Starting Off on the Right Foot: Common Factor Elements in Early Psychotherapy Process

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Effective psychotherapy builds on a strong foundation developing as early as the first session. The aim of this review is to identify clinical research related to nonspecific (i.e., common factors) treatment effects and to expand upon those findings in developing techniques for applied clinical practice. Clinicians across treatment modalities can implement these techniques that are informed by empirical evidence in an effort to develop a collaborative treatment relationship with new patients. Three therapeutic principles identified in this review are: fostering positive expectancies, role preparation, and collaborative goal formation. Research related to these factors is reviewed as are suggestions for implementing them into applied clinical practice during early treatment interventions.

Keywords: common factors, goal collaboration, role preparation, positive expectancies, early treatment interventions

Preparation and collaboration are essential to the successful execution of any team or group effort. Similarly, a solid foundation of a therapeutic relationship allows for greater success as treatment develops. The early development of the therapeutic relationship contributes to positive treatment outcomes (for a review, see Hilsenroth & Cromer, 2007) and may even be essential to the continuation of the therapeutic work (in terms of reducing early attrition/termination). Positive expectancies, role preparation, and collaborative goal formation are three core psychotherapeutic factors that influence early psychotherapy process and are empirically linked with subsequent treatment adherence and outcome. These thera-

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peutic process elements are considered common factors as they are not linked to specific theories of human development, psychopathology, or psychotherapy and are endemic to multiple treatment modalities (Lambert, 2005).

This review follows a common factors approach to psychotherapy integration by identifying effective core ingredients found across forms of psychotherapy and exploring methods and techniques by which those process elements can be facilitated and enhanced (Norcross, 2005; Stricker & Gold, 1996). We will review research linking therapeutic outcome to positive expectancies, role preparedness, and goal agreement followed by exploration of techniques for actively harnessing these positive elements in the early stages of psychotherapy.

GREAT EXPECTATIONS

Early in treatment, clinicians may find importance in exploring what the patient's expectations of their work together are (cf. Van Audenhove & Vertommen, 2000). Starting from a similar domain, we begin by examining the literature regarding the expectations of and beliefs about therapeutic process held by potential clients.

Freud wrote that "expectation colored by hope and faith is an effective force with which we have to reckon . . . in all our attempts at treatment and cure" (Freud, 1905/1953, p. 289). Subsequent research has borne out his statement by addressing the importance of assessing what clients expect on entering treatment and how those expectancies may impact the progression of subsequent treatment. Jerome Frank et al. (1959) compared treatment effects across three forms of psychotherapy: group therapy, individual therapy once a week, or minimal contact treatment not more than one half hour every 2 weeks. After 6 months, patients in all three therapies, as well as patients who terminated within the first four sessions, showed on average equal changes in well-being. In a follow-up study, Frank et al. (1963) examined the positive effects of placebo administration in alleviating patient ratings of discomfort. This work led Frank (1961/1973, 1982) to develop his views on the roles of persuasion and expectation in the treatment process. He elucidated various components shared among therapeutic modalities, discussing the importance of fostering positive expectations and change attributions within a collaboratively formulated, emotionally charged and confiding relationship.

Expectations are at work even before treatment begins, as Snyder et al. (1972) observed that many possible clients are deterred from seeking therapeutic services because of holding low expectancies of receiving help.

Negative expectations may contribute to whether or not patients remain in treatment after the initial interview (Heilbrun, 1970) and appear to negatively impact therapeutic effectiveness (Goldstein, 1962; Kraus et al., 1969). Studies across therapeutic modalities identify patients achieving significant reduction in symptoms even before attending their first psychotherapy session (Beckham, 1989; Frank et al., 1959, 1963; Friedman, 1963; Kellner & Sheffield, 1971; Piper & Wogan, 1970; Shapiro et al., 1980). Degree of pretreatment symptom improvement is significantly related to positive treatment expectations (Friedman, 1963; Goldstein, 1960) and the dose-effect meta-analysis of psychotherapy outcome performed by Howard, Kopta, Krause, and Orlinsky (1986) suggested that about 15% of patients achieved measurable improvement associated with making an initial psychotherapy appointment.

In a more recent review of numerous dosage and phase model studies of psychotherapy, Howard et al. (1996) termed the initial phase of therapeutic improvement "remoralization." Individuals beset by turbulent emotional and relational difficulties may quickly become despondent and hopeless, triggering a vicious circle of poor coping and increased social or emotional upset. This phenomenological experience of hopelessness may be the most amenable challenge faced early in treatment as patients connect with a service provider offering a mutable, more hopeful life approach. Upon examining the expectations reported by a group of clients who had completed a course of short-term psychotherapy, Dimcovic (2001) noted that the majority of these clients harbored moderate or "realistic" expectations for their therapeutic change, that client expectations became more positive after they had started working with their therapist, and that more positive expectations after the start of psychotherapy predicted a greater degree of therapeutic change.

By manipulating client expectancies or disguising the therapeutic intentions of systematic desensitization, many studies found reduced (or even eliminated) therapeutic effectiveness for this form of treatment in reducing anxiety (Kirsch, 1990; Kirsch & Henry, 1977; Leitenberg, Agras, Barlow, & Oliveau, 1969; Lick & Bootzin, 1975; Marcia, Rubin, & Efran, 1969). That is, clients' anxiety may be reduced by their expectations for receiving a powerfully effective treatment more so than through the specific techniques used in standard desensitization procedures. Kirsch (1990) reviewed 15 studies using expectancy modifications (i.e., where individuals were informed before intervention that they were about to receive a very powerful treatment) before comparing the efficacy of desensitization treatments and control treatments for various specific phobias. Of these studies, 13 showed negligible differences between the desensitization treatments and the control conditions. One study actually showed the control treatment to be *more* effective than

desensitization, an effect achieved by informing the control group (but not the desensitization group) that they were about to receive a powerful treatment for their specific phobia (Tori & Worrell, 1973). Only one study (Gelder et al., 1973) demonstrated greater efficacy for desensitization; however, this effect was found on only one self-report measure and was limited to certain phobias. Kirsch (1990) noted that the greater efficacy in the Gelder et al. study may be accounted for because the pretreatment interview for the control condition was less effective than the one used for the desensitization treatment in modifying individuals' positive expectations for treatment.

Placebo control studies also provide some insight into the impact of expectancies on subsequent therapeutic outcome. For example, Moncrieff, Wesseley, and Hardy (1998) suggest that antidepressant efficacy is substantially influenced by a placebo effect. Their meta-analysis demonstrated only a small effect size (ES = .17) in mood improvement when comparing antidepressants to "active placebos" (i.e., placebos that mimic the side effects of an antidepressant). In a substantial meta-analysis that collected numerous effect sizes reported from over a thousand psychotherapy studies, Lambert and Bergin (1994) reported an aggregated within groups effect size for clinical management or placebo control groups versus no-treatment conditions of .42, over half of the .82 effect size found when comparing average psychotherapy outcome to no-treatment controls (p. 151). Clearly these findings support the value of psychotherapeutic treatment above and beyond expectancy effects, but they also highlight the powerful effect of some factor(s) found in placebo control conditions. Further meta-analyses of placebo effect sizes include Lipsey and Wilson (ES = .44; Lipsey & Wilson, 1993) and Grissom (ES = .48; Grissom, 1996). Again, these studies reinforce that therapists are actively bringing about changes in their patients above and beyond no-treatment and placebo controls, but Lambert (2005) notes that such studies are also one type of methodology involved in isolating possible causal mechanisms of patient improvement. One placebo control study meta-analysis (Barker, Funk, & Houston, 1988) expanded on these findings by examining possible mechanisms of action in placebo conditions; measures of patients' expectations were not significantly different in patients entering bona-fide treatment versus those entering placebo control treatments.

In light of such pervasive research findings, Weinberger (1995; Weinberger & Eig, 1999) concluded that expectancies form a major common factor (along with the therapeutic relationship, exposure to and confrontation of problems, experiences of mastery or cognitive control over problems, and attributions of therapeutic outcome) causally involved in creating therapeutic change through varied therapeutic approaches. He further

advocated that certain common factors are highlighted in certain treatment modalities while other factors are relatively neglected, contributing to comparative psychotherapy research findings of outcome equivalence. Greenberg, Constantino, and Bruce (2006) conducted a thorough review of expectancy research related to psychotherapy process and outcome. They concluded that expectancy effects substantially affect psychotherapy outcome and the importance of the effects are frequently overlooked. Thus, greater focus on harnessing the commonly ignored factor of expectancies (as well as the other common factors described), should lead to more effective and lasting outcomes.

How can clinicians capitalize on research findings of the importance of fostering positive expectancies and translate them into applied clinical practice? Frank (1973, 1982) suggested two factors contributing to the remoralization of patients despairing of psychological ills: (1) developing a rationale, conceptual scheme, or myth that provides a plausible explanation for the patient's symptoms; and (2) prescribing a ritual that requires active participation of both patient and therapist and that is believed by both to be the means of restoring the patient's health.

Before a patient and therapist can collaboratively develop a rationale, conceptual scheme, or myth (many psychotherapists may prefer the term "narrative" to the spiritually connotative "myth") explaining a patient's symptoms, they must first understand together what those symptoms are. Questions asked early in the first meeting such as "What brings you to seek treatment?," "What's important in your life right now?," "What challenges have you been facing lately?," "What led you to eventually pick up the phone and call the clinic/office?" may facilitate the discussion of these presenting problems. Hilsenroth, Peters, and Ackerman (2004) demonstrated how an extended therapeutic assessment integrating psychological assessment and the provision of clinical feedback contribute to beneficial therapeutic outcomes and reduced termination rates.

Once these symptoms are formulated, a therapist and patient work together to develop an understanding or rationale that is experienced as plausible. As behavior is multidetermined, clinicians from different practice orientations will focus on diverse conceptualizations of what contributes to symptom development. Just as a few broad examples: Luborsky (1996) advocated identifying recurrent maladaptive relational patterns related to symptomatic responses, while Beck (1979) discussed raising hypotheses about the automatic thoughts contributing to maladaptive affect and behavior, and Linehan (1993) described the use of behavioral analysis with patients to develop a conceptual understanding of problematic behavior. It is vital that patients and therapists work

together to identify how the data accumulated in session fits into the clinical formulation.

In addition to the actual content of the clinical formulation, the relationship in which the formulation is developed is also a major factor contributing to the utility of that conceptualization. Ackerman and Hilsenroth (2001, 2003) reviewed the empirical literature to identify therapist characteristics and techniques that either positively or negatively affect the therapeutic alliance. Qualities such as the therapist being flexible, honest, alert, and warm coupled with interventions such as accurate interpretation, support, and facilitating affective expression were found to increase therapeutic alliance. In a practice review, Hilsenroth and Cromer (2007) covered empirical findings on and provided process dialogue examples of gathering assessment data, developing a clinical formulation, and supplying patient feedback in ways to facilitate a positive therapeutic alliance. Markers for recognizing when formulation is contributing to positive expectancies include patients stating that they feel understood, acknowledging that their difficulties make more sense, expressing confidence in the treatment, and identifying eagerness to return for further treatment sessions.

In addition to helping patients feel remoralized through collaborative formulation, clinicians must also engender confidence in the prescribed treatment. Based on their review of the literature, Greenberg et al. (2006) suggest that "any treatment approach (especially those with empirical support) should be convincingly presented as producing relatively reliable and typically gradual change over time" (p. 671). Therapists should be honest and confident in discussing their credentials, their treatment experience, and the types of problems they typically see. Often, when patients inquire about such topics, they may be approaching the issue of trust. Therapists can acknowledge that trust is not something that happens between two people right away, but that the therapist is committed to staying present and involved, is enthusiastic about working together, and hopeful that by allowing for working through shared experiences that greater trust will develop over time.

There are many ways in which therapists can normalize peoples' concerns and communicate realistic confidence in the treatment process. The following statements highlight ways for helping individuals feel less isolated with their problems and gain a greater sense of confidence in the treatment: "the types of experiences you have described certainly sound distressing, many people come to therapy with similar concerns, and they are exactly the kind of concerns that therapy can be helpful with," "I'm glad you came in to seek help with this," "I'm really hopeful that our work together will be beneficial," "I have seen many people describing similar feelings get significant relief from treatment." Consider the following statement made to a patient from VandenBos (2008):

> That shouldn't have happened to you, it shouldn't have happened to anyone, but something awful did happen to you, and it hurt you, and anyone who experienced what you experienced would have symptoms just like you are having now, but you don't need to stay this way, it can be changed, and by talking and exploring your life and your experiences, you and I can change it, you will be able to better understand what did and did not happen to you, and you can think afresh about the nature of interpersonal relationships, so you can experience new events, such as our work together, with a fresh, new view of events (p. 41).

Note how the above statement contains normalization ("anyone who experienced what you experienced would have symptoms just like you"), gives a brief introduction to the process of treatment ("by talking and exploring your life and experiences"), and fosters positive expectations for treatment ("you don't need to stay this way, it can be changed," "you can think afresh," "you can experience new events").

In summary, therapists can help to realistically assuage anxieties by normalizing their patients' concerns as within the bounds of human experience, by expressing confidence in the effectiveness of the treatment endeavor (to be supported by available evidence), and noting their commitment to the development of the treatment relationship.

CHANCE AND PSYCHOTHERAPY FAVOR THE WELL-PREPARED

In addition to engendering faith in the treatment rationale, patients should be educated about the actual treatment process. It seems that the early and active provision of information about and discussion of what patients might expect from and how they might best participate in their own treatment yields positive effects on the therapeutic progression. Orlinsky et al. (1994) examined numerous studies concluding that "role preparation produces better outcomes more often than not and does no harm" (p. 282). The studies lend credence to the adage that "an ounce of prevention is worth a pound of cure" by noting the beneficial effects of addressing roles and expectations even before formal treatment has begun.

In researching the effects of psychoeducational interventions before psychotherapy begins, Coleman and Kaplan (1990) examined the effects of presenting a standardized pretreatment videotape informing children entering psychotherapy and their mothers about the structure and process of the psychotherapy the children were about to receive. Both children and mothers who viewed the videotape demonstrated greater knowledge about psychotherapy than individuals who had not viewed the videotape; young children in the sample learned as much from the videotape as did adolescents in the sample; and prepared children displayed fewer problematic behaviors after four sessions of psychotherapy than nonprepared children

who had also received psychotherapy. Their findings were echoed by Shuman and Shapiro (2002) who found that materials designed to educate parents about their children's psychotherapy increased the accuracy of parental expectations for treatment, and that parents with more accurate expectations consequently had higher rates of treatment utilization.

Two similar studies examined the effects of presenting an 11-min pretherapy orientation videotape to adult outpatients about to receive psychotherapy. These studies found that patients who viewed the tape effectively recalled and understood the information presented, showed a greater decrease in self-reported symptoms than the control group after 1 month, positively rated their experience of viewing the tape (Zwick & Attkisson, 1985), or had more accurate expectations of psychotherapy and less state anxiety than nonoriented controls (Deane et al., 1992).

One standard role preparation utilized in psychotherapy trials is the socialization interview (SI) developed by Lester Luborsky (1984), an informative document addressing patient roles and potential expectations for patients entering supportive-expressive psychotherapy. The SI reviews what to expect in psychodynamic psychotherapy, outlines the patient's and clinician's roles during treatment, and outlines potential reactions (both positive and negative) to previously unexamined patterns or issues that may arise during treatment. Ackerman et al. (2000) and Hilsenroth et al. (2004) utilized this SI as one component of a collaborative feedback session held during investigations into the beneficial effects of conducting a therapeutic model of assessment that focuses on collaborative goal setting and development of a therapeutic bond (Finn & Tonsager, 1992, 1997; Fischer, 1994). The varied benefits of conducting a therapeutic model of assessment that included provision of the SI versus a traditional information gathering model of assessment are described at length in Hilsenroth et al. (2004) who identified significant reduction in early termination rates and stated that "the presentation of the SI at this time enhanced the patient's understanding of psychotherapy and highlighted the relational focus of the therapeutic process" (p. 337). In treatments where patients had received the SI, patients rated the statement "my therapist explained the rationale behind his or her technique or approach to treatment" as one of the most highly ranked items in a set of specific therapeutic techniques related to later symptomatic improvement (DeFife, Hilsenroth, & Gold, 2008).

Even as role preparation is important at the outset of treatment, the *implementation* of preparing patients for the treatment process is going to vary widely among different treatment modalities and individual therapists. However, there can be key targets and questions that practitioners should develop answers for, and they can work to communicate those elements to their patients early in treatment. One of the more basic elements to negotiate is the nature of the treatment frame. Issues related to treatment

frame include length and frequency of sessions, expected duration of treatment (i.e., time-limited vs. open-ended), and service fee.

A second factor in role preparation involves the discussion of what patients are expected to bring to treatment: patients may be asked to complete diary cards tracking emotional and behavioral experiences that will be reviewed at the beginning of each session; the therapist might inform patients about the value of completing tailored homework assignments between sessions and/or highlight the importance of regular session attendance and medication compliance. In a similar vein, patients should be prepared with guidance about what types of content their therapies are likely to focus on. Patients can be encouraged to discuss any number of salient treatment themes such as behaviors that are distressing and problematic, upsetting thoughts that feel automatic, affects that are difficult to experience, current or past relational interactions that have been unsatisfying, or even whatever comes to their minds during treatment. In his SI, for example, Luborsky (1984) writes: "Ordinarily, people don't talk about lots of things because they are too personal, or because they would hurt other people's feelings, or for some other similar reasons. You will find that with your therapist you will be able to talk about anything that comes to your mind" (p. 198). Another example of preparation for open-ended treatment process comes from Day (1993) who, as one part of developing a treatment contract, encourages group patients "to feel free enough to be spontaneous and responsible enough to be appropriate" (p. 660). Such an injunction, he notes, engages a variety of mental processes: open expression of wants/needs; activation of conscience, values and belief systems; executive functioning, judgment, and decision making. Furthermore, it seems important to note that treatment is never a simple solution to any problem and some difficulties are to be expected as a natural part of the process. Patients may find that certain behaviors are difficult to change, painful emotions may emerge, or they may become impatient with the pace of treatment progress. Again these experiences are common to any treatment promoting meaningful life changes, and patients should be encouraged to discuss these concerns with their treatment providers as they arise.

Finally, treatment preparation involves informing patients about what their therapists will (or will not) be doing to aid their work together. For example, Luborsky (1984) cautions that the therapist is not in the practice of doling out advice, that "it's the therapist's job not to give advice but to help you find out for yourself how you are going to solve your problems" (p. 194). Whether this involves tracing links contributing to maladaptive behaviors, identifying and altering irrational cognitive processes, discussing events that occur within the context of the treatment relationship, or examining repetitive maladaptive relational patterns across time, it falls to the therapist to inform the patient about what techniques are typical of

their treatment practice as well as their conceptions of how those treatment techniques are designed to influence therapeutic change. To optimize this process, therapists and patients need to work together to conceptualize the types of treatment changes desired while collaborating on the methods provided toward achieving those goals.

GOING FOR THE GOALS

Opening up a discussion of the chief concerns leading someone to seek treatment and identifying what types of changes are desired paves the way toward a collaborative formulation of reasonable treatment goals. Bordin (1979) identified three major features of a working alliance including agreement on goals, assignment of tasks, and the development of patient-therapist bond. Though his concepts have been supplemented with other factors of therapeutic alliance, Bordin's factors of goal-task agreement and therapeutic bond remain firmly imbedded in current conceptualizations and measurement instruments of therapeutic alliance (Bordin, 1994; Hatcher, 1999; Hatcher & Barends, 1996; Horvath, 2001). Orlinsky, Grawe, and Parks (1994) note that contractual "clarity and consensus tend to be important factors when assessed from the patient's perspective or by means of an objective index, but curiously irrelevant from the therapist's process perspective" (p. 282). Their findings generate reasonable concerns about the amount of collaborative goal setting performed in real-world practice. If a therapist perceives no discernable outcome effects from the collaborative formulation of an explicit treatment contract, this process may be overlooked in the crucial early periods of psychotherapy, eliminating a valuable aspect of the patient's therapeutic experience.

In their review of psychotherapy research on goal consensus and collaboration, Tryon and Winograd (2002) identify the relationship of a therapist actively providing information to and collaboratively engaging with his or her patient to the patient's return following the intake or initial psychotherapy session. As they note, attendance after initial therapeutic contact is not viewed as a therapeutic outcome in and of itself, but (aside from being essential for the continuation of the therapeutic work) is a critical early benchmark to achieve. In a meta-analysis of 125 studies across diverse treatment settings, Weirzbicki and Pekarik (1993) found a psychotherapy dropout rate of 46.86% of patients. Not only has it been argued that "the largest percentage of clients that drop out of therapy do so after one session" (Odell & Quinn, 1998, p. 369; Phillips, 1987), but also that patients who return after the initial therapeutic contact tend to stay in treatment until an agreed upon termination date (Tryon, 1985; Tryon & Tryon, 1986). Tracy (1977) highlighted the importance of the therapist

establishing a collaborative relationship and goal consensus during the intake evaluation; investigating two models of intake interview revealed that significantly more patients returned following interviews in which their problems were formulated and treatment goals were negotiated. A later study also showed that significantly more patients returned for treatment following intake sessions in which therapists rated their own intake behavior as more focused on explicitly identifying and clarifying the presenting problems with their patients (Tryon, 1989).

Tryon and Winograd (2002) further reviewed studies examining the relationship of goal consensus and collaboration with outcome starting by looking at immediate session effects. Eisenthal et al. (1983) obtained observer ratings of mutuality of treatment decision making and clarity of therapist communications of rationale from audiotaped sessions of intake interviews. Patient ratings of intake session satisfaction were related to both factors of goal negotiation and clarity of the therapists' explanatory processes. Furthermore, neither goal negotiation nor therapist clarity as measured by the external raters was related to therapist ratings of session satisfaction or therapist perception of their patient's satisfaction with the session. The authors concluded that initial interview outcomes may be negatively impacted by divergences in therapist valuation of certain interview processes and by therapist misperceptions of patient satisfaction. These findings highlight the significance of early interactive role-goal negotiation and psychoeducational clarity as processes important to patients entering psychotherapy, an importance that may be overlooked by their therapists. These processes may not only impact client satisfaction, but also a subjective sense of well-being: for example, therapist agreement on goals and responsiveness to patient requests during an intake session was positively associated with reductions in postintake distress levels in a hospital crisis center sample (Kirk, Stanley, & Brown, 1988). Session effects from goal discussion are found not only at intake, but also in subsequent sessions. Two studies found observer ratings of "goodness" of sessions from short-term psychodynamic psychotherapy positively related to independent ratings of therapeutic actions focused on goal discussion (Hoyt, 1980; Hoyt et al., 1983): again, the same therapeutic actions were not related to therapists' ratings of "good" sessions (Hoyt et al., 1983), further supporting the notion that therapeutic activities viewed as beneficial or even essential to patients' well-being may be overlooked in clinicians' beliefs about change processes.

Tryon and Winograd (2002) note that patient-therapist goal consensus ratings have also been examined for the prediction of global therapeutic outcome, though with mixed results. Paivio and Bahr (1998) obtained patient rated Goal Agreement scale scores from the Working Alliance Inventory (WAI; Horvath & Symonds, 1989) after the third and final

sessions of a 12-session experiential psychotherapy. Only one relationship with outcome from the obtained Goal Agreement scores reached significance: Goal Agreement scores procured at the conclusion of treatment were negatively related to change scores of an author-created measure of unresolved relational issues. Perhaps the negative correlation found in the Paivio and Bahr study may be explained in that high Goal Agreement scores obtained at the conclusion of treatment suggest that both patient and therapist recognize the presence of salient maladaptive relational issues still needing to be addressed, thus counterindicating termination at that point.

Other studies have found positive relationships between early ratings of goal consensus and global therapeutic outcomes using diverse measures in a range of treatment samples. In a Dutch outpatient sample, patient ratings of agreement with the therapist as well as ratings of experienced goal consensus following the second session of psychotherapy were predictive of patient and therapist ratings of symptom reduction as late as 6-months after the beginning of treatment (Dormaar et al., 1989). In a sample of couples receiving brief therapy (Quinn et al., 1997), wives', but not husbands', ratings of goal consensus after the third session were positively correlated with their final ratings of treatment outcome. Pretreatment ratings of patients' commitment to therapeutic goals were positively related to remission of bulimic symptoms in patients about to receive a 12-session cognitive–behavioral group therapy for bulimia (Mussell et al., 2000). Even in inpatient settings, patient participation in elaborating treatment goals is related to goal involvement as well as treatment outcome (Evans, 1984; Willer & Miller, 1976).

Even with a collaborative goal setting process, goal disagreement can occur. Three studies utilizing the Goal Disagreement scale of the California Psychotherapy Alliance Scales (CALPAS; Marmar et al., 1986) provide mixed results in assessing the relationship of goal consensus with depression symptom reduction. Across three types of treatment (cognitive, behavioral, and brief dynamic therapy) completed within 16–20 sessions, Beck Depression Inventory (BDI; Beck et al., 1961) change scores were not significantly predicted by Goal Disagreement scores obtained after the 5th session (Marmar et al., 1989). A replication and extension of the Marmar et al. study yielded no significant prediction of BDI measured symptom reduction from Goal Disagreement ratings obtained after the 5th, 10th, and 15th sessions of psychotherapy (Gaston et al., 1991). However, Safran and Wallner (1991) found that patient-rated CALPAS Goal Disagreement scores obtained after the third session of a 20-session cognitive therapy for depression were significantly predictive of depression symptom reductions as measured by the BDI and the Millon Clinical Multiaxial Inventory (Millon, 1983) at termination.

The importance of early therapeutic contract negotiation is further highlighted in an examination of factors related to drop-out in the treatment of patients with Borderline Personality Disorder (BPD; Yeomans et al., 1994). Noting that BPD patients are characterized by a particularly high drop-out rate, the study demonstrated that external ratings of therapists' contributions to and skills in formulating a collaborative treatment contract related to the duration that patients remained in treatment. Utilizing a treatment contract as part of a structured clinical treatment model, the study produced a substantially reduced drop-out rate (17% by the third session, 36% by 6 months) and further demonstrated that the therapist's skill in discussing the treatment contract was an important factor in determining the patient's length of stay in treatment, independent of therapeutic alliance rating.

Clearly, the inclusion of patient feedback during collaborative goal formation is fundamental during the early stages of the therapeutic process. Therapeutic activities geared toward collaborative goal setting, the importance of which may be overlooked in clinicians' views of essential change elements, contribute to patients' return to treatment after intake, subjective sense of well-being, and the experiential quality of their treatment sessions. The relationship of goal consensus ratings obtained beyond the third session of treatment to global therapeutic outcome is not firmly established. Given the time-limited structure of treatments found in many of the above mentioned psychotherapy process-outcome studies, high goal agreement scores obtained later in treatment may signal the presence of treatment issues that may be left unresolved in briefer therapies; high goal agreement scores at the end conclusion of a brief therapy may suggest that both patient and therapist feel that there are significant therapeutic goals to be achieved through further treatment. Nonetheless, these findings strongly suggest that goal setting activities and patients' felt contribution and understanding within a collaborative goal setting process have positive overall effects on patients' experiences of the therapeutic relationship. Indeed, the experience of mismatch was labeled as a significant hindering factor in a qualitative study of patients' perceptions of curative factors in psychotherapy (Lilliengren & Werbart, 2005). The mismatch factor described in the Lilliengren and Werbart study covers a range of patient concerns such as disagreement on treatment modality, feelings of disconnection from the therapist, and incongruence of therapeutic roles and goals.

With an open dialogue about the concerns bringing someone into treatment, treatment goals can be identified and a technical scheme to achieve these goals can be developed. Treatment goals (and some examples) can: be short-term (return to a regular sleep schedule) or long-term (maintain medication compliance even after periods of symptomatic im-

provement); cover wide domains of functioning (increase occupational satisfaction; increase contact with community activities; decrease social isolation); be specific (decreased frequency of a specific compulsive behavior, identification of a recurrent problematic relational theme) or general (increased family cohesion, greater feelings of intimacy and stability in relationships). Another important piece of the goal negotiation process is the question of how will progress toward these goals be measured? Progress may be recorded formally (e.g., with diagnostic criteria or formal symptom measures) or through patient and therapist observations. Once treatment goals are set, they should be reviewed periodically. While much has been written on the concepts of conflict, resistance, defense, rupture, and stalemate, it is vital to recognize and reinforce positive therapeutic progress with patients. This can be accomplished through discussion of coping strategies, thoughts, or behaviors that lead to positive affect, subjective sense of well-being, or prosocial functioning. As treatment progresses, comparisons and contrasts can be made between current and past modes of functioning.

CONCLUSION

Starting treatments off on the right foot creates the development of mutual, collaborative, and fulfilling treatment relationships that will in turn promote meaningful and lasting life changes. This review follows a common factors approach to psychotherapy integration through identifying research evidence and suggesting practice implications for three major factors at play during the crucial early phase of treatment including fostering realistic and positive expectancies, role preparation for treatment, and collaborative goal setting (for summary, see Table 1).

A common factors approach is one of the main routes to psychotherapy integration (Arkowitz, 1989). By identifying the core therapeutic ingredients that are effective across different forms of psychotherapy (Frank, 1961/1973), therapists can more actively focus on facilitating those methods as agents of change. The advantage of this approach is to capitalize on therapeutic elements with demonstrated efficacy while still allowing the therapist to work within their practiced, grounding framework.

Hubble, Duncan, and Miller (1999; Miller, Duncan, & Hubble, 2005) suggest that successful treatment arises less from a therapist-driven model and more from adopting the client's frame of reference as a defining theory of the psychotherapy. Such a perspective, they argue, fits empirical findings demonstrating that "the quality of the client's participation in treatment stands out as the most important determinant of outcome" (Orlinsky et al.,

Table 1. Summary of Early Treatment Stage Principles and Techniques Contributing to Positive Therapeutic Outcome

Fostering positive expectancies
Develop a plausible rationale or conceptual scheme for symptoms
Utilize qualities and techniques designed to enhance the therapeutic relationship (e.g., flexibility, alertness, honesty, accurate interpretation, and fostering affective expression)
Identify an explicit treatment course geared at alleviation of problems
Engender confidence in the treatment process (e.g., invoke evidence and experience for treating patient concerns)
Identify commitment to the therapeutic relationship and process
Normalize patient concerns
Role preparation
What is the treatment frame? (e.g., length, duration, frequency, fee)
What is the patient's role in treatment?
What activities are they suggested completing?
What types of content should they expect to focus on?
What will the therapist contribute to the process? (e.g., What is the treatment rationale for how techniques will contribute to treatment change?)
Collaborative goal formation
Clarify concerns leading patients to seek treatment
Identify short-term and long-term goals
Identify goals across a range of functioning
Develop a method for assessing treatment changes over time
Regularly review progress towards treatment goals
Highlight adaptive changes
Identify areas for continued growth
Compare and contrast current and past functioning

1994, p. 361). Yet a question remains as to what methods are most effective for engaging the patient as an active "copilot" in the treatment situation. Given that psychotherapy process research is typically correlational in nature, causal inferences between process elements and subsequent outcome often cannot be asserted with certainty. Furthermore, it is difficult to generalize across clinical populations as some of the suggested clinical techniques may be more difficult to implement in certain cases. Research should continue to work on identifying the subsequent effects of treatment techniques geared toward fostering positive expectancies, role preparation and goal collaboration in treatment. In addition, studies might examine outcomes related to the training of practitioners in techniques aimed at achieving these factors. It falls to clinicians to utilize the best available research evidence in their endeavors toward effective patient care.

There is no "one-size-fits all" approach to meeting how individuals relate and would like to be related to (Duncan & Miller, 2000). As such, no circumscribed technical approach will match everyone's individual needs. At crucial moments early in the therapeutic process, therapists can transcend the constraints of discrete treatment models by engaging the patient as an active collaborator through soliciting their treatment expectancies,

preparing them for an active role in treatment, and constructing therapeutic goals together. Clinical indications suggest that an initial phase of remoralization occurs when patients feel heard and understood in an environment where they are encouraged to discuss their current concerns and priorities in life. Together, the patient and therapist begin to shape a plausible formulation in which symptoms can often be identified as nonoptimal attempts at problem resolution and normalized through their commonalities to others with similar concerns. With this formulation developed, commitment to the treatment relationship is expressed and a treatment is prescribed with confidence gained from evidence and experience. Patients are then prepared for this treatment by a discussion of frame issues, suggestions of what they may bring to and talk about during treatment sessions, and a negotiation of therapeutic techniques designed to elicit change. Short-term and long-term treatment goals are collaborated on and targeted at both specific symptom-level changes as well as broad quality of life improvements. Finally, a system is developed in which these treatment goals are to be assessed and periodically reevaluated for progress.

Such an approach is not meant to supplant specific technical approaches to facilitating therapeutic change. Specific treatment effects contribute incrementally to treatment outcome measurements, especially in cases of greater degrees of diagnostic severity (Stevens, Hynan, & Allen, 2000). However, fostering positive treatment expectancies, role preparation, and goal collaboration fall in the domain of common factors of treatment that have been identified through prior research as effective therapeutic elements occurring across multiple psychotherapy modalities. Techniques capitalizing on these research findings should be considered beneficial foundational elements to any integrative therapeutic endeavor, setting the groundwork for significant and meaningful treatment change.

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