

**Common Factors  
in Couple  
and Family Therapy**  
*The Overlooked Foundation  
for Effective Practice*

Douglas H. Sprenkle  
Sean D. Davis  
Jay L. Lebow



THE GUILFORD PRESS  
New York      London

# Contents

<b>1</b>	<b>What Is Responsible for Therapeutic Change?: Two Paradigms</b>	<b>1</b>
	Two Paradigms of Therapeutic Change	3
	The Broad and Narrow Conceptualizations of Common Factors	9
	Resistance to Common Factors among Relational Therapists	10
	The Plan for This Book	11
<b>2</b>	<b>A Brief History of Common Factors</b>	<b>14</b>
	Early School-Based Theories	15
	First-Generation Family Therapies	16
	Beginnings in the Understanding of Common Factors:	
	Early Stirrings	18
	Jerome Frank	19
	Carl Rogers	19
	The Generic Model	21
	Luborsky and the Dodo Bird Verdict	23
	Karasu, Gurman, and Goldfried's Classifications of Change Agents	23
	Results from Meta-Analyses of the Impact of Psychotherapy	24
	Lambert's Analysis	26
	The Great Psychotherapy Debate	27
	The Heart and Soul of Change	27
	The American Psychological Association Division of Psychotherapy Report	29
	The Integrative Movement in Psychotherapy and Family Therapy	30
	Sprenkle and Blow's Moderate Common Factors Approach	32
<b>3</b>	<b>Common Factors Unique to Couple and Family Therapy</b>	<b>34</b>
	Conceptualizing Difficulties in Relational Terms	35
	Disrupting Dysfunctional Relational Patterns	37
	Expanding the Direct Treatment System	38
	Expanding the Therapeutic Alliance	42

<b>4</b>	<b>The Big-Picture View of Common Factors</b> Client Characteristics as Common Factors 46 Therapist Characteristics as Common Factors 49 Dimensions of the Therapeutic Relationship as Common Factors 53 Dimensions of Expectancy as Common Factors 53 Nonspecific Mechanisms of Change as Common Factors 54 Other Mediating and Moderating Variables as Common Factors 55	<b>45</b>
<b>5</b>	<b>A Moderate View of Common Factors</b> Believes One Treatment Is as Good as Another versus Questions Claims about <i>Relative</i> Efficacy 61 Disparages Effective Models versus Supports Them 64 Sees the Therapeutic Relationship as All There Is versus Views the Relationship as Only One Aspect of Change 65 Minimizes Clinical Trials Research versus Supports It 66 Supports Either–Or versus Both–And in the Common Factors and Specific Factors Debate 67	<b>60</b>
<b>6</b>	<b>Getting Clients Fired Up for a Change:          Matching Therapist Behavior with Client Motivation</b> Clients as the Most Important Common Factor 69 Transtheoretical Stages-of-Change Model 73 Facilitating Client Engagement through Motivational Interviewing 78 Facilitating Client Engagement and Motivation in Relational Therapy: Functional Family Therapy 81 Applying Principles of Motivation to Relational Therapy: A Clinical Vignette 82	<b>69</b>
<b>7</b>	<b>A Strong Therapeutic Alliance</b> Understanding the Therapeutic Alliance 88 Establishing and Maintaining an Alliance in Couple or Family Therapy 98 Intervention as a Method of Building Alliance 105 The Significance of the Therapeutic Alliance 105	<b>87</b>
<b>8</b>	<b>Models: All Roads Lead to Rome</b> Common Distressed Relational Processes and Treatment Goals: Interactional Cycles and Patterns 110 Model-Specific Conceptualizations of Common Distressed Relationship Processes 112 Additional Common Processes of Distressed and Healthy Relationships 122	<b>107</b>

<b>9</b>	<b>A Meta-Model of Change in Couple Therapy</b>	<b>123</b>
	The Need for a Meta-Model of Change	123
	Empirical Development of the Model	125
	How Narrow and Broad Common Factors Interact to Produce Change in Couple Therapy: A Meta-Model	126
	Strengths and Limitations	142
	Special Considerations for Family Therapy	142
<b>10</b>	<b>The Case against Common Factors</b>	<b>144</b>
<b>11</b>	<b>Common Factors Training and Supervision</b>	<b>159</b>
	Assumptions Underlying Common-Factors-Driven and Model-Driven Change Training Approaches	161
	Components of a Common Factors Training Program	163
	Practical Examples of Our Common Factors Training Approach	165
	Implications for Supervision	167
	A Climate of Reflective Theoretical Inclusivity	168
<b>12</b>	<b>Implications for Clinicians and Researchers</b>	<b>170</b>
	General Implications for Clinicians	171
	Specific Implications for Clinicians	174
	General Implications for Researchers	177
	Specific Implications for Researchers	180
	<b>Appendix A: Moderate Common Factors Supervision Checklist</b>	<b>183</b>
	<b>Appendix B: Instruments from Other Authors Related to Common Factors</b>	<b>192</b>
	References	199
	Index	219

# 1

## What Is Responsible for Therapeutic Change?

### *Two Paradigms*

**W**hat is responsible for therapeutic change? Science offers many examples of misguided assumptions about causality. Until the early 1980s, the majority of physicians as well as lay people believed peptic ulcers were caused by worry, stress, and personality variables (or by excessive coffee drinking or spicy foods). Today we know that about 90% of peptic ulcers are primarily caused by the *H. pylori* bacteria, which typically can be treated successfully through a 1- to 2-week regimen of antibiotics.

When I (D. H. S.) was growing up, most people thought “good foods” were those rich in vitamins. I was encouraged to eat a lot of spinach since it was high in vitamins A and C. I was discouraged from eating blueberries since they had few vitamins and therefore did not contain the essential ingredients that caused good health. Now we know that phytochemicals make a much greater contribution to wellness and that some foods like blueberries, with relatively few vitamins, are loaded with phytochemicals that powerfully promote health. In this instance, while vitamins contribute to good health, they turned out to be not as central as science had previously assumed.

This book challenges the commonly held assumption that what causes change in psychotherapy is primarily the unique ingredients in therapy models and techniques. While, like vitamins, these ingredients are typically beneficial and we hold them in high regard, we nonetheless challenge their centrality in the process of change. We

also think that the question “What is responsible for therapeutic change?” should be incredibly important to the psychotherapeutic practitioner, as well as to the theoretician and the researcher. For the answer surely guides what we do in the consulting room, determines how we view or explain what we do, and should be the focus of what we investigate.

Our answer to this question differs from how we (the three authors of this book) were trained and goes against the grain of most of the most powerful forces in the psychotherapy establishment. This book sets forth an emerging paradigm (common-factors-driven change) of why therapy works, with a special emphasis on how this paradigm plays out in couple and family therapy. In brief, this paradigm suggests that psychotherapy works predominantly not because of the unique contributions of any particular model of therapy or unique set of interventions (what we call the model-driven change paradigm) but rather because of a set of common factors or mechanisms of change that cuts across all effective therapies. We further believe that this emerging view has powerful implications for therapists, supervisors, and trainers, and that mastering this approach will improve your results.

As is discussed in more detail in the next chapter, while we call it “emerging,” this paradigm is not technically “new.” Its roots go back over 70 years, and there has been a vocal minority of scholars and clinicians within psychotherapy that has long advocated for it (Karasu, 1986; Lambert, 1992; Lambert & Ogles, 2004; Luborsky, Singer, & Luborsky, 1975). There has also been a small group of relationship therapists (Hubble, Duncan, & Miller, 1999) upon whose ideas we have built the particulars of our approach. But the paradigm remains “emerging” in the sense that it remains a countercultural minority position that is not consciously at the center of the practice of most psychotherapists or important to the major funding agencies like the National Institutes of Health (NIH) or the psychotherapy research establishment. These groups largely remain committed to the model-driven paradigm.

The three authors of this book are all practicing therapists (with a special emphasis in couple and family therapy). Although we also teach and do research at universities, we see individuals, couples, and families on a daily basis and have the hearts of clinicians. Because we work in the trenches, we will endeavor to speak to practitioners as the primary audience for this book. We also, however, share a lifelong passion for thinking about why change occurs, and we believe that

theory-driven (as opposed to “seat-of-the-pants”) therapy is likely to be more coherent and effective. Hence, we try to engage you, the reader, in the theoretical rationale for our approach under the assumption that there is “nothing as practical as a good theory.” Finally, we are also applied researchers who value evidence. We came to believe in this emerging paradigm because we thought the evidence for it is more compelling than for the earlier paradigm. Wherever possible, then, we do not expect you simply to take our word for these ideas but instead offer data that we think support the emerging paradigm. In sum, this book is written for practitioners and students who are open to being theoretically and research-informed.

## **Two Paradigms of Therapeutic Change**

If you ask most psychotherapists why change occurs, they would explain the process primarily in terms of their preferred model of change. A structural family therapist, for example, might say that change occurs when the therapist facilitates families’ changing their organizational pattern—like from rigid or diffuse boundaries to clear boundaries. A narrative therapist might say that change occurs when therapists encourage clients to reauthor their lives from disempowering, subjugated life stories to self-narratives that are empowering and self-efficacious. Common factors that cut across all successful therapies might be mentioned and might even be valued (considered necessary), but they would not likely be considered the major reasons that change occurs. Instead, the emphasis would be on the unique contribution of the model.

If you had asked all three of us the same question 10–15 years ago, we probably would have probably answered it in terms of the earlier paradigm. For me (D. H. S.), it would have never occurred to me to think otherwise. Remember that a paradigm is a large interpretive framework that shapes how we see things, and until and unless we undergo a paradigm shift, it is almost impossible for us to view things differently. When I came into the couple and family therapy field in the 1970s, it was the “golden age” of the great model developers, and I remember being mesmerized at workshops by such luminaries as Salvador Minuchin, Carl Whitaker, Virginia Satir, Jay Haley, and James Framo. What these people seemed to be doing with clients was so remarkable that I never questioned that what was responsible for therapeutic change was anything other than the specific contribu-

tions of each model. For me, the only real question was which models were “true” and which model or models should guide my work.

Couple and family therapy, of course, is not unique in its fascination with models. At least 400 different models of psychotherapy have been documented as model developers have continued the unending quest to answer the question that opened this chapter. Indeed, this proliferation of models led Sol Garfield (1987) to quip, “I am inclined to predict that sometime in the next century there will be one form of psychotherapy for every adult in the Western world” (p. 98). One potential benefit, then, of adopting the new paradigm is that it may no longer be necessary to continue inventing new models (Sprenkle & Blow, 2004a)!

Some of the major factors that distinguish the two paradigms—old and new—are depicted in Figure 1.1. In the explanations that follow the figure, we make clear that the two paradigms are not polar opposites but rather represent matters of emphasis that probably exist along a continuum. We also believe that there is some merit to the model-driven change paradigm. We will elaborate on these ideas in Chapter 5 when we talk about our “moderate” approach to common factors.

More details of the two paradigms will be supplied in later chapters. In keeping with our thesis that the two paradigms are not

### **Model-driven change**

#### Primary Explanation for Change

Emphasizes the unique elements and mechanisms of change within each model.

#### Guiding Metaphor

*Medical*: considers treatment as analogous to medical procedures and drugs.

#### Therapists' Role in Change

Emphasizes the treatment that is dispensed rather than who offers it.

### **Common-factors-driven change**

Emphasizes the common mechanisms of change that cut across all effective psychotherapies; models are the vehicles through which common factors operate.

*Contextual*: believes such qualities as credibility, alliance, and allegiance “surrounding” the treatment are more important than the unique aspects of treatment.

Asserts that the qualities and capabilities of the person offering the treatment are more important than the treatment itself.

(continued)



### Clients' Role in Change

More therapist-centric: although therapy can be collaborative, places greater emphasis on the value of the therapist's performing the treatment in a *specified manner*; and invests a stronger conviction in clients using the treatment in the ways the therapist intends and recommends.

More client-centric: places less importance on performing the treatment in a specific way and more on improvising to match the clients' needs and world views; and invests a stronger conviction in clients using whatever is offered in therapy for their own purposes in often unique and idiosyncratic ways.

### Place in the Culture

Most funded research (e.g., NIH research) emphasizes this paradigm; represents the majority voice; and advocates lists of "approved" treatments.

Funding sources deemphasize this paradigm; represents the minority voice; and opposes lists of "approved" treatments.

FIGURE 1.1. Two paradigms of therapeutic change.

opposite entities, we underscore the observation that models *do* play an important role in common-factors-driven change. However, proponents of our favored paradigm see models less as unique sources of change than the vehicles through which common factors operate. Therapists need models to give their work coherence and direction, but this paradigm values them more for their capacity to activate common mechanisms of change found in all successful psychotherapies.

The older model uses a medical lens through which to view psychotherapy—hardly surprising, given that the earliest psychotherapists were physicians. It follows that many psychotherapy researchers believe that therapies “are analogous to medications that need to be assessed in tightly controlled research that establishes specific variants of therapy as safe and effective for the treatment of particular disorders; essentially drug research without the drugs” (Lebow, 2006b, p. 31). In his well-documented challenge to the medical model, Wampold (2001) makes a strong empirical case for the greater impact of certain “contextual” qualities that surround treatment—like “allegiance” (the commitment of the therapist to the model) and “alliance” (the quality of the client–therapist relationship and the extent to which clients believe therapists are on the “same page”); and he documents empirically that a number of other variables *not* specific to the treatment contribute more to the outcome variance in psychotherapy than the “specific” treatment factors do.

Of course, we think that the medical model has done wonders for medicine. We also believe it has been very beneficial for psychotherapy to the extent that it has encouraged the use of randomized clinical trials in psychotherapy research to demonstrate that psychotherapy “works.” Because of these trials we can say to external audiences, like third-party payers, with considerable confidence that psychotherapy (both individual and relational) is very effective (Wampold, 2001; Shadish & Baldwin, 2002). We will never understate the importance of this hard-fought knowledge gained through clinical trials research.

However, it is one thing to say that we know that psychotherapy is effective but quite another to say that we know *why* psychotherapy is effective. While appreciating the contributions of the medical model, we argue against the medical model assumptions that the various “treatments” explain the “why” and that comparative treatments should be the primary focus of research attention in the same way that competing drugs are the focus in drug investigations.

Another major difference between the two paradigms is the role of the therapist. It follows, in the older paradigm, that if psychotherapies are like medications, then the treatment being “dispensed” is much more important than who administers it. As Lebow (2006) has put it:

Psychotherapy researchers typically focus exclusively on different clinical interventions while ignoring the psychotherapists who make use of them. It’s as if treatment methods were like pills, in no way affected by the person administering them. Too often researchers regard the skills, personality, and experiences of the therapist as side issues, features to control or to ensure that different treatment groups receive comparable interventions. (pp. 131–132)

In the emerging paradigm, the role of the therapist is essential to activating the model or treatment, and without the therapist’s expertise the model is little more than words on a piece of paper. New-paradigm advocates suggest that the role of the therapist is underemphasized in traditional psychotherapy research, given its emphasis on pitting treatments against one another. This focus also flies in the face of common sense since it is obvious that therapists differ in their effectiveness. As Wampold (2001) has noted, just as some lawyers achieve better outcomes than others, some artists produce more memorable sculptures, and some teachers engender greater student achievement, it only makes sense that some therapists will achieve better results. In spite of these truisms, the older paradigm gives relatively little atten-

tion to therapist variables as contributors to outcome. We present the empirical case for differences in therapist effectiveness in Chapter 4.

Because of its emphasis on the unique treatment being offered, the older paradigm often ends up being more therapist-centric. Granted, it would be inaccurate to say that all model-driven therapists see therapy as something they “do” as an “expert” to a relatively passive client. Many model-driven therapists, especially those with a social constructionist bent, work in ways that are very collaborative. Nonetheless, we believe there is often a tendency—if a therapist believes that change is due to a very specific set of operations found within a treatment model—to focus more on “dispensing” or “performing” those specific operations. And this “true believer” therapist will more likely believe that how faithfully he or she performs those specific operations will determine whether change occurs. When change does occur, we believe this therapist is also more likely to believe the client will think the change is due to these unique operations. In other words, this therapist will believe that the clients use the therapy in the way that the therapist thinks he or she uses it. For example, the structural family therapist will believe that the family in treatment was successful because its members used the therapy to develop more clear boundaries. Similarly, the narrative therapist will believe that therapy was successful because his or her clients learned to create new and more empowering stories about themselves.

In the newly emerging paradigm, there is more of a tendency to see clients as actively utilizing *whatever is offered for their own purposes*. While the family in treatment may have used the therapy to develop more clear boundaries, or to develop more empowering narratives, alternately family members may believe they have changed because they used the therapy to learn how to manage their differences or to gain insight about how to perform better at work (or any one of myriad other explanations that were not central to the therapist’s belief as to why the treatment succeeded). Of course, both the therapist’s and the clients’ perspectives may be “valid,” but the new paradigm privileges the clients’ interpretation. Therapists who take the time to ask their clients why they think therapy succeeded are often shocked to discover that clients often say it had little to do with the therapists’ cherished explanations (Helmeke & Sprenkle, 2000). Our central point here is that clients using whatever is offered for their own purposes largely explains or accounts for the robust finding (Shadish & Baldwin, 2002; Wampold, 2001) that there are typically only modest differences in the results achieved by very disparate therapies that

independently have been shown to be effective. For example, in the largest and arguably the best psychotherapy outcome study ever completed, cognitive-behavioral therapy for depression achieved no better results than interpersonal therapy, a psychodynamic treatment (Elkin et al., 1989). Shadish and Baldwin (2002) have demonstrated that the results of 20 meta-analyses show no differences or only modest ones between the various seemingly disparate relational therapies. That is, clients use whatever is offered, in their own idiosyncratic ways, to achieve their goals.

I (D. H. S.), for example, have even had numerous experiences with clients totally misinterpreting me and later thanking me for something I never intended to say or do. For example, a recently divorced woman told me her life changed dramatically for the better when she became single; and she thanked me for “telling” her to leave her husband. I believe I bent over backwards to help her look at all sides of her ambivalence during divorce decision-making therapy and never “told” her what to do. If anything, I thought I encouraged hope for the relationship throughout couple and individual sessions with this client. She used—as clients often do—whatever the therapist offered for her own purposes in getting better.

Finally, engaging and motivating clients is at the heart of the new paradigm since the client’s involvement is more important than the therapist’s specific activity. In fairness, though, some old paradigm models give considerable attention (along a continuum from considerable to very little) to engaging and motivating clients, and so, once again, we don’t want to portray the two paradigms as “either-or.”

Finally, the old paradigm is much more entrenched in the dominant culture. Lebow (2006) points out that the medical model-type research “makes up the preponderance of research on mental health treatment funded over the last 20 years by the National Institutes of Health” (p. 31). It is much more closely aligned with the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) power structure in that it assumes certain mental health “diagnoses” are best treated by manualized models demonstrated to be “effective” in randomized clinical trials. In fairness, however, the NIH does fund process research, and so it is not the case that its entire emphasis is on comparative treatment research. So, to repeat, the contrasts between the two paradigms should not be overdrawn. Proponents of the model-driven paradigm push for approved “lists” of efficacious treatments, and there is a growing trend in the mental health provider establishment to reimburse only for treatments put on these lists.

Although the new paradigm has a strong research base (Shadish & Baldwin, 2002; Wampold, 2001), most common factors research is not funded by major sources like NIH, since this type of research focuses not on unique treatments but, rather, shared sources of variance in therapeutic outcomes. While proponents see some value in the DSM as a way of reliably identifying patterns of symptoms, they reject the notion that a diagnosis alone is a meaningful basis for treatment planning since, for example, the etiology of “major depression” is too varied to prescribe limited treatment options. Furthermore, they believe the notion of “lists” of approved treatments is misguided since they reject, among other things, the notion that what makes treatments effective are their unique elements. They believe that this movement too readily embraces the most commonly researched models (typically cognitive behavior and its variations) when other approaches (often better suited to particular therapists) are likely to be just as effective. Given the varied and changing needs of clients, proponents of common factors also want to make a larger place for therapist *improvisation*. The proponents of the new paradigm are considered at least somewhat “countercultural” and at times are even labeled gadflies, iconoclasts, or rebels.

In summary, advocates of the two paradigms typically use the same ingredients, but they view them very differently. Just as the Ptolemaic and Copernican paradigms both included the earth, the sun, and the planets but saw their interrelationships differently, similarly advocates of both the old and the emerging paradigms of change use the same phenomena—models, therapists, clients, and the process of change—but see their interrelations differently. It is our contention (invoking Gregory Bateson’s famous phrase) that it is a “difference that will make a difference” in your clinical work. For example, if your competence as a therapist—independent of the model you adopt—is more important than the model itself, you are likely to search for common ingredients in therapist expertise and push for researchers to learn more about these variables.

### **The Broad and Narrow Conceptualizations of Common Factors**

Although our definition of “common factors” focuses on those variables that contribute to change that are not the province of any particular theoretical approach or model, we acknowledge that com-

mon factors can be narrowly and broadly defined. The narrow view (Lambert, 1992) conceptualizes them in terms of common aspects of interventions found in disparate models under different names (for example, creating changes in meaning may be labeled “insight,” “reframing,” or “externalizing the problem”). The broad conceptualization (Hubble et al., 1999) sees common factors as including other dimensions of the treatment setting—like client, therapist, relationship, and expectancy variables. From this perspective, for example, one can see “therapist variables” (characteristics of the therapist that contribute to the outcome) as a common factor since it is quite clear that therapist competence (independent of whatever model he or she employs) is an important contributor to outcome. Generally speaking, the broader approach is favored throughout this book. But whether broadly or narrowly defined, common factors can be contrasted with *specific* factors—those variables that contribute to outcome that are unique to a particular approach or model.

### **Resistance to Common Factors among Relational Therapists**

We believe that there appears to be more resistance to the common factors paradigm among relational therapists than among individual therapists. This heightened resistance may be attributable to the fact that the application of common factors to couple and family therapy did not appear in the literature to any great extent prior to the 1990s. Nonetheless, we also believe that the history of relationship therapy has tended to emphasize differences—first, in order to differentiate it from mainstream psychotherapy and, second, from other relational approaches. Couple and family therapy model developers have typically been highly charismatic individuals with exceptional capacities to “sell” their models and gain adherents. This emphasis on distinctiveness was made easier because the field has not been particularly influenced by research but has grown more on the basis of intuitive or emotional appeal (Nichols & Schwartz, 2001). In addition, the field has historically focused on difficult cases, and this tendency may have contributed to the belief that unique models and methods are necessary for successful outcomes. Moreover, the field has always welcomed innovation and may therefore attract people with an above-average need to believe what they are doing is uniquely relevant. For whatever reasons, relationship therapists seem to be very emotionally invested in their models, and there may be simply too much cognitive disso-

nance for them to admit that their pet theories may not be demonstrably superior after all. Finally, since couple and family therapies are frequently promoted by charismatic figures on the workshop circuit, such an undramatic approach as common factors may seem dull by comparison. As Frank (1976) expressed it, “Little glory derives from showing that the particular method one has mastered with such effort may be indistinguishable from other methods in its effects” (p. 47). Of course, not all model developers are charismatic, and some value evidence more than dogma; but we maintain that the field has had more than its share of religion masquerading as science.

