their clients through video-feedback of their own sessions. The emotional components of the MISC (warmth, smiling, eye contact, synchrony, turn-taking, empathy, sharing happiness, etc.) are well in line with common factors in psychotherapy but go beyond some professional attitudes of abstinence or distance. However, in the treatment of PD emotional components alone are not strong enough to overcome epistemic mistrust. To open the gate to social learning, the client must feel understood and it is in the slowing down of the interaction through application

of the mediational (cognitive/learning) components that the therapist signals a strong desire to understand the client. As explained elsewhere (Sharp et al., 2020) the mediational components powerfully cue to the recipient an interest in his/her mind, establishing a "royal road" to the formation of epistemic trust, because they necessarily involve recognition of the recipient's subjectivity and agency, and signal an interest in collaboration and cooperation. A strong interest in the client's mind is communicated, while giving generous access to the therapist's mind—marking the availability of the therapist's mind for the client's learning, as well as the investment and interest of the therapist's mind in the client. These components may be especially useful in high emotional interactions where therapist mentalizing shuts down, as they help to structure the interaction giving the therapist time to recover their own mentalizing. MBT is already in line with many ideas from MISC in its outline and has differentiated more clearly, as described above, that mentalizing the partner in an implicit learning interaction is the fundamental ingredient to have a sensitive teaching moment. As such, the stance of not-knowing the exact mental states of the other, being mindful of the "teacher's" own mentalizing and staying curious without interpreting, needs to be added to the MISC intervention. Bringing both approaches together opens the possibility to implement and observe micro changes in what should be termed now implicit cognitive and emotional corrective experiences. With all modesty, we try to argue that the here outlined implicit mediated learning in the social context of a professional relationship between therapist and patient has indeed been the core change mechanism of corrective emotional experiences. However, in former descriptions of corrective emotional experiences in psychotherapy, explicit naming of and insight in differences between now and then have been the focus of elaborating this mechanism of change. Thus, we propose to shift attention and understanding towards implicit learning within professional relationships, meaning internalizing a new way of thinking about any life-event that requires adaption and thus creating adaptive capacities via mental flexibility as the general change mechanism of PD treatment in any therapeutic setting that should be investigated in the future.

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Psychological Clinical Science: Meeting the Challenge of Public Mental Health

Richard J. McNally [1]

[1] *Department of Psychology, Harvard University, Cambridge, MA, USA.*

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Corresponding Author: Richard J. McNally, Department of Psychology, Harvard University, 1230 William James Hall, 33 Kirkland Street, Cambridge, MA 02138 USA. Tel.: 1+(617) 495-3853. E-mail: rjm@wjh.harvard.edu

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Abstract

The purpose of this article is to provide a brief overview of how clinical psychology evolved in the United States as a prelude to discussing the emergence of psychological clinical science in the closing years of the 20th century. Despite the growth of clinical psychology, mental disorders remain highly prevalent, compelling us to envision new ways to deliver services in an effective but efficient manner. Topics include the dissemination gap, the affordable access gap, and the Psychological Clinical Science Accreditation System (PCSAS). Examples of novel methods for addressing the problem of public mental health in the 21st century are discussed. Finally, I close by considering the potential relevance of our experience in America for European clinical psychology.

Keywords

clinical science, Psychological Clinical Science Accreditation System, PCSAS, public mental health

Highlights

- The history of clinical psychology in America is traced.
- The clinical science movement emerged from struggles with the APA's accreditation system.
- The development of the Psychological Clinical Science Accreditation System (PCSAS) is described.
- Can the clinical science model flourish in Europe?

The Origins of Clinical Psychology in America

The founder of experimental psychology, Wilhelm Wundt, was an immensely productive man. He was the author or co-author of 503 publications (Simonton, 2002, p. 37) and the supervisor of 186 Ph.D. dissertations, including those of 16 Americans who had traveled to the University of Leipzig to study under his direction (Benjamin et al., 1992). One of these students, Lightner Witmer, coined the term *clinical psychology* (Witmer, 1907/1996). Like many of Wundt's American students, Witmer was eager to apply the new science of psychology to practical problems. Upon his return from Germany, he established the first psychological clinic in 1896. Based at the University of Pennsylvania, the clinic aimed to help children who were struggling in school, had difficulties with attention or memory, or who exhibited disruptive behavior. Witmer and his assistants worked closely with physicians, social workers, and schoolteachers (Witmer, 1909).

Meanwhile, three faculty members in the precursor to Harvard University's Department of Psychology – William James, Morton Prince, and Hugo Münsterberg – were engaging in psychotherapy, often involving hypnosis, to treat adult patients with psychoneuroses (Taylor, 2000). Each of them had an M.D. and Münsterberg also had a Ph.D. earned under Wundt's mentorship. However, President Charles Eliot of Harvard advised Münsterberg to cease "the hypnotic treatment of women" after one of Münsterberg's patients smuggled a pistol into a therapy session and threatened to shoot him, causing a bit of a scandal.[1]

Despite these early beginnings, psychotherapy was not the main role for clinical psychologists during the first half of the 20th century (Benjamin, 2005). Indeed, psychiatrists treated patients with psychosis, and neurologists, such as Freud in Austria and Münsterberg in the United States, treated patients with neuroses. Although some self-described clinical psychologists began practicing psychotherapy, physicians vigorously and effectively opposed them, claiming that psychotherapy was solely the province of medicine. The upshot was that clinical psychologists were largely confined to developing, administering, and interpreting what another American mentee of Wundt, James

1) I thank Ludy T. Benjamin, Jr. for providing me with a copy of President Eliot's letter to Professor Münsterberg, dated April 30, 1909.

McKeen Cattell, called *mental tests.* Tests of cognitive ability, personality, and psychopathology (e.g., Minnesota Multiphasic Personality Inventory) figured prominently in the careers of clinical psychologists who often worked closely with educators, the military, and psychiatry.

The Golden Age of Clinical Psychology

World War II changed everything. Despite psychiatric screening of military inductees designed to eliminate the psychologically vulnerable, psychiatric battle casualties were very common and some never recovered. Approximately 60% of the men receiving medical treatment from the Veterans Administration (VA) in the late 1940s were suffering from the psychiatric consequences of warfare (Levenson, 2017). There were far too few psychiatrists to treat the tsunami of cases, and so the VA asked the American Psychological Association (APA) to establish a formal curriculum to train clinical psychologists capable of delivering psychotherapy to troubled veterans. Leaders of the field convened at the University of Colorado and formulated an educational and training curriculum known as the Boulder or scientist-practitioner model of clinical psychology (Committee on Training in Clinical Psychology of the American Psychological Association, 1947). Clinical psychologists were to be hybrids. They conducted research worthy of the scholarly Ph.D. and they received clinical training, including an internship, thereby qualifying them to join psychiatrists as psychotherapists.

In the late 1940s, the APA assumed the responsibility of evaluating clinical psychology Ph.D. programs and giving its stamp of approval for those that met its accreditation criteria. The federal government poured vast amounts of money into the VA and university departments of psychology to support the training of clinical psychologists. The number of accredited clinical psychology programs grew, and graduates joined the ranks of VA practitioners, others became professors, and very many others commenced lucrative careers in the private practice of psychotherapy. In the United States today, 44.7% of clinical psychologists are in private practice, 17% practice in hospitals, and 11% work in universities.

The profession of clinical psychology grew immensely in the following decades, but so did dissatisfaction with the APA's scientist-practitioner model. A group of 14 prominent practitioners who called themselves "the Dirty Dozen" transformed clinical psychology in America (Wright & Cummings, 2001). The reference to dirt in their self-applied moniker denotes their willingness to engage in political lobbying on behalf of their profession as well as "all sorts of psychologically unseemly acts" (Wright, 2001, p. 2). They wrote a revelatory book describing how they gained control over the APA and used it as a vehicle for "professionalizing" clinical psychology. Their volume is a self-congratulatory tale of triumph over both psychiatry and over the science-oriented, academic clinical psychologists whose attitudes regarding practice, they argued, ranged

from benign neglect to hostile contempt. The Dirty Dozen believed programs accredited by APA were biased toward research at the expense of preparing graduates for clinical practice – the chief career goal for most graduates. Utterly clueless about the intensely competitive healthcare marketplace, academic clinicians, they said, were wholly inept at lobbying Congress in defense of the professional and economic interests of clinical psychologists in private practice who were struggling to compete against social workers and psychiatrists for healthcare dollars in the 1980s as managed care in the health insurance industry began to curb reimbursement for mental health.

The politically astute Dirty Dozen and their allies in private practice secured control of state psychological associations and eventually the power structure of APA itself. Four of them were elected president of APA: Theodore H. Blau in 1977, Nicholas A. Cummings in 1979, Max Siegel in 1983, and Jack G. Wiggins in 1992. Among their achievements was ensuring that clinical psychologists could obtain acceptable reimbursement for their services from insurance companies governed by managed care.

Rejecting the scientist/practitioner model, some Dirty Dozen members established proprietary professional schools of clinical psychology awarding the Doctor of Psychology degree (i.e., the Psy.D.) which does not require a research-based dissertation. Following a conference held in Vail, Colorado in 1973, their practitioner-scholar model of clinical training was recognized by the APA as an accreditation-eligible approach to clinical training.

Yet there are ironies to the Dirty Dozen's approach to professionalizing clinical psychology (McNally, 2003). In the early 20th century, physicians professionalized medicine by *strengthening* the connection between practice and science (Starr, 1982, pp. 112-127), whereas the Dirty Dozen strive to do the opposite. Unfortunately, their gambit will likely undermine the professional status of our field. As sociologists emphasize (e.g., Freidson, 2001, pp. 152-176), a profession must possess epistemic authority to survive. Practitioners acquire prestige when they possess specialized knowledge and expertise unavailable to those outside the profession. A clinical psychology increasingly divorced from science will cease to command the allegiance of clients, Congress, or society at large.

Moreover, as medicine professionalized by bolstering its scientific base in the early 20th century, many free-standing proprietary medical schools vanished (Starr, 1982, p. 118). They folded because they lacked funds for laboratories, libraries, and the technology that were available to university-based medical schools, such as those at Johns Hopkins and Harvard. Ironically, members of the Dirty Dozen have been among the most enthusiastic supporters of proprietary professional schools.

The Emergence of Clinical Science

The Dirty Dozen repudiated the scientist-practitioner model because they believed that it overemphasized often-irrelevant science at the expense of training for a successful career

in the private practice of psychotherapy. Yet another group of clinical psychologists were also dissatisfied with the model, but for precisely the opposite reason. Their views were canonically captured in McFall's (1991) essay, "Manifesto for a Science of Clinical Psychology" (See also, McFall, 2000). McFall argued that the scientist-practitioner model implied that a clinical psychologist can be either a scientist or a practitioner, thereby suggesting that scientific reasoning, empirical principles, and evidence-based assessment and treatment are not necessarily relevant for a practitioner of psychotherapy. He argued that the Ph.D. first and foremost confirms the psychologist as a scientist regardless of whether he or she works in a lab or in a clinic.

McFall emphasized that scientific clinical psychology is – or should be – the *only* clinical psychology. Just as patients rightly expect that their cardiologists, oncologists, and internists will always base their practice on the best available science, patients of clinical psychologists have every right to expect the same. Unfortunately, in the years since McFall's manifesto, our field has remained cluttered with popular interventions whose efficacy remains empirically untested (e.g., Bessel van der Kolk's 'the body keeps the score' approach to treating trauma; McNally, 2023); tested, but ineffective (e.g., psychological debriefing for trauma; McNally et al., 2003); or downright harmful (For a review, see Lilienfeld, 2007).

McFall's call to arms resonated with many Directors of Clinical Training (DCTs) of the scientifically strongest clinical psychology Ph.D. programs and clinical internship programs, resulting in the founding of the Academy of Psychological Clinical Science in 1994 (Benjamin, 2005). Academy members struggled within APA to strengthen the role of science in the training of psychotherapists and managed to convince APA to recognize the *clinical science* as the third accreditable training model. As of this writing, the APA has accredited 108 Psy.D. and 256 Ph.D. programs in clinical psychology, and 68 of these Ph.D. programs are members of the Academy of Psychological Clinical Science. Hence, of the three models of training – scientist-practitioner, practitioner-scholar, and clinical scientist – clinical scientist programs are in the minority.

Continued frustration with the APA accreditation system motivated the Academy to development an alternative, science-based clinical psychology accreditation system to rival that of the APA. A vote of Academy members overwhelmingly supported and authorized this system in 2007, named the Psychological Clinical Science Accreditation System (PCSAS). The founding Executive Director was Richard M. McFall.

The goal of PCSAS is to foster excellent, science-centered education and training in university programs granting the Ph.D. in clinical psychology and to advance the knowledge base for disseminating and delivering the safest, most cost-effective psychological health services to the public. Note that *clinical science* is transtheoretical. Although many programs favor a cognitive-behavioral approach to training and treatment, such an orientation is independent of the empirical, sciened-based focus of PCSAS.

Also, diverse meta-theoretical perspectives are compatible with the clinical science approach including categorical diagnostic (e.g., American Psychiatric Association, 2013; Haeffel et al., 2022), dimensional (e.g., Kotov et al., 2017; Kotov et al., 2021), and network analytic (e.g., Borsboom, 2017; McNally, 2021) ones. Hence, the guiding questions regarding an intervention are: "Does it work?" and if so, "How do we know?"

One major difference between APA and PCSAS accreditation procedures concerns input versus output. That is, the APA has a checklist of course and content coverage essential for accreditation, whereas PCSAS emphasizes the *outcomes* of training. Are graduates of clinical science programs functioning as clinical scientists? For example, the criteria for classifying a graduate as functioning as a *clinical scientist* in the Department of Psychology at Harvard University is as follows:

1. The graduate of our clinical science program is generating new knowledge via research. Evidence of this may be employment as a postdoctoral fellow, faculty member at a college or university, or scientist at a research facility or hospital affiliated with a medical school.
2. Their position involves the widespread dissemination of clinical science research. This may be accomplished through scholarly publications, conference presentations, teaching of clinical science related courses, or research supervision. Any publications are expected to go beyond work done solely in graduate school.
3. Leadership role in a clinical setting involving program development, new initiatives in training or assessment, or public policy work where the graduate is clearly using clinical science skills. Simple application of evidence-based assessment and treatment in a clinical setting (e.g., a VA) is not sufficient.

For accreditation, PCSAS requires that at least 50% of a program's graduates qualify as clinical scientists.

As of this writing, PCSAS has accredited 46 Ph.D. programs in clinical psychology at universities in the United States and Canada. These are among the finest programs. *U.S. News & World Report* ranks the top clinical psychology programs in America, and 40 of the top 50 programs are accredited by PCSAS as are all 20 of the top-ranked programs.

The Challenge of Public Mental Health

The Academy sponsored the *Summit on Clinical Science Training* at Washington University in St. Louis on May 4-5, 2023. The purpose was to address pressing issues concerning our field. Most participants were DCTs or representatives of other relevant stakeholders (e.g., National Institute of Mental Health). The videos of the major talks and summaries of the intensive breakout discussion groups are now available online as are the lists of participants for each of these groups.[2]

The Summit covered a range of topics including how best to select Ph.D. students for clinical science training, concerns about how to streamline course curricula, mentoring models, ensuring the mental health of our Ph.D. students[3], underrepresentation of racial minorities in clinical science,[4] and occupational opportunities for psychological clinical scientists outside academia (e.g., in government, in think tanks). Some of these issues have been thoughtfully discussed by Gee et al. (2022).

However, the chief challenge was how to improve public mental health. Despite the emergence of evidence-based treatment protocols for many common mental disorders (e.g., Barlow, 2021), epidemiologic data indicate that we failing to move the needle regarding their incidence and prevalence (Insel, 2022). Why?

One explanation is a failure of clinical scientists to disseminate treatments established as efficacious in randomized controlled trials (RCTs). The assumption is that clinical training programs, including clinical practicum and internship sites, are failing to teach these interventions to their clinical psychology trainees.

A related explanation is there is insufficient time for students to master all the evidence-based treatment programs that have been confirmed as efficacious in RCTs. David H. Barlow and his team have addressed this problem by developing and confirming the efficacy of their Unified Protocol for treating the often-comorbid syndromes of depression, panic disorder, and so forth (Barlow et al., 2017). This transdiagnostic approach targets problems that often co-occur in different disorders (e.g., avoidance behavior, emotion regulation problems), thereby obviating the need to master many disorder-specific, evidence-based treatment manuals.

Although the dissemination gap is surely a problem, there is also a treatment access gap, at least in the United States (McNally & McNally, 2016). Because practitioners who are expert in evidence-based psychotherapy possess a relatively rare set of skills, their services are in high demand. Accordingly, they can set their fees as a function of the market and need not accept insurance. Relatively affluent patients can afford to write

2) The videos summarizing the content of the Summit on Clinical Science Training can be viewed here: https://www.acadpsychclinicalscience.org/summitproceedings.html. The topics and members of the workgroups can be viewed here: https://drive.google.com/file/d/1_GZOpkqmL1iWhMczyRhw0-Ia7YJhCvmJ/view?usp=sharing.

3) My research group has devised a brief, scalable workshop for teaching emotion regulation skills to help Ph.D. students manage stress and counteract burnout, modified to accommodate the stressors characteristic of diverse departments (e.g., physics, economics, psychology, philosophy, etc.). Our pre-post data are favorable (Bernstein et al., 2021; Bernstein et al., 2023).

4) For the past several years, Harvard's Department of Psychology have offered a free, intensive weekend workshop delivered nationally via Zoom providing mentoring guidance for college students keen on obtaining a Ph.D. in psychology (including clinical science) at universities throughout the country. The enrollees are from throughout the United States, and are members of underrepresented minority groups, first-generation college students, and others who are unlikely to acquire the tacit knowledge about the educational and other experiences enabling applicants to gain admission to graduate school. Our aim is to level the playing field by transmitting key knowledge, which is readily available to upper-middle class undergraduates, to potential applicants who are otherwise unlikely to be acquainted with it. The link to our program is here: https://psychology.fas.harvard.edu/pprep

a check to pay for such expert care, but less affluent patients who rely on their health insurance are out of luck. This problem is less common in European countries with comprehensive health insurance coverage.

As Kazdin and Blase (2011) emphasized, the mental health needs in the United States far exceeds the capacity of clinical psychologists trained to deliver face-to-face interventions over the course of several months of weekly 50-minute sessions. The clinical psychologist David M. Clark and the behavioral economist Richard Layard joined forces to solve this problem in England. They developed a remarkable program entitled Improving Access to Psychological Therapies[5] (IAPT; Clark, 2018).

Clark and Layard lobbied Labor and the Tories, respectively, making the case that we now have evidenced-based CBT treatments that can ameliorate the suffering of people struggling with depression and anxiety disorders, enabling them to recover and rejoin the work force of productive English citizens. Moreover, Layard calculated, by enabling these patients to return to the workforce as tax-paying, productive citizens who no longer require financial support for psychiatric disability, the program would pay for itself.

By 2018, the senior clinical psychologists had trained over 10,500 new *nondoctoral* therapists to deliver CBT protocols for depression and anxiety disorders. Data were collected for each session to enable progress to be tracked. When frontline therapists encountered difficulties, senior doctoral clinicians were available to provide supervisory guidance. The IAPT program treats more than 560,000 patients per year, and about 50% recover and two-thirds of the remaining patients experience worthwhile progress. The data tracking and feedback mechanisms built into the computerized database enable fine-tuning of clinical practice. Indeed, the effectiveness of the therapeutic interventions has thereby improved over the years since the program was launched in 2008.

Clark and Layard's remarkable achievements were built on the preexisting National Health Service (NHS). In effect, they made the NHS both more effective and efficient by mandating evidence-based treatment and tracking progress via standardized systematic data collection. I suspect that Clark and Layard's counterparts in European countries with comprehensive national health coverage could replicate these positive results.

Unfortunately, it would be challenging to accomplish this throughout the United States without a nationwide healthcare system. However, Bradley C. Riemann, Ph.D., has established a conceptually similar program for treatment of OCD in Oconomowoc, Wisconsin at the nonprofit Rogers Behavioral Health System. Riemann, an expert in the behavioral treatment of OCD established inpatient and outpatient services for OCD 28 years ago, and then established an intensive training program for individuals with a B.A. or B.S degree in psychology to conduct intensive *in vivo* exposure and response prevention under the supervision of senior Ph.D. clinical psychologists. Frontline therapists

5) The program has been renamed the *NHS Talking Therapies for Anxiety and Depression*.

"shadow" expert clinicians conducting behavior therapy and must read a considerable amount of scientific literature on the psychopathology and treatment of OCD, including passing examinations on the material they must master. They, in effect, become highly expert in a narrow area of specialization. Like Clark and Layard, Riemann has a standard ongoing, computerized assessment of OCD, depression, and related symptoms.

Working with expert colleagues throughout the United States, Riemann has now established similar programs at 20 other hospital sites. Strikingly, these paraprofessional therapists for OCD are just as effective as Ph.D. clinicians who are expert in the behavioral treatment of OCD. The upshot is that the number of patients receiving state-of-the-art therapy has vastly increased. In a talk he gave in Paris at the International Convention of Psychological Science (Riemann, 2019), he presented data showing that the percentage of patients receiving intensive treatment increased by 168% and that was when he had established "only" eight additional program in addition to his original one in Wisconsin.

What are the prospects of others replicating Riemann's achievements elsewhere in America? The essential ingredients appear to be a nonprofit facility keen to offer disorder-specific, efficacious psychological therapy for a relatively common mental disorder (e.g., bulimia nervosa, panic disorder, non-melancholic major depression). When Riemann launched his program, there were only a handful of facilities in the country providing intensive exposure and response prevention for OCD despite its prevalence being much greater than most specialists surmised.

Another possibility for improving public mental health is expansion of training in Barlow's Unified Protocol. Given its wide applicability, it has the potential of transforming the practice of scientific clinical psychology, especially among "generalist" practitioners.

