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The Empirical Case for the Common Factors in Therapy: Quantitative Findings

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ith the rise of managed care and the growing emphasis on accountability in health care, it is not surprising to see researchers advocate empirically “validated” psychotherapy (Task Force, 1995), treatment guidelines, and manual-based therapies (Wilson, 1998). However well intended these efforts may be, they scream of scientific or theoretical arrogance (Lambert, 1998) or as Silverman (1996) has suggested, “painting by numbers.” Indeed, the conclusions reached here do not offer strong or widespread support for the field’s pursuit of model-driven, technical interventions and approaches. On the contrary, much of what is effective in psychotherapy is attributable to pantheoretical or common factors, those shared by many schools of therapy. In this chapter, we first present a sampling of research findings on the general effects of psychotherapy and then direct particular attention directed to research on common factors.

Is Therapy Effective?

Spanning six decades, reviews of psychotherapy outcome research document the empirical evidence supporting the effectiveness of psychotherapy (Bergin, 1971; Bergin & Lambert, 1978; Lambert & Bergin, 1994; Lambert, Shapiro & Bergin, 1986; Meltzoff & Kornreich, 1970; Smith, Glass, & Miller, 1980). These reviews include controlled studies on thousands of patients, hundreds of therapists, a wide range of presenting problems, and highly diverse therapeutic

approaches. Assorted and comprehensive measures of change have been used, incorporating perspectives from patients, their families, mental health professionals, and society in general.

These reviews leave little doubt. Therapy is effective. Treated patients fare much better than the untreated. The positive conclusions about the effects of psychotherapy are also supported by more abstract mathematical summaries of the research literature. One mathematical technique, meta-analysis (used to summarize large collections of empirical data), has been successfully used to estimate, in percentages, the size of treatment effects. With meta-analysis, Smith et al. (1980) found that at the end of treatment, the average treated person is better off than 80% of the untreated sample. Later meta-analytic reviews have reported comparable positive treatment effects across a variety of treatments and client problems. A list of meta-analytic reviews of psychotherapy is provided in Table 1. Figure 1 graphically displays the general conclusions from these studies. In short, the evidence supporting outpatient psychotherapy is now well established.

The good news about the effectiveness of therapy is enhanced by data suggesting that the road to recovery is not long. For example, a meta-analysis by Howard and his colleagues (Howard, Kopta, Krause, & Orlinsky, 1986) as well as a session-by-session analysis of patient progress (Kadera, Lambert, & Andrews, 1996) found that about 75% of clients significantly improved after 26 sessions or 6 months of weekly psychotherapy. The investigators also found that, even with as few as 8 to 10 sessions, approximately 50% of clients show clinically significant change. These results are reproduced in Figure 2 for a subset of clients who met criteria for "recovery" (Kadera et al., 1996). The amount of therapy needed to produce effects, moreover, continues to be discussed (Kadera et al., 1996; Kopta, Howard, Lowry, & Beutler, 1994; Shapiro, Barkham, Rees, Hardy, Reynolds, & Startup, 1994; Steenbarger, 1994). More refined and clinically valuable studies are expected. At length, the patterns of change during psychotherapy have been examined, with some research suggesting that different symptom clusters improve at different times during treatment: early restoration of morale, followed by symptomatic improvement, and finally characterological changes.

Besides finding that the road to recovery is short for the majority receiving therapy, researchers have discovered that improvement is sustained. Believing that psychotherapy will forever safeguard a person from psychological disturbance is unwarranted, but many clients who undergo therapy do achieve a healthy adjustment for long periods. To illustrate, in a meta-analytic study of this research literature—concerned with whether follow-up evaluations provide different conclusions than posttreatment evaluations—it was found that treatment

