Chapter 14

COMMON FACTORS IN PSYCHOTHERAPY

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The great tragedy of science—the slaying of a beautiful hypothesis by an ugly fact.
—Thomas Henry Huxley,
Presidential Address to the British
Association for the Advancement of Science

Mental health professions can rightly claim they have arrived—we know clinical services make a difference in the lives of our clientele. In fact, the effect size[1] of psychotherapy is remarkably robust, about .85, meaning that the average treated client is better off than 80% of those untreated (Smith & Glass, 1977; Smith, Glass, & Miller, 1980; Wampold, 2001). However, we have yet to agree on what enables our therapy to work. If therapy is a mighty engine that helps convey clients to places they want to go, what provides the power? This question is central to our identity and possibly survival as we traverse the next millennium (Hubble, Duncan, & Miller, 1999a).

The search for what works has fueled research and sparked debate for over 50 years. New schools of therapy arrive with regularity, each claiming to be the corrective for all that came before and to have the inside line on the causes of psychological dysfunction and best remedies. A generation of investigators ushered in the age of comparative clinical trails, bent on anointing winners and discrediting losers. As Bergin and Lambert (1978) described this time, "Presumably, the one shown to be most effective will prove that position to be correct and will serve as a demonstration that the 'losers' should be persuaded to give up their views" (p. 162). The result was that "behavior, psychoanalytic, humanistic, rational-emotive, cognitive, time-limited, time-unlimited, and other therapies were pitted against each other in a great battle of the brands" (Duncan, 2002b, p. 35). As it turns out, the underlying premise of comparative studies—that one (or more) therapies would prove superior to others—has received virtually no support (Norcross & Goldfried, 1992). Besides the occasional significant finding for a particular therapy, the critical mass of data reveals no differences in effectiveness between the various treatments for psychological distress (Wampold, 2001).

If specific models can't explain why therapy works, what does? Enter the common factors. In 1936, writing in the *American Journal of Orthopsychiatry,* Saul Rosenzweig concluded that, since no form of psychotherapy or healing is without cures to its credit, its success is not reliable proof of the validity of its theory. Instead, he suggested that some potent implicit common factors, perhaps more important than the methods purposely employed, explained the uniformity of success of seemingly diverse methods.

[1] *Effect size* here and elsewhere in the chapter refers to the measure of the magnitude of the treatment effect.

Over time, Rosenzweig's prophetic insight garnered increasing interest. With "little evidence to recommend the use of one type of therapy over another" (Norcross & Goldfried, 1992, p. 9), psychotherapy observers and researchers redirected their attention away from a "mine's better" focus (see Garfield, 1992) and, instead, attempted to identify the pantheoretical elements that made various treatments effective. The organizing question became, if therapies work but not as the result of their bells and whistles, what are the common therapeutic factors?

This chapter addresses the efforts of researchers and clinicians alike to answer this question. Covering historical and empirical foundations, we explore the evolution of common factors as a metatheoretical framework for research and the emergence of transformative clinical practice. By definition, a common factors framework is not a model, psychotherapy, or specific set of techniques. As such, it cannot be "manualized" but informs the immediate therapeutic encounter *one client at a time*. We incorporate this distinction throughout while exploring past and present interpretations and clinical applications. Specifically, we discuss how this insight has inspired client-directed, outcome-informed practice (CDOI), where client views, not models or theories, guide the therapy process. We describe CDOI at the end of key sections and in "Description of a Specific Approach," tracing the progression of this particular viewpoint from a common factors heritage. In so doing, we make the case that CDOI practice is a logical heir to the conceptual and empirical common factors tradition.

HISTORY AND VARIATIONS

Beginnings

Saul Rosenzweig's classic 1936 article, "Some Implicit Common Factors in Diverse Methods of Psychotherapy," is likely the beginning of common factors as it is known today. Rosenzweig, a 1932 Harvard PhD and schoolmate of B. F. Skinner and Jerome Frank, suggested that the effectiveness of different therapy approaches had more to do with their common elements than with the theoretical tenets on which they were based. He summarized these common factors:

> *. . . the operation of implicit, unverbalized factors, such as catharsis, and the yet undefined effect of the personality of the good therapist; the formal consistency of the therapeutic ideology as a basis for reintegration; the alternative formulation of psychological events and the interdependence of personality organization. (p. 415)*

Luborsky (1995), whose comprehensive review of comparative trials later confirmed Rosenzweig's insight (see Luborsky, Singer, & Luborsky, 1975), said that Rosenzweig's paper "deserves a laurel in recognition of its being the first systematic presentation of the idea that common factors across diverse forms of psychotherapy are so omnipresent that comparative treatment studies should show nonsignificant differences in outcomes" (p. 106).

Shortly after Rosenzweig's seminal publication, an altogether forgotten panel (notable exceptions: Goldfried & Newman, 1992; Sollod, 1981; Weinberger, 1993), assembled several prominent theorists at the 1940 conference of the American Orthopsychiatric Society. This presentation, "Areas of Agreement in Psychotherapy," was later published in

the responsibility for choice on the client, and enlarging the client's understanding of self). Watson, in his conclusion, also said:

> *If we were to apply to our colleagues the distinction, so important with patients, between what they* ***tell us and what they do, we might find that agreement is greater in practice than*** *in theory. . . . We have agreed further . . . that our techniques cannot be uniform and rigid, but vary with the age, problems and potentialities of the individual client and with the unique personality of the therapist. . . . A therapist has nothing to offer but himself. (p. 29)*

On this panel, Rosenzweig outlined his implicit common factors with some further elaboration, and Carl Rogers presented about areas of agreement in working with children. Rogers highlights this panel as recommended reading in his first book, *Counseling and Psychotherapy* (1942), and also references Rosenzweig's 1936 paper. Sollod (1981) notes that the 1940 panel, especially the ideas offered by Watson, significantly influenced Rogers.

Following this auspicious beginning, little was published about the common factors until an interesting study by Heine (1953) foreshadowed later comparative investigations. Heine credits the questions raised by Rosenzweig as providing the impetus to conduct a study that compared several prevailing methods of the day. Given comparable results, Heine supported Rosenzweig's analysis by concluding that a common factor(s) was operating in the different forms of psychotherapy investigated. Heine suggested that theory and technique are less important than the characteristics of the individual applying them—a conclusion that reiterates the 1940 panel's assertions and has since gained much empirical support. He recommended that the field devote itself to developing *a psychotherapy* rather than a variety of psychotherapies. Heine's influential study was often referenced by later scholars. Heine was also acknowledged **in Fiedler's (1950) classic** investigation of the ideal therapeutic relationship.

Nineteen years after Rosenzweig's original article, Paul Hoch echoed Rosenzweig's words in a 1955 article:

> *If we have the opportunity to watch many patients treated by many different therapists using different techniques, we are struck by the divergencies in theory and in practical application and similarity in therapeutic results. . . . There are only two logical conclusions . . . first that the different methods regardless of their theoretical background are equally effective, and that theoretical formulations are not as important as some unclear common factors present in all such therapies. (p. 323)*

Rosenzweig said:

> *What . . . accounts for the result that apparently diverse forms of psychotherapy prove successful in similar cases?* ***Or*** *if they are only apparently diverse, what do these therapies actually have in common that makes them equally successful? . . . it is justifiable to wonder . . . whether the factors that actually are in operation in several different therapies may not have much more in common than have the factors alleged to be operating. (pp. 412–413)*

Hoch posited two common factors: the establishment of rapport and trying to influence the patient. He articulated six methods of influence (reassurance, catharsis, interpretation, manipulating interpersonal relationships, and altering environmental forces). In 1957, Sol Garfield, noted common factors theorist and significant contributor to the advancement of a common factors perspective, included a 10-page discussion of common factors in his book, *Introductory Clinical Psychology*. He identified features

common to psychotherapy including a sympathetic nonmoralizing healer, the emotional and supporting relationship, catharsis, and the opportunity to gain some understanding of one's problems.

The same year as Garfield's (1957) exploration of common factors, Carl Rogers published the profoundly influential paper, "The Necessary and Sufficient Conditions of Therapeutic Personality Change," in the *Journal of Consulting Psychology*. Rogers proposed that, in effective psychotherapy, therapists create core relational conditions of empathy, respect, and genuineness. Although the recognition of the importance of the therapeutic relationship was widespread as early as 1940 (see Watson, 1940), Rogers raised the stakes by suggesting that therapist-provided variables were "sufficient" for therapeutic change. Remarkably, Rosenzweig (1936), 21 years earlier, comments:

> *Observers seem intuitively to sense the characteristics of the good therapist time and again . . . sometimes being so impressed as almost to believe that the personality of the therapist would be* **sufficient** *(emphasis added) in itself, apart from everything else, to account for the cure of many a patient by a sort of catalytic effect. (p. 413)*

This may be the first report of the sufficient nature of therapist-provided variables as popularized by Rogers's groundbreaking 1957 article.

Building on Rogers's understanding of therapist-provided variables, Truax and Carkhuff (1967) define empathy as the therapist's ability to be "accurately empathic, be with the client, be understanding, or grasp the client's meaning" (p. 25). Genuineness, or congruence, speaks to the therapist's ability to relate transparently and honestly with the client, casting aside the façade of the professional role. Respect, according to Rogers (1957), means the ability to prize or value the client as a person with worth and dignity; it refers to the unconditional acceptance of the client, including a positive, nonjudgmental caring and a willingness to abandon suspicions regarding the authenticity of the client's account. While these definitions describe therapist-provided variables, they do not describe the idiosyncratic interpretations of therapist behavior by the client. Duncan, Solovey, and Rusk (1992) argue that "the therapist's reliance on standby responses to convey empathy [genuineness, or respect] will not be equally productive . . ." (p. 34), and make the point that the implementation of Rogers's core conditions must rely instead on a fit with the client. Bachelor's (1988) study of client perceptions of empathy concluded that this factor had different meanings for different clients and should not be viewed or practiced as a universal construct. Nevertheless, Rogers's work spawned great practical and theoretical interest, influencing clinical training, practice, and a wave of research focused on the role of the relationship as a core variable across therapy models.

Key Figures and Variations

If Rosenzweig wrote the first notes of the call to the common factors, Johns Hopkins University's Jerome Frank composed an entire symphony. Frank's (1961) book, *Persuasion and Healing,* was the first entirely devoted to the commonalities cutting across approaches. In it, he incorporated much of Rosenzweig's brief proposal, but articulated a much expanded theoretical and empirical context, especially regarding the profound effects of hope and expectancy in healing endeavors. In this and later editions (1973, 1991), Frank placed therapy within the larger family of projects designed to bring about healing. He (joined by his daughter, Julia, in the last edition) looked for the threads linking such different activities as traditional psychotherapy, group and family therapies, inpatient treatment, drug therapy, medicine, religiomagical healing in nonindustrialized societies, cults, and revivals.

In his analysis, Frank (1973) concluded that therapy in its various forms should be thought of as "a single entity." He proposed:

> *Two apparently very different psychotherapies, such as psychoanalysis and systematic desensitization, might be analogous to penicillin and digitalis—totally different pharmacological agents suitable for totally different conditions. On the other hand, the active ingredient of both may be the same, analogous to two compounds marketed under different names, both of which contain aspirin. I believe the second alternative is closer to the mark. (pp. 313–314)*

Frank also identified four features shared by all effective therapies: (1) an emotionally charged, confiding relationship with a helping person; (2) a healing setting; (3) a rationale, conceptual scheme, or myth that plausibly explains the patient's symptoms and prescribes a ritual or procedure for resolving them; and (4) a ritual or procedure that requires the active participation of both patient and therapist and that is believed by both to be the means of restoring the patient's health.

Frank's common factors bear a resemblance to Rosenzweig's original formulations, especially the notions of a conceptual scheme and alternative explanation, and the therapeutic relationship. In addition, Frank's "single entity" concept resembles Heine's idea of developing "a psychotherapy" (see Heine, 1953).

During the 1970s, theorists picked up on Frank's far-reaching discussion of hope and expectancy (referred to in the literature as *placebo effects*), conceptualizing the common factors in these terms (e.g., A. Shapiro, 1971; A. Shapiro & Morris, 1978). The 1970s also ushered a more refined definition of the basic ingredients of psychotherapy (e.g., Garfield, 1973; Strupp, 1973), an increased empirical argument for the common factors (e.g., Strupp & Hadley, 1979), and the empirical confirmation of Rosenzweig's original insight that diverse psychotherapies have equivalent outcomes. This finding has since been summarized by quoting the dodo bird from *Alice's Adventures in Wonderland,* who said, "Everybody has won and all must have prizes" (Carroll, 1962/1865). It was Saul Rosenzweig (1936), a devotee of Lewis Carroll, who first invoked the words of the now infamous dodo bird to illustrate his prophetic observation of this phenomenon (Duncan, 2002a). Almost 40 years later, Luborsky et al. (1975) empirically validated Rosenzweig's conclusion in their now classic review of comparative clinical trials. They dubbed their findings of no differences among models the "dodo bird verdict."