Barack Obama's Affordable Care Act ("Obamacare") was a significant step toward enhancing access to health services in the United States. Further advances, including those specific to mental health, will require considerable political efforts. Although some politicians regard spending on mental health as merely a cost, it is truly an investment in the future. Early detection and efficacious treatment of mental health problems saves money in the long run. Unfortunately, steps that successfully prevent disasters in the distant future seldom seize the attention of politicians preoccupied with the immediate future.

Conclusion

The most important question, especially for an author writing for *Clinical Psychology in Europe*, is how well favorable trends in America generalize to countries in Europe. I am grateful for two anonymous peer reviewers whose comments partly mitigated my ignorance of the European scene.

Clinical psychology Ph.D. programs in the USA integrate coursework, research, and clinical assessment and treatment practica within departmental clinics or in affiliated clinics (e.g., specialized practica in treating certain disorders in clinics at Harvard Medical School teaching hospitals). Ph.D. programs with a clinical science orientation confine practica to evidence-based sites as well as involve more research activity than do programs with a scientist-practitioner focus. Accredited full-time, 12-month clinical internships complete the requirements for the Ph.D. The best internship sites are those with a compatible clinical science orientation. The course load, the clinical work, and sheer amount of research and writing that students do in a clinical science program hones their time and task management skills, enabling then to flourish despite the heavy workload. The entire process including the internship takes about 6-7 years. Apparently, in some European countries, students complete a research-oriented Ph.D. and then apply to a diversity of clinical training sites to do receiving supervised clinical training in various schools of therapy.

I was surprised to learn how influential psychoanalytic psychotherapy remains in Italy and Germany as well as in France. Psychoanalysts and apparently humanistic psychotherapists vigorously oppose policies confining public spending to mental health services having a solid evidential basis. Moreover, I learned, that when clinical psychologists address the public through the media, they are usually psychoanalytic practitioners, and seldom clinical scientific ones. This is strikingly different from America where mainstream journalists from the *New York Times,* the *Washington Post*, the *Wall Street Journal*, *National Public Radio,* CNN, MSNBC, and other prestigious outlets almost invariably rely on clinical scientists for comment. Apparently, we have a much better chance of influencing public opinion than do many of our continental European counterparts. Alas, dissemination of "pseudoscientific" therapies abounds on social media (e.g., YouTube videos), and thus has a popular platform.

Another route to educating the public other than through the mainstream media is through public policy think tanks concerned with health care. This option was favorably discussed at the St. Louis *Summit on Clinical Science Training* as a career option for clinical scientists who do not plan to work in clinical or academic settings.

Clark and Layard's program in England is unquestionably the most important clinical science success story in public mental health. By making the case for evidence-based clinical psychology to both the political Left and political Right, they succeeded in gaining bipartisan support for incorporating clinical science into the NHS. The patchwork character of mental health services in the United States poses serious challenges to replicating the English program here. However, I suspect that the public health systems in European countries may be far more amenable of translating Clark and Layard's system to their respective nations especially as it is just as cost effective as it is efficacious.

In conclusion, clinical science has made major strides in developing treatments for mental disorders, established as efficacious by randomized controlled trials. Yet the need

for mental health services is immense. The challenges we face are daunting but are beginning to inspire innovative ways of reaching more people as never before. Ultimately, the prospects for progress are bright if we continue to base our efforts on the best science available.

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Scientific Update and Overview

Responding to Key Process Markers as a Focus of Psychotherapy Training and Practice

James F. Boswell[1], Michael J. Constantino[2], Averi N. Gaines[2], Ashleigh E. Smith[1]

[1] *Department of Psychology, University at Albany, State University of New York, Albany, NY, USA.* **[2]** *Department of Psychological and Brain Sciences, University of Massachusetts, Amherst, MA, USA.*

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Corresponding Author: James F. Boswell, University at Albany, State University of New York, 1400 Washington Avenue, Albany, NY 12222, USA. Phone: 518-442-3402. E-mail: jboswell@albany.edu

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Abstract

Historically, evidence-based psychotherapy training has favored the standardized application of discrete treatment packages, with key outcomes being the therapist's adherence to and competent delivery of theory-prescribed ingredients. However, this model often fails to align with the priorities and values of clinicians, and research casts doubt on the notion that a therapist's faithful application of treatment protocols is a valid index of clinical expertise. Considering this, training and practice models that emphasize evidence-based clinician flexibility and patient-centered tailoring of interventions are receiving increased attention. In this article, we outline one such model informed by the context-responsive psychotherapy integration (CRPI) framework. Consistent with CRPI principles, we describe several "if this/then try that" marker-response sequences that could become a centerpiece of a more nuanced, clinically representative, and evidence-based psychotherapy training paradigm. Finally, we offer several recommendations for future work on CRPI.

Keywords

psychotherapy training, therapist development, responsiveness, context-responsive psychotherapy integration, evidence-based practice

Highlights

- Psychotherapy training has traditionally valued therapist fidelity to narrow intervention packages over other facilitative therapy processes.
- Growing research supports that psychotherapy training and practice can be more effective if it is personalized to both the patient and provider with contextual and intentional responsivity.

Psychotherapy training, particularly in clinical psychology, has traditionally focused on the theory and application of discrete treatment models. For example, students in a given training program may be expected to complete coursework and supervised practica centered on empirically supported treatments (ESTs), such as cognitive behavioral therapy (CBT) or psychodynamic psychotherapy. Within the CBT tradition, in particular, clinical training has privileged the use of diagnosis-specific treatment protocols or manuals that outline a specific and structured sequence of interventions that, ostensibly, help standardize across patients the clinician actions presumed to be therapeutic. Yet, beyond the training context, the chasm between applied clinical science (which often touts using ESTs like CBT) and everyday clinical practice remains wide.

When clinical researchers lament this science-practice gap, discussions often focus on the perceived low rate at which therapists adopt EST manuals, or even when adopted, therapist variability in adhering to and competently delivering the theory-specific ingredients to their patients. At a basic level, the ability to skillfully apply what one is trained to do strikes us as an appropriate goal for clinical training and practice. However, when considering the psychotherapy research base, it is hard to ignore that greater therapist protocol adherence tends not to correlate with better patient outcomes (Southam-Gerow et al., 2021; Webb et al., 2010). Although there is more evidence to support a small competence-outcome correlation, this finding is far from consistent (Power et al., 2022).

Perhaps the null or mixed results for the adherence- and competence-outcome associations, respectively, are unsurprising when considering the methodological and clinical complexities. For example, despite each construct's inherent focus on theory-specific treatment actions, competence assessments often include more general therapist behaviors, such as rapport building, which are not necessarily tied to the unique treatment model being delivered. In addition, training therapists to become sustainably adherent and competent in the delivery of a multi-component treatment protocol has proven quite difficult (Frank et al., 2020). Even in controlled trials that involve intensive training and ongoing supervision, treatment adherence and competence can vary significantly among therapists (e.g., Imel et al., 2011). Thus, outside of controlled efficacy studies, adherence and competence levels among routine practicing therapists are predictably even more suspect. Finally, on a broader scale, psychotherapy training practices and trainee outcomes are not consistently linked with *patient* outcomes (Knox & Hill, 2021).

Although we are painting a sobering picture of prevailing training and clinical practices, alternative (or complementary) approaches exist and are receiving more attention (e.g., Boswell et al., 2020). In this article, we (a) introduce and briefly summarize one such approach that veers away from the goals of unwavering adherence to a theory-specific treatment package; (b) suggest potential training structures and activities to support the implementation of this more flexible and context-responsive approach; and (c) provide recommendations for future work in this area.

Responsive Clinical Practice and Training

It is important to acknowledge that even within the protocol-adherence approach to training and practice, the importance of flexibility and adaptability is arguably still recognized (Kendall & Frank, 2018; Wiltsey Stirman et al., 2017). Many theorists, researchers, and clinicians appreciate that a one-size-fits-all approach to psychotherapy is limited, and even treatments with the most research support have the potential to result in negative outcomes for certain patients or under certain circumstances (Castonguay et al., 2010). Notably, results from a meta-analysis of studies that directly compared manualized versus non-manualized treatments failed to find significant outcome differences (Truijens et al., 2019), which generally supports there being benefit to therapist plasticity and clinical improvisation. Moreover, studies have demonstrated the potentially detrimental effects of *rigidly* adhering to a treatment protocol (e.g., Castonguay et al., 1996), as well as the potential benefits of within-adherence *flexibility* (i.e., the natural integration of techniques from other approaches; Owen & Hilsenroth, 2014).

Another sign of the growing recognition of the importance of flexibility and adaptability can be found in transdiagnostic (e.g., Barlow et al., 2017) and modular (e.g., Weisz & Chorpita, 2012) treatments, which explicitly instruct therapists to select from a menu of potential strategies and sequence them in different ways, and for different durations, from patient to patient. In addition, approaches to integrating model-exogenous strategies into CBT have been proposed and tested (e.g., Constantino et al., 2008). Such approaches are consistent with the emerging evidence base and are likely to be more consistent with how therapists operate in routine practice (Weisz & Chorpita, 2012). However, the field has been slow to adopt coinciding training methods.

An underlying feature of evidence-informed flexibility and adaptation is the meta-competency of responsiveness (Castonguay et al., 2023). Such action involves responding appropriately to the clinical context, both at the start of treatment (e.g., selecting the most suitable initial intervention) and during sessions in key moments (e.g., when a patient feels micro-aggressed against; Constantino et al., 2023). For clinical training and practice, both pre- and within-treatment responsiveness imply an *if-then* decision-making scheme (e.g., if a patient presents with these characteristics, then begin treatment with this CBT module; if a patient views a CBT intervention as low in credibility, then

shift to a different CBT strategy or to a different therapy that has a more personally credible rationale). One training framework that privileges such if-then decision-making is *context-responsive psychotherapy integration* (CRPI; Constantino et al., 2013, 2023).

Context-Responsive Psychotherapy Integration

To guide clinical training and practice, CRPI supports the use of timely evidence-based strategies that can be employed in response to the identification of specific and commonly occurring treatment markers (Constantino et al., 2020, 2023). These markers can include patient characteristics and within-session processes, which sometimes call for "staying the course" (e.g., when a current strategy is mutually agreed upon and achieving the expected or intended impact) or doing something deliberate and possibly different when particular contexts that have established relevance for patient outcomes present themselves. Such contextual markers have been, and can continue to be, identified through research and systemic clinical observations. For example, some clinical scholars have identified the following notable candidate "if" markers that may indicate a need to "then" engage in a clinical departure (either temporarily or more permanently): alliance ruptures, low patient motivation or change ambivalence, diminished patient outcome expectation, missed cultural opportunities or missteps, and not-on-track signals from routine outcomes monitoring (ROM) (Constantino et al., 2013, 2020; Constantino, Goodwin, et al., 2021; Constantino et al., 2023).

Example Candidate Markers and Responses

Alliance Rupture-Repair

The quality of the therapeutic alliance is a well-recognized contributor to treatment outcome across different psychotherapies for various mental health concerns (Flückiger et al., 2018). Alliance ruptures reflect negative shifts in the patient-therapist bond or collaboration and are associated with maladaptive treatment processes and outcomes (Eubanks et al., 2018). Rupture markers are thought to typically fall into one or both of two categories: withdrawal or confrontation (both of which can be overt or covert). Thus, to be engaging in evidence-based practice beyond the aforementioned delivery of ESTs, therapists must be equipped to recognize potential rupture markers (*if*) and respond to them skillfully (*then*)—which may often require at least a temporary departure from the existing treatment plan (especially one that is not centered on interpersonal processes within the patient-therapist relationship). Theory and research point to some core resolution strategies, such as inviting patients to discuss potential problems in the relationship, exploring and validating patients' experience of the rupture, and taking at least partial responsibility for the rupture (Constantino et al., 2008; Eubanks et al., 2018). These strategies are core components of *alliance-focused training* (Eubanks-Carter et al.,

2015). Contrary to an earlier meta-analysis, Eubanks et al. (2018) did not find a statistically significant effect of rupture-resolution training on patient outcome. However, they examined theoretical model as a potential moderator of the training-outcome association and found that rupture-resolution training was associated with better patient outcomes in CBT-oriented treatments when compared to psychodynamic treatments.

Missed Cultural Opportunities or Missteps

Psychotherapy quality disparities exist for patients with underrepresented and historically marginalized sociocultural identities (e.g., race/ethnicity, sexual orientation, gender, economic, etc., McGuire & Miranda, 2008). Awareness of and responsiveness to such identities and associated contextual factors is part of evidence-based practice, yet research findings illuminate that patients often experience their therapist as missing the cultural or identity mark (Owen et al., 2016, 2018). Moreover, patients often view their therapist as engaging in potentially harmful behaviors and microaggressions (Hook et al., 2016). Consistent with the broader alliance rupture-repair literature, engaging in potentially harmful behavior (of omission or commission) in the absence of acknowledgment and steps to address it is worse for patient outcome than engaging in potentially harmful behavior and making an explicit attempt to address and correct it (Yeo & Torres-Harding, 2021). To help guide training and practice in making attempts to redress cultural missteps, the multicultural orientation framework outlines three transtheoretical and transdiagnostic therapist factors/actions: cultural comfort, cultural humility, and cultural opportunities (Davis et al., 2018). The latter stresses the ever-present importance of identifying (*if*) and responding to (*then*) cultural- and identity-relevant patient characteristics and communications in session. Such markers can be present when patients express a belief or value, discuss a role, or mention other personally relevant characteristics (e.g., family customs). Owen et al. (2016) found that patients who perceived a higher degree of missed cultural opportunities from their therapist also reported poorer treatment outcomes, yet this negative effect was attenuated when patients perceived the same therapist as possessing above average cultural humility. Though in need of further testing, personally tailoring treatment and responding to a patient's salient (and especially marginalized) sociocultural identities holds promise for better addressing long-standing quality disparities in mental health care.

Routine Outcomes Monitoring

As another framework for guiding evidence-informed training and practice, ROM involves routinely assessing patient progress using standardized tools, and then integrating the feedback from these assessments into treatment decision-making. There is convincing evidence that the integration of ROM feedback into routine psychotherapy enhances patient improvement relative to routine care without ROM feedback (de Jong et al., 2021). Procedurally, many of the controlled ROM feedback-outcome studies have

involved systems that alert a therapist when their patient is "not on track" (NOT) for an expected positive outcome based on predictive modeling. Notably, the magnitude of the ROM-feedback effect is further enhanced for these NOT cases. Thus, this negative outcome risk signal (*if*) can prompt the therapist to consider specific actions (*then*) to address the problem (e.g., learning that a patient has a recently diminished social support network) and get the psychotherapy back on track. Evidence indicates that a therapist's subsequent attention to potentially relevant factors for NOT cases, such as alliance quality, social determinants, and treatment intensity, further reduces the risk of a negative outcome (Barkham et al., 2023). In fact, the relevance of routine monitoring to aid clinical responsiveness extends beyond outcome scales, with some systems monitoring and providing valued feedback on process variables, such as the working alliance and motivation (e.g., Demir et al., 2022). A focus on such relevant *if-then* scenarios may require unique and complementary training methods. Next, we identify and briefly discuss potential training structures and activities to support CRPI implementation.