TABLE 1

Meta-Analytic Reviews of Outcome in Anxiety Disorders

Researchers	Diagnosis/treatment	No. of studies	Effect size
Anderson & Lambert (1995)	Mixed	11	0.71
Andrews & Harvey (1981)	Neurotic	81	0.72
Andrews, Guitar, & Howie (1980)	Stuttering	29	1.30
Asay et al. (1984)	Mixed	9	0.82
Balestrieri, Williams, & Wilkinson (1988)	Mixed	11	0.22
Barker, Funk, & Houston (1988)	Mixed	17	1.05
Benton & Schroeder (1990)	Schizophrenia	23	0.76
Blanchard et al. (1980)	Headache	35	40%–80%
Bowers & Clum (1988)	Behavior therapy	39	0.76
Christensen et al. (1980)	Behavior treatment	14	1.16
Crits-Christoph (1992)	Short-term dynamic therapy	11	0.82
Dunn & Schwebel (1995)	Marital therapy	15	0.79
Dush, Hirt, & Schroeder (1983)	Self-statement modification	39	0.74
Engels, Garnefski, & Diekstra (1993)	Rational emotive	31	1.62
Giblin, Sprenkle, & Sheehan (1985)	Family therapy	85	0.44
Hahlweg & Markman (1988)	Behavioral marital therapy	17	0.95
Hazelrigg, Cooper, & Borduin (1987)	Family therapy	7	0.45
Hill (1987)	Paradoxical treatment	15	0.99
Holroyd (1990)	Migraines/Biofeedback	22	47.3%
Kirsch, Montgomery, & Sapirstein (1995)	Cognitive-behavioral	20	1.23
Laessle, Zoettle, & Pirke (1987)	Bulimia	9	1.14
Landman & Dawes (1982)	Mixed	42	0.90
Lyons & Woods (1991)	Rational emotive therapy	70	0.98
Markus, Lange, & Pettigrew (1990)	Family therapy	10	0.70
Miller & Berman (1983)	Cognitive-behavioral therapy	38	0.83
Nicholson & Berman (1983)	Neurotic	47	0.70
Prout & DeMartino	School-based therapy	33	0.58
Quality Assurance Project (1984)	Schizophrenia	5	0.00
Shadish et al. (1993)	Behavioral family therapy	13	0.55
Shadish et al. (1993)	Marital therapy	12	0.87
Shapiro & Shapiro (1982a)	Mixed	143	1.03
Shoham-Salomon & Rosenthal (1987)	Paradoxical treatment	10	0.42
Smith, Glass, & Miller (1980)	Mixed	475	0.85
Svartbert & Stiles (1991)	Short-term dynamic therapy	3	0.14
Wampler (1982)	Marital communication	20	0.43
Weisz et al. (1995)	Child behavioral therapy	197	0.54
Weisz et al. (1987)	Mixed adolescent	108	0.79
Whilebreat & McGown (1994)	Bulimia/cognitive behavioral	9	1.72

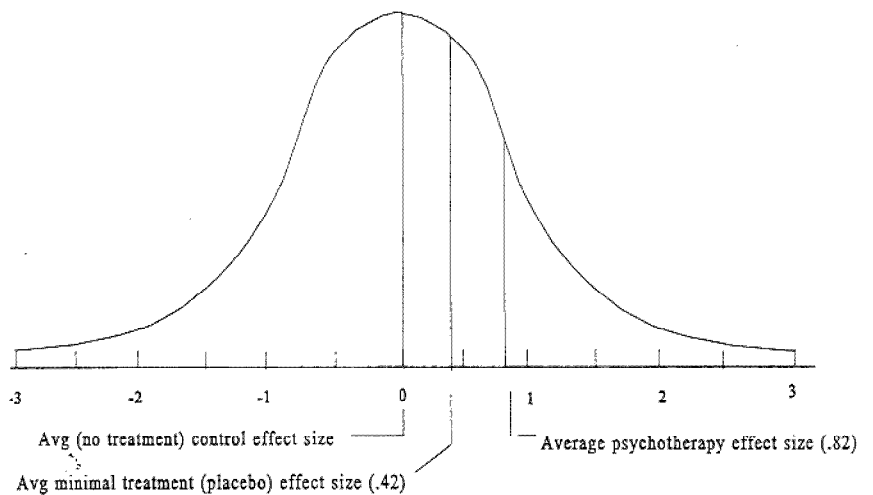
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TABLE 1 CONTINUED

Meta-Analytic Reviews of Outcome in Anxiety Disorders

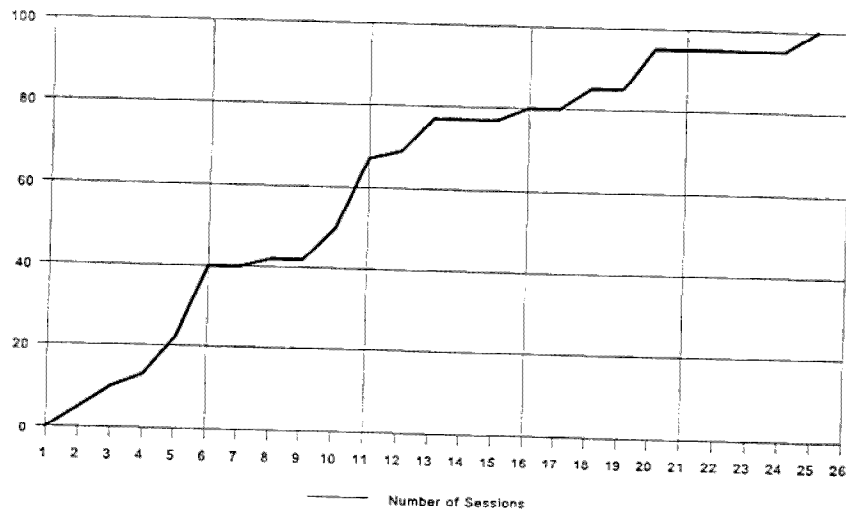
Researchers	Diagnosis/treatment	No. of studies	Effect size
Allen et al. (1989)	Public speaking anxiety	97	0.51
Christensen et al. (1987)	OCD/exposure Tx	5	1.37
Clum, Clum, & Surls (1993)	Panic	28	0.88
Clum (1989)	Panic/behavioral Tx	283	70%
Feske & Chambless (1995)	Social phobia/exposure	9	0.99
Gould, Otto, & Pollack (1995)	Panic	27	0.68
Hyman et al. (1989)	Relaxation training	48	0.58
Jorm (1989)	Trait anxiety	63	0.53
Mattick et al. (1990)	Agoraphobia	51	1.62
QA Project (1982)	Agoraphobia	25	1.20
QA Project (1985a)	OCD/exposure Tx	38	1.34
QA Project (1985b)	Agoraphobia	19	2.10
Von Balkom et al. (1994)	OCD/behavior therapy	45	1.46

FIGURE 1



Comparison of placebo and psychotherapy effects in relation to no-treatment control. From Psychotherapy Versus Placebo [Poster presented at the annual meetings of the Western Psychological Association, April 1993, by M. J. Lambert, F. D. Weber, and J. D. Sykes.]

FIGURE 2



Relation of Percentage Recovered to Number of Sessions Received for 21 Previously Dysfunctional Clients Receiving Psychotherapy.
 Note. From "How Much Therapy Is Really Enough? A Session-by-Session Analysis of the Psychotherapy Dose-Effect Relationship," by S. W. Kadera, M. J. Lambert, and A. A. Andrews, 1996, *Journal of Psychotherapy: Practice and Research*, 5, p. 10. Copyright 1996 by the American Psychiatric Press. Reprinted with permission.

gains are maintained. Specifically, posttherapy status correlated with follow-up status (Nicholson & Berman, 1983). This review, the most impressive on this topic, is consistent with the conclusion that psychotherapy has lasting effects and that most clients can be expected to maintain their gains over time.

For all that, certain groups of clients may be more vulnerable to relapse, including those with substance abuse problems, eating disorders, recurrent depression, and those diagnosed with personality disorders. A portion of clients will relapse and require additional or extended treatment; yet, the data on the durability of treatment gains should be encouraging to clinicians who are often challenged about the efficacy or long-term effects of their work. Evidence also indicates that the maintenance of treatment effects can be enhanced by efforts directed at this goal in the final therapy sessions. For instance, research findings show that change is more likely to be long lasting in clients who attribute their changes to their own efforts (Lambert & Bergin, 1994).

The Determinants of Treatment Outcomes

That psychotherapy is, in general, effective, efficient, and lasting has been empirically supported time and again. Its legitimacy is confirmed. The next important question is, What leads to positive patient outcomes?

One line of research pertinent to this question has focused on the differential effectiveness between schools of psychotherapy. Several traditional reviews of comparative studies have been conducted (Bergin & Lambert, 1978; Beutler, 1979; Lambert & Bergin, 1994; Rachman & Wilson, 1980), along with more recent investigations using meta-analytic techniques (see Table 2). Most reviews conclude there is little evidence to indicate differences in effectