

Webinar Title: Beyond Efficacy: Unveiling the Mechanisms of Change in Psychotherapy

Webinar Date and Time: Wednesday, November 5, 2025 at 1pm ET

Speaker 1: Hello, and welcome to today's webinar, *Beyond Efficacy: Unveiling the Mechanisms of Change in Psychotherapy*. This topical webinar is paid for by Newport Healthcare, a national leader in teen and young adult behavioral health treatment, providing sustainable healing for mental health and co-occurring disorders. Some important points before we get started. Dr. Michael Roeske, the presenter for today's webinar, has a working relationship with Newport Healthcare. As such, he has both a financial and intellectual interest in the webinar content.

The purpose of this presentation is to provide a balanced view on the ongoing debate about what leads to change in psychotherapy and the implications for training and supervision. APA does not endorse any products or services. The content was created by Newport Healthcare and does not reflect the views of APA or its editorial staff. Email advertising@apa.org to learn more.

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Now, let me introduce our presenter, Dr. Michael Roeske. Dr. Roeske is a licensed clinical psychologist who has worked and studied in a variety of treatment settings since 2003, including adult substance use disorder and adolescent mental health programs, community-based psychological services, and inpatient psychiatric hospitals. He is trained as a full battery assessor of children to older adults and has functioned as a supervisor, clinical director, educator, presenter, and operator. Welcome, Dr. Roeske.

Dr. Michael Roeske: Thank you. Thank you for the introduction and the opportunity to be here. This is an important topic. I work primarily as a researcher right now and haven't been client-facing in a few years, but I still supervise psych associates. It's been a lot of time. Particularly, I have one psych associate supervisor that is relatively early in his career. We've spent a lot of time talking about this topic. It's really relevant to what I'm doing right now. It's relevant to the day-to-day activities that we describe and discuss in the context of supervision.

The talk today, thinking about how to go through considerations about what leads to change psychotherapy, I think it's useful to start at the beginning of the field of psychology and its emphasis upon technique. Then I'll go through my beginning, what happened to me during the course, particularly during training. Then I'll come to

what I believe to be the biggest point of disconnect between what I was trained and what I experienced with patients. It really comes down to the conflation of theory, technique, and efficacy research. It's more complicated than that, but that's one lens by which we can view that issue.

Then we'll take a look at what we might describe as a dialectic, particularly supported treatments on one side, the thesis, and then the antithesis, perhaps the common factors, and then the tension that's resolved through that. As a synthesis, as an example, APA's evidence-based practice in psychology. We could also think of it as a complementarity that is something that has contrasted theories that seem to explain a phenomena that can't do it singularly, that combines. An example of that is the wave-particle theory of light. Then we'll take a look specifically at a most prominent common factors model called the contextual model. It's Wampold's model.

Then we'll end it with talking about what does this mean for training and supervision, and practice? Obviously, it's a fairly large question. We'll dig through a few of the maybe more pragmatic considerations to it and probably leave more questions and answers ultimately at the end. It's, again, to spark conversation. I do want to acknowledge at this point, I'm going to appear at times to privilege common factors over a technical approach. It really isn't my intention. I do view it as a complementarity where it does require both of these to have effective therapy.

The way I conceptualize why I seem to bias towards common factors is in part because of maybe a corrective place, because it's not as emphasized in training and supervision. Maybe as a way to move the needle over a little bit, I probably overemphasize the role of common factors. Here's the beginning, or here's a beginning of psychology. Late 19th century, there was a patient known as Anna O. She was being seen by a neurologist named Breuer. Many of you, as psychologists, probably know the story. Something remarkable happened in the course of therapy. As she started to talk about events from her life, her symptoms improved simply by talking about those things. She was so impressed by it that she called it the talking cure.

Breuer was relating this case to Freud. He was so intrigued by it, he put it into his seminal work, *Studies in Mystery*, in 1895. Over the next five years, started to really consider not exclusively the Anna, but really why did that work? Why did just talking about her symptoms lead to alleviation? Obviously, those of you that know the history of Anna know that she didn't have sustained relief. She was quite an interesting person. Take a look at Wikipedia.

It really brought to mind, what was it? What happened in the 1900, he wrote *Interpretation of Dreams*, where he outlined his first conceptualization of the mind as having an unconscious and a conscious part. What he really thought happened with Breuer was that there was this unconscious part. Many of you have seen the picture of an iceberg where the tip is the conscious and underneath is all this other material of the mind. That largely drives behavior. In fact, what Breuer was able to do was take the conscious material and move to the conscious and then effectively reduce the power it had over the ability to control symptom formation. That was his technique. Try to understand what is unconscious in the patient. Then over the rest of his career, he further refined and revised his theories about what psychotherapy was, psychopathology, and how to address it.

Then I just randomly picked some here. We could look at a lot of different ones. Over the course of the next century, different theorists came along and said, I think actually it might be a different focus or there might be a different mechanism of change. If you think of the 1960s, Aaron Beck noticed that a lot of people with depression had these, what he called dysfunctional schema, I'm unlovable, everyone's going to leave me, various things like that. He really associated that with those thoughts, leading them to depressed feelings. If you could replace those or diminish those, you would alleviate depression. Ultimately, you get cognitive behavioral therapy.

Psychoanalytic approach. Most of you may or may not know psychoanalysis really is a heterogeneous group of theories and techniques these days. You have object relation, psychology. In the 1980s, Stephen Mitchell came along, did a lot of work with people that were narcissistically organized, and said, "My primary role is to understand why. What's the bid? Why do they need to engage with others there? If we can understand that, we can really unpack it. Intervene on it. That's the focus of therapy. Why this way of relating to others?"

Then you have Stephen Hayes in the 1980s, also, who said, "Well, I really think the primary focus of therapy should be around accepting really difficult thoughts and feelings and really aligning actions with someone's values. That really should be the focus of effective therapy." Then in the 1980s as well, because a lot of thinking was happening in the 1980s, you have Sue Johnson and Les Greenberg who came along and said, "You know what, I really don't think we should focus on thoughts and behaviors. It really should be focused on emotional intelligence, emotional language, emotional processing." Each of them made claim to, this is what is the mechanism of change or the active ingredient of psychotherapy.

When I got into graduate school, there was pressure to adopt a theory and technique. This is true obviously, of many programs. You may have a particular model. You may be CBT-focused or DBT-focused. There was a real pressure to adopt one of those. As a new clinician, I was more than happy to do that. You're sitting with the patient. You don't really quite know what to do or really how to help. Having theory and structure and technique really alleviated my anxiety, made me feel better about what I was doing. Then this was presented in the context of both the training, the classroom work, and supervision as synonymous. Aaron Beck's view about dysfunctional schema and reducing those as a way to reduce depression was linked to efficacy research on CBT. It all was presented as the same thing. I didn't question it. It made intuitive sense. Then, as I started to sit with patients, they taught me something else, and I could have given a number of examples. I just chose two here.

The first one was silences, the consequence of silences. I often didn't know what to say or do. I had a supervisor give me the 80/20 rule, which is let them speak 80% of the time and you speak 20% of the time. Largely, a lot of what I did were elaboration and clarification questions. Can you tell me more about what did you mean by? That was a lot of what I did. I found it to be really, really helpful. Patients reported it was really helpful.

I started to think about my own experience. Most people have not been deeply listened to. I joke with supervisees. It's obviously a joke. When I am client-facing, the

joke is that 90% of what's effective for me is that I'm really listening to what they say rather than the great, insightful interpretation I might make or the intervention that I introduce that I expect them to perform outside of the therapy room.

Then you have things like rapprochements. This is in reference to Mahler's theory of child development that a lot of the way the sense of self develops is how a child handles ruptures in their relationship with the parental figure. How do they reconnect? How do they rebind? I would have patients that were maybe behind in payment or didn't show up to a therapy session. Then the working through of that in the context of therapy often really moved things along. I really started to wonder, maybe something else is happening here. Maybe there are other things that are more important or equally important, or different ways of thinking about really what is the emphasis of psychotherapy.

It all really calcified for me when I was a relatively new clinician and I ended up treating a 25-year-old female patient in an outpatient setting. She had graduated from a prestigious school. She was an accomplished athlete. Family was wealthy, had a lot of resources. On the surface, she really had a lot going in her life, you would ostensibly say, if you were to see her on the metro, it was in the Bay Area at the time, you would say, "Oh, look, this person looks like they have a pretty good life."

The fact was that by the age of 10, she started to be suicidal, had suicidal thoughts, non-suicidal self-injurious behavior, experienced depression, ended up with an eating disorder or an alcohol use disorder, ended up with three suicide attempts, first at the age of 13, and then the last one at the age of 18 was attempted hanging, and her mother found her. Just wrecked the family. Everyone was really devastated. She was in and out of therapy. Ended up in an inpatient, obviously, following each of the events.

By the time I saw her, she had been sober or abstinent from alcohol for about-- had been for about four years. She had graduated school. She had a job that she mostly liked. She was in a committed romantic relationship. In a lot of ways, she had really progressed and done well, but about six months earlier, prior to coming in, she had decided that because all the other things were going well in her life, maybe she could resume alcohol. Her partner drank. He went out to a bar one night, and she drank and had been unable to get more than a few days sober since, and she was back in treatment.

One of the things that struck me, and it still raises the hair on my arm when I think back to the moment, in the very first session of collecting history, she told me this story about her chronic suicidality. She said, "Every time I would go to my mother and say to her, 'Hey, I want to kill myself. I really don't want to be alive anymore.'" Her mother's response would be, "Well, you're so pretty. You're so smart. You have so much to live for. You shouldn't feel that way." Then she would be in therapy, and people would be focused on, okay, you have this dysfunctional schema that life is not worth living. We're going to address that. We're going to have you journal. Replace that with more positive views of the world."

She said every time that happened, she would feel more and more alone. Ultimately, in learning to know her, this ended up escalating the behavior because something

else was going on, and she was not able to be heard. She said that when things changed, she was in an inpatient psychiatric unit, and the medical director was talking to her, and she was explaining everything in her life, and she said, "I think I'm going to kill myself ultimately." He leaned forward, and he said, "I think he might also." She said it was the first time ever since she started to have problems that either a therapist or a family member or anybody was willing to be in there with her, that he wasn't afraid of what she was saying. He wasn't going to run away. He was just going to be present with her about this.

He really talked honestly about his belief that she may do it. It was the way he did it that really allowed her to feel connected and heard, and that started a progression of health and healing that ultimately led to all those improvements and all those abilities to do things in life. Obviously, she was still in treatment when I saw her, but she was doing much better. That really taught me something vitally important about the effectiveness of therapy. Also, that patients would teach me how to work with them. That's been true ever since. If I'm listening closely enough, patients will do that.

Really, the thoughts started to really spin. Maybe the cart's before the horse. I knew and had read efficacy research, and I knew randomized controlled trials, the gold standard of efficacy research, really strong designs when they show good effect size. You really can trust that they found something in the effectiveness of the therapy. I had no doubt about the ability for CBT or EMDR, or any of the various ones to treat patients.

As Kazdin taught me in 2000s, I don't remember when I actually read this. The thing that gets problematic in that is that RCTs are not actually designed to talk about whether or not Aaron Beck-- I don't mean to be picking on CBT, just the example that comes to mind. They're not designed to test whether or not Aaron Beck's view about dysfunctional schemas and the reduction of dysfunctional schemas, or what actually leads to change in the patient's symptoms or however it's being measured. They're actually not designed to do that. That question is actually much more complicated and difficult to answer. We'll get into some of those toward the end when we really think about some of the limitations on both the ESTs and the common factors. It really is a difficult one to answer, and one that really RCTs are not designed to do.

Then the more I thought about it, most psychotherapies provide these often really richly described understandings about why their particular therapy works. You think about EMDR, I think it's Shapiro, and the description of the track, trauma within the brain and the bilateral stimulation allows it to be processed. It really has a compelling narrative about why it works. You see, I have some colleagues that are really good adherents of EMDR who were big believers in it. I hear anecdotally the response of the patient, so I have no doubt about its effectiveness. There's actually, again, very little support for those mechanisms of change. Again, using EMDR as an example, we really don't know why, ultimately, the tapping with the bilateral stimulation, if that's really what it is. We really don't know. Again, it leads to that conflation between efficacy research theory and technique.

Then what happens in practice? I can tell you that I went into the clinical field with pressure to adopt a particular model. As I mentioned, I was grateful for that. I wanted that. It really helped reduce my anxiety. When I work with supervisees, especially those that are relatively early in their careers, they want the same thing. What do I

do? How do you handle this? What do I say? What kind of treatment plan do I put in place? Over time, and this was certainly my experience, clinicians tend to evolve towards an informal eclecticism. It's really based upon experience with patients. Now, Behran rightly says that's not the only reason. For example, it's difficult to keep up with research. There's a lot of reasons why over time, clinicians might do it, but a lot of it has to do with the patient experience about what is working and why, and what you think is going to be effective with them. The majority of clients identify as integrative or eclectic. When we look specifically at what they think are the common mechanisms of change, they endorse common factors. The most endorsed factor actually is relationship one, like a therapeutic relationship.

That's really precisely been the progression for me in my clinical experience, where I really latched on to technical views of things. Then over time, started to realize that strict adherence really wasn't as needed or effective, especially when I had more diverse patients or patients with different cultural backgrounds or different needs. It required greater flexibility. I had to really consider what I was saying and why, and try to understand, for example, idioms of distress. I'm not really sure that what they're describing is how I'm interpreting it, so really trying to understand their perspective. It really became preoccupying for me as a clinician that was practicing.

How do we think about this? How do we resolve this? How do we understand this better? In terms of what really helps and leads to change in psychotherapy, there are two competing paradigms. The first one is specific factors or empirically supported treatments. These are therapies that are designed for a specific condition under certain circumstances. I can use RCT as an example of a way to study effect size about whether or not this particular therapy is working. Then you have non-specific or common factors. These are factors that are considered to be part of all psychotherapies, whether or not it's EMDR or CBT, or psychoanalysis. Regardless, they're common to them all. We'll break those down a little bit and look at some of the criticisms.

Where do ESTs come from? Prior to the 1990s and mid-1990s, a lot of clinicians were practicing without specific goals or more long-term approaches and really ways to measure success. Then in the same time period, in the early to mid-'90s, pharmacology organizations were able to widely disseminate practice guidelines that prioritize medications over psychotherapy. Unfortunately, often without a great deal of evidence to support those claims. They were really effective. If you remember correctly, I don't remember what year Time magazine had the big picture of the smiley face, Prozac. I may be misremembering some of the historical pieces here.

There was a real sense that psychopharmacology was going to be able to resolve psychiatric issues, psychological issues, and that it really was the wave of the future. In a way to combat that, to really take a look at our field, honestly, APA set up a task force in 1995 to take a look at, okay, how do we establish guidelines? How do we understand what is effective therapy? How do we measure it? How do we make recommendations to people about what to do? It really started to pick up momentum around that with that first task force.

Then it gets a little bit challenging because NIMH really used the design and methodology of the pharmacology research as the evaluation standards for psychotherapy research. Obviously, it really is going to dominate the way people

think about psycho-efficacy research, the type of efficacy research that they apply for, are going to be ones that fit in with those methodology and design standards. The things that don't, you think about psychoanalytic treatments, they don't really fit well into some of those design and methodology criteria.

Again, trying to make an effort to improve the field. The argument really was, okay, we want to take a look and have the best available research. That is part of evidence-based practice and ultimately is considered the gold standard to do that. It's hard to argue against it. How do you not advise that we should try to really understand effectiveness of therapy, and then that's what you should use if things aren't studied well or don't do well in testing? You might be a little more reluctant.

The criticisms also quickly emerged of ESTs. They were obviously brief. Again, with the design and methodology restrictions, you start to have more than a couple of months of therapy, start to lose the control factors on the design of the study. They did it in weeks or a lack of months. The problem is many times we have patients that have more chronic conditions that aren't necessarily treated in a long-term way over a couple of weeks or a couple of months. They weren't really common factors in them, no consideration to things like patient expectations, therapeutic alliance, providing a rationale for what you're doing that the patient agrees with.

They also lack generalizability. They really were not designed to take a look at different patient populations. When we get to Westen and colleagues down at the bottom here, I'll mention a more concrete example. Then when, I don't know if I'm pronouncing it right, Sakuluk and colleagues took a look at some of the meta-analyses for ESTs, it was inconsistent in terms of the evidential value. A lot of them had low-power replicability estimates. Then the assumptions that ESTs themselves are not terribly empirically supported. An example of that in ESTs, in RCTs, you tend to exclude complicated heterogeneous populations.

In clinical practice, I used to joke, I don't know that I've ever treated one of those individuals. Excluding all these people that tend to end up in practice from these studies really does create a lot of problems about whether or not it's generalizable and whether or not this is really going to support your particular patient at this particular time. Then you switch to common factors model. It was introduced in Rosenzweig in 1936, also known as the Dodo Bird Verdict from Alice in Wonderland. If you remember Lewis Carroll's story, during the Caucus Race, at a certain point, there's a pronouncement, everybody wins, everybody gets a prize.

Rosenzweig used that to explain what he saw observationally, which was that all therapies seem to have a similar effectiveness. They all seem to do the same. Everyone gets a prize, you're all doing good. Then in 1961, there's been a lot of different models, but it really was popularized. We really see the beginning of the modern view of common factors models with Frank's publication in 1961. These, again, are things that we see resonate today. There's rituals involved. There's a particular setting where the therapy would take place, therapeutic alliance, the relationship, patient expectations, and understanding the rationale for the therapy. The best and most well-developed is Wampold's contextual model, which we'll talk about in a little more detail.

The contextual model, those of you that are familiar with common factors obviously know Wampold's work. He's not without his detractors. I'm not here to claim that everything he says and does is without criticism or critique. I just find it really accessible. I find it really compelling and, again, as a good corrective to what I found to be a very technically heavy focus in training and supervision. He really views psychotherapy as a social healing practice. That's the overarching umbrella upon which psychotherapy and his conceptualization of it should be viewed. It basically is made up of four parts of the initial therapeutic relations, and then there's three specific pathways.

The initial therapeutic relationship, I do take issue with him saying this precedes the work. The way I was taught as a clinician is that thinking about like, curvy alum, everything's squished through the mill. There is no preceding the work. It's all part of the work, but I don't mean to get into. The reason I say that is because I think this gets revisited in the context of therapy, perhaps many times during the course of therapy. I spent a lot of time with this particular piece with early career psychotherapists, the first thing that's most important is, does the patient find you trustworthy? Do they think you're expert enough to help them? Do you think that you're going to give time and effort? For many of us who have been in therapy or obviously practicing clinicians, the apt example might be when you go to a medical doctor for a condition. Think about how important it is to feel like, okay, I trust what this person's saying, I know what they're talking about, and I don't feel like they're trying to get out of the room to get onto the next patient. How important that is in the context of your treatment? Again, you can really sink your teeth into it when you think about it that way, because particularly in the field of medicine, you often feel pressure to move on. When you find a physician that does those three things, you're really like, "Oh, I really like that person. I'm going to go back. I feel like they can help them."

Then there's the real relationship. This is somewhat in reference to a psychoanalytic approach of the transference, which is not considered. It's from the crucible of earlier relational dynamics that get projected out into the world that you invite people to act in certain behavioral ways. There's also beneath that, a real relationship in there. In psychotherapy, it has general processes. You can be kind and various things, but also unusual social processes. There are limitations to confidentiality. The flip side of that, you talk about things that are perhaps very embarrassing or really potentially illegal, and you don't generally worry about loss of the relationship.

I had a patient once who admitted to me that he had committed manslaughter. He was in a bar. One night, him and some other guy were out on the balcony outside. They got into a fight. He pushed him over the balcony. The guy fell and landed on his neck and died. He ran away. The person died. A lot of guilt associated with that. Now I have that, and he and I are working through it.

Then there's patient expectations. These have a really strong influence on experience and symptom maintenance and motivation, and change. Really, all treatments, we can think about it in the context of placebo effects, which significantly influence all clinical research. Essentially, it's a byproduct of simply a person believing that the clinical setting or the environment, or the treatment is going to be effective, even though it obviously is an inert. Typically, if it's a no treatment versus treatment, it's an inert experience. Maybe it's in the context of psychopharmacology,

it's a sugar pill. You really see that the sugar pill produces a great deal of effect. It really has a lot to do. You really want to spend a lot of time making sure that the patients understand the explanations for the difficulties that are happening, that the therapy will help. If that's in place, the therapy is much more likely to be effective.

This is where you can think of Wampold, who's known primarily as a common factors theorist, but he really is a complementary approach here. He does not suggest that common factors don't require specific ingredients. In fact, he ends here and says, "Look, this is where the specific factors come in." All this is based, all that ability to be trustworthy expert that I'm going to take time and effort to listen is based upon the idea that this person, the clinician in this case, has something in mind as to what is going to be helpful and understand how it's going to work.

I have a colleague who is our national director for OCD and anxiety programs. I went to her with this and said, "If there are any therapies that tend to really show effectiveness over others, you think of exposure and response prevention for the treatment of OCD. If my child or I, or a patient had really crippling OCD, I would recommend without hesitation an ERP clinician." I said, "How do you think about this? It really is the technical piece here that appears to be the most important part of ERP. Where does this come in?" She said, "I actually think it's more important in the context of ERP because ERP is very, very difficult. If you have contamination OCD, it might require at a certain point that a person puts their hand on the side of a dirty toilet seat and they can't wash their hands. It's really, really distressing."

It has to really provide a rationale as to why they should go through this really difficult time. It really was compelling when she said that to me. She said, "I actually think in the context of your example, it's actually more relevant." Wampold then says that the next consequence of that is that it induces expectations and action. I gave the example of journaling, which is a common one. I've used journaling. I have colleagues and friends, and patients that have done it and talked about how it works.

Ultimately, and I 100% agree with Wampold's view, his view is that if you have all these things in place, if it produces action, it will work. That obviously is an exaggeration, just because it produces action, it won't work. In a general sense, that is the key piece of it. Whatever they think is working and they have that sense, and you're there with them, and then they commit to it will produce generally salubrious effects. Maybe not in a linear place, but that's generally been my experience both as a clinician, as a parent, as a human being. That's been my experience. When I take action, when I have a sense, things get better.

Then Wampold throws in here some meta-analysis of efficacy research. There are criticisms. We'll get into the limitations on some of these things. You can see here on the left-hand side, those are contextual model factors. If you remember from Cohen's view on effect size, 0.5 is medium effect. You can see all the empathy and alliance, the breadth of it is the number of meta-analyses. Then all the way on the right side, you can see here where specific ingredients. There's very little from an effect size perspective in terms of treatment outcomes. Again, there are sound criticisms of the way that he approached the data and the way he presents it, but again, it certainly tells a very compelling story.

Here are limitations for common factors. One of the problems is there's no defined list. They're nebulous. People are left with trying to figure out like, say, okay, if we're going to teach this, if we're going to supervise around this, what are we teaching, and how do we provide it in a uniform way? We don't have that. Then what's good-- What do they say? What's good for the goose is good for the gander. I don't even know what a gander is.

If it's difficult to explain efficacy through RCTs or other research capabilities of specific ingredients, the same is true of common factors. It's still ultimately speculative as to really what we're seeing here. One alternate explanation for why CBT and DBT and EMDR, and ACT all show effectiveness is they may just have different mechanisms of action that work and all roads lead to Rome. It may be the various things that Marsha Linehan described for people that are emotionally dysregulated. Those things precisely work for that population, but so does psychoanalysis when it focuses on characterological change.

Then the other piece, the way to really understand whether or not-- a lot of the meta-analyses are correlational rather than dose response or temporal associations, longitudinal studies, which really, if anybody remembers or is still in research, is really problematic in terms of what you can say about a particular outcome or result. A few of them have those particular features in their design. There's a lot of issues with low power. There's issues with blinding and randomization. It really becomes problematic. You can do what are called dismantling or decomposing studies, where you take a piece or additive studies where you take--

We run into this all the time when we try to do residential research, because there's so many multi-components pieces of the treatment, how do you isolate out what is the effectiveness of the family therapy versus the individual therapy versus the experiential therapies like wilderness, [unintelligible 00:40:02] like adventure, yoga, music, and various things. One option would be if you have family therapy and you have it one time per week, you would do an additive study where you do two times a week or three times a week and see if you see changes. The implications of all this, when we think about what does all this mean and where do we go from here? On both sides of it, on specific factors and common factors, there's limitations in the evidence, and really the ability to draw clear conclusions about is not there. The power battles that seemingly develop over time, have developed over time between those two fields are not going to move the field forward. They're not doing anything. In all fairness, the specific techniques theorists, they all tend to identify and recognize the importance of common factors. If anything, it is more the common factors theories who tend to be a little bit more-- this is not truth per se, but common factors heavily outweighs the impact of technical features.

Ultimately, though, we really don't have evidence to support one way or the other. The ongoing conversation about is it this or that really isn't very helpful. The change really likely is the dynamic interplay of both. One of the challenges, though, is how do you balance which to privilege or how to do it in the context of training and supervision, even in the context of when we talk about further implications on the next slide, even in the implications around licensing requirements, third-party payer pieces. Again, it's very difficult to discern which is more important in that, or how do you balance it all?

One way to think about it would be in orthogonal axes. If you think about axes where on the one hand you have common factors, on the other hand, you have specific techniques. In that field, let's say on the, in my mind, I'm just trying to, upper right. Where you have the highest potency of specific common factors, you can expect that the greatest efficacy of the therapy. Then if you come down to the bottom left, where you have limited common factors, you don't have a patient having a sense of rationale or expectations, don't really feel that you're trustworthy, you're going to listen, and you don't really have a technical approach.

You're not really taking them through something that you have a sense of as being effective for the particular reason that they came into treatment. That's going to be the least effective. Then obviously, on the other quadrants, you're going to see, if you weigh more heavy towards common factors or weigh more towards specific factors, you're going to see some loss of efficacy. Generally, that's probably the best way to conceptualize it is one that I use in supervision that seems tangible for people to get their minds around.

When it comes to the evidence-based practice in psychology, the APA came out with a revision and expansion in 2021 that provided some clinical illustrations and pragmatic considerations. It really is a good model. I do recommend people to get that, download it, and read it. It provides some good guidance as a way to balance both of those things because it maintains connection and recommendation towards the best available research. It also takes into consideration the expertise of the clinician, who is the particular patient that you were working with? Were there cultural considerations that really need to be taken into consideration in terms of how you approach?

Then, ultimately, also patient preferences. I mentioned working with that chronically suicidal female. Most important to her, and this isn't true for every patient, most important for her was at very least, she felt like I was listening and wasn't going to be scared about what she told me. I really made a concerted effort, which at times is difficult, especially in the context of suicidality. Again, by the time I saw her, she had largely been non-suicidal for a long period of time. It really could become particularly problematic. I really wanted to pay attention to what it was that she preferred. It's identified in the EBPP.

Then I do recommend everybody download. It is public domain. Wampold's *How Important Are Common Factors In Psychotherapy*. You can see it's 10 years old, but it really is about eight pages long. I love brief reports. I give it to every supervisee that I work with and say, "Hey, read this. We're going to use this in the course of our supervision. We'll refer back to it." I find it very helpful, very accessible, and easy to read.

We're coming to the end of the talk here. I mentioned in the beginning that we might leave with more questions than answers ultimately, because I really don't know what it means from a clinical training perspective. I certainly know, and I've seen this in the literature, that most psychologists don't get a lot of exposure to common factors unless they come from a more integrative type of program. There might be mention of it, but it's not really a focus of the training. At the very least, some way in which common factors ideally could be greater incorporated in the classroom setting, in the expectations of supervision.

The same thing with licensing and licensing exams. There's so much. We think about the EBPP. There's so much information in there that is related to the technical piece, technical practice, interpretation of ethical guidelines. I'm not suggesting that those are not important to think. I do think people that are going to practice independently as a psychologist should have a wealth of knowledge around these things and be able to articulate them. It's been a while since I took the EBPP. I wouldn't pass it today.

At that particular moment, I really had a very vast and deep understanding of psychological topics that I do think is important, and it's an important gatekeeping feature. How do we bring in this more nebulous, difficult to measure, not agreed upon component that really is effective? Those of you that have worked with colleagues that are just great with patients, that are able to develop these expectations, that are able to explain their rationale, to get people to induce into behavior, they may not be really very good on those other pieces.

I don't know if this is a true story or not, but I remember Rollo May, one of the founders and developers of existential-humanistic psychotherapy. The story that I was told was that he helped create the licensing questions for existential psychotherapy, but couldn't pass the licensing exam. Again, I don't know if this is a true story or not. What I was told was they eventually just grandfathered him in because he's like, "Look, I wrote these questions. Come on, I've been practicing for a while. Are you not going to go to Rollo May? I'm going to him. Anyway, a bit of a tangent there.

Then you think about third-party payment or even outcomes monitoring. We do a lot of outcomes monitoring that does focus on common factors, WAISR, for example, which is a short working alliance measure that we give at a repeated over the course of treatment to take a look at the relationship that they have with the therapist. Those of you that do concurrent reviews or have to try to justify continued stays in the context of psychotherapy, there's not questions about the common factors generally. It's stabilization, symptom reduction, effort towards lower-level care. That sounds harsh. I don't mean to be judgmental. They have difficult jobs as well trying to consider resource utilization. There's really very little consideration to that. It's such an important feature. You talk about working alliance. The relationship to outcomes, the literature is pretty robust around it. Beyond that, you think about even patients that have difficult attachment histories, difficult trauma histories, that have difficult time in the context of therapy, feeling safe and comfortable, I've seen in the literature that it really comes down more so to the individual therapist than it does the patient in terms of the ability to develop therapeutic alliance and then ultimately outcomes.

It really is vitally important to the work that we do, and really is also not emphasized almost at all in the context of the financial reimbursement piece, which drives ultimately, I could include here again, going back to NIH funding, it drives a lot of the financial incentives to change our behavior and contribute to the things that we do. That's it. I'm going to pause here and see if people have questions and give some consideration. Many of you probably are-- This is a common conversation regardless. I'm looking forward to if there's any questions you have.

Speaker 1: Wonderful. Thank you so much, Dr. Roeske. We're now moving into the live Q&A. Thank you to everyone who submitted questions during registration and to

those adding them in the Q&A box today. Dr. Roeske will do his best to hint for as many as possible, though he may not get to all of them. Your questions are appreciated. Let's dive in. We have one question that asks, "A lot of my clients want solutions and advice, especially parents. They don't just want validation. How would you approach this population?"

Dr. Roeske: Yes. Again, I'm not client-facing now, but I work with adolescents. When I was on-site, I met with every family, and that's what they wanted. They came in hot. Their child is sneaking out of the house. Their grades are bad. They're in their room just on the phone or self-harming. They're like, "What do we do here?" We use attachment-based family therapy as our clinical model around it. Really, it's a reframe. Probably what you're doing is very similar to what I would be doing. The reframe is to get them back to-- I think you're talking in the context of families and children. Get them back to the idea of improving the relationship between them, making sure that they feel that you are someone that's trustworthy. You're someone that has expertise, and that you're going to take the time with them. Then get them to focus on re-relating with their kids, invoking the parental empathy piece of it.

With my suicidal patient, you could argue, and I feel very strongly about it, her suicidality was directly related to the lack of connectedness that she felt both within her family and in the psychotherapy context. As soon as she felt that, the symptoms diminished. I've seen that with adolescents, and particularly young adults. I don't know if I've directly answered your question, but I totally identify with it.

Speaker 1: Thank you so much. We have another question that asks, "Does CBT also have inconsistent evidential value and low power, and replicability estimates?"

Dr. Roeske: Right. CBT is fairly broad. A lot of the RCTs are looking at specific techniques under specific conditions. It's a heterogeneous group, and it's hard to make claim about it as a whole. In general, yes. I guess more so, not necessarily that CBT isn't effective. It's just the efficacy research is not very good overall.

Speaker 1: Perfect. Thank you. We have another question that asks, "Should graduate students still be trained first in psychotherapy theories rather than common factors?"

Dr. Roeske: That's a great question, and one that I ask myself many times. It goes to a question in the context of psychotherapy. If you have a patient with a substance use disorder and co-occurring post-traumatic stress disorder, there's a group of people who say, you got to get them emotionally resourced in order to be able to handle maybe the SUDP. We're going to work on the trauma first. There's other people like, no, no, we got to get them stabilized on the substances because if they're still using substances, they're not going to be able to engage in the trauma work.

The contemporary thinking today is that you can treat both simultaneously. It's a gold standard approach with co-occurring disorders from SAMHSA. I think of it in the same way. I think ultimately, I present these things simultaneously. I think ultimately, that's probably the best way to do it. Even though both my own experience and my supervisor's experiences, I want technical. That's the piece that I'm-- feels most relevant to me. I think it has to be done hand-in-hand. A lot of that can be mirrored. It

can be based on how I can reflect that in my supervision style, the common factors piece.

Speaker 1: Thank you. Another question asks, "From the client's side, what is important to know about what makes therapy work? How does it affect how to show up as a client?"

Dr. Roeske: Great question. I think I mentioned it before when we were talking about when I've gone to physicians for various health elements. The things that I look for, the trustworthiness, expertise, and are they doing it at the time, and are they going to commit to that piece of it? When family members or people, friends, come to me and say, "Hey, I'm thinking about doing psychotherapy. What do I look for? How do you know if it's a good fit?" I do refer them back to some version of that. Those are things to look out for.

Obviously, a clinician might have an off day. They might have had a bad session before. I don't want to lay claim to not going back to a therapist just because they had a rough session before, maybe they weren't on their game. In general, that's the recommendation that I have for people that are contemplating psychotherapy. I think about it for myself, again, most relevantly in the context of medical treatment.

Speaker 1: Wonderful. Thank you. Another question asks, "What do you see as the greatest source of resistance to this point of view?"

Dr. Roeske: I think a legacy of the impact of psychopharmacology research, that we need to remove everything that can't be measured well. We can go back 400 years to Descartes. I don't want to get too historical here. The 500 years. The cleaving of science from religion to medicine back then. What he said was, anything we can't know with mathematical precision needs to go. We're not going to consider it. A lot of great things happened from that. Obviously, plate tectonics, astronomy, and chemistry. All these things happened when we did that. I think psychologists have that same hope that if we make this a pure science in the same sense that Descartes recommended 500 years ago during the Enlightenment or Renaissance or whatever. We're going to do that.

There's that desire for that validation or legitimacy that is found in cardiology or other areas of health science. I just don't think that that's the case. I think we need to let go of that aim and really stick with what is happening in the context of psychotherapy. I think it's partly the legacy of, uh-oh, we're going to be outbid by the psychiatrist here. We got to get on our game.

Speaker 1: Wonderful. Thank you so much for joining us, Dr. Roeske. Thank you to all our listeners for your participation. We'd also like to thank Newport Healthvare for making this webinar possible. A recording of this presentation will be emailed to everyone in two weeks time. The recording will include the presentation slides. As soon as the webinar has ended, a short survey will appear on your screen. Please take the survey and give us your feedback. We thank you for your attention and hope you have a great day.

[00:59:33] [END OF AUDIO]