From 1980 forward, the debate concerning what works in psychotherapy was fueled by an increasing interest in common factors (Weinberger, 1995). Grencavage and Norcross (1990) collected articles addressing common factors and noted that a positive relationship exists between year of publication and the number of common factors proposals offered. Perhaps in response to the comparative studies and reviews of the 1970s and 1980s (e.g., Luborsky et al., 1975; D. Shapiro & Shapiro, 1982; Smith et al., 1980; Stiles, Shapiro, & Elliot, 1986) reflecting the equivalence of outcome, these decades gave rise to greater prominence of common factors ideas, particularly in the eclecticism/integration movement (see Lazarus; Stricker & Gold, this volume). Many noteworthy common factors proposals appeared (e.g., Garfield, 1982; Goldfried, 1982; S. Miller, Duncan, & Hubble, 1997; Patterson, 1989; Weinberger, 1993).

In the 1990s, integrative theoreticians looked to common factors to provide a conceptual framework for practice across diverse models. Based in part on Lambert's 1986 review (cited in Norcross & Goldfried, 1992) proposing that client-specific variables (out-of-therapy events, client ego strength, and others) along with therapist empathy, warmth, and acceptance account for the bulk of outcome variance. Norcross and Goldfried's (1992) *Handbook of Psychotherapy Integration* contained Lambert's influential paper describing percentages of variance attributable to four common factors—client and extratherapeutic

factors, relationship factors, placebo factors, and model techniques. Though not derived from a strict statistical analysis, Lambert wrote that the four factors embody what empirical studies suggest about psychotherapy outcome. Lambert added that the research base for this interpretation of the factors was "extensive, spanned decades, dealt with a large array of adult disorders, and a variety of research designs, including naturalistic observations, epidemiological studies, comparative clinical trials, and experimental analogues" (p. 96). Duncan et al. (1992), in *Changing the Rules: A Client-Directed Approach to Therapy,* was the first effort to articulate a clinical application and enhancement of these key factors.

Inspired by Lambert's proposal, S. Miller et al. (1997) expanded the use of the term *common factors* from its traditional meaning of nonspecific or relational factors, to include four specific factors: client, relationship, placebo, and technique.[2] Based on this broader conceptual map of the common factors, Hubble, Duncan, and Miller (1999b) assembled leading outcome researchers to review 4 decades of investigation and reveal the implications for practice. The results favored an increased emphasis on the client's contribution to positive outcome and provided a more specific delineation of clinical guidelines (Hubble et al., 1999a). Since Lambert's formulations, Wampold (2001), through his analysis of existing outcome data, refined the relative contributions of clients to known existing common factors, concluding that model factors (techniques) accounted for as little as 1% of the overall change resulting from psychotherapy intervention, with client factors predominating. Alliance factors were found to be responsible for a hefty portion of treatment effects, along with therapist and allegiance effects. Wampold's groundbreaking work has been a definitive blow to model proponents and a compelling treatise supporting what he terms a "contextual" metamodel.

Interest in common factors has spread beyond traditional psychotherapy. Research on common factors has been juxtaposed with family therapy models (see Duncan, Miller, & Sparks, 2003; Duncan et al., 1992; S. Miller et al., 1997). Wampler (1997) asserted that the family therapy field was remiss in ignoring common factors, whereas other family therapists posited factors deemed unique to family systems work, notably relational conceptualization, expanded direct treatment system, and expanded therapeutic alliance (Sprenkle & Blow, 2001, 2004; Sprenkle, Blow, & Dickey, 1999). Drisko (2004) has suggested that common factors, particularly its emphasis on relationship and persons-in-situations, is consistent with social work's worldview and deserves greater attention in social work education, research, and practice. Finally, Bickman (2005) has called for service organizations to collect data for expanding common factors research in underrepresented community treatment settings, particularly those that work with children and adolescents.

Most recently, common factors inform therapies that honor client perceptions, not theories, as pivotal guideposts to the direction of any therapeutic endeavor (e. g., Lambert et al., 2001; S. Miller, Duncan, Brown, Sorrell, & Chalk, in press; S. Miller, Duncan, & Hubble, 2004). This perspective informs our conceptualization of the progression of common factors, specifically, the call for consumer-driven, consumer-accountable practice (see S. Miller et al., 2004). A client-directed, outcome-informed approach (CDOI), as described here and elsewhere, takes advantage of the extant literature on the role of nonspecific factors, particularly client variables and engagement via the therapy alliance, client perceptions of early progress and the alliance, and known trajectories of change. As such, it is more about change than about theoretical content. The work of Prochaska and colleagues (Prochaska, 1999; Prochaska & Norcross, 2002) similarly embraces a change-oriented, transtheoretical perspective. According to Prochaska, DiClemente, and Norcross

[2]This interpretation of common factors represents a return to Rosenzweig's original formulation.

(1992), clients will more likely engage in change projects when their therapists and other interested parties "assess the stage of a client's readiness for change and tailor their interventions accordingly" (p. 1110). While often cited as an example of theoretical integration (Norcross & Newman, 1992), Prochaska's own description suggests that the model is less about amalgamating theories of therapy than about understanding how change occurs (Prochaska, 1999).

Moving beyond theory-based treatment toward client-informed practice avoids the common factors paradox—how to use what is known about common processes of change without losing a shared, or common, orientation. Instead of adding one more model to the plethora already in existence, CDOI necessarily requires the tailoring of treatment to each unique situation based on client feedback. The systematic collection and incorporation of client feedback throughout therapy operationalizes this insight (see "Description of a Specific Approach" later in this chapter). A client-directed, outcome-informed, approach represents a logical evolution of the ideas first expounded by the earliest common factors theorists and offers a progressive perspective on psychotherapy theory, research, and practice in the twenty-first century.

GENERAL THEORY OF PERSONALITY AND PSYCHOPATHOLOGY

The common factors literature has largely focused on therapist-generated events (Grencavage & Norcross, 1990). Tallman and Bohart astutely note that even the language of psychotherapy (e.g., therapist *intervention* and client *response*) maintains a therapist-centric perspective and denotes clients as passive recipients. Theories of personality and psychopathology traditionally have viewed clients as deficient—possessing more or less stable core traits that when identified require remediation. Indeed, the field has a long history of disparaging clients, perhaps reflecting the view of people in general held by psychotherapy's "founding father," Sigmund Freud (1909/1953), who once said, "I have found little that is good about human beings. In my experience, most of them are trash" (p. 56). Duncan and Miller (2000b) write:

> *Whether portrayed as the "unactualized" message bearers of family dysfunction, manufacturers of resistance, or targets for the presumably all-important technical intervention, clients are rarely cast in the role as chief agents of change or worthy of mention in advertisements announcing the newest line of fashions in the therapy boutique of techniques. (p. 57)*

The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), "the professional digest of human disasters" (Duncan, Miller, & Sparks, 2004, p. 23), enjoys virtually unquestioned acceptance and widespread use in everyday practice, carrying on the field's preoccupation with client dysfunction. This is the case, even though the *DSM* fails basic parameters of validity and reliability, and psychiatric diagnoses do not correlate with treatment outcome (Duncan et al., 2004; Kutchins & Kirk, 1997; Sparks, Duncan, & Miller, 2006).

While client pathology continues to provide the bedrock of most psychotherapy theories and practices, research refutes the idea of the "unheroic" client. Tallman and Bohart's (1999) review makes clear that the client is actually the single, most potent contributor to outcome in psychotherapy—the resources clients bring into the therapy room and the factors that influence their lives outside it. These factors might include persistence, openness, faith, optimism, a supportive grandmother, or membership in a religious community: all factors operative in a client's life before he or she enters therapy; they also include serendipitous interactions between such inner strengths and happenstance, such

as a new job or a crisis successfully negotiated (S. Miller et al., 1997). Asay and Lambert (1999) ascribe 40% of improvement during psychotherapy to client factors. Wampold's (2001) meta-analysis assigns an even greater proportion of outcome to factors apart from therapy—87% to extratherapeutic factors, error variance, and unexplained variance. These variables are incidental to the treatment model and idiosyncratic to the specific client—part of the client and his or her environment that aid in recovery regardless of participation in therapy (Lambert, 1992).

Among the client variables frequently mentioned as salient to outcome are severity of disturbance, motivation, capacity to relate, ego strength, psychological mindedness, and the ability to identify a focal problem (Asay & Lambert, 1999). However, in the absence of compelling evidence for any of the specific client variables to predict outcome or account for the unexplained variance, this most potent source of variance remains largely uncharted. This suggests that the largest source of variance cannot be generalized because the factors affecting the variance differ with each client. Studies indicating that people overcome significant difficulties even without formal intervention support the evidence of client resourcefulness and resiliency in psychotherapy outcome (Tallman & Bohart, 1999). Prochaska and his colleagues have asserted, "in fact, it can be argued that all change is self-change, and that therapy is simply professionally coached self-change" (Prochaska, Norcross, & DiClemente, 1994, p. 17). The picture emerging from the literature is of client strength rather than pathology. In fact, although clients may bring different vulnerabilities to the therapy endeavor, client engagement far outweighs specific diagnoses in predicting outcome (Duncan et al., 2004). In sum, the common factors literature puts forward no specific frameworks of client personality or psychopathology as empirically correlated with outcome, but affirms the preeminent role of nonspecified client factors across therapies and self-generated change. Moreover, the burden of evidence points toward the resourceful engagement of clients as pivotal regardless of predetermined assessments of dysfunction.

GENERAL THEORY OF PSYCHOTHERAPY

By definition, *common factors* is a pantheoretical framework defined by factors shared by all treatment approaches. Common factors are nonmodel-specific and considered efficacious above specific treatment effects (Wampold, 2001). Theorists have attempted to organize levels of common factors within various frameworks. To bridge diverse groupings, Goldfried (1982) suggested that therapies contained, if not shared techniques, shared general strategies, such as providing corrective experiences and offering direct feedback. Patterson (1989) made a convincing argument that specific factors common to all theories could provide a foundation for a systematic eclecticism, particularly therapist acceptance, permissiveness, warmth, respect, nonjudgmentalism, honesty, genuineness, and empathic understanding. Castonguay (1993) proposed three categories of meaning: (1) global aspects of all therapies; (2) social and interpersonal variables, including the therapeutic alliance; and (3) nontherapy variables such as client expectancy and involvement. Grencavage and Norcross (1990) compiled five overarching clusters encompassing client characteristics, therapist characteristics, change processes, treatment structures, and relationship elements. Frank and Frank's (1991) four components of effective therapy (see "Key Figures and Variations" earlier in this chapter) highlights the role of the therapist–client relationship in client remoralization and the fit of client beliefs with the therapist's explanation for the problem and rationale for a ritualistic method for resolving it.

Wampold (2001) cogently argues, however, that codifying any specific ingredient derived from these various frameworks to apply across therapies necessarily transforms a transtheoretical, common paradigm into a level of abstraction consistent with specific models and their theories. Based on Wampold's definition of a contextual versus a medical (specific ingredients) model and further elaborations (see "Description of a Specific Approach" later in this chapter; Duncan et al., 2004; S. Miller et al., 2004), a common factors paradigm, as described in this chapter, is incompatible with the notion of specific ingredients, even when they are deemed common to all therapies. While this may lead to the conclusion that specific techniques are not important, this is not the case. Frank and Frank (1991) explain this well:

> *My position is not that technique is irrelevant to outcome. Rather, I maintain that, as developed in the text, the success of all techniques depends on the patient's sense of alliance with an actual or symbolic healer. This implies that ideally therapists should select for each patient the therapy that accords, or can be brought to accord, with the patient's personal characteristics and view of the problem. Also implied is that therapists should seek to learn as many approaches as they find congenial and convincing. (p. xv)*

Following this insight, the actualization of effective strategies takes place within each singular therapy experience regardless of therapy modality (Duncan & Moynihan, 1994).

Without specific ingredients as a focal point, describing a common factors perspective represents a challenge. First, it is impossible to divorce any discussion of goals, interventions, and a therapy process in general without framing these within the context of potent common factors such as the therapy alliance, client and therapist variables, and the role of hope and expectancy. Second, to expound on treatment specifics disembodied from the largest source of change, the client—his or her engagement in therapy and extratherapeutic world—misses the mark of 50 years of empirical evidence. The following sections conceptualize psychotherapy practice within a metaframework (common factors) that provides practical, empirically grounded information for clinicians without enshrining techniques that must be practiced universally regardless of their fit with the client in each unique therapy relationship.