### **The Plan for This Book**

#### **Foundations of Common Factors in Couple and Family Therapy**

The first five chapters are foundational and more general. Chapter 2 traces the history of common factors. While the contemporary history stretches back to 1936, you may be fascinated to learn—or be reminded—that as early as the late 1700s healers were making causal claims for specific methods that undoubtedly worked through common factors. Indeed, the history of psychotherapy in general and relationship therapy in particular is a history of growing awareness and appreciation (albeit only relatively recently for relationship therapies) of commonalities among change models.

Although much more has been written about common factors in the individual therapy literature, Chapter 3 focuses on four common factors that are unique to couple and family therapy: (1) conceptualizing difficulties in relational terms, (2) disrupting dysfunctional relational patterns disruption, (3) expanding the direct treatment system, and (4) expanding the therapeutic alliance. While few in number, these common factors are extremely important and rooted in the ways in which relationship therapy is itself distinctive.

Chapter 4 paints a “big picture” view of the major common factors (both “broad” and “narrow”) that we believe drive change. Six categories of common factors are offered, along with an overview of the research evidence supporting them. This chapter sets the stage for Chapters 6–9, which present most of these categories in greater detail.

Chapter 5 focuses on our “moderate” view of common factors and how it differs from more radical versions that, among other things, suggest that models are irrelevant, impotent, or both. We articulate

in greater depth our “both–and” position that values models but emphasizes that their major role is to activate common factors. Other common misconceptions (e.g., common factors are mostly about the therapeutic relationship) are also dispelled.

### **Specific Applications of Common Factors in Relational Therapy**

Chapters 6–9 are the most practical sections of the book, offering many clinical examples. Chapter 6 looks at key “client” and “therapist” common factors and, specifically, how therapists can engage clients and match their level of motivation. The chapter applies Prochaska’s (1999) transtheoretical stages of change and also Miller and Rollnick’s (2002) motivational interviewing—two models traditionally used with individuals—as common factors lenses that can also inform relational therapy.

Chapter 7 hones in on the important therapeutic alliance—what it consists of and how it is formed, torn, and repaired—and the unique aspects of the alliance in couple and family therapy. Although most therapists think that they are skillful at building alliances, doing so successfully is a complex task requiring considerable skill, given both the unique alliance needs of specific clients and the pitfalls and intricacies of the multiple alliances in relational therapy.

Chapter 8 focuses on the unique relational common factor of interrupting dysfunctional relational patterns/cycles. What makes this chapter fascinating is that interventions from three seemingly disparate models (object relations, emotionally focused, and solution-focused) are shown to operate in similar ways as they interrupt the dysfunctional cycles of the same client couple. When one “stands meta” to (i.e., as though outside) these specific “different” interventions, it is clear that they utilize common principles of change.

Chapter 9 concludes this section by presenting a common factors meta-model of change for couple therapy. This “model of models” offers a guide to the change process irrespective of which relational model is being used. It integrates broad and narrow common factors into a coherent principle-based explanation of therapeutic change.

### **Conclusions, Implications, and Recommendations**

Chapters 10–12 focus on conclusions, implications, and recommendations based on the common-factors-driven paradigm of change.



Although we are common factors proponents, we are also “evidence people” and thought we should also include a chapter (Chapter 10) on “The Case against Common Factors.” Here we review the challenges to common factors and our responses to them. Chapter 11 discusses the implications of the common factors movement in relationship therapy for training and supervision. Our approach does not require educators to dramatically overhaul the content they teach, but it does have implications for both how models are viewed and how skills are taught in relation to one another. We also stress the need to learn multiple or flexible models because of the need to adapt to different types of clients. Finally, Chapter 12 offers specific recommendations to clinicians, supervisors, and researchers based on the ideas explored and explicated in this volume. We also use this opportunity to speak to the field of couple and family therapy.

Taken together, the chapters that follow add flesh to the bones of the contrast between the model-driven and the common-factors-driven paradigms of change set forth in Chapter 1. Hopefully, they will lead you, the reader, to think differently about, as well as weigh the implications of, our opening question, “What is responsible for therapeutic change?”

## 2

# A Brief History of Common Factors

Common factors play a crucial role in all psychotherapies, but their role often goes unnoticed or unacknowledged. Thus, it was not until 50 years after the beginnings of psychotherapy that the discourse about treatment began to include consideration of these factors. There are several possible reasons for this state of affairs, but we think that one emerges as most powerful and succinct. Model developers have largely been the leading writers and presenters in the field, and model developers and proponents have an intrinsic interest in highlighting the unique aspects of their approaches. In this regard, psychotherapies are not so different from other services and products in our society. Automobile advertisements, for example, don't speak to why it's good to have a car or why an automobile has a certain set of safety devices; rather, they underscore why, say, a Toyota is special and different from a Honda. It's left to *Consumer Reports* to tell us that Toyotas, Hondas, Lexuses, and other Japanese cars share much of the same technology.

In today's world of evidence-based behavioral practice, typically model developers simultaneously develop the treatments, disseminate the treatments, do the research on the treatments, evaluate the feasibility of grants to assess the impact of those treatments, and write the major reviews that evaluate those treatments. In such an environment, it is no great surprise that treatment differences are accentuated and brand names come to predominate. This trend is, if anything, even stronger in the world of couple and family therapies than in methods

of individual therapy. Although there are many “named” individual therapies, these are typically subsumed within a broad approach to therapy. Thus, panic control therapy, the treatment developed by Barlow and Craske (Craske & Barlow, 2001) is often spoken of as cognitive-behavioral therapy for panic, though there also are several other unrelated cognitive-behavioral methods that deal with that problem or others. In contrast, in family therapy we today have five different but closely related models for the family treatment of adolescent substance use disorders, each separately named and evaluated and competing for adoption (Chamberlain, 2003; Henggeler, Schoenwald, Rowland, & Cunningham, 2002; Liddle & Rowe, 2002; Sexton & Alexander, 2005; Szapocznik et al., 2002).

### **Early School-Based Theories**

There is an irony in common factors entering discourse about psychotherapy so late because before the beginnings of psychotherapy one well-known treatment that promised dramatic effects on functioning already had been notoriously exposed as stemming solely from the impact of common factors. Franz Anton Mesmer, the 18th-century German physician-performer, put forth a theory of “animal magnetism,” in which he viewed health as being affected by the gravitational pull of the various planets. Mesmer traveled far and wide throughout Europe “curing” a wide range of illnesses through the practice of “mesmerism,” which featured his passing magnets and his hands over people. In 1784, Louis XVI (who later was beheaded in the French Revolution) assembled a commission of scientists that included Benjamin Franklin to assess Mesmer’s techniques. The commission concluded that, although some people felt better, these changes could in no way be related to Mesmer’s specific techniques. The changes Mesmer described were unrelated to the techniques he employed or the theory he espoused. The changes that occurred could better be explained by the impact of the common factor of engendering hope and positive expectations in his patients than by the impact of his specific methods.

When Freud (1987) developed psychoanalysis as the first widely circulated psychotherapy, his focus was on articulating a specific theory of personality, psychopathology, and psychotherapy and elaborating specific methods of practice that fit with this theory and were effective in leading to change. Classic psychoanalysis first posited a

specific treatment for a specific disorder, hysteria, and then expanded that technique to the treatment of other problems. As Jung (1916, 1935), Adler (1924/1957), and other theorists elaborated and debated what constituted the best methods of analysis, their focus too came to be on the theory of psychopathology and the various strategies in treatment. Jung emphasized a focus on the importance of the collective unconscious, Adler on feelings of inferiority, and each succeeding theory within the psychoanalytic school underscored a different emphasis. Although a reader today examining these approaches can readily see how these approaches invoke the common factors we describe in this book, these authors focused little if any attention in their writing or presentations on these factors.

During the era following World War II, this failure to focus on the commonalities that are present in all treatments was only further accentuated as therapies became increasingly diverse. Challengers began to emerge to the psychoanalytic paradigm, drawing from the quite distinct traditions of behaviorism (in such treatments as behavior therapy) and humanism (in such treatments as Gestalt and experiential therapies). The emerging books and presentations on how to do psychotherapy focused on identifying and debating what the key elements of human functioning were and how to change those factors, whether it be unconscious processes, behavior, cognitions, emotional life, or biology. Proponents of different approaches accentuated different levels of human experience, and even within these respective schools different specific approaches came to focus on differences in technique (e.g., as in the differences between rational-emotive [Ellis, 1962] and cognitive therapy [Beck & Weishaar, 1989] among the cognitive therapies). In this tradition of dueling therapies, little, if any, attention was directed toward what therapies shared.

### **First-Generation Family Therapies**

Given the limited attention to common factors in therapies for individuals, it is remarkable that the first-generation couple and family therapies evidenced even less attention to these factors. Indeed, some of these early therapies promoted the extreme position of advocating deliberately *not* engaging in strategies that increase such common factors as positive expectancy and the therapeutic alliance described in this volume and specifically described tactics for *decreasing* these factors.

The Palo Alto variant of strategic therapy (Watzlawick, Weakland, & Fisch, 1974), a prominent set of methods in its time, called for exercising care to assure that the therapeutic alliance did not become too powerful. This approach utilized therapeutic directives coming from behind a one-way mirror to, in part, limit the connection between client and therapist, and called for an abrupt end to therapy when change occurred in order to avoid what was regarded as a dependency on the therapist as an agent of change. Another early therapy, Haley's problem-solving therapy (Haley, 1987), similarly emphasized reducing what we now know to be the common factor of creating positive expectancy in clients through focusing on paradoxical directives that promoted psychological resistance to the message of the therapist. These early systemic therapies had little faith in client resilience or an innate process of change, instead emphasizing homeostasis in systems and consequently methods through which a powerful strategic therapist could join with and trick the system into changing through such tactics as suggesting the family did not need to—or would not be able to—change.

Even when the message did not overtly undermine what we now regard as common factors, the first generation of approaches (as was true in individual therapies) focused on the unique value of the particular theory and the strategies of change within each school. Proponents of different theories argued the respective benefits of an emphasis on family structure, felt experience, differentiation of self, strategies of change, or object relations. Thus, Minuchin (1974) privileged structure and the use of enactments; Bowen (1972), coaching for interchanges within the family of origin; and Haley (1997), paradoxical directives. Books and presentations in the field focused on these theories and the methods of practice that flowed from them.

It is important to note that this dominant discourse about differences among theories and strategies for change among these family therapies obscured other commonalities that we can now see, with the passage of time, underlay these debates. Foremost, all these theories and approaches in family therapy centered on one shared vision, that of invoking social support and utilizing the family as a pathway to change. The strategies of intervention may have differed, but these approaches shared the common pathway of invoking change in family as a pathway toward other change.

Further, most of the early family therapies did agree about the importance of building alliance in some shape or form. For example,

Minuchin and Fishman (1981) devoted much of one volume to techniques for the practitioner's creating a therapeutic alliance with the family being treated; and Ackerman (1970), Bowen (1960), and Whitaker (Whitaker & Malone, 1953), and Boszormenyi-Nagy (Boszormenyi-Nagy & Spark, 1973) each allocated considerable attention to how to "join" with the family, that is, to create a therapeutic alliance. That these methods were presented as part of the core theory of practice in each school in languages that were unique to that school obscured the presence of underlying common factors applicable across all conjoint therapies.

Ultimately, the unique public demonstrations of the various approaches to family therapy in large workshops conducted around the world by the master therapists who were the founders of the schools of treatment offered an opportunity for those observing to begin to see common factors across the work of these therapists. When the actual work of these pioneers was observed, far more commonality was evident than might have been thought when first encountering descriptions of theory and strategy. Each of the charismatic generation of pioneers who developed focused theories and strategies clearly engaged in a much wider range of actual behavior in session than they spoke to in their writings, and all promoted closely connected human interaction in families as well as individual development. A research study during that time that examined the methods of these pioneers found significant overlapping in what they actually did in session (Pinsof, 1978).

### **Beginnings in the Understanding of Common Factors: Early Stirrings**

Although the focus on differences in theory and strategy was the predominant paradigm in psychotherapy, there were early voices that began to talk about common factors as early as the 1930s. In the first prominent mention of such factors, Saul Rosenzweig (1936) published the earliest paper on common factors, suggesting that the effectiveness of psychotherapies stemmed more from their common elements than their specific methods. Specifically, Rosenzweig pointed to how each therapy centered on a relationship between client and therapist and each built on a theory of explanation. Rosenzweig also made the first reference to the "dodo bird verdict"—that therapies are roughly equal in outcome—described later in this chapter.

## Jerome Frank

Despite Rosenzweig's (1936) work and that of a few other pioneers, it was only with the landmark work of Jerome D. Frank (1961) that a common factors viewpoint was brought fully to the attention of psychotherapists. In his bestselling volume *Persuasion and Healing*, Frank (coauthor with his daughter of the later editions of this work) looked to common threads that cross all efforts at healing, seeking to explain the impact of not only psychotherapy but also medicine and even traditional healers such as medicine men. He (Frank, 1973; Frank & Frank, 1991) identified four key aspects of such relationships: (1) an emotionally charged confiding relationship with a helping person, (2) a healing context, (3) a rationale that provides a plausible explanation for the client's problems and how to resolve them, and (4) a procedure that involves active participation of client and therapist and is believed by both to be a means of restoring health. It was these common elements (close confiding contact, a place that was agreed to be helpful, a shared rationale, and an agreed-upon frame for healing) that Frank suggested were the true foundations for change. Consistent with our own formulation, Frank suggested that therapist procedures matter, not because they are effective in and of themselves, but at least to a considerable degree because of the shared beliefs that they represent in suggesting the availability of paths to healing. Frank further argued that psychotherapy works principally because it helps to remoralize demoralized people, and that the generation of hope is ultimately the crucial ingredient in all psychotherapies, and for that matter, most other methods of healing.

Frank's work had considerable impact on the field of psychotherapy in its time. Although it certainly did not retard the movement to specific therapies (which continued—and still continue—to be created and augmented), it influenced the practice of many therapists and laid the foundation for today's integrative movement in psychotherapy.

## Carl Rogers

Carl Rogers (Raskin & Rogers, 1989; Rogers, Kirschenbaum, & Henderson, 1989) brought another perspective to this conversation about shared elements. Rogers was the developer of a major school of treatment, person-centered therapy, in which he articulated a specific set of methods of treatment that he believed to be effective. In the

language of today's evidence-based therapies, he created a manual-driven empirically supported treatment<sup>1</sup> based on a technology of empathic listening. Yet, Rogers's methods emphasized the common factor of the healing relationship and thereby also serve as a guide to all therapists about a transcendent set of principles of treatment. Rogers's notions of what constitutes a healing relationship by virtue of the personal qualities of the therapist now serve as the basis for most such concepts in the psychotherapy field as a whole.

Rogers suggested that there were three essential dimensions of the therapist that led to successful therapy: empathy, positive regard, and congruence. Empathy involves understanding the client's frame of reference and ways of experiencing the world. Rogers's concept of empathy focused on both cognitive and emotional understanding. He defined it as the therapist's sensitive ability and willingness to understand the client's thoughts, feelings, and struggles from the client's point of view—the ability to see completely through the client's eyes, to adopt his or her frame of reference (Rogers, 1957, 1961). He underscored the core importance of the therapist's capacity to take on the perspective of the client and express understanding and acceptance of his or her experience, an idea now almost universally accepted as a foundation of psychotherapy.

Rogers's second core aspect of the person of the therapist was positive regard (Farber & Lane, 2002). Rogers stated: "To the extent that the therapist finds himself (herself) experiencing a warm acceptance of each aspect of the client's experience as being part of that client, he is experiencing unconditional positive regard.... It means there are no conditions of acceptance.... It means prizing of the person.... It means caring for the client as a separate person" (Rogers, 1957, p. 101). Warmth is clearly part of this regard; at other points Rogers referred to "non-possessive warmth." Whether in a beginning trainee or veteran therapist, such an ability to convey respect and acceptance clearly represents a crucial aspect of successful psychotherapy.

---

<sup>1</sup>Ironically, Rogers's research-based therapies don't qualify for lists of empirically supported treatments (ESTs) today because the clients were not subjected to the kind of medical model-based assessment of their pathology that Rogers rejected as inconsistent with his approach. In all other ways, Rogers created a manual-driven treatment that was demonstrated to be effective in clinical trial research, the core criterion for determining which treatments qualify as ESTs. That a person-centered treatment cannot qualify for lists of ESTs because Rogers's research did not focus on a specific medical model-based diagnostic category is an indictment of the methods used in determining which therapies qualify as ESTs (see Chapter 11).



Rogers's third core aspect of the effective therapist he called "congruence" (Rogers, 1957). Congruence refers to the therapist's ability to freely and deeply be himself or herself. Rogers suggested that the therapist does not need to be able to remain congruent in all aspects of his or her own life, but pointed to the crucial importance of doing so in the therapeutic relationship. Rogers believed the therapist must be genuine and not deceive the client about his or her feelings. Although many models do not emphasize this quality in the therapist, few therapies are likely to be successful without the therapists remaining congruent.

Rogers's core set of therapist characteristics became prominent in the field of psychotherapy during the 1950s and 1960s as a by-product of the popularity of his person-centered therapy (earlier called client-centered therapy). This level of attention to these factors initially declined after Rogers's death and the consequent reduction in training and practice in person-centered therapy that accompanied it. Nonetheless, although the specific model never regained widespread popularity, the basic importance of the ingredients Rogers emphasized has become part of the core of much psychotherapy (Norcross, 2002b). Furthermore, narrative, collaborative, and experiential models have emerged that contain Rogers's concepts at their center.

### **The Generic Model**

Orlinsky and Howard (1987) added to the view of common factors in articulating what they called a "generic" view of psychotherapy. The generic model focused on core aspects of all psychotherapies, leaving room for each specific approach to treatment to be filled in within the context of the model. Orlinsky and Howard specified four generic frames within which psychotherapy could be considered.

The first of these, which they called "co-oriented activity," consists of the behavioral interactional aspects of social relations. This frame includes the therapist's behavior, the client's behavior, and the behavioral interaction between them. The Rogerian facilitative conditions (such as empathic listening) are examples of therapist behavior that fall into this category. Orlinsky and Howard suggested there also are a parallel set of generic client behaviors that matter in successful therapy, such as communicating about problems and expressing oneself.

The second frame, which they called "concurrent experience,"

includes the phenomenological perception of social events by the client, the therapist, and conjointly between client and therapist. Here, Orlinsky and Howard included client self-perceptions, client perceptions of the therapist, client perceptions of the therapeutic relationship, therapist perceptions of the client, therapist self-perceptions (for example, as competent or not), and therapist perceptions of the therapeutic relationship. Orlinsky and Howard viewed each of these factors in treatment as having enormous impact on the treatment that transcends the specific method.

The third generic frame, which they called “dramatic interpretation,” includes the symbolic formulations of meaning and value that are made and communicated by participants in a relationship. This is the territory of meaning. What is the meaning of therapy for the client and the therapist? What does each of them view as the purpose of the treatment and his or her own sense of involvement?

The final frame suggested by Orlinsky and Howard, termed “regular association,” encompasses the normative prescriptive patterns of relatedness that bind participants to the therapeutic relationship and includes such aspects as the frequency of meetings and the existence of a therapeutic contract about arrangements and confidentiality. These simple aspects of regular association—such as how long we meet, how often we meet, where we meet, and what the fee is—are rarely the center of attention in texts about treatments (indeed, we think that some of them, such as fees and fee collection, are almost never represented in treatment manuals within empirically supported treatments). Yet, they may have vast implications for treatment and represent a crucial core set of generic ingredients. For example, Orlinsky and Howard note that almost all psychotherapies are offered in units of 45 minutes to 1 hour and sessions are most often once per week, suggesting that there must be some underlying generic ingredient basic to psychotherapy at work here.

The major contribution of Orlinsky and Howard (1987) consists in calling attention to the many levels at which a therapy functions. Psychotherapy is both a shared experience between client and therapist—which has meaning in itself as a relationship—and a path to individual change for the client about the targets of that treatment. Orlinsky and Howard also called attention to such generic aspects of treatment as the therapeutic contract. Treatment contracts vary in expectations about length and the nature of what the client and therapist will do, but all treatments involve a contract (stated or unstated) that shapes the treatment, sometimes in significant ways.

## Luborsky and the Dodo Bird Verdict

In one of the most commonly cited papers in psychotherapy Lester Luborsky and his colleagues (Luborsky et al., 1975), analyzed the impact of various treatments on clients receiving those treatments. What emerged was what they termed the “dodo bird verdict” (a term borrowed from Rosenzweig and inspired by a passage in *Alice in Wonderland* where “everybody has won and all must have prizes”). They concluded that all treatments on average had the same level of effects, impacting positively in a substantial way on about three of every four clients. Basing their view on this analysis, Luborsky and colleagues concluded that the essence of treatments lies not in the specific methods highlighted in models but in the common factors that underlie all good treatments.

Luborsky’s article has been the subject of much debate among researchers since its publication. The advocates of specific treatments that have been shown through research to be effective have questioned the “dodo bird verdict” of this research (Chambless, 2002). Yet, analysis (and reanalysis) of these data and the data subsequently accumulated as psychotherapy research has grown (to now thousands of studies) and continues to support this conclusion (Luborsky et al., 2002).

## Karasu, Gurman, and Goldfried’s Classifications of Change Agents

Several other insightful theorists have aimed to explicate the dimensions of change that underlie treatment models. Karasu (1986) regarded the specific interventions of particular psychotherapies as impacting the client by moving him or her to engage in one of three core processes: affective experiencing, cognitive mastery, or behavioral regulation. He suggested that, although the various approaches begin with different ideologies and strategies of change, each ultimately involves the client in one of these three core domains. For example, in psychoanalysis, the technique of free association invokes affective experiencing, interpretation invokes cognitive mastery, and reassurance promotes behavioral regulation. For Karasu, each therapy follows specific procedures to encourage clients to embrace similar goals and processes.

In a similar vein, Gurman (1978) explicated a set of mediating

and ultimate goals of treatment that transcend the specific treatment approach undertaken. Mediating goals are short-term process goals within the treatment, whereas ultimate goals represent the ends sought in the therapy. Gurman laid out a classification scheme specifying which ultimate and mediating goals were invoked by each treatment approach, creating in the process a very comprehensive and cogent table. He found a great deal of overlap in the goals of the various approaches, especially when a common language was used to describe these goals.

In another highly influential contribution, Goldfried and Padaver (1982) differentiated among three levels of intervention in psychotherapy, namely, theories, strategies, and interventions. They argued that while therapists often act as if they are very different from one another because their theories differ, there remains a great deal of overlap among them at the level of strategies of change and interventions. For example, they suggest that although a cognitive therapist, an experiential therapist, and an analyst might differ considerably in how they envision the process of change, each may well help a client to engage in self-talk and to deepen his or her experience in the process of promoting therapeutic change.

Within the family field, Pinsof (1995) has created a matrix for describing intervention approaches, with the level of the system in focus in the problem and intervention (family, couple, individual, or larger system) specified along one axis and a meta-category describing the locus of the problem or intervention (e.g., behavioral, cognitive, emotionally focused, psychodynamic) along the other. And Breunlin, Schwartz, and Mac Kune-Karrer (1997) have suggested a number of meta-frameworks at work underlying the methods of family therapy, ranging from a focus on internal process to one on development and one on culture.

With the emergence of the integrative movement (discussed later in this chapter), there now are many such systems of classifying interventions into their core ingredients. Most of these systems appear to speak to the same core set of factors, described from slightly different points of view and with different language and divided in a slightly different way.

### **Results from Meta-Analyses of the Impact of Psychotherapy**

Smith and Glass (1979) examined the impact of psychotherapy in the first major meta-analysis of psychotherapy outcomes. For read-

ers not familiar with meta-analysis, it is a quantitative procedure that combines the results of many studies, typically by creating a common metric called an “effect size.” Having a common metric is necessary since studies typically use different outcome measures and therefore comparing results is like comparing apples and oranges. The standardized difference between group means is the most common effect size. If a therapy approaches or achieves an effect size of 1.0 across many studies, this means that, on average, the mean of the treatment group is one standard deviation higher than the mean of the control group (Sprenkle, 2002). Smith and Glass (1979) found that psychotherapy did have a substantial impact. In research in which a group receiving psychotherapy and a control group not receiving it were compared, when the results of studies were summed, the difference between psychotherapy and control groups was statistically significant, having an effect size (0.84) that is statistically labeled a “large” effect. Translated into other terms, this means that about three of four treatment clients change more than control clients (to create some context for the meaning of these numbers, one should note that the relationship between smoking and cancer manifests a small effect size). The researchers also found no difference in effectiveness across treatments in their meta-analysis when mediating and moderating factors were controlled. A similar conclusion emerged in a subsequent meta-analysis of the impact of psychotherapy (Lambert & Ogles, 2004).

A quite similar conclusion emerged in a similar meta-analysis of couple and family therapy conducted by Shadish and colleagues (Shadish & Baldwin, 2002, 2003; Shadish et al., 1993; Shadish, Ragsdale, Glaser, & Montgomery, 1995; Sprenkle, 2002). Specifically, Shadish and his colleagues’ work provided strong support for the conclusion that, although relational approaches have indisputable evidence for their effectiveness, there is almost no evidence that these approaches are differentially effective when compared to one another. Shadish et al. (1995) concluded: “Despite some superficial evidence apparently favoring some orientations over others, no orientation is yet demonstrably superior to any other. This finding parallels the psychotherapy literature generally” (p. 348). The researchers found it likely that the modest differences accounted for by approach may well be the result of confounds with other variables such as client characteristics. When they entered potential methodological confounds into a regression analysis, no effect was found for orientation at all. Similarly, Shadish and Baldwin (2002) concluded that “there is little evidence for differential efficacy among the various approaches to marriage and family

interventions, particularly if mediating and moderating variables are controlled” (p. 365). Although some differences among treatments do show up in individual studies, these disappear in meta-analyses when confounds are controlled across large numbers of studies.

### **Lambert’s Analysis**

Beginning with the lens of looking to see how much various factors affect the outcome of psychotherapy, Michael Lambert articulated what is now the most widely disseminated way of classifying factors that affect treatment. Lambert divided the factors affecting treatment outcome into client factors, relationship factors, placebo factors, and treatment factors. Although the techniques that make up treatment factors are typically seen as the core set of ingredients in treatment, Lambert’s reviews of empirical studies (Lambert, 1992; Lambert & Ogles, 2004) found such treatment factors to account for only a small percentage of the variance in studies of psychotherapy, a percentage dwarfed by client, relationship, and placebo factors. In his 1992 work, Lambert suggested that 40% of change occurring in treatment was attributable to extratherapeutic factors in the client’s life (such as changing jobs, or life events that occur), 30% to relationship factors having to do with the alliance between the client and therapist, 15% to placebo factors or positive expectancy, and only 15% to the treatment intervention itself. Although the exact percentages of the variance accounted for by each of these factors has been much debated, Lambert’s figures remain very influential. An important caveat is that his figures were estimates based on a literature review and were not formally mathematically derived. Thus, the most commonly accepted numbers, while admittedly inexact, do point to the preponderance of effects that stem from common factors while allowing for only a small impact from treatment factors.

In his analyses, Lambert (1992) also suggested that treatments do not vary much in their overall impact (in effect, reiterating the dodo bird verdict) and highlighted the strong evidence for the impact of the therapeutic alliance on outcomes. Lambert in his 1992 work also articulated yet another division of common factors into what he termed support factors, learning factors, and action factors. He suggested that the evidence points to a sequencing of these factors, with support setting the stage for learning, which in turn sets the stage for action.

## The Great Psychotherapy Debate

Bruce Wampold (2001), in the widely circulated volume *The Great Psychotherapy Debate*, performed another meta-analysis of the impact of treatment and common factors on outcomes and arrived at an even more radical conclusion than Lambert, finding that treatment factors contributed almost nothing to outcomes. While Wampold's analyses have been questioned more than Lambert's, his bestselling book instantly transported his arguments for the limited impact of treatments and the crucial role of common factors from the relatively arcane world of psychotherapy researchers into the much wider discourse of practicing clinicians. Wampold made the crucial point that sometimes treatments claimed as effective are compared not to "bona fide" therapies widely practiced but rather to pseudotreatments that bear little resemblance to psychotherapy of any kind. For example, several studies have contrasted a therapy that was under review for empirical support with a version of humanistic therapy in which therapists simply limited their input to bland support and more repetition of client statements. When actual humanistic therapies, such as emotionally focused therapy, are studied, the rates of success are much different from those in these pseudotherapy versions of humanistic therapy. However, the major point of Wampold's book is that when treatments are compared with bona fide alternatives, his meta-analysis showed that data support the common factors paradigm. For example, effect sizes associated with the therapeutic alliance, therapist factors, and allegiance variables all trumped effect sizes associated with specific treatments.

## The Heart and Soul of Change

Hubble and his associates (1999) followed these efforts with a major edited volume that included chapters examining each of the factors Lambert had designated and assessing the impact of common and treatment factors in different treatment contexts. The chapters in this volume suggested that the common factors, in Luborsky's words, take "all the prizes" in providing the essential impact of treatment. Like Wampold, Hubble et al. assumed what we call a radical view of common factors: that common factors wholly are the essence of psychotherapeutic treatment. Methods of intervention matter little, but what does matter is the generation of such aspects of treatment as a strong

alliance and taking into account the vast importance of client factors (Duncan, Miller, & Sparks, 2004). They also placed great emphasis on the tracking of alliance factors and outcomes during the treatment to be sure it was being maximally effective.

As we have already noted, there is considerable debate about the numbers invoked by Wampold and Hubble and associates emerging out of meta-analyses for the relative contributions of treatment versus common factors that suggest the relatively trivial impact of specific treatments and treatment factors. Critics (Chambless, 2002; Wampold, Ollendick, & King, 2006) claimed that treatment factors account for more of the outcome in meta-analyses than common factors proponents would allow. These critics also argued that treatment factors tend to be underestimated in these meta-analyses (though we note here that even the most generous assessments fail to credit treatment factors for the most substantial part of the impact of therapy) because the treatments assessed in these meta-analyses are so diverse that the effects of treatment are lost. From the defenders' perspective, a better test of the impact of treatment factors would be to look at a more limited set of studies such as those comparing cognitive-behavioral treatments for treating anxiety disorders and other approaches.

As we discuss later (primarily in Chapters 5 and 11), we believe the correct balanced approach allows for acknowledging problems for which certain treatments work better than others as well as for those where treatment factors are unimportant—and “all must have prizes.” Examples that emerge from the treatment research in which certain treatments do appear to have unique effectiveness for certain problems as compared to other treatments include sex therapy for sexual disorders (McCarthy, 2002), family psychoeducational treatments for schizophrenia (Anderson, Hogarty, & Reiss, 1980), and cognitive-behavioral treatments for panic disorder (Barlow, Pincus, Heinrichs, & Choate, 2003), obsessive–compulsive disorder (Franklin & Foa, 2007), and simple phobias (Barlow, Allen, & Basden, 2007).

However, the limited range of such findings must be juxtaposed against the wide array of problems and situations for which people seek therapy in which there are no similar results and where many treatments appear equally effective. For all of the more typical problems for which clients enter therapy, such as relationship problems, problems in living, and problems with self-esteem and depression, no one has yet demonstrated that treatment factors make much difference. Even if evidence-based ESTs can be created by showing that



these treatments work, there is no reason to believe these treatments work any better than other treatments not yet subjected to research. What is missing from the literature is clear. No one has yet shown consistent treatment effects across studies comparing bona fide treatments aimed at these problems; and the number of research studies that have found that such bona fide treatments (when examined in relation to no treatment) don't work is very small, mostly concentrated in the treatment of a few difficult-to-treat problems.

### **The American Psychological Association Division of Psychotherapy Report**

Recently, the Division of Psychotherapy of the American Psychological Association commissioned another volume examining which common factors have a sufficient empirical basis for their impact on outcomes to be regarded as established (Norcross, 2002b). This group found the therapeutic alliance, cohesion in group therapy, empathy, goal consensus, and collaboration to be well-established general elements in the therapy relationship. Looking at this list more specifically, the task force found overwhelming evidenciary support for the impact of the alliance between client and therapist on treatment outcome. In the group therapy context, they found that cohesion in the group (how members felt in relation to one another) had an analogous impact to that of the therapeutic alliance in individual therapy; that is, clients who feel connected to one another in group therapy generally have better outcomes. This task force also found that higher levels of therapist empathy led to better therapeutic relationships and outcomes, as did clients and therapists sharing the same goals for treatment. The task force also found that two ways of customizing the therapy to the individual client have been shown to have a favorable impact, namely, adapting the treatment to enable a better alliance with the client and adapting the treatment to the level of the functional impairment and the coping style of the client. In other words, considering carefully who the client is matters when framing a particular strategy of intervention.

The task force also identified a number of promising elements that had emerged from research but for which there were not as yet sufficient findings for these to be regarded as "well-established" relationship factors. These included positive regard and congruence (which we described earlier on our discussion of Carl Rogers); the feedback

between client and therapist about progress; repairing alliance ruptures when the client comes to see the therapist in a negative light; therapist self-disclosure about his or her own life; the positive management of countertransference that arises in treatment; and offering relational interpretations about the relationship between client and therapist. Other factors identified as promising included adapting the therapy relationship to the individual client and his or her readiness to change (Prochaska, DiClemente, & Norcross, 1992), client expectations and preferences, client attachment style, client spirituality, and cultural diversity. In summary, the division task force made a strong case for the power of common factors in treatment and the potentially wide range of such factors.

### **The Integrative Movement in Psychotherapy and Family Therapy**

In recent years a widespread movement has emerged within psychotherapy in general and more specifically within family therapy toward integration of treatments (Lebow, 2002). Any close observation of recent writing or clinical practice would suggest how completely the trend toward integration and eclecticism has transformed psychotherapy. Not only has a considerable literature emerged concerned with integration and eclecticism, but also numerous models have been developed and widely disseminated. Yet, oddly and perhaps emblematic of a paradigm shift, the move to integration and informed eclecticism has become so much part of the fabric of our work that it goes largely unrecognized.

There are many signs of this emerging paradigm. Methods often broach the boundaries of what earlier were distinct schools of psychotherapy (Goldfried & Norcross, 1995). The methods of “behavioral” therapists now often include strains of strategic therapy (Haas, Alexander, & Mas, 1988). “Cognitive” therapists pay far greater attention to affect than previously, and experiential therapists grapple with structure (Linehan et al., 1999). Work with “object relations” frequently involves the teaching of behavioral skills and pragmatic help in solving problems (Stricker & Gold, 2005). Articles and presentations refer again and again to a merging of concepts across diverse orientations.

Although professional identities continue to form within training programs grounded in schools of treatment and to be maintained

despite the idiosyncratic pathways of professional development, actual methods of practice continue to broaden. While integrative and eclectic models in psychotherapy have existed for several decades, the extent of their acceptance is unprecedented. Surveys suggest that the great majority of practitioners identify themselves as integrative or eclectic in orientation (Norcross & Newman, 1992). Although new therapies, strategies, and techniques continue to be developed, the impact of these therapies often is greatest when concepts and interventions are integrated with more traditional methods. Little time passes between the development of an approach and its integration with other methods.

In today's clinical practice, even the broadest disjunction—that between “individual” and “couple” or “family” therapy—is regularly negotiated. Increasingly, interventions and precepts derived from individual therapy (e.g., cognitive-behavioral, psychodynamic, or self-psychology practices) are utilized in conjunction with systemic perspectives, and individual, couple, and family sessions are mixed freely in treatments. This is in marked contrast to early family therapy, whose practitioners criticized those who utilized concepts from individual therapy, asserting that the therapist was insufficiently systemic (Keith, Connell, & Whitaker, 1991; Minuchin, 1974), and to earlier individual-focused therapy, whose practitioners saw inclusion of family members as, at best, diluting the focus, and perhaps as harmful (through such mechanisms as undermining therapist–client transference).

A common language that transcends approach has begun to emerge as well as the beginnings of generic catalogs of interventions that transcend orientation. Several thoughtfully constructed integrative and systematic eclectic therapies also have been developed that have acquired considerable numbers of followers (Breunlin et al., 1997; Duncan, Sparks, & Miller, 2006; Liddle, Rodriguez, Dakof, Kanzki, & Marvel, 2005; Pinsof, 2005; Sexton & Alexander, 2003) and have helped popularize integrative and eclectic practice.

One major thread of integration consists in those approaches that highlight and emphasize common factors (Lebow, 2008). These methods focus primarily on the best implementation of common factors in psychotherapy, much as we do in this book. The emergence of the integrative/ informed eclectic paradigm probably was inevitable, but it was anticipated by few as arriving so quickly. Most therapists have switched from belaboring differences to instead focusing on integration in their practices.

## Sprenkle and Blow's Moderate Common Factors Approach

Looking at the history of evidence described above and focusing on the role of common factors in the practice of marriage and family therapists, Sprenkle and Blow (2004a) articulated what they term a moderate common factors position. This position differed from the more extreme interpretations of common factors offered by Wampold (2001) or Hubble et al. (1999). From Sprenkle and Blow's (2004a) perspective, common factors are important, but one approach is not "just as good as another." They argue, instead, that it does matter what therapists do but that among effective psychotherapies there are only relatively small differences in treatment outcome. This view leaves room for the findings of clinical trial research as well as the meta-analyses that point to few differences in outcomes across treatments, as was described earlier. Sprenkle and Blow suggest that the contrast of common factors versus treatment factors need not be an either-or position. They allow for the likelihood of added specific benefit from treatment factors beyond that of common factors but want to be sure that common factors are accorded their rightful credit in treatment and in training.

Sprenkle and Blow (2004a) divide common factors into client factors, therapist effects, the therapeutic relationship, expectancy effects, and the nonspecific treatment variables described by Karasu (1986): behavioral regulation, emotional experiencing, and cognitive mastery. In the current volume we add a sixth miscellaneous category that includes allegiance effects and the organization or coherence of the model employed (see Chapter 4). In bringing the discourse about common factors into the domain of the practice of relational therapies, Sprenkle and Blow also added three common factors unique to relational therapies, namely, a relational conceptualization of problems, the expanded direct treatment system, and the expanded therapeutic alliance. These factors are described in detail in Chapter 3, where a fourth common factor is also discussed, namely, disrupting dysfunctional relational patterns.

The work of Sprenkle and Blow serves as much of the basis for this book. The publication of their paper in the *Journal of Marital and Family Therapy* (Sprenkle & Blow, 2004a, 2004b) led to an exchange of papers with Sexton, Ridley, and Kleiner (2004) in that journal debating the importance of common factors in couple and family therapy.

This chapter has traced the rich history of common factors.

While explicit mention of this term goes back to 1936 (Rosenzweig), the entire history of psychotherapy can be described as a dramatic conflict between the forces of specificity and commonality. Our commitment is to evidence. We believe that the evidence is more supportive of the common-factors-driven model of change, although we take a more moderate stance on this issue than some of our colleagues in the common factors camp. A detailed explanation of our “moderate” view will be offered in Chapter 5.