Training Activities

Although a comprehensive review of the CRPI framework and its implementation is beyond the scope of this article, we comment briefly on potential training structures and foci. Process research findings are the foundation of CRPI, including what is known about clinically relevant markers and the responsive clinical strategies that typically optimize outcomes. Taking alliance rupture-repair as an example, one must learn how to identify rupture markers and then repair them. We conceive of this *if-then* scenario as a potential training *module*. Psychotherapy courses and practica could be designed to cover a series of such modules (e.g., rupture identification and resolution training), which could be delivered in efficient doses that heighten their appeal to trainees. In addition, these training modules can be packaged in training videos for use by licensed professionals as part of continuing education. We now provide a few select examples of potential training activities.

Training on First-Step Responsiveness

Addressing this first form of responsiveness, one key task is for trainees to become at least conversational on key principles and strategies from as many theoretical models as possible (Constantino et al., 2023). This breadth of theoretical and practical knowledge will allow therapists to maximize their ability to flexibly offer personalized therapy directions that a *given patient* finds credible and inspiring (e.g., one patient may find behavioral notions of exposure personally compelling, whereas another may find credible the idea of exploring relationship patterns about which they may be currently unaware). As another key task, trainees should become humbly knowledgeable about their own

strengths and weaknesses (as grounded in patient outcomes data) in treating specific types of problem domains or using certain types of therapeutic interventions or processes. Doing so will both allow current personalization to the patient (by matching patients to therapists' current strengths; Constantino, Boswell, et al., 2021) and personalization to the therapist (by directing training efforts to fortify strengths and improve weaknesses; Coyne et al., 2022).

Training on Timely Departures in Response to In-Session Markers

Addressing this second form of responsiveness, one key task is for trainees to gain proficiency in marker identification. In addition to reading and hearing about markers, training therapists in process coding schemes is a complementary and potentially fruitful training activity that is receiving increased attention (Westra & Di Bartolomeo, in press). An example observational coding system is the Rupture Resolution Rating System (3RS; Eubanks et al., 2019), which identifies the presence of within-session alliance ruptures and therapist engagement in resolution strategies. The 3RS can help trainee-therapists learn how to identify rupture markers and their surrounding nuance, and demonstrate therapist resolution attempts, whether good, bad, or ugly. Viewing and discussing these behaviors is likely to be a useful training activity, yet it will ultimately need to be augmented to support its translation to trainees' own clinical practice. To facilitate this translation, deliberate practice methods provide an opportunity for trainees to engage in repeated practice and to receive more direct feedback regarding marker identification and responsive behavior (Rousmaniere, 2017). The responsive behavior component reflects the second key task in training on timely clinical departures. For example, trainees can both learn and practice pointed theory-driven strategies that have an empirically demonstrated greater likelihood of effectively addressing contextual markers (such as using motivational interviewing to address diminished motivation for change), rather than simply adhering to the original treatment course (e.g., Westra et al., 2016, 2021).

Recommendations and Future Directions

As the field reckons with growing evidence for therapist flexibility over strict model adherence, it stands to reason that research should place more weight on the therapist themselves and the benefit of their timely, in-the-moment interventions. It is notable that psychotherapy process research has uncovered more about potentially facilitative or hindering *patient* characteristics and behaviors than it has about *therapist* responses to these contexts (although see Ladmanová et al., 2022, for a qualitative meta-analysis of patient identified helpful events). For example, although therapist rupture repair, broadly conceived and measured, is associated with better outcome, we lack more precise empirical evidence supporting the effectiveness of specific resolution strategies for

specific types of alliance rupture. A similar absence of fine-grained if-then empirical evidence exists to guide responsiveness to ROM markers, although innovations such as the Trier Treatment Navigator (TTN; Lutz et al., 2019) have shown promise to advance both marker detection and intervention selection. Furthermore, any shifts in our training models will also need to account for therapist differences in using interventions to beneficial effect, including with "then" responses to identifiable "if" markers; that is, even if everyone learned to notice a key marker, we need to contend with the fact that no one responsiveness strategy is likely to be effective in the hands of *all* clinicians. This complexity necessitates another thread of future research to match clinician to responsiveness *options* in order to optimally address negative process.

Similar challenges can be found on the patient side. For example, in its fullest form, context-responsiveness is concerned with responding to both patient characteristics (e.g., initial treatment selection) and within-treatment markers (e.g., alliance ruptures). It would reinforce uniformity myths in psychotherapy to assume that a particular therapist response will be optimal for all patients with a particular pre-treatment characteristic or all instances of a particular within-session process marker. Accordingly, optimizing our training paradigm to align with the realities of real-world practice will require that psychotherapy process research continue to explicitly uncover a range of key contextual markers (for a precedent of such work, see Greenberg & Watson, 2006) and test the best ways therapists can respond to them.

In addition, there is both direct and indirect evidence that even clinically and empirically well-grounded training interventions can be associated with negative consequences in specific contexts (Castonguay et al., 2010). Furthermore, the universal trainability of process-acuity related skills, in particular, remains an open question. Individual differences among therapists present a key challenge to training implementation. Training methods, such as deliberate practice, emphasize the importance of tailoring the focus and difficulty of training to the individual (Rousmaniere, 2017), yet more research on deliberate practice implementation process and outcome is required.

The need for more research on training implementation process and outcome is not unique to deliberate practice and remains broadly relevant to pre- and post-graduate training in psychotherapy (Knox & Hill, 2021). Although the benefit of context-responsiveness integration has been demonstrated in multiple research studies (e.g., Constantino et al., 2008; Westra et al., 2016), the feasibility of implementing the CRPI framework in routine practice and training contexts remains an open question. As described at the beginning of this article, the prevailing training structures and philosophy represent potential barriers. However, frameworks such as the CRPI embrace the inherent complexity and nuance of psychotherapy. Although rather speculative, this acknowledgement of complexity may ring truer for therapists, and thus, predict greater openness to adoption. Moreover, CRPI may have inherent adoption appeal in that the use of focused, timely, and often temporary "then" responses, which can be integrated

into any foundational treatment being administered, does not require a clinician to dramatically change their professional identity—other than to include that they are an empirically responsive [insert treatment modality] clinician!

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Twitter Accounts: @JFBoswellPhD

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Scientific Update and Overview

A Process-Based Approach to Transtheoretical Clinical Research and Training

Stefan G. Hofmann[1], Steven C. Hayes[2]

[1] *Department of Psychology, Philipps-University of Marburg, Marburg, Germany.* **[2]** *Department of Psychology, University of Nevada, Reno, NV, USA.*

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Corresponding Author: Stefan G. Hofmann, Department of Psychology, Philipps-Universität Marburg, Schulstrasse 12, 35037 Marburg/Lahn, Germany. Tel. Germany: +49 (0)172 489 2245. E-mail: stefan.hofmann@uni-marburg.de

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Abstract

Background: The science and practice of psychopathology and psychological intervention of today is more like an island archipelago than it is a single land mass, and connections between different traditions are both limited and fraught with misunderstanding.

Method: Our analysis and solution to the problem is process-based therapy (PBT). PBT defines psychopathology as failed adaptation processes to a given context. Therapy involves adaptation through context-dependent or context-altering applications of biopsychosocial strategies that allows a goal to be met.

Results: This coherent approach to more transtheoretical and integrative concepts of clinical training and practice provides a firm foundation by targeting biopsychosocial processes of change, analyzing these processes using an idiographic complex network analytic approach, and organizing findings on the intellectual agora of multi-dimensional and multi-level evolutionary science.

Conclusion: PBT is a new empirical form of functional analysis, resulting in interventions and trainings that are built on elements or kernels of direct relevance to client's specific needs. In PBT, case formulation continues as long as treatment persists.

Keywords

psychopathology, psychotherapy, evolutionary science, adaptation, context, processes, dynamic networks

Highlights

- Clinical psychology and psychiatry are too syndrome focused.
- This limits the potential of the interventions.
- An idiographic, context-sensitive approach will resolve this impasse.
- Process-based therapy offers such an approach.

Most clinical concepts in wide use in psychotherapy have emerged from particular applied theoretical positions or technological approaches, linked to specific normative measures, and clusters of treatment methods. It is not unusual for these to be especially focused on particular disorders, populations, or treatment settings. Methods differ in the emphasis across dimensions of human experience: this method is more cognitive, that is more bodily focused, while another emphasizes social relationships. Training occurs by experts in these clusters, and entire training programs in major universities are often readily characterized in that way.

In effect, the science and practice of psychopathology and psychological intervention is more like an island archipelago than it is a single land mass, and connections between different traditions are both limited and fraught with misunderstanding. There has long been pressure and regular efforts to build a great sense of cooperation across these distinct theoretical and practical clusters, especially by practicing clinicians, but the barriers to doing so are considerable. Clinical researchers and treatment developers may give lip service to the importance of transtheoretical conversations, but the methods they develop and test are often distinctive as compared to others.

Over the last decade, however, a new focus and analytic approach has emerged that now has a growing record of fostering evidence-based transtheoretical and integrative concepts in psychotherapy research, and in clinical training and practice. This focus breaks down barriers between the various "schools" of psychological therapy, and provides a new and more functional approach to psychopathology and intervention concepts and methods. It promises to profoundly transform the future of scientifically based clinical training and practice.

We named this approach *Process-based Therapy* (PBT: Hayes & Hofmann, 2021; Hayes, Hofmann, & Ciarrochi, 2020; Hofmann & Hayes, 2019; Hofmann, Hayes, & Lorscheid, 2021). PCT is not a new therapy as such – it is a new vision of the central tasks that need to be accomplished by evidence-based intervention science. PBT has a characteristic target, analytic approach, and meta-model. Its target is the understanding of biopsychosocial processes of change and how they can be modified by treatment components or kernels to help accomplish the goals of the client. Its analytic approach is to measure, predict, and influence idiographically assessed processes of change with high levels of precision, scope, depth and to generate nomothetic generalizations only to the degree to which doing so increases idiographic fit within complex networks. Its

meta-model is meant to create a kind of intellectual agora based on a common language of multi-dimensional and multi-level evolutionary science.

PBT defines psychopathology as failed adaptation processes to a given context. PBT applies socially extended principles of contextual adaptation from evolutionary science to psychopathology and psychological interventions, hereby focusing on the human ability to adapt to or alter environmental challenges through variation (in contrast to psychology inflexibility), selection of adequate strategies, and retention of successful strategies at the psychological, biophysiological, sociocultural levels of analysis (Hayes, Hofmann, & Ciarrochi, 2020; Hayes, Hofmann, & Wilson, 2020). Broadly defined, adaptation is the context-dependent or context-altering application of biopsychosocial strategies that allows a goal to be met, whereas psychopathology is the maladaptation of these processes. Maladaptation can include a larger failure to create a more adaptive context itself, so the focus on adaptation is not passive and it is not socially blaming or irresponsible. Entire families or communities can in principle be pathological.

In each level of organizational complexity, specific dimensions can be involved in healthy variation, that is selected and retained in context. For example, the biophysiological level might involve genes, epigenes, brain circuits, or organ systems, among various others. A psychological level might include dimensions of affect, cognition, self, attention, motivation, and overt behavior, among other dimensions. There are no hard and fast divisions among dimensions – the point is that the extended revolutionary meta-model can accommodate a variety of useful dimensions and levels of processes of change.

This model has been termed an Extended Evolutionary Meta-Model (EEMM; Hayes et al., 2019; see Figure 1), because it can serve as a meta-model for more specific, independent psychotherapeutic schools, and because of its roots in the knowledge on evolutionary science (Badcock, 2012) applied to the individual in all of its socially-situated complexity (Hofmann, Curtiss, & Hayes, 2020; Hofmann, Curtiss, & McNally, 2016; see Ong et al., 2022 for a recent case description).

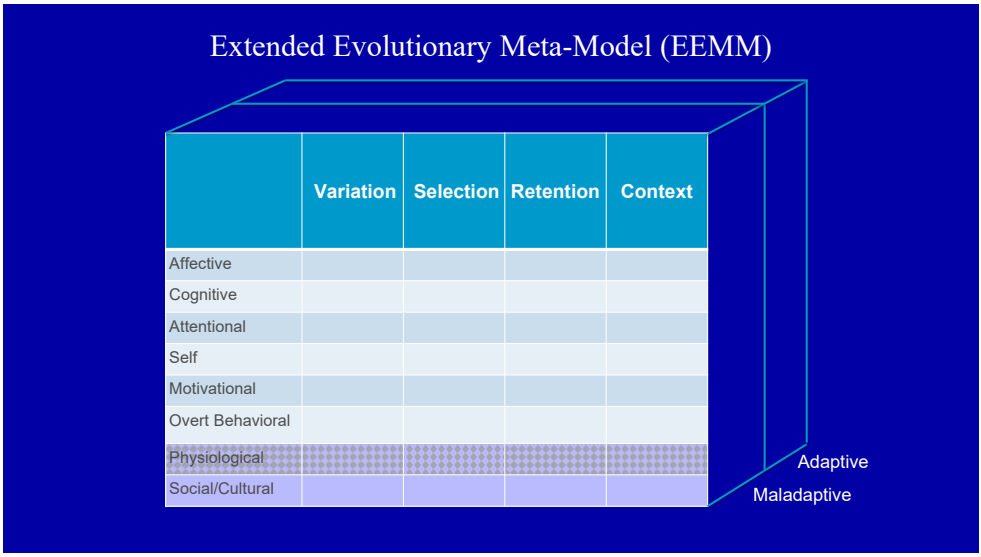
It is important to understand that a meta-model is not a new model. It is a model of models. Consider any row of the EEMM – say, the cognitive dimension – to begin to explore why a meta-model is helpful to a transtheoretical appoach.

A given model of psychopathology or treatment may emphasize that persons who develop psychological problems tend to have characteristic cognitive styles or modes of thinking. Perhaps these styles are rigid, irrational, or over-generalized, for example. These are theoretically grounded ways of speaking about how given cognitions or cognitive styles can be insensitive to the actual context or fail to vary when a wider range of possibilities need to be considered. Understanding the person's history might lead to an understanding about why these styles became dominant for a particular person, that is, how they were selected and retained. For example, a person may have had

critical parents who modelled irrational thinking styles or who might have reverted to over-generalizations to avoid criticisms by others.

Figure 1

A Conceptual Space for the Examination of Adaptive and Maladaptive Change Processes Provided by Modern Multi-Dimensional, Multi-Level Evolution Science



Note. The bottom two rows represent nested levels of analysis relevant to the psychological level – although not the topic of this paper a full explication of these levels would require similar matrices of their own. Copyright Steven C. Hayes and Stefan G. Hofmann.

The EEMM is not meant as a substitute for a specific model – it is instead meant as a generic way of considering them and studying them in a transtheoretical fashion. If another specific model emphasizes that cognitive rigidity comes from seeing thoughts as facts, it would be an easy matter to study this idea in comparison to cognitive over-generalization in a given instance. Two theorists might feel compelled to compete if an entire model is at stake, but when specific processes are being compared, it is far easier to have shared interests in any given outcome.

Idionomic Versus Normative "Latent Disease" Analysis

Analytically, a PBT approach is a radical departure from the traditional latent disease model of psychiatry. It relies on network analysis as a form of functional analysis using the framework of evolutionary science.

In a latent disease model, the signs and symptoms of psychopathology in a given syndrome for a given individual are meant to orient towards underlying entities that are assumed to be driving the particular features that are seen. Latent diseases are inherently normative and categorical. The statistical methods used in traditional psychometric evaluations of measures rely heavily on consistencies between people as the metric for evaluating consistencies across persons that are assumed to be driven by underlying variables that cannot be directly measured but must be inferred. Clinically speaking, after assessment people are grouped in diagnostic de-individualized categories (Greenhalgh et al., 2014). In line with this, particular collections of data, theories, and interventions are utilized with the intention of encompassing and benefiting the entire group. Such labels are commonly found in traditional CBT protocols. The latent disease model gives priority to the prescribed symptoms and syndromes rather the psychological processes underlying psychopathology and mental health. This view tends to reduce human suffering to brain abnormalities and biological dysfunctions and de-emphasize the importance of the biopsychosocial context of the individual (Greenhalgh et al., 2014). Despite the increased transdiagnostic focus of CBT approaches as process-based approach gains strength (Hayes & Hofmann, 2021), narrow attention to the patient's specific symptoms and normative views of presenting problems remains a main feature of CBT case formulation and treatment delivery.

It is increasingly apparent that the central tendencies of groups do a very poor job of modeling individual life trajectories. Statistical physics long ago proved the ergodic theorem, which suggests that the measurement of a collection of elements can adequately reflect the behavior of individual elements only if the behavior involved is stationary and all individual elements share the same dynamic model. Statisticians agree that this ergodicity is an underlying assumption of common biostatistical methods but by definition processes of change are not stationary, and they unfold in different ways at different times and different people.

In a PBT approach, this problem is avoided through idiographic analyses that model the relation of processes of change as they bear on particular outcomes within the person over time. Only then are individual results related to those of other people. Relations that become evident by extending the analysis to the nomothetic or group level are retained if and only if they improve ideographic fit for most people. This is what is meant by the neologism "idionomic analysis", offered as a substitute for "normative analysis."

Functional Analysis in an Idionomic Approach

Because processes of change interact, process-based therapists conduct functional analyses through contextual sensitive idionomic network assessment. Psychopathology is represented as an idionomic network of problems, conditions, and processes. The goal of PBT is to help clients replace their maladaptive networks with adaptive networks. This is done by strengthening processes that promote well-being while moving toward desirable goals and values.

Early functional analysis and later CBT case formulations (Persons, 2008; Persons et al., 2013) were important steps toward the translation of general processes of change to individual applications. According to PBT, we ask: What core biopsychosocial processes should be targeted with this client given this goal in this situation, and how can they most efficiently and effectively be changed? (Hofmann & Hayes, 2019, p. 38). PBT does not demarcate case conceptualization, assessment and treatment. PBT visualizes a client's problem as a dynamic network that is maintained through maladaptive processes. Once we understand them, we can effectively intervene. This network is not static, but dynamic and changes with time and treatment. Therefore, high density data monitoring are essential, such as ecological momentary assessment (EMA), dynamic network analysis, and time-series analysis. Examples of some available methods that can be taken in clinical settings are frequent measures of processes taken in session and between sessions, and measures of social, psychological, and physical context (Hayes et al., 2019).

In that way, frequent, contextually focused assessment sets the stage for the creation of a comprehensive empirical form of functional analysis for each client. That is, idionomic analysis of longitudinal assessments leads to the identification of relevant and controllable functional relations to an individual's specific behavioral targets (Haynes & O'Brien, 1990).

This is quite different from traditional forms of functional analysis that were common in the early days of cognitive and behavioral therapy. In those times, applying principles to individual patterns of behavior was more an art than a science, making replicable case analysis difficult (Hayes & Follette, 1992). Traditional functional analysis was neglected from psychology literature for decades because of that, in addition to the fact that the range of processes considered was too limited, appropriate statistical analytic methods were under-developed, and consequently it was difficult to show superior outcomes from functional analysis for addressing human suffering. In recent decades, newer forms of CBT have reemphasized a functional approach (Hayes, Hofmann, & Ciarrochi, 2020), and research has expanded our clarity about the key processes of change that need to be targeted (Hayes, Ciarrochi, Hofmann, Chin, & Sahdra, 2022), revitalizing a functional analytic approach. Additionally, interventions based on a functional-analytic assessment have demonstrated utility in improving clinical outcomes of some conditions (Ghaderi, 2006; Hurl et al., 2016). It is particularly worth noting that every significant mediator of a randomized control trial of a psychosocial method focused on a mental health outcome,

easily fits within the EEMM (Hayes, Ciarrochi, et al., 2022). This means that the EEMM is in fact the intellectual agora sought by PBT: it provides a stable transtheoretical ground for all current approaches to processes of change.

From Packages to Kernels in Personalized Interventions

PBT is based on the idea that efficient and effective intervention should be based on the individual's unique biopsychosocial characteristics, goals, and needs. In other words, the dynamic process-based case formulation can and should lead to specific treatment elements or kernels. PBT rejects the a priori focus on symptoms from DSM or ICD-defined syndromes and instead focuses on processes that ameliorate problems or promote prosperity when positive goals are ascendant. Rather than just reduction in symptoms, the aim of PBT is to strengthen processes that promote well-being in accordance to the clients' values and goals.

We have a great deal to learn about how well treatment elements or components modify processes of change, but systematic reviews of the ability of treatment kernels to do so are already available in some areas (e.g., Levin et al., 2012). The claim that the EEMM can serve as an agora for a transtheoretical approach is also strengthened by evidence that all current positive psychology methods and models also readily fit within the EEMM (Ciarrochi et al., 2022).

Concluding Thoughts

Broadly-cast transtheoretical approaches to processes of change should lead to an increased ability to share treatment methods without losing intervention coherence. Said in another way, instead of vapid eclecticism, a PBT approach encourages researchers and practitioners to develop broader models of change, to communicate across theoretical boundaries about overlapping interests in processes of change, and to share intervention kernels that successfully alter idiographically relevant biopsychosocial processes. This approach allows the strengths that come from clarity about philosophical assumptions and basic or applied theory, on the one hand, while reaping the benefits that can come from theoretical consilience and cooperation, on the other.

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