Goals

Bachelor and Horvath (1999) convincingly argue that next to what the client brings to therapy, the therapeutic relationship is responsible for most of the gains resulting from therapy. Referred to typically as the alliance, this common factor is the most mentioned in the therapy literature (Grencavage & Norcross, 1990) and has been called "the quintessential integrative variable" (Wolfe & Goldfried, 1988, p. 449). The fact that the role of the alliance has captivated psychotherapy researchers these past 50 years can well be traced to the pioneering work of Carl Rogers (1951). Roger's "core" or "necessary and sufficient [conditions] to effect change in clients" (empathy, respect, genuineness [Meador & Rogers, 1979, p. 151]) have not only galvanized pivotal research, but have long provided a key emphasis in training programs and clinical practice. Patterson (1984) concluded:

> *There are few things in the field of psychology for which the evidence is so strong as that supporting the necessity, if not sufficiency, of the therapist conditions of accurate empathy, respect or warmth, and therapeutic genuineness. (p. 437)*

Over the past 50 years, researchers and theoreticians have gradually expanded Rogers's groundbreaking thinking into a broader concept of the "therapeutic alliance," shifting focus from therapist-provided conditions to what happens when the therapist and client work together, side by side, in the service of therapeutic change. Bordin's (1979) three interrelated alliance elements—the client's felt sense of connection with the therapist, agreement on goals, and agreement between on tasks—encapsulate this working relationship. A discussion of the goals of therapy, therefore, cannot be divorced from the role of the alliance as a premier common factor.

The alliance is one of the most researched variables in all psychotherapy outcome literature reflecting over 1,000 findings and counting (Orlinsky, Rønnestad, & Willutzki, 2004). Researchers repeatedly find that a positive alliance is one of the best predictors of outcome (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Data from the Treatment of Depression Collaborative Research Project (TDCRP; Elkin et al., 1989), the landmark National Institute of Mental Health (NIMH) project considered one of the most sophisticated comparative trials ever done, found that the alliance was predictive of success for all conditions while the treatment model and the severity of the presenting problem were not (Blatt, Zuroff, Quinlan, & Pilkonis, 1996; Krupnick et al., 1996). In another large study of diverse therapies for alcoholism, the alliance was also significantly predictive of success (sobriety), *even* at 1-year follow-up (Connors, DiClemente, Carroll, Longabaugh, & Donovan, 1997). Moreover, the data suggest that the alliance quality is an active factor (Gaston, Marmar, Thompson, & Gallagher, 1991). Thus, the relationship *produces* change and is not only a reflection of beneficial results (Lambert & Bergin, 1994). Finally, based on the Horvath and Symonds (1991) meta-analysis, Wampold (2001) portions 7% of the overall variance of outcome to the alliance. Putting this into perspective, the amount of change attributable to the alliance is about seven times that of a specific model or technique. As another point of comparison, in the TDCRP, mean alliance scores accounted for up to 21% of the variance, while treatment differences accounted for at most 2% of outcome variance (Wampold, 2001), over a 10-fold difference.

Bordin's alliance elements have been combined under the concept of the "client's theory of change" (Duncan & Miller, 2000a; Duncan & Moynihan, 1994; Duncan et al., 1992; Hubble et al., 1999a; S. Miller et al., 1997). This concept suggests that each client has an idiosyncratic set of ideas about the nature of the problem as well as preferred ways to resolve it. To the degree that the therapist matches the client's theory of change—provides a therapy that fits the client's view of the desired type of therapist/client connection, goals, and therapy activities (e.g., steps to reach goals, homework assignments, in-session interventions)— the chance of a positive outcome increases. Studies, in fact, support the notion of matching clients' theories of change. Hester, Miller, Delaney, and Meyers (1990) compared the efficacy of traditional alcohol treatment with learning-based counseling approach. While no differences were found at the conclusion of the study between the two groups, at 6-month follow-up, differences emerged stemming from beliefs clients held about the nature of alcohol problems *prior* to the initiation of treatment. Similarly, a post hoc analysis of the TDCRP data found that congruence between a person's beliefs about the causes of his or her problems and the treatment approach offered resulted in stronger therapeutic alliances, increased duration, and improved treatment outcomes (Elkin et al., 1999). Essentially, the client's theory of change is the seat of a three-legged stool that connects the legs of the empirical evidence for what constitutes a positive therapy alliance; it ties together client preferences into a stable platform on which the entire therapy rests (Duncan et al., 2004).

The importance of clients' views of the alliance has been confirmed in the research literature. Client perceptions of the relationship are the most consistent predictors of

improvement (Bachelor, 1991; Gurman, 1977). Blatt et al. (1996) analyzed client perceptions of the relationship in the TDCRP and found that improvement was substantially determined by the client-rated quality of the relationship. The *unequivocal* link between clients' ratings of the alliance and successful outcome makes a strong case for an emphasis in psychotherapy on tailoring therapy to the client's perceptions of a positive alliance. To do this on day-to-day basis requires avid attention to the client's goals, including the flexibility to alter goals based on an ongoing assessment of client perceptions of whether the therapy is proceeding in an expected and positive direction (Duncan et al., 2004; S. Miller et al., 2004). Whereas some clients may prefer a formal goal statement, some may not; rigid goal frameworks can get in the way of rapidly evolving change processes and can interfere with core features of the alliance (see, e.g., Norcross & Beutler, 1997). Even in situations of clients mandated to therapy, respecting client goals is associated with enhanced treatment effects (e.g., see W. Miller, 1987; W. Miller & Hester, 1989; Sanchez-Craig, 1980). Rather than setting goals that reflect therapeutic assumptions about pathology or curative factors, the empirical literature calls on therapists to place client goals at the forefront in the interest of ensuring a strong alliance, positive client engagement, and successful outcome.

Assessment

Assessment, whether based on psychiatric diagnosis or other problem frameworks, consists of specific problem identification strategies based on the theoretical, or model, assumptions. Assessment procedures can be consistent with Wampold's definition of a contextual model where "specific ingredients are necessary to construct a coherent treatment that therapists have faith in and that provides a convincing rationale to clients" (Wampold, 2001, p. 25). More often, however, psychological assessments conform to a "medical model" in which the methods of problem definition are largely theory-derived, consist of more or less invariant prescribed steps, and stand apart from the client's frame of reference and worldview. In these instances, assessment procedures are specific, not common, factors. Outcome data spanning nearly 50 years has consistently failed to support the assumption that specific therapist technical operations are largely responsible for client improvement (Duncan & Miller, 2006; Duncan et al., 2004; Luborsky et al., 1975; Wampold, 2001). After his meticulous review of the literature, Wampold concluded that the evidence that specific ingredients account for treatment effectiveness remains weak to nonexistent. Wampold emphatically asserts, "Decades of psychotherapy research have failed to find a scintilla of evidence that any specific ingredient is necessary for therapeutic change" (p. 204). Diagnosis, a distilled assessment, is assumed to provide a blueprint for correct procedure and is, therefore, frequently required before intervention. The literature, however, indicates that diagnosis is not correlated with outcome or length of stay, and cannot tell clinicians or clients the best approach to resolving a problem (Brown, Dreis, & Nace, 1999; Wampold, 2001). Similarly, diagnosis tells clinicians little that is relevant to why people enter therapy or how they change (Duncan et al., 2004). Nevertheless, diagnoses proliferate each year, making Jerome Frank's ironic observation (1973)—that psychotherapy might be the only treatment that creates the illness it treats—particularly salient.

While *automatic* reliance on diagnosis is not empirically warranted, Frank and Frank (1991) noted the importance of the client's belief in a plausible therapist-provided rationale; some clients may view formal assessments, including diagnosis, as expected parts of the therapy ritual and find empowerment in a socially sanctioned or medicalized problem explanation. The correct tailoring of treatment to the client's theory of change enhances the therapeutic alliance and outcome. A client-directed, outcome-informed

approach (CDOI), uses an assessment of client views at each session to learn how clients respond to standardized assessment and other procedures (Duncan et al., 2004; S. Miller et al., 2004). This approach continually evaluates whether the therapist's explanation and procedures resonate with client expectations for the change process.

Similarly, Prochaska and colleagues (Prochaska, 1999; Prochaska & Norcross, 2002; Prochaska et al., 1994) focus on the client's readiness to change, or stage of change, as critical information required not only prior to treatment but as treatment progresses to ensure engagement in the change process. The word *stage* implies the client's specific state of motivational readiness that the therapist must accommodate to make progress. Clients in the *precontemplation* stage have not, as yet, made a connection between a problem in their lives and their contribution to its formation or continuation. Consequently, precontemplative clients usually do not establish an alliance with a helping professional (Prochaska, 1995). Clients in the *contemplation* stage recognize that a change is needed, but may be unsure whether the change is worth the cost in time and energy and are ambivalent about the losses attendant to any change they might make (S. Miller et al., 1997). Clients in the *preparation* stage perceive a problem as well as their role in it and actively seek help in formulating solutions. In the final *action* stage, clients are firmly committed to and actively pursue a plan for change. Failure of the therapist to assess the client's stage of change and match treatment strategies accordingly is likely to result in an unsatisfactory outcome, particularly in settings that serve mandated clients (e.g., court-ordered addictions counseling) due to client disinterest in or disengagement from the process. Prochaska's stages-of-change framework has focused the field away from a preoccupation with theoretical content toward an assessment of client motivation and client engagement as central, common factors across models.

Both Prochaska's readiness for change assessment and a client-directed, outcome-informed approach make the case for using client feedback throughout therapy to determine the strength of the alliance and whether measurable progress is being made. This type of real-time assessment is based not only on the alliance literature, but on an entire tradition of using outcome to inform process that enjoys a substantial empirical base. Outcome research indicates that the general trajectory of change in successful therapy is highly predictable, with most change occurring earlier rather than later in the treatment process (J. Brown et al., 1999; Haas, Hill, Lambert, & Morrell, 2002; Hansen & Lambert, 2003; Howard, Moras, Brill, Martinovich, & Lutz, 1996; Smith et al., 1980; Steenbarger, 1992; Whipple et al., 2003). More recently, researchers have been using early improvement—specifically, the client's subjective experience of meaningful change in the first few visits—to predict whether a given pairing of client and therapist or treatment system will result in a successful outcome (Garfield, 1994; Haas et al., 2002; Lambert et al., 2001). To take advantage of what is empirically known about the fit of clients' views of the alliance and their perceptions of meaningful change in the early stages of therapy, CDOI uses brief alliance and progress measures at each session or point of service (see "Description of a Specific Approach" later in this chapter). Continual feedback allows therapists to adjust their approach to better fit the client's stage and preferences, enhancing the possibility for success. From this point of view, assessment is a living, ongoing process that engages clients, heightens hope for improvement, and is a core feature of therapeutic change.

The Process of Psychotherapy

The tendency to confound levels of abstraction complicates the task of describing the role of common factors in the process of psychotherapy. There is a distinct difference in talking about factors common to all therapies than talking about discrete model components.

Typically, the frameworks used to define and discuss model components derive from a medical model equation—therapy can be divided into relatively clear-cut phases, each with core elements (Duncan et al., 2004; Wampold, 2001). This phenomenon is no more evident than in the outline for chapters in this current volume (e.g., assessment precedes intervention), representing a challenge for those describing a different paradigm (common factors) and generating a classic square peg/round hole dilemma. The following, nevertheless, tackles this dilemma, illustrating how common factors permeates each category in a fluid, nonstepwise, therapy process that can only come to life in the always unique collaboration between client and therapist.

Role of the Therapist

There is substantial evidence of differences in effectiveness between clinicians and treatment settings (Lambert et al., 2003; Luborsky et al., 1986; S. Miller et al., in press; Wampold, 2001). Conservative estimates indicate that between 6% (Crits-Christoph et al., 1991) and 9% (Project MATCH Research Group, 1998) of the variance in outcomes is attributable to therapist effects. These percentages are particularly noteworthy when compared with the variability among treatments (1%). Some therapists are simply better than others, regardless of adherence to a given treatment protocol, a point Wampold states once again supports a contextual/common factors over a medical paradigm. The TDCRP offers a case in point. Blatt, Zuroff, Quinlan, and Pilkonis (1996) reanalyzed the data to determine the characteristics of effective therapists. This is a telling investigation because the TDCRP was well-controlled, used manuals, and employed a nested design in which the therapists were committed to and skilled in the treatments they delivered. A significant variation among the therapists emerged in this study, related not to the type of treatment provided or the therapist's level of experience, but rather to his or her orientation toward a psychological versus biological perspective, and longer term treatment.

While little research has been conducted to determine precisely those attributes that account for differences in therapists' effectiveness, some clues have surfaced in the literature. A recent study found that the most effective therapists emphasized the relationship (Vocisano et al., 2004). Luborsky, McLellan, Diguer, Woody, and Seligman (1997) found that some therapists were consistently better across client samples. Significantly, clients rated these therapists as helpful after only a few sessions and felt allied to them. This supports the robust alliance literature as well as the importance of client perceptions of that variable early on (Bachelor, 1991; Garfield, 1994; Gurman, 1977; Haas et al., 2002; Lambert et al., 2001); it also suggests that therapists adept at forming early alliances and matching their style and approach to client preferences will achieve better outcomes.[3] The one-approach-fits-all is a strategy guaranteed to undermine alliance formation (see Hubble et al., 1999a).

To increase the chances that therapists will learn and implement procedures that resonate with their clients, client-directed, outcome-informed (CDOI) practitioners collect feedback data from the first session and through subsequent sessions to determine if therapist provided variables, including method and intangibles such as warmth or professional demeanor, fit with client views and expectations. This approach challenges therapists to enhance the factors across theories that account for successful outcome by privileging the client's voice and purposefully forming strong therapeutic partnerships. This requires that therapists be willing and able to flexibly adjust their style and approach based on client

[3]Therapist-provided variables, especially the core conditions popularized by Carl Rogers (1957), have not only been empirically supported, but are also remarkably consistent in client reports of successful therapy (Lambert, 1992).

feedback. CDOI clinicians, as a consequence, become "clienticians" who possess the following attributes: (a) the ability to showcase client talent and maximize client resources; (b) the belief that clients know what is best for their own lives and have the motivation and the wherewithal to reach their goals; (c) skills at forming alliances with those that others find difficult and structuring therapy around client goals and expectations; (d) natural ways of connecting, showing appreciation, listening, and expressing understanding; (e) optimism; and (f) a willingness to be accountable to their clients and those who make services possible (Duncan & Sparks, 2007).

Length of Therapy

Outcome research has much to tell us about when change happens in therapy and, once again supports the role that common factors, specifically client variables, play in the change process. Researchers Howard, Kopta, Krause, and Orlinsky (1986), estimated that approximately 15% of clients show measurable improvement *prior* to the first session of treatment, pointing to extratherapeutic factors as key in helping clients resolve difficulties. In therapy beyond one session, the research shows that improvement between treatment sessions is the rule rather than the exception. In one pioneering study, Reuterlov, Lofgren, Nordstrom, Ternstrom, and Miller (2000) followed 175 cases over the course of treatment and found that at the beginning of any given session 70% of clients reported complaint-related improvement. Even more encouraging, however, was the finding that half of the 30% of clients who initially reported no between-session improvement did identify specific, complaint-related improvement by the conclusion of any given session.

Change happens often and early in the therapy process. Howard et al. (1986), in their now classic meta-analytic study of nearly 2,500 clients, found that as many as 65% were measurably improved by the seventh session and 75% within 6 months. These same findings further showed "a course of diminishing returns with more and more effort required to achieve just noticeable differences in patient improvement" as time in treatment lengthens (p. 361). To illustrate, Howard, Lueger, Maling, and Martinovich (1993) not only confirmed that most change in treatment took place earlier than later, but also found that an absence of early improvement in the client's subjective sense of well-being significantly decreased the chances of achieving symptomatic relief and healthier life functioning by the end of treatment. Similarly, in a study of more than 2,000 therapists and thousands of clients, researchers J. Brown et al. (1999) found that therapeutic relationships in which no improvement occurred by the third visit did not on average result in improvement over the entire course of treatment. This study also showed that clients who worsened by the third visit were twice as likely to drop out as those reporting progress. Variables such as diagnosis, severity, family support, and type of therapy were "not . . . as important [in predicting eventual outcome] as knowing whether or not the treatment being provided [was] actually working" (J. Brown et al., 1999, p. 404).

The empirical data about when clients change provide a golden opportunity for therapy practice. The research is clear that, rather than therapy being an arduous task based on models of stability and deficit with contingent notions of resistance, chronicity, and lengthy treatment, change happens frequently and early in the therapy process. As mentioned, most standardized measures of pathology cannot predict whether a client will change or when. Instead, studies increasingly find that clients' views of change in the first few sessions provide more accurate predictions of eventual treatment success. Client-directed, outcome-informed practitioners capitalize on this empirical window of opportunity by creating formal feedback loops with clients from the first encounter and at each subsequent session to proactively attune therapy to client preferences (S. Miller et al., 2004, in press; see "Description of a Specific Approach" later in this chapter).

The Therapeutic Alliance

The importance of the therapeutic alliance as a crucial common factor has been unequivocally confirmed in outcome literature (Horvath & Symonds, 1991; Orlinsky et al., 2004). Recall that Wampold (2001) portions 7% of the overall variance of outcome to the alliance, or about seven times the amount of change than that attributable to a specific model or technique. Horvath (2001) concludes that as much as 50% of the variance of treatment effects is due to the alliance. Recognition of the disparity between alliance and technique effects has led to the creation of a counterbalancing movement by the APA Division of Psychotherapy to identify elements of effective therapy relationships (Norcross, 2001).

Data on the importance of client factors and the alliance, when combined with "the observed superior value, across numerous studies, of clients" assessment of the relationship in predicting the outcome (Bachelor & Horvath, 1999, p. 140), makes a strong empirical case for putting the client in the "driver's seat" of therapy. At the conclusion of each session or point of service, CDOI practitioners use client-report alliance rating scales to obtain invaluable clues about the fit of therapy with client expectations, including the method, congruence on goals, and felt sense of connection with the therapist. In turn, this information serves as pivotal guideposts for the re-alignment of therapy to the client's preferences in the interest of enhancing outcome (Duncan et al., 2004; Duncan, Miller, & Sparks, 2007; S. Miller et al., 2004).

Strategies and Interventions

Recall that techniques account for as little as 1% of the overall outcome in psychotherapy (Wampold, 2001). Nevertheless, techniques can provide a cogent structure and rationale for therapy, engender hope, and foster strong therapy alliances. The following discussion of strategies and interventions spans these two levels of abstraction—the role of technique as a potential catalyst for common factors and as a minor outcome variable relative to extratherapeutic, client, and alliance factors.

Major Strategies and Techniques

In a narrow sense, model/technique factors may be regarded as beliefs and procedures unique to specific treatments. The miracle question in solution-focused therapy, the use of thought restructuring in cognitive-behavioral therapy, hypnosis, systematic desensitization, biofeedback, transference interpretations, and the respective theoretical premises attending these practices are exemplary. In concert with Frank and Rosenzweig, model/technique factors can be interpreted more broadly as therapeutic or healing rituals. When viewed as a healing ritual, even the latest therapies (e.g., EMDR) offer nothing new. Healing rituals have been a part of psychotherapy dating back to the modern origins of the field (Wolberg, 1977). Whether instructing clients to lie on a couch, talk to an empty chair, or chart negative self-talk, mental health professionals are engaging in healing rituals—technically inert, but nonetheless powerful, organized methods for enhancing the effects of placebo factors. These methods include providing a rationale, offering a novel explanation for the client's difficulties, and establishing strategies or procedures to follow for resolving them. Depending on the clinician's theoretical orientation, different content is emphasized. Rosenzweig proposed that whether the therapist talks in terms of psychoanalysis or Christian Science is unimportant. Rather it is the formal consistency in adhering to the selected doctrine that offers a systematic basis for change and an alternative formulation to the client.

At first blush, tapping into client resources, ensuring the client's positive experience of the alliance, and accommodating therapy to the client's theory of change appear to offer a range of strategies that might be called a "common factors model." At the same time, closer examination makes clear that any concrete application across clients merely leads to the creation of another model for how to do therapy (Duncan et al., in press). On this point, the research is clear, whether common factors or not, models ultimately matter little in terms of outcome. Emphasizing "outcome-informed," client-directed, outcome-informed theorists have added a crucial element to mitigate this dilemma—the continuous collection of client feedback throughout therapy to assess the fit of methods to clients' views and preferences. This process ensures an empirically justifiable psychotherapy where the implementation of techniques occurs idiosyncratically at each therapy encounter (see "Description of a Specific Approach" later in this chapter).

Typical Sequences in Intervention

Techniques are often sequentially arranged in evidence-based practice (EBP). Evidence-based practice assumes that specific ingredients of a given approach account for change and that adherence to these strategies will result in better outcomes. Hence, the proliferation of manuals detailing the precise model-specific steps, including sequences of intervention required to bring about change. When manualized psychotherapy is portrayed in the literature, it is easy to form the impression of technological precision.

> *The illusion is that the manual is like a silver bullet, potent and transferable from research setting to clinical practice. Any therapist need only to load the silver bullet into any psychotherapy revolver, and shoot the psychic werewolf terrorizing the client. (Duncan & Miller, 2006, p. 143)*

However, well-controlled studies argue the opposite point. While research shows that manuals can effectively train therapists in a given psychotherapy approach, the same research shows no resulting improvement in outcome and the strong possibility of untoward negative consequences (Beutler et al., 2004; Lambert & Ogles, 2004). High levels of adherence to specific technical procedures may actually interfere with the development of a good relationship (Henry, Strupp, et al., 1993), and with positive outcomes (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996). In a study of 30 depressed clients, Castonguay et al. (1996) compared the impact of a technique specific to cognitive therapy—the focus on correcting distorted cognitions—with two other nonspecific factors: the alliance and the client's emotional involvement with the therapist. Results revealed that while the two common factors were highly related to progress, the technique unique to cognitive-behavioral therapy—eliminating negative emotions by changing distorted cognitions—was negatively related to successful outcome. Duncan and Miller (2006) observe, "In effect, therapists who do therapy by the book develop better relationships with their manuals than with clients and seem to lose the ability to respond creatively" (p. 145). Little evidence, therefore, exists to support manualized treatments with sequenced, stepwise interventions, offering additional confirmation of the minor role played by technique compared with more robust common factors in therapy outcome.

Typical Clinical Decision Process

Increasingly, clinical decisions (e.g., what constitutes a correct sequencing of intervention, as discussed earlier) are predetermined using model-derived, manualized formulas. The proliferation of manuals has led to greater and greater technical precision in clinical procedures, to the extent that rating scales can easily measure adherence to treatment

operations (Ogles, Anderson, & Lunnen, 1999). No longer the exclusive province of researchers, manuals have become widely promoted, taught, and used in many clinical practice settings (Ogles et al., 1999). Where model theories once allowed a degree of flexibility in therapist decisions, treatment manuals require an increasing specificity of techniques, defining the "standard of care."

This trend reflects the belief that therapists' technical operations are responsible for client improvement and that taking the guesswork out of treatment through manuals will produce consistently better outcomes. As we have seen, this is not the case. In light of the failure of manualized formulas to reliably improve outcomes, some researchers and clinicians have turned to an alternative empirical basis for guiding clinical decisions—in particular, research regarding the trajectory of therapeutic change and the role of client perceptions of progress and the alliance in predicting of outcome. In the mid-1990s, some researchers began using data generated during treatment to improve the quality and outcome of care. In 1996, Howard et al. (1996) demonstrated how measures of client progress could be used to "determine the appropriateness of the current treatment . . . the need for further treatment . . . [and] prompt a clinical consultation for patients who [were] not progressing at expected rates" (p. 1063). That same year, Lambert and Brown (1996) made a similar argument using a shorter, and hence more feasible, outcome tool. Finally, Johnson and Shaha (1996) were the first to document the impact of outcome and process tools on the quality and outcome of psychotherapy as well as show how such data could foster a cooperative, accountable relationship with payers.

More recently, CDOI practitioners have used brief alliance and outcome measures to guide clinical process (S. Miller et al., 2004, in press). Gathering and responding to clients' views of change and the alliance as therapy progresses brings the largest portion of known variance in psychotherapy outcome—the client—center stage in clinical decision making. Moreover, continuous incorporation of client feedback gives clinicians a chance to intervene in accordance with client views prior to client dropout or negative outcome. To date, research on this approach is promising, indicating improved efficiency in overall service utilization and enhanced outcome across client populations and presenting problems (S. Miller et al., in press).

Homework

Between-session tasks or activities designed to further therapy goals are key components of many therapies, particularly behavioral, cognitive, and systemic (Kazantzis & Ronan, 2006). Badgio, Halperin, and Barber (1999) suggest that homework, defined as the acquisition of skills acquired through work done between sessions, is shared by both behavioral and dynamic therapies. Whether therapist or client generated, homework may represent a common process variable across therapy models. A common factors rationale exists for homework assignment, given the significant role of extratherapeutic factors in psychotherapy outcome. Assigning tasks for clients to perform at home presumably can increase client engagement in the therapy process, activate extratherapeutic resources, and provide a structure for therapy that enhances client expectation for success (Duncan et al., 1992). Kazantzis & Ronan recommend research to determine more precisely the mechanisms by which homework produces effects beyond classic and operant conditioning specific to behavioral and cognitive therapies and in line with common processes across diverse approaches.

Just as with any specific model technique, no empirical evidence exists that recommends the routine assignment of homework as curative in and of itself. Although some studies have found homework improves outcome, others have found effects only on selected measures or have failed to detect effects at all (Kazantzis & Ronan, 2006).

According to Kazantzis & Ronan, the data does not support homework as a factor for effective psychotherapy beyond cognitive and behavioral approaches. Where effects have been found in the correlation between completed homework and positive outcome, the causal role of homework has not been examined apart from the therapy alliance and fit with client theories of change. Ahn and Wampold's (2001) extensive meta-analysis of component studies found little evidence that specific components of treatments were required to obtain the beneficial outcomes (see "Adaptation of Strategies to Specific Presenting Problems" in this chapter). Based on this, as well as the bulk of data about the negligible impact of specific ingredients on outcome, denoting homework as enhancing all therapies is not empirically justified, despite its growing popularity beyond its behavioral roots.

Consistent with client-directed, outcome-informed work is the notion that each client will experience therapist intervention, including homework assignment, idiosyncratically. The refusal of clients to accomplish homework provides information to the therapist that the client may not perceive the task as being relevant to his or her situation or view of problem resolution. Similarly, clients who refashion assignments to fit their own tastes indicate that homework has a meaningful role despite its lack of congruence with the specifics of the therapist's original task. From a CDOI perspective, client utilization of therapist tasks is indicative of engagement and the fit of the method with client expectations, ultimately boding well for a positive outcome. At the same time, client nonparticipation in tasks does not speak to client deficiency (e.g., resistance or "not a good candidate for psychotherapy") but simply to a lack of fit for the client and the particular intervention. In this case, therapists can use the information either to continue on a certain track (assigning tasks, etc.) or to try something different.

Adaptation of Strategies to Specific Presenting Problems

The assumption that active, unique ingredients of a given approach produce different effects with different disorders—a kind of psychotherapy pill—underlies the manualization of psychotherapy and the presumed superiority of evidence-based practices (EBPs). Problems arise when applying this assumption to psychotherapy. First, as noted, the empirical persistence of the dodo bird verdict points toward common versus specific factors as responsible for therapy outcomes. Second, what emerges from estimates found in the literature indicates the true impact of specific ingredients to outcome is insignificant in comparison with client, relationship, and therapist factors (Lambert, 1992; Wampold et al., 1997). Finally, component studies, which dismantle approaches to tease out unique ingredients, have similarly found little evidence to support any specific effects of therapy. In a prototypic component study by Jacobson et al. (1996), depressed clients were assigned to different groups containing varying combinations of the specific ingredients of cognitive behavioral therapy. At termination and follow-up, investigators found no differences between groups. Perhaps putting this issue to rest, a recent meta-analytic investigation of component studies (Ahn & Wampold, 2001) located 27 comparisons in the literature between 1970 and 1998 that tested an approach against that same approach without a specific component. The results revealed no differences. These studies have shown that it doesn't matter what component you leave out—the approach still works as well as the treatment containing all of its parts. When taken in total, comparative clinical trials, meta-analytic investigations, and component studies point in the same direction. Quite simply, there are no unique ingredients to therapy approaches and little empirical justification to strategically match a particular problem with a particular disorder (Duncan & Miller, 2006). This conclusion has prompted CDOI theorists to assert that, instead of using strategies adapted to presenting problems, therapists should adapt strategies based

on elements known to empirically correlate with outcome, particularly client views of change and the therapy alliance.

View of Medication

Despite its vaunted status as a favored treatment, albeit often in concert with psychotherapy, medication fares no better than any other specific ingredient in the alleviation of client distress. In the TDCRP (Elkin et al., 1989), medication proved no better than any of the other treatments, including placebo.[4] Others have determined that the difference in outcome between antidepressants and chemically inert pills is much smaller than the public has generally been led to believe (e.g., Antonuccio, Danton, DeNelsky, Greenberg, & Gordon, 1999; Greenberg, 1999; Greenberg & Fisher, 1989, 1997; Kirsch & Sapirstein, 1998). Relatedly, side effects *by themselves* may predict the results seen in antidepressant studies (Greenberg, Bornstein, Zborowski, Fisher, Greenberg, 1994) and are correlated with positive outcomes (Kirsch & Sapirstein, 1998), suggesting that the expectancy of being on a powerful drug may be enough to activate client hope for progress. Kirsch and Sapirstein's meta-analytic review of nineteen studies involving 2,318 people showed that 75% of the response to antidepressants was duplicated by placebo. The review also echoed a point made by others (Greenberg & Fisher, 1997; Moncrieff, Wessely, & Hardy, 2004): Using *active* placebos (those that mimic the side effects of the real drug), studies might show the advantage for antidepressants to be quite small or possibly even nonexistent. Finally, an analysis based on data submitted to the U. S. Food and Drug Administration (FDA) for six widely prescribed antidepressants indicated that approximately 80% of the response was duplicated by placebo control groups. Moreover, the drug-placebo difference was less than *two points* on the physician-rated measure of outcome.

If antidepressants have attained near mythical, but empirically unjustified status, antipsychotics are the grand myth of psychiatry. Here, medication is not a choice but a requirement—those diagnosed with severe psychiatric disorders can expect continuous medication to manage a presumed lifelong struggle, regardless of client preference of views of change. However, a series of studies discredit the medication-necessity myth (Harding, Zubin, & Strauss, 1987; see also Sparks et al., 2006). Equally taken for granted is the assumption that medication plus psychotherapy works better than either alone. This too, succumbs under the scrutiny of empirical analysis. Reviews prior to 1997 demonstrated no advantage for combining approaches, and later studies (e.g., Keller et al., 2000; Treatment for Adolescents with Depression Study (TADS) Team, 2004) contain significant methodological flaws compromising their prodrug-therapy combination conclusions (Duncan et al., 2004; Greenberg & Fisher, 1997; Sparks & Duncan, in press). These same flaws are abundant in the trial literature for psychotropic medications for children and adolescents (see Sparks & Duncan, in press). The APA Working Group on Psychoactive Medications for Children and Adolescents (2006) review of the literature concluded that the evidence did not support drugs for those under 18 as first-line treatment.

The increasing emphasis on medication for the alleviation of emotional and behavioral distress represents a major trend toward a medical, noncontextual approach in psychotherapy. As medication becomes, more and more, a necessary specific ingredient, common factors take on secondary roles such as forming relationships to ensure "illness management" or medication compliance. The assumption is made that, for certain

[4]Shea et al. (1992) conducted an 18-month follow-up study of TDCRP clients and reported that the psychotherapies outperformed medications and placebo on almost every outcome measure.

diagnosed problems, medication is the best solution. However, a critical review of the literature reveals that the presumed superiority of medication over other approaches is questionable, at best; head-to-head comparisons with psychotherapy do not yield definitive evidence for medication as a necessary first-line treatment. Nor do key clinical trials, when methodological problems are considered, grant medications a clinically significant edge over placebo. In sum, the case for the effectiveness of medication because of specific (vs. common) factors remains dubious.

When medication is associated with positive outcomes, we ask, "What are the factors that produce an effect?" We propose that how one answers this question makes a difference in the choices clients are offered, particularly in the required use of medications in some settings (see, e.g., Whitaker, 2002) and whether the adverse events (side effects) associated with psychotropic medications, especially in children, can be avoided. Our analysis suggests that medication may work, not by virtue of its impact on neurotransmitters and the like, but as the result of common factors. In particular, the research indicates that the belief by clients that they are getting a powerful healing agent and the hope for improvement this engenders, play powerful roles in outcome. Similarly, who administers the medication (therapist effects), and, presumably, the relationship he or she establishes with the client, significantly determine whether the treatment is effective (Wampold, 2001, 2006). In the TDCRP, differences in therapist effects were significant and independent of whether the therapist was in the medication or therapy group (Blatt et al., 1996). Nonetheless, outcomes were better for therapists who held a psychological rather than a medical orientation, suggesting that clients resonated more in this treatment context with this mindset and were less inclined to view their problems or the solutions to their problems as medical (Blatt et al., 1996).

Therapist allegiance may also play a role when medication has a desired effect. Wampold (2001) notes that not only the client's but the therapist's belief in the efficacy of an approach greatly enhances treatment effects (see also, Greenberg, 1999). When therapists have allegiance to a medical approach, they are likely to reinforce expectancy for improvement. Similarly, the ritual of medicine—the diagnostic interview, the formal explanation (diagnosis), and the prescriptive treatment (medication)—holds all the allure of healing rituals that are part of the cultural scripts characteristic of human societies (Frank's framework of common factors particularly suits this understanding of medication efficacy). Greenberg (1999) summarizes these common elements in psychiatric drug therapy:

> *Medication response can be readily altered by who delivers the drug, how its properties are described, the degree of familiarity with the setting in which it is presented, and the ethnic identity or socioeconomic status of the person ingesting it. (p. 301)*

The argument we make is that, based on an analysis of the empirical evidence, the specific ingredients of medication and their alleged biochemical impact are secondary to common factors effects in producing desired outcomes.

A common factors perspective does not preclude medication as one choice among many, particularly when clients believe their problems have a biological origin and drugs might be helpful. Honoring the client's theory of change maximizes client participation, strengthens the therapeutic bond, and enhances therapeutic outcomes. What we do not support is the automatic trigger to recommend medication without consideration of client preferences and the full range of options based on the known data. The belief in the power of chemistry over social and psychological process forms the basis of pharmacology's growing centrality in psychotherapy research, training, and practice.

Some clients may be helped some of the time with this focus, but it misdirects the field away from an empirically correct understanding of what is responsible for change. Additionally, it promotes prescriptive treatments of questionable sustainability, fraught with potentially dangerous effects. We advocate that psychotherapy in the twenty-first century adopt a critical perspective of psychophamacology, examine its impact on our clients and our field, and realign ourselves with known processes of change common across psychological and medical models.

Curative Factors

Even if model ingredients appear to be the magic bullet, their effects are not due to their unique properties but to the client's use of them within a strong therapy relationship. An empirically appropriate frame for curative factors in psychotherapy may be called *client* utilization. Here, focus is on how clients take what therapy offers to fashion unique and perfectly fitting solutions for even the most daunting dilemmas (Duncan & Moynihan, 1994; Sparks, 2000; Tallman & Bohart, 1999). From this point of view, therapists may well think of themselves as simply not getting in the way of their clients. One way that therapists accomplish this is to work with clients to create a context, with the appropriate exercise of intervention palatable to the client's worldview, wherein clients essentially cure themselves.

Another important common factor interweaves with clients' own curative capacities—known variously as placebo, hope, or expectancy. Asay and Lambert (1999) put the contribution of these variables to psychotherapy outcome at 15%. In part, this class of therapeutic factors refers to the portion of improvement deriving from client's knowledge of being treated and assessment of the credibility of the therapy's rationale and related techniques. Expectancy parallels Frank's idea that in successful therapies both client and therapist believe in the restorative power of the treatment's procedures or rituals. These curative effects, therefore, are not thought to derive specifically from a given treatment procedure; they come from the positive and hopeful expectations that accompany the use and implementation of the method. Frank's (1973) classic discussion of remoralization as the final common pathway of all therapeutic intervention speaks to the power of hope to counter the most demoralized client.

That the procedures are not in and of themselves the causal agents of change matters little (Kottler, 1991). What matters is that therapy participants have a structured, concrete method for mobilizing placebo factors. From this perspective, any technique from any model may be viewed as a healing ritual, rich in the possibility that hope and expectancy can inspire (see Hubble et al., 1999b). Similarly, therapist allegiance to a model is a prominent constituent of positive change (see Wampold, 2001), supporting Frank's (1973) idea of the importance of therapist and client belief in a given therapy procedure. As researchers Benson and Epstein have noted, treatment professionals "who have faith in the efficacy of their treatments . . . are the *most* successful in producing positive placebo effects" (O'Regan, 1985, p. 17). Broadly speaking, the simple belief in the possibility, indeed inevitability, of change in general is sufficient to inspire clients and promote problem resolution.

Special Issues

Despite its impressive empirical heritage, the dodo bird's pronouncement has become not only a metaphor for the state of psychotherapy outcome research, but also a symbol of a raging controversy regarding the privileging of specific approaches for specific

disorders based on demonstrated efficacy in randomized clinical trials (e.g., Chambless & Ollendick, 2001; Garfield, 1996; Goldfried & Wolfe, 1998; Hubble et al., 1999a; D. Shapiro, 1996)—the so-called empirically based treatments. Evidence based practice (EBP), or the move in many treatment settings to prefer, or require, empirically validated treatments for specific problems, derives from the medical model and has been shoehorned into mental health practice. According to Duncan et al. (in press):

> *There is nothing wrong with wanting to know which approaches are effective. However, one should always ask, "Whose evidence is it and what kind of evidence is it really?" Only then can it be determined whether this evidence warrants privilege of this approach or any mandate of its practices. (p. 6)*

The notion that specific technical operations are largely responsible for client improvement is empirically bankrupt. Similarly, the preponderance of the data refutes any claim of superiority when two or more bona fide treatments fully intended to be therapeutic are compared (see "Empirical Support" later in this chapter). If there are no specific technical operations that can be reliably shown to produce a specific effect, then mandating EBP seems to make little sense. More damning to EBP, perhaps, is that the repeated demonstration that superiority over placebo or treatment as usual is not really saying that much; psychotherapy has demonstrated its superiority over placebo for nearly 50 years! Therapy is about twice as efficacious as placebo and about four times better than no treatment at all. This research tells us nothing that we already do not know—therapy works. Demonstrating efficacy over placebo is not the same as demonstrating efficacy over other approaches.

When differential efficacy is claimed, a critical analysis is warranted. First, the studies that find differences between bona fide approaches are no more than one would expect from chance. Further, closer inspection of studies that claim superiority reveals two major issues that must be considered: allegiance effects (whose evidence?) and indirect comparisons (what kind of evidence? Wampold, 2001). Allegiance effects are those that are attributable to the therapist or researcher's affinity toward the treatment at hand; Wampold (2001) suggests that allegiance accounts for up to 40% of any treatment effects. Though some reviews have found a very small advantage for cognitive-behavioral approaches, later studies found that the differences disappeared completely when the allegiance of the experimenters to the methods being investigated was taken into account (Lambert & Ogles, 2004; Miller, Wampold, & Varhely, in press). Another important issue in evaluating claims of differential efficacy is whether the study really presents a fair contest—is the comparison actually a contrast between two approaches fully intended to be therapeutic? Or is it, in fact, the pet approach of the experimenters pitted against a treatment as usual or less than ideal opponent? Wampold (2001) calls such unfair matches indirect comparisons. An inspection of one such comparison involving serious juvenile offenders (Borduin et al., 1995) reveals that multisystemic therapy (an intensive family and community-based treatment for juvenile offenders, e.g., Henggeler, Melton, & Smith, 1992), conducted in the home, involving parents and other interacting systems, by therapists regularly supervised by founders of the approach is compared with therapy of the adolescent *only*, with little to no outside input of parents or others, conducted in an outpatient clinic by therapists with no special supervision or allegiance. This type of comparison represents a treatment as usual contrast rather than a bona fide treatment comparison.

Finally, EBP neither explains nor capitalizes on the sources of variance known to affect treatment outcome—the so-called extratherapeutic factors and the alliance. Strategies for forming strong relationships that may find their way into treatment manuals, without

client feedback, are no more than prescriptive techniques, garnering scant support as predictive of or useful to outcome (see "Description of a Specific Approach" later in this chapter). Turning to variance attributed to the therapist, the explosion of EBPs has not eliminated the influence of the individual therapist on outcomes. Treatment still varies significantly by therapist (Lambert et al., 2003; S. Miller et al., in press). Given the data, the move toward empirically based practice virtually ignores the most significant body of evidence currently available to the field, potentially hamstringing therapists and clients alike in creating the dynamic, evolving partnership that is the heart of successful therapy.

The evidence-based practice debate may create an unfortunate dichotomy that detracts from efforts to capitalize on the known evidence of what makes therapy effective. Addressing this dilemma, the APA Presidential Task Force on Evidence-Based Practice (APAEBP) defined evidence-based practice in psychology as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (2006, p. 273). The task force recommends:

> Clinical decisions should be made in collaboration with the patient, based on the best clinically relevant evidence, and with consideration for the probable costs, benefits, and available resources and options.
>
> - Psychological services are most effective when responsive to the patient's specific problems, strengths, personality, sociocultural context, and preferences.
> - The application of research evidence to a given patient always involves probabilistic inferences. *Therefore, ongoing monitoring of patient progress and adjustment of treatment as needed are essential* (APAEBP, 2006, pp. 284–285, italics added).

Evidence here, then, means the findings of nearly 5 decades of research on the common factors of change and known predictors of success *and* evidence of the progress and fit of services collected collaboratively with clients that significantly improves effectiveness and efficiency in real clinical settings—or what we call *practice-based evidence*. The APA's definition and its implications reject mandating approaches without client input and, instead, embrace a collaborative, contextualized, culturally responsive and client-informed practice.

Culture and Gender

Despite the vicissitudes of public confidence about whether it is an enterprise worth one's time and money (see, e.g., APA, 1998), psychotherapy is an accepted fact of life in Western society. What is often not realized is the scope of its reach into the lives of millions of people, and the political forces that underpin its influence. The President's New Freedom Commission has recommended mental health screening for youth ages 0 to 18, with schools serving as primary testing sites. Once a child is identified, a referral to a mental health specialist ensues, with the goal of definitive diagnosis and, if required, specified treatment. Similarly, families identified as "at risk" find themselves recipients of "services," often for years and even generations, navigating complex government and mental health systems. Those deemed to have a serious mental illness (SMI) face predetermined protocols such as medication guidelines, illness management, family psychoeducation, supported employment, and integrated substance abuse and mental health treatment (Calhoun, 2002; Scheyett, in press). While society increasingly turns to the quick fix of psychiatric medications, psychotherapy comprises no small portion of the array of services affecting millions of families. No longer the luxury choice of the

troubled well-off, it is frequently a mandated intervention into the private lives of those viewed ill or, in some way, unable to manage socially acceptable norms.

Given the long reach of psychotherapy's arm into the everyday lives of so many people, it is crucial to examine its differential impact across dimensions of diversity: race, gender, ethnicity, social class, age, sexual orientation, religion, immigrant, refugee, and colonization heritage, and disability status. Recent government reports have concluded that nondominant groups face treatments that fail to consider their unique contexts and are, therefore, ineffective (Sue & Zane, 2006). Emphasis on cultural competency in training and professional discourse, however, may inadvertently reinforce psychotherapy's blindness to the inherent power and privilege disparity between typically white, heterosexual, middle-class mental health professionals and their diverse clientele (Levant & Silverstein, 2006). Simply learning about difference does not address contexts of oppression, prejudice, and discrimination that nondominant groups face. The ghettoization of "diverse populations" continues the marginalization of the very groups it seeks to mainstream (L. Brown, 2006). Similarly, focusing on individual pathology detracts from an analysis of systems of power and privilege that underpin oppressive relationships (Duncan et al., 2004; Levant & Silverstein, 2006; Waldegrave, 1990). Finally, simple knowledge of diversity fails to deconstruct the underlying premises of psychotherapy theory in which unequal relations of power are embedded.

A common factors perspective, particularly the distinction between practice-based evidence and evidence-based practice, has relevance for providing culturally aware, respectful, and effective services to diverse client groups. Despite the evidence that clients—their resources, networks, and life circumstances—make up by far the largest portion of variance in psychotherapy outcome, evidence-based practice focuses on the matching of specific treatment approaches to particular identified problems. This script forms the bedrock of much of psychotherapy practice. It also draws clients as "cardboard cutouts"; more a diagnosis or problem to be corrected by the EBP. As a result, a culture of client disability and passivity can take shape, devoid of context and stripped of the richness of client histories and culture. Despite well-intentioned efforts to invite clients' voices, the machinery of psychotherapy (paperwork, policies, procedures, and professional language) codifies noncontextualized descriptions of client dysfunction and effectively silences client views, goals, and preferences.

Consideration of the unquestioned assumptions that form the infrastructure of psychotherapy, particularly the evidence-based paradigm, opens a door to a culturally respectful practice. Recall that this paradigm begins with an assessment or diagnosis. Assessments often reproduce views of health and normality that can stigmatize persons who differ from dominant social norms. The history of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1952; 1968; 1980; 1987; 1994; 2000) reflects just how much diagnoses change as our social tolerances and preferences do (Beutler & Clarkin, 1990) and how they mirror more politics and economics than science (Kutchins & Kirk, 1997). Diagnosis and evaluations, such as those common in court settings, differentially affect various cultural groups (Duncan et al., 2004; Mezzich, Kirmayer, & Kleinman, 1999; Reynolds, 1995). Not surprisingly, those who do not fit smoothly into prescribed roles come out on the short end of the diagnostic and assessment stick, reinforcing inequalities and prejudice along cultural, racial, gender, socioeconomic, and sexual identity lines. The underlying bias in diagnosis is but the tip of the normative iceberg in much of the mental health field. Cultural, racial, gender, and other prejudices have been found to permeate much of psychotherapy theory (e.g., see Hardy & Lazloffy, 1994; Hare-Mustin, 1994; see also Brown, this volume). The psychological idea of a disembodied, rationalistic mind promotes Western, white, male values at the expense of

more contextualized, socially constructed knowledge and ways of being (Gergen, 1985). The notion that a good theory can transcend culture and history, providing a universal formula for understanding human behavior is at the root of much of the oppression often inflicted by well-intentioned services on marginalized groups. At the same time, grand theories of psychotherapy dismiss potent local theories and healing practices that have served families and cultures through generations (McGoldrick, 1998; Richards & Bergin, 1997; Waldegrave, 1990).

The blind adherence to "best practice" without a cultural critique is not without consequence. The history of the treatment of those labeled mentally ill in the United States is replete with the best practices of the day, including forced drugging, restraint, social isolation, brain surgery, and shock (see, e.g., Whitaker, 2002). While current evidence-based treatments are heralded as advances over earlier methods, those most affected still may have little voice to either reject them or to recommend something different. The call to expand evidence-based research to diverse groups (see Sue & Zane, 2006) does not go far enough. A move to honor the rightful roles of clients in psychotherapy, based not simply on a desire to sidestep the mistakes of the past but to engage clients as the most potent common factor, requires a culture of feedback. This milieu is grounded in knowledgeable and affirming practice (L. Brown, 2006) and an appreciation of context. It also entails asking for, listening to, and valuing each client's meanings, hopes, and preferred forms of help at each therapy encounter (Duncan et al., 1992). Culturally competent practitioners enhance outcomes by not imposing goals derived from unquestioned theory or personal bias but by tailoring the intervention process to each person being served. A psychotherapy where evidence flows up from clients rather than down from theory can provide an antidote to the sometimes dehumanizing aspects of prescriptive care; it ensures that clients' unique worldviews, preferences, and values are not only respected but central to the therapy process.

Adaptation to Specific Problem Areas

The previous review of the literature by now should be sufficient to support the claim that nonspecific, common factors play the major role in psychotherapy outcome *across problem areas and specified disorders*. Adaptation, or application, to a specific problem area again calls forth the square peg/round hole conundrum; since common factors is not a model, it cannot be adapted or applied. Nevertheless, it is worthwhile to consider whether research on common factors, based primarily on adults, bears up when considering psychotherapy with children. It is also relevant to examine recent efforts to establish evidence-based practice for children and adolescents, and the role common factors can play in designing more effective services for youths and their families.

The news about what works for our youngest clients is mixed. Kazdin (2004), citing numerous research reviews, concludes that youth psychotherapy is effective when compared with no treatment. The effect size in child efficacy studies is relatively large (.70), rivaling similar estimates in the adult literature. However, effectiveness studies carried out in real-world settings tell a different story. According to Bickman (2002), the literature regarding effectiveness of treatment as usual for children and adolescents in the community is, "depressingly consistent in its poor outcomes" (p. 195). Dropout rates for young people being treated in community settings are as much as 40% to 60% (Kazdin, Holland, & Crowley, 1997). One study reports that most children who start psychotherapy never make it past the 2nd session (Armbruster & Fallon, 1994). Despite the disconnect between upbeat outcomes based on clinical trials and the disappointing results of community-based studies, recommendations based on trials forge full speed ahead with expanding lists of evidence-based practices and treatment guidelines (see, e.g., Kazdin, 2002).

Perhaps the real world/clinical trial discrepancy speaks to "barking up the wrong tree." Specifically, as Bickman (2002) notes, clinical trials and treatment of children in general may hamstring itself through an overreliance on diagnosis as well as a failure to examine the role of common factors in the treatment of young persons, resulting in tunnel vision for EBPs. As mentioned, problems with *DSM* diagnosis in adults abound. These problems are particularly problematic when it comes to children. The Surgeon General's Report states:

> *The science [of diagnosis] is challenging because of the ongoing process of development. The normally developing child hardly stays the same long enough to make stable measurements. Adult criteria for illness can be difficult to apply to children and adolescents, when the signs and symptoms of mental disorders are often also the characteristics of normal development. (U.S. Department of Health and Human Services, 1999)*

Similarly, the World Health Organization states,"Childhood and adolescence being developmental phases, it is difficult to draw clear boundaries between phenomena that are part of normal development and others that are abnormal" (World Health Organization, 2001).

Bickman (2002) pointedly questions the utility of child and adolescent diagnosis:

> *Suffice it to say that I do not believe that there is adequate scientific evidence to support the diagnostic approach in developing services. Our own research . . . has suggested that diagnostic categories have a great deal of overlap (i.e., show low discriminate validity), are arbitrary in setting standards for caseness, and are most often used for economic and social reasons. (p. 196)*

Bickman (2002) further notes that as much as 50% of children seen in clinic practice have more than one diagnosis. Consistent with a medical model, diagnosis should provide a path toward effective treatment. However, as with adults, virtually no evidence exists to support the notion that a diagnosis can lead to an effective treatment-matching system (Bickman):

> *It is my observation that most of the interventions are developed by individuals who have a particular interest in a diagnostic category and design their intervention based on the theory of that disorder . . . it creates silos of intervention that have little relationship to each other. (p. 196)*

Apart from questionable validity and reliability, giving a psychiatric diagnosis to a child can overlook cultural and societal factors, missing key opportunities to provide effective *social* intervention beyond changing internal chemistry or cognition. Diagnosis also carries a significant stigma, labeling the child as impaired, potentially creating a lifelong deficit identity that influences the child's ability to succeed.

The direction of child and adolescent psychotherapy apparently mirrors that of their older counterparts—an increasing search for and reliance on specific treatments for specific disorders (EBP). As with adults, this focus overlooks a potentially more fruitful avenue—the examination of common factors and the reformation of services based on elements known to correlate with positive outcome (Karver, Handelsman, Fields, & Bickman, 2005). Researchers have found that the alliance is related to outcome across diverse types and modes of child treatment, whereas treatment characteristics (family, individual, behavioral, nonbehavioral, etc.) do not moderate associations between the relationship and outcome (Shirk & Karver, 2003). Child-therapist and parent-therapist alliances are both related to positive changes in the child; parent-therapist alliance to improvement in parenting skills and interactions at home (Kazdin, Marciano, & Whitley,

2005). As with the adult literature, client and therapist views of the alliance differ. Kazdin et al. found that child and parent evaluations of the alliance produced more consistent findings than therapist evaluations; a large real-world study found no significant relationship between youth and counselor views of the therapeutic alliance (Bickman, de Andrade, Lambert, & Coucette, 2004). Finally, in the Cannabis Youth Treatment Study (CYT; Dennis et al., 2004), a state-of-the-art study randomly assigning 600 youth with multiple problems (including marijuana addiction) to five different intervention models, alliance predicted outcome as well as dropouts and posttreatment cannabis use (Shelef, Diamond, Diamond, & Liddle, in press).

Just as treatment characteristics did not predict outcome or moderate associations between the alliance and outcome in Shirk and Karver's (2003) study, other youth studies have failed to demonstrate differential efficacy between various approaches. The CYT (Dennis et al., 2004) compared five different intervention models at different doses; overall, the different types and doses of intervention worked with about the same effectiveness. A recent meta-analytic study of the child/adolescent literature, after controlling for allegiance effects, found a treatment effect size of .22, comparable to the effect size (ES) in Wampold et al.'s 1997 adult meta-analysis, indicating a miniscule portion of the variance in youth treatment attributable to specific factors; no differences were found between bona fide child and adolescent approaches for key problem domains (Miller, Wampold, et al., in press). Another meta-analysis failed to find superiority for behavioral interventions over other bona fide child treatments when allegiance confounds were considered (Spielmans, Pasek, & McFall, in press).

All signs point to significant similarities in the psychotherapy literature between child/adolescent and adult approaches related to evidence for common factors and against specific ingredients. Notably, studies also support similar change trajectories. In the CYT, change occurred within the first 3 months. Despite a growing cadre of studies that proclaim superiority of one approach over another, critical analysis reveals the same flaws that taint adult claims of differential efficacy—allegiance effects and indirect comparisons (Duncan & Miller, 2006). The CYT found no clear superiority of best practice or researched based intervention (Godley, Jones, Funk, Ives, & Passetti, 2004). Miller, Wampold, et al. (in press) conclude:

> *None of the effects of any of the approaches deemed "evidence-based" by the American Academy of Child and Adolescent Psychiatry and the Task Force on the Promotion and Dissemination of Psychological Procedures has been shown to be demonstrably superior to other treatments intended to be therapeutic for the disorder treated. (p. 3)*

What is slowly gaining focus in the child/adolescent research is the critical role young people, within a strong therapy alliance, play in their own change (Karver et al., 2005). Client variables frequently mentioned for youth treatment include youth age-developmental status, youth-parent interpersonal functioning, parental status, family environment, and youth-parent expectancies of efficacy (Karver et al., 2005). From a common factors perspective, these are potent elements to engage in the interest of better outcomes. As with adults, a growing body of common factors research recommends demoting EBPs and, instead, promoting children, adolescents, and their significant networks to the forefront of therapy.

Empirical Support

The dodo bird verdict, representing the empirical case for common factors, has become the most replicated finding in the psychological literature, encompassing a broad array of

research designs, problems, populations, and settings (Asay & Lambert, 1999), including marriage and family approaches (Shadish & Baldwin, 2002), and child and adolescent therapies (Dennis et al., 2004; Spielmans, Pasek, & McFall, in press; Miller, Wampold, et al., in press). While comparative studies exist that indicate differential efficacy between one approach and another, these are rare in relation to the total body of comparative findings and can be compromised by Type I error, allegiance effects, reactive measures, or comparisons between unequal treatments (Duncan & Miller, 2006; Wampold, 2001). Consequently, the preferred method for examining whether one treatment has better outcomes than another is the meta-analysis. With this design, many studies can be examined, controlling for findings that may be unrepresentative of a larger sample and providing precise quantitative measures of differences in effect size across studies (Wampold, 2001). Smith and Glass (1977) were the first to use meta-analysis to examine differential efficacy among various treatment approaches. Despite what Wampold describes as a "torrent of criticism" by those interested in proving superiority of their favored approach, the 1977 Smith and Glass study fully supported the dodo bird hypothesis. In 1980, Smith, Glass, and Miller and D. A. Shapiro and Shapiro (1982) extended and refined Smith and Glass's 1977 analysis, and also found that differences between therapeutic approaches did not reach a level of significance, providing support for something other than specific model ingredients as responsible for outcomes.

The dodo bird hypothesis has since garnered increasingly unequivocal support. Ushering in the age of the randomized clinical trial, the TDCRP (Elkin et al., 1989), a study that represented the state-of-the-art in outcome research, found that the four investigative treatments—including placebo—achieved about the same results. Further confirmation of the dodo bird's assertion of uniform efficacy across treatment models was found in the Wampold et al. (1997) study addressing methodological problems of earlier meta-analyses. This meta-analysis included some 277 studies conducted from 1970 to 1995 and verified that no approach has reliably demonstrated superiority over any other. At most, the effect size (ES) of treatment differences was a weak .2. "Why," Wampold et al. ask, "[do] researchers persist in attempts to find treatment differences, when they know that these effects are small?" (p. 211). Finally, an enormous real-world study conducted by Human Affairs International of over 2,000 therapists and 20,000 clients revealed no differences in outcome among 13 approaches, including medication as well as family therapy (J. Brown et al., 1999).

The fact that the dodo bird verdict has emerged *by accident*—while researchers were trying to prove the superiority of their own models—makes it even more compelling. It is a finding free of researcher bias. As Rosenzweig amazingly said some 71 years ago, because all approaches appear equal in effectiveness, there must be common factors that overshadow any perceived or presumed differences among approaches. Intervention works, but our understanding of how it works cannot be found in the insular explanations of theoretical orientations.

DESCRIPTION OF A SPECIFIC APPROACH

Although a core group of common factors has been identified and defined, a paradox is created the moment any attempt is made at operationalization. Having identified common factors, to ask therapists to simply augment them in their work does little more than replicate another model. As has been true throughout much of the history of psychotherapy, the result is that the therapist is still "in charge," this time finding client strengths, determining the status of the alliance, understanding the nature of the client's theory, and

choosing which, if any methods, might be congruent with that theory. Once again, the key player in the therapy drama, the client, is but a bit actor. In fact, studies do not support therapists' beliefs that they know when their interventions enhance common factors. Data on the relationship between therapist experience and the quality of the alliance is at best equivocal (Bein et al., 2000; Dunkle, 1996; Mallinckrodt & Nelson, 1991). Similarly, research to date shows that training therapists to focus on the alliance has not been productive (Horvath, 2001).

For a field as intent on identifying and codifying the methods of treatment as therapy is, abandoning process in favor of outcome may seem radical indeed. Research provides a rich source of data concerning how change happens, providing therapists with readily usable tools to make optimal clinical decisions. Specifically, this research indicates that (a) change in successful therapy is highly predictable, with most occurring early in the treatment process; (b) the client's experience of change early in the treatment is predictive of outcome; and (c) the client's early ratings of the therapeutic alliance are highly correlated with outcome (see "Typical Clinical Decision Process" earlier in this chapter). Recognition and deliberate utilization of extant knowledge of change and the importance of client feedback in psychotherapy led to the development of an "outcome-informed approach" (Duncan et al., 2004). The diverse number of approaches encompassed in the change data hinted that the particular brand of therapy employed was of less importance than whether the current relationship was a good fit. Obtaining clients' views of fit using client-rated outcome tools was already underway, though most of these efforts occurred in laboratory settings using lengthy measures not suitable for everyday clinical practice (e.g., see Howard et al., 1996; Johnson & Shaha, 1996, 1997; Lambert & Brown, 1996).

To resolve this dilemma, a set of clinical measures that were valid and reliable as well as feasible were developed (Duncan et al., 2004). The Session Rating Scale 3.0 (SRS; Johnson, Miller, & Duncan, 2000) and the Outcome Rating Scale (ORS; Miller & Duncan, 2000)[5] are brief, four-item measures of the therapeutic alliance and client perceptions of improvement. Each measure is completed by the client and discussed with the therapist at each session and generally takes less than a minute to complete and score. Research to date has shown the measures to have sound psychometric qualities (Duncan et al., in press; S. Miller, Duncan, Brown, Sparks, & Claud, 2003).

At this point, the two tools have been employed in clinical settings with positive effect. First, because the scales are brief and are clinician and client friendly, the number of complaints about the use of outcome tools has plummeted and compliance rates have risen dramatically (S. Miller et al., 2003). Second, use of the SRS and ORS has resulted in significant improvements in both client retention and outcome (S. Miller et al., in press). Clients of therapists who opted out of completing the SRS were twice as likely to drop out of treatment and three to four times more likely to have a negative or null outcome. On the whole, the average effect size of services at the agency where both measures were employed shifted from .5 to .8. These results are consistent with findings from other researchers. Using a different set of scales, Lambert et al. (2001) found an effect size of .39 for feedback, meaning that 65% of those clients at risk who got feedback were better off than those at risk who did not get feedback, a finding largely equivalent to that reported by S. Miller et al. (in press; .3/.5 = .60). In another study, Whipple et al. (2003) found that clients whose therapists had access to outcome and alliance information were less likely to deteriorate, more likely to stay longer, and twice as likely to achieve a clinically significant change. The results of the authors' research as well as that of Lambert

[5]Both the ORS and SRS are available at www.talkingcure.com/measures.htm.

and colleagues were obtained without any attempt to organize, systematize or otherwise control treatment process. Neither were the therapists in these studies trained in any new therapeutic modalities, treatment techniques, or diagnostic procedures. The individual clinicians were completely free to engage their individual clients in the manner they saw fit. Availability of formal client feedback provided the only constant in an otherwise diverse and chaotic treatment environment.

CASE ILLUSTRATION: USING CLIENT FEEDBACK TO INFORM PRACTICE

Claudia was a 35-year-old, self-described "depressive" brought to treatment by her partner because she was too "down" to come to the session alone. Once an outgoing person making steady progress up the career ladder, over the past several years Claudia had grown progressively more reclusive and morose. "I've always been a high energy kind of person," *she said at some point during her first visit,* "now, I can hardly get out of bed." *She added that she had been to see a couple of therapists and tried several medications.* "It's not like these things haven't helped," *she said,* "it's just that it never goes away, completely. Last year, I spent a couple of days in the hospital."

In a brief telephone call prior to the first session, the philosophy of an outcome-informed approach to clinical practice had been described to Claudia and her partner, Marie. As requested, the two arrived a few minutes early for the appointment, completing the necessary intake and consent forms, as well as the outcome measure in the reception area while waiting to meet the therapist. The intake forms requested basic information required by the state in which services were offered. The outcome measure used was the ORS (S. Miller & Duncan, 2000). In this practice, the entire process takes about five minutes to complete.[6]

The therapist met Claudia and Marie in the waiting area. Following some brief introductions, the three moved to the consulting room where the therapist began scoring the outcome measure.

Therapist: You remember that I told you on the phone that we are dedicated to helping our clients achieve the outcome they desire from treatment?
Claudia: Yes.
Therapist: And that the research indicates that if I'm going to be helpful to you, we should see signs of that sooner rather than later?
Claudia: Uh huh.
Therapist: Now, that doesn't mean that the minute you start feeling better, we have to stop.
Claudia & Marie: Uh huh. Okay.
Therapist: It just means your feedback is essential. It will tell us if our work together is on track, or whether we need to change something about the treatment, or, in the event that I'm not helpful, when we need to consider referring you to someone or someplace else to help you get what you want.
Claudia: (nods).
Therapist: Does that make sense to you?
Claudia: Yes.
Marie: Sounds good.

[6]An attractive feature of an outcome-informed approach is the immediate decrease in the process-oriented paperwork and external management schemes that consume an ever-increasing amount of time and resources.

Once completed, scores from the ORS *were entered into a simple computer program running on a PDA. The results were then discussed with the pair.*

Therapist: Let me show you what these look like. Um, basically this just kind of gives us a snapshot of how things are overall.
Claudia: Uh huh.
Therapist: . . . this graph tells us how things are overall in your life. And, uh, if a score falls below this dotted line . . .
Claudia & Marie: Uh huh.
Therapist: Then it means that the scores are more like people who are in therapy and who are saying that there are some things they'd like to change or feel better about . . .
Claudia & Marie: (nod)
Therapist: . . . and if it goes above this dotted line that indicates more the person saying you know "I'm doing pretty well right now."
Claudia: Uh huh.
Therapist: And you can see that overall it seems like you're saying you're feeling like there are parts of your life you'd like to change, feel better about . . .
Claudia: Yes, definitely.
Therapist: (setting the graph aside and returning to the ORS form). Now, it looks like interpersonally, things are pretty good . . .
Claudia: Uh huh. I don't know how I would have made it . . . without Marie. She's my rock . . .
Therapist: Okay, great. Now, individually and socially, you can see . . .
Claudia & Marie: (leaning forward).
Therapist: . . . that, uh, here you score lower . . .

Both Claudia and Marie confirmed the presence of significant impairment in individual and social functioning by citing examples from their daily life together. At this point in the visit, both Claudia and Marie indicated that they were feeling comfortable with the process. Claudia seemed visibly more alert, and the session continued for another 40 minutes.

As the end of the hour approached, both were asked to complete the SRS.

Therapist: This is the last piece . . . as I mentioned, your feedback about the work we're doing is very important to me . . . and this little scale . . . it works in the same way as the first one . . . (pointing at the individual items) with low marks to the left and high to the right . . . rating in these different areas . . .
Claudia & Marie: (leaning forward). Uh huh.
Therapist: It kind of takes the temperature of the visit, how we worked today . . . If it felt right . . . working on what you wanted to work on, feeling understood . . .
Claudia: All right, okay (taking the measure, completing it, and then handing it back to the therapist).
(A brief moment of silence while the therapist scores the instrument)
Therapist: Okay . . . you see, just like with the first one, I put my little metric ruler on these lines . . . and measure . . . and from your marks that you placed, the total score is 38 for you, Marie, and . . . Claudia, you scored 39 . . . and that means that you felt like things were okay today . . .
Claudia: (both nod) Uh huh.

Therapist: That we were on the right track . . . talking about what you wanted to talk about . . .
Claudia: Yes, definitely.
Therapist: Good.
Claudia: I felt very comfortable.
Therapist: Great . . . I'm glad to hear that . . . at the same time, I want you to know that you can tell me if things don't go well . . .
Claudia: Okay.
Therapist: I can take it . . .
Claudia: Oh, I'd tell you . . .
Therapist: You would, eh?
Claudia: (smiling). Yeah . . . just ask Marie . . .

In consultation with the couple, an appointment was scheduled for the following week. In that session, and the handful of visits that followed, the therapist worked with the couple and, on occasion, at Claudia and Marie's request, Claudia alone to develop and implement a plan for dealing with her depression. While her depression was palpable during these visits, Claudia nonetheless gave the therapy the highest ratings on the SRS. However, her scores on the outcome measure evinced little evidence of improvement. By the 4th session, the computerized feedback system was warning that the therapy with Claudia was "at risk" for a negative or null outcome.

The warning led the therapist and Claudia to review her responses to each item on the SRS at the end of the fourth visit. Such reviews are not only helpful in ensuring that the treatment contains the elements necessary for a successful outcome, but also provide another opportunity for identifying and dealing with problems in the therapeutic relationship that were either missed or went unreported. In this case, however, nothing new emerged. Indeed, Claudia indicated that her high marks matched her experience of the visits.

Therapist: I'm just wanting to check in with you . . .
Claudia: Uh huh . . .
Therapist: . . . and make sure that we're on the right track . . .
Claudia: Yeah . . . uh huh . . . Okay . . .
Therapist: And, you know, looking back over the times we've met . . . at your marks on the scale . . . about the work we're doing . . . the scores indicate that you are feeling, you know, comfortable with the approach we're taking . . .
Claudia: Absolutely . . .
Therapist: That it's a good fit for you . . .
Claudia: Yes . . .
Therapist: I just want to sort of check in with you . . . and ask, uh, if there's anything, do you feel . . . or have you felt between our visits . . . even on occasion . . . that something is missing . . .
Claudia: Hmm.
Therapist: That I'm not quite "getting it."
Claudia: Yeah . . . (shaking head from left to right). No . . . I've really felt like we're doing . . . that . . . this is good . . . this is right, the right thing for me.

Despite the process being "right," both the therapist and Claudia were concerned about the lack of any measurable progress. Knowing that more of the same approach could only lead to more of the same results, the two agreed to organize a reflecting team for a brainstorm session. Briefly, this process is based on the pioneering clinical work of T. Anderson (1987) and is often useful for generating possibilities and alternatives.

As frequently happens, Claudia found one team member's ideas particularly intriguing. For the next three visits, Claudia and the therapist tried incorporating the team member's suggestions into their work to little effect. When these changes had not resulted in any measurable improvement by the eighth visit, the computerized feedback system indicated that a change of therapists was probably warranted. Indeed, given the norms for this particular setting, the system indicated that there was precious little chance that this relationship would result in success.

With regard to outcome, the research literature, as reviewed earlier, shows that the majority of change in treatment occurs earlier rather than later. Thus, an absence of improvement in the first handful of visits could serve as a warning to the therapist, signaling the need for opening a dialogue with the client about the treatment. Using Howard and colleagues' work as a guide, Lebow (1997) recommends a change of therapists whenever a client deteriorates in the initial stages of treatment or "is responding poorly to treatment by the eighth session" (p. 87). The same data gives some general guidance for the proper frequency of sessions, with more visits scheduled in the beginning when the slope of change is steep and fewer as the rate of change decelerates (J. Brown et al., 1999).

Clients vary in their response to a frank discussion regarding a lack of progress in treatment. Some terminate prior to identifying an alternative; others ask for or accept a referral to another therapist or treatment setting. If the client chooses, the therapist may continue in a supportive fashion until other arrangements are made. Rarely is there justification for continuing to work therapeutically with clients who have not achieved reliable change in a period typical for the majority of cases seen by a particular therapist or treatment agency. In essence, clinical outcome must hold therapeutic process "on a leash."

In the discussions with the therapist, Claudia shared her desire for a more intensive treatment approach. She mentioned having read about an out-of-state holistic center that specialized in her particular problem. When her insurance company refused to cover the cost of the treatment, Claudia and her partner put their only car up for sale to cover the expense. In an interesting twist, Claudia's parents, from whom she had been estranged for several years, agreed to cover the cost of the treatment when they learned she was selling her car.

Six weeks later, Claudia contacted the therapist. She reported having made significant progress during her stay and in reconciling with her family. Prior to concluding the call, she asked whether it would be possible to schedule one more visit. When asked why, she replied, "I'd want to take that ORS one more time!" Needless to say, the scores confirmed her verbal report. In effect, the therapist had managed to "fail" successfully.

SUMMARY

Unless revolutionary new findings emerge, the knowledge of what makes therapy effective is already in the hands of mental health professionals. Nearly 50 years of research points the way toward the defining role of common factors. Saul Rosenzweig, Jerome Frank, Carl Rogers, and many others blazed the early common factors trail. Over time, innovative researchers and theoreticians consolidated and built on their work. What has emerged is a vision of psychotherapy radically different from one that places specific technical procedures center stage. A twenty-first-century psychotherapy that takes to heart the rich common factors heritage necessarily rejects a medical paradigm and embraces a contextual framework. The resulting psychotherapy is accountable to those who consume it and answerable to the diverse voices that make up its clientele.

Whereas ongoing research gives clinicians a new foundation for being accountable to their clients, shifting from process to outcome, from theory to client-driven therapy, may prove difficult within current infrastructures—policies, procedures, and paperwork—of psychotherapy practice. The process-oriented ethical codes of most mental health professional organizations neither require that therapists practice effectively nor monitor the effectiveness of their work in any systematic fashion. Instead, codes only require that practitioners work, "within the boundaries of their competence and experience" (APA, 2003 [Principle 2]; www.apa.org/ethics/code2002.html#2).[7] In the real world, however, few care whether an ineffective treatment is delivered competently. And yet, competence has so regularly been conflated with effectiveness in professional discourse and training that it is no longer possible to tell them apart. Similarly, while many practice settings advocate for the inclusion of clients' voices, one has to question whether even the best intentions are possible when psychiatric diagnosis, theory-driven assessments and treatment plans, and specialized language permeate policies, procedures, and paperwork (Duncan & Sparks, 2007). Becoming client-directed and outcome-informed requires a transformation of all these. Failing to do so limits the degree to which current practices truly partner with clients to provide not only effective, but culturally aware and socially just service.

To summarize, the medical model provides an empirically incorrect map of the psychotherapy terrain that sends both research and practice in the wrong direction. Psychotherapy is not an uninhabited planet of technical procedures. It is not the sterile, stepwise, process of surgery, nor the predictable path of diagnosis, prescription, and cure. It cannot be described without the client and therapist, coadventurers in a journey across largely uncharted territory. The psychotherapy landscape is intensely interpersonal, and ultimately, idiographic. Monitoring the client's progress and view of the alliance and altering treatment accordingly is one way to manage the complexity and wonderful uncertainty that accompanies psychotherapy (Duncan et al., 2004).

While the vision of the future of psychotherapy that has evolved from the days of common factors' earliest articulations finds opposition in the current EBP climate, the debate can move the field forward. Refining the parameters of this discussion clarifies how to embrace the empirical basis of common factors without creating a new model and provides clearer distinctions for the choices facing the therapy profession. From this can grow a mature picture of how psychotherapy can answer the rightful calls to accountability by consumers and payers, and flourish in the twenty-first century. What is required in this endeavor is an unflinching willingness to examine the evidence and, as H. Anderson and Goolishian (1988) advocated, keep the conversation going.

REFERENCES

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[7]An exception to this is the American Counseling Association. Also, the American Association of Marriage and Family Therapy's "Core Competencies" define the minimum skills and knowledge sets that marriage and family therapists must possess to practice effectively. Client feedback and participation infuse the perceptual, executive, and skill domains, establishing these as foundations of effective practice.