

EDITORIAL

On Building a Science of Common Factors in Trauma Therapy

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Research on therapy outcome routinely finds that common factors (e.g., warmth, genuineness, trustworthiness) account for more variance than does therapy technique. This article makes the case for more attention to training in positive common factor variables within graduate schools and internships and for research on the effectiveness of such training. Recommendations are given for a change in focus in research and training, including more discussion of taboo topics in trauma therapy; attention to therapist behaviors that enhance the experience of warmth or trustworthiness; and research on client characteristics that impede the experience of being in the presence of a warm, genuine, and trustworthy other.

KEYWORDS countertransference, common factors, therapy outcome, trauma therapy, posttraumatic stress disorder (PTSD)

If you are of my generation, give or take a decade, then you were not taught the empirically based therapies for trauma during your graduate career. Cognitive behavior therapy was gaining a toehold in graduate schools as I approached graduation in the mid-1980s, and the first manualized therapies were emerging (e.g., Beck & Emery, 1985; Beck, Rush, Shaw, & Emery, 1979). Now, 30 years later, we are inundated with manuals that are quite specific to trauma (e.g., Foa, Hembree, & Rothbaum, 2007; Resick & Schnicke,

Received 15 January 2014.

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1993; Shapiro, 2001), and specific treatments can be compared to each other with some degree of assurance as to their replicability across settings. We also have guidelines for treatment from reputable organizations (e.g., posttraumatic stress disorder treatment guidelines from the International Society for Traumatic Stress Studies, dissociative disorder treatment guidelines from the International Society for the Study of Trauma and Dissociation) and books by extraordinary clinicians that take these treatment guidelines to new depths (e.g., Briere & Scott, 2012; Cloitre, Cohen, & Koenen, 2006; Gold, 2000). Surveys of therapists have shown that they particularly value lists of specific techniques, structured session-by-session plans, and worksheets for patients (e.g., Najavits, Weiss, Shaw, & Dierberger, 2000). In my own lifetime as a psychotherapist, the quality of this type of information has vastly improved.

Within each of these new therapy alternatives, the authors typically bow, at least perfunctorily, to the importance of the relationship. It is common for the trauma expert or trauma manual to underline the key role of feelings of safety and trust for the new client entering trauma treatment, suggesting, for instance, that “clinicians should never underestimate the difficulties that [dissociative identity disorder] patients have with establishing and maintaining a treatment alliance” (International Society for the Study of Trauma and Dissociation, 2011, p. 140). The importance of the common factors (e.g., warmth, genuineness, and affirmation) in the prediction of outcome is too well known to reiterate here (Ackerman & Hilsenroth, 2003; Najavits & Strupp, 1994), but these factors are generally understood to explain up to 9 times more of the variability in outcomes than the “specific ingredients” (e.g., cognitive processing therapy vs. prolonged exposure; Ahn & Wampold, 2001). Furthermore, I would remind you that the trauma patient is often cited in the list of difficult patients—that is, patients who do not readily elicit warmth and affirmation from their therapists. Complex trauma patients are overrepresented among those with rocky and unpredictable transference experiences (Dalenberg, 2000), among those with suicidal ideation and self-harming behaviors (Youssef et al., 2013), and among those who make unexpectedly slow progress within empirically based therapies (e.g., Jepsen, Langeland, Sexton, & Heir, 2013; Siever, 2013). Enhancing our effectiveness with the traumatized population, therefore, involves not only encouraging research on innovative techniques for changing affect and thought patterns in clients but also developing research protocols that test methods of improving and protecting the working alliance between the trauma therapist and traumatized client.

Much of my own work has been on countertransference in trauma therapists (see, for example, Dalenberg, 2000, 2008). Here the focus is on the ways in which therapists might contribute to impasses, premature terminations, or downturns in the alliance by virtue of their reactions to the behaviors of trauma patients or to the evocative nature of the trauma itself. My most central message is this: If it is true that a positive connection between therapist

and client sets the foundation for virtually any other positive change, as many suggest, and/or if this positive connection is the best predictor of beneficial outcome, then more research attention should be given to obstacles to the formation of positive therapeutic relationships in the context of trauma treatment. The obligatory few lines in virtually every trauma treatment book or guidelines telling the therapist to develop trust and provide safety are insufficient. At this point, I believe we need two shifts in foci. First, we need both a partial shift in focus for the case presentations of expert therapists, giving more time to the method used to build and support the relationship in contrast to the method of producing symptom relief.

Second, we need a set of researchable questions within the area of empirically supported techniques of relationship enhancement and alliance building. A research plan to answer these questions would involve at least two sets of interlocking lines of research:

What are the dimensions of the therapeutic relationship that lead to a positive alliance with the therapist and/or positive engagement in the therapeutic process?

How can these underlying dimensions be altered by therapist verbal and nonverbal behaviors?

I would humbly suggest that we have made much more progress in answering the first question than the second. The therapy process literature is quite reliable in suggesting that outcome is enhanced by at least four therapist or therapy characteristics that cross therapy orientation: value/goal congruency (Division 29 Task Force, 2001), clarity of rationale for therapy (Wollersheim, Bordewick, Knapp, McLellam, & Paul, 1982), warmth/caring (Division 29 Task Force, 2001; Orlinsky & Howard, 1978), and credibility/trustworthiness/genuineness (Division 29 Task Force, 2001; Orlinsky & Howard, 1978). In general, though, the clinically relevant information stops here. Let's suppose that in a given case the client does not see the therapist as warm. What now? New therapist? Reeducation of the client so that he or she can understand that transference distortions are blinding him or her to the therapist's true warmth? Shall we (and can we) teach the therapist to turn up the volume on warmth within the session? What behaviors translate as warmth to the traumatized client? This article is a call for change in our research priorities.

ENHANCING VALUE/GOAL CONGRUENCY AND BUY IN TO THE RATIONALE FOR THERAPY

The extensive interviews conducted in the San Diego Countertransference Study (Dalenberg, 2000, 2004, 2008) with more than 500 clients who have

been through trauma therapy have taught me more than I have learned through any other research project. One theme that I have discussed is the degree to which both therapist and client withhold important information from the other in unhappy and unsuccessful dyads (see also Pope, Sonne, & Greene's, 2006, intriguing text *What Therapists Don't Talk About and Why*). Some of these taboo topics (e.g., sex and money) are relatively unsurprising given the social mores of our culture. It was more surprising to me to learn that in looking across my own samples (which, again, contain only clients being treated for trauma), therapists reported that less than 50% of their clients had asked for a rationale for their therapeutic method, and more than 50% of patients stated that they felt that the therapist would not feel comfortable being "challenged" (here defined as being asked a direct question) about why specific techniques were chosen in a given treatment case.

We have chosen to practice in a field in which one of the symptoms of the primary disorders we treat is avoidance, and we should therefore not be surprised to meet variants of this strategy everywhere. Trauma clients may be avoidant of trauma reminders, trauma discussion, and the most potent aspects of trauma treatment. It is worthy of research energy to experiment with methods of encouraging approach behaviors to therapy itself. For example, should new patients read short descriptions of the rationale and benefits of trauma treatment from a variety of sources, hoping that a specific phrasing, a specific metaphor, or a specific emphasis produces a turning point for a given client? Should these descriptions be written by other clients, maximizing likeness to the current clinical participant, or should they represent sources deemed high in credibility for reasons of expertise (therapists, physicians) or social standing (celebrities, those in power)?

The initial discussion of rationale includes an effort to sell the patient on the idea that the journey that is commencing is a shared journey. To the extent that it is a guided tour, the role of guide varies moment to moment as both client and therapist offer plausible suggestions for exploration. This is particularly true if we accept the theoretical formulation (as I do) that there are unformulated, dissociated facets of any individual and that these patterns might be sensed and described by the client or noticed and described by the therapist. Neither individual is remembering in the narrative sense. A key part of my own rationale of trauma treatment is thus to convince the individual that holding mind in mind is at least possible. It is at least possible, that is, to think about an emotional reaction, to hold it up to a light created by another interested and intelligent partner, and to hand it back and forth, spinning it on our metaphorical fingertips and looking from different angles. Champions of acceptance and commitment therapy have developed a number of relevant strategies here to help an individual who has fused a thought (e.g., "The world is dangerous," "I am hideous") with a reality (Strosahl, Hayes, Wilson, & Gifford, 2004). At times, the authentic emotional expression of the therapist—self-disclosure of pain, empathy, or anger—is the bridge to the

client's willingness to allow the engagement that is necessary for therapy to work (cf. Dalenberg, 2000).

Initial agreement on the values and goals of therapy also can be hampered by our taboos about discussing race and culture. In one of our countertransference studies that is not yet published, we interviewed Black and Hispanic clients who had finished trauma treatment with White therapists. In this study, 47% of the clients stated that race had never been mentioned in their therapies, 48% thought that their therapists were uncomfortable discussing race, and only 34% thought that race-related issues had been handled well in therapy. This finding underlines a general recommendation that “talking about talking about” taboo issues such as race—that is, engaging in a discussion about what might be difficult to discuss in therapy (race, trauma-related thoughts and emotions, negative feelings about one's therapist, doubts about the therapy rationale)—should be more routinely conducted.

The trauma literature generally shows that a reliable minority of clients show a short-term exacerbation of anxiety symptoms (9%–25%) with the commonly used evidence-based treatments that include exposure (Hembree et al., 2003), and it is not uncommon for clients to fear the treatment as strongly as they do the continuation of their symptoms. In my discussions with therapists, it is not uncommon to find that the therapists share these fears—both fear of the traumatic material and fear of causing negative reactivity. With clients who have developed an identity that is centered on trauma, client and therapist fears increase. Research and training that takes these countertransference fears into account would center on promoting acceptance of the process of trauma therapy through (a) work on the development of client-friendly methods of explaining the work and normalizing the difficulty of treatment; and (b) work on enhancing therapist comfort in describing, championing, and living through these experiences with the client.

WARMTH BETWEEN CLIENT AND THERAPIST

The positive benefits of warmth in the prediction of therapeutic outcome are well replicated. It is interesting to note, however, that two fairly independent subgroups of studies inform this conclusion. First, many correlational studies show that therapist warmth as rated by the client predicts outcome as rated by a variety of sources (Bedics, Atkins, Comtois, & Linehan, 2012; Truax, Wittmer, & Wargo, 1971). Second, experimental studies show that deliberately warm therapists conducting short-term therapy (e.g., systematic desensitization) achieve a better outcome than do deliberately cold therapists (Morris & Suckerman, 1974; Ryan & Moses, 1979). Absent from the literature are two lines of research that are extremely relevant to our thesis here.

First, can a trauma therapist be trained to be more warm and less avoidant in the face of extreme threat? Predictive studies treat warmth as a stable characteristic of the therapist rather than a facet of the personality that can be imagined and made. The requisite research in part depends on a more specific set of behavioral indicators for warmth that can be described to the young therapist and trained over time, which may in turn require the therapist to become more aware of his or her unconscious responses to trauma. My dissertation student Kevin Fawcett, for instance, found that therapists faced with repeated and chronic tales of trauma became less responsive to the client's emotional cues across time, although their response to positive cues did not change or increase (Fawcett, 2009). These tendencies are clearly modifiable. In addition, more direct requests for evaluation from the therapist—asking the client to assess the felt warmth of the therapist, for example—might lead to opportunities for therapist self-correction. Therapist discomfort with criticism (cf. Dalenberg, 2000) as well as client reticence to disclose negative information about their feelings toward the therapist (cf. Pope et al., 2006) both mitigate against the discovery of this information without more routinized assessment.

The second relevant line of research begins with the assumption that the warmth of the therapist is actually an interactional experience. As a brief clinical example, I recall individual clients in the caseload of one of my psychological assistants. Most of her clients thought well of her and proceeded through their therapies quite predictably. One client, however, called my student repeatedly, and when my student did not return the calls immediately in the dead of night, the client left me a message that stated that my student was not caring and supportive. The other dissatisfied patient, a single father, felt that my student was intrusive, demonstrating a level of emotional connection (and warmth) that was impossible to reciprocate. Research here might focus on the traumatized client's ability to recognize and to tolerate warmth, as well as the potential to teach recognition of the signs of the wish for emotional connection.

GENUINENESS AND THE TABOO AGAINST SELF-DISCLOSURE

Genuineness is another of the strong predictors of success in psychotherapy and is again discussed as if it were an inevitable characteristic of a given therapist rather than a series of therapeutic choices. We do, of course, have an active tradition against self-disclosure that can be seen in some cases as a refusal to be genuine. The therapeutic purposes behind this general prohibition are quite understandable—protection of the therapy from being dominated by therapist rather than client material, distraction of the client by irrelevant knowledge of the therapist, and so on. Yet the practical implementation of the strategy is left to the whim of the therapist,

and these choices do seem at times to be grounded in countertransference. Anderson and Anderson (1989), for instance, found that therapists were more likely to answer questions about therapist experience, worldview, strengths in their own characters, and sources of positive affect than they were to answer questions about general opinions, weaknesses in their own characters, and sources of negative affect. Similarly, emotional disclosure—such as crying in response to client tragedy—is thought to be burdensome to the patient. In Blume-Marcovici, Stolberg, and Khademi's (2013) study of more than 600 therapists of varying orientations, 69% were concerned that their tears would cause the client concern that the therapist was excessively burdened by or could not handle the client's emotion. No evidence was presented, however, that this was actually the case. In my view, thoughtful theory-based discussion should be devoted to the question of appropriate verbal and emotional self-disclosure and the effect on genuineness, especially given that nonresponsiveness to emotional need is a clear facet of insecure parenting (Bowlby, 1988).

Nonetheless, emotional and verbal self-disclosure are complicated. In my own sample of clients who have completed trauma therapy, 290 were asked what types of questions they had asked their therapists during treatment. For our purposes here, I would like to focus on three—a question regarding the therapist's sexual orientation, a question as to the therapist's trauma history, and a question regarding one of the therapist's other patients. Of the 290 respondents, 17 had asked a question about the sexual orientation of the therapist, 19 had asked a question about another patient, and 42 had asked a question related to the trauma history of their therapist. According to the patients, 74% of therapists answered the question about orientation, 50% of the therapists answered the trauma question, and 24% answered the question about the other patient. Clients reported virtually uniformly negative impact if the therapist *did* answer the question about the other patient, perhaps because refusal is seen as protective of their valued confidentiality. However, they reported uniformly negative affect if the therapist *did not* answer the question about therapist orientation, perhaps because some aspects of the therapist serve as interpretive frames for the patient and feel necessary for making use of the alliance. Therapist self-disclosure, therefore, is not simply positive or negative. In fact, the question about whether the therapist had a trauma history was refused as often as it was answered, and each choice had both negative and positive reported repercussions for the client. Thus, simplistic refusals in the service of the blank screen or simplistic disclosures in the service of enhanced genuineness do not seem appropriate. Conversations are necessary across therapeutic forums to determine appropriate avenues, timing, and methods of disclosure.

As a final example, my laboratory has recently completed a study on client sexual transference to therapists. Our pilot work had shown that therapists were very likely to make hostile and distancing statements to clients

who disclosed sexual transference, most likely out of fear. After gathering hundreds of therapist responses to client sexual disclosures differing in their level of aggression, we asked nonprofessional research participants to put themselves in the role of the client and to rate the therapist responses as to their likely effect on the alliance. We found that there were types of refusals here (as in, no, we cannot have a sexual relationship) that could be framed in a way that was not automatically experienced as distancing, ingenuine, or uncaring. In fact, one category—the boundary statement plus positive statements about present role—was thought to be alliance building. As is true in many of the difficult clinical situations endemic to the rocky transference roads that complex trauma patients travel to achieve health, it was not obvious to the young clinicians how to be both genuine and therapeutic. Again, if management of client views of the therapist as warm, genuine, and trustworthy was made a focus of research, clinical discussion, and, ultimately, clinical training, it is highly likely that treatment outcomes would improve. I am encouraged by the theoretical discussion inspired by proponents of relational-cultural theory (Comstock et al., 2008; Miller, Jordan, Kaplan, Stiver, & Surrey, 1991), who advocate for the primacy of mutual empathy in psychotherapy, arguing that such a foundation encourages individuals to be “empathically attuned, emotionally responsive, authentically present, and open to change” (Miller et al., 1991, p. 11).

SUMMARY

Although there remain obstacles to the empirically validated treatment movement, it is clear that progress has been made. Manualized treatments allow for more controlled study of the components of successful therapy, and many such trials are now in progress. Nonetheless, the common factors that are shown to be effective across therapies, often accounting for more variance in outcome than therapy technique, are typically treated as if they were error variance rather than modifiable characteristics of treatment. Here, I would argue that the common factors are complex predictors that are affected by relevant trauma-related variables (e.g., prior trust in authority figures, insecure attachment) and that these factors should be more routinely assessed and more directly addressed in treatment and training. More specifically, I believe the following recommendations are warranted:

Recommendations to Psychotherapy Training Centers and Individual Clinicians

1. Supervisors should discuss with therapists comfortable and professional ways to check in with patients about the degree of warmth, genuineness, and trustworthiness that they are experiencing, to allow for therapist self-correction and to open the door for valuable discussion.

2. Common questions asked by trauma clients should be discussed with trauma therapists with the goal of developing a nuanced and alliance-building method of limited self-disclosure.
3. The attention of supervisors should be focused not only on technique but also on therapists' individual level of warmth, genuineness, and implied trustworthiness.
4. Extended discussion of the rationale for the treatments being provided should occur in supervision, such that each therapist becomes comfortable with multiple client-friendly ways of discussing these rationales.
5. Supervisors should take time to discuss those topics that are difficult to raise in psychotherapy—race, sex, and money, for instance—and help beginning therapists to more comfortably open the door to these topics for their clients.

Recommendations to Trauma Researchers

6. In examining the importance of specific components of successful treatment (e.g., Is exposure necessary?), researchers should consider tests of training models aimed toward enhancing the clinician's ability to promote the common factors.
7. The common factors could be seen and researched as interactional in nature rather than as properties of a given clinician, such that knowledge is gained about (a) behaviors that enhance the experience of warmth, for instance, for most clients and (b) client characteristics that impede the experience of being in the presence of warmth when it is offered.

The techniques that we have to offer are of ever increasing efficacy. It is time that we began to address more seriously the art and science of enhancing therapy acceptance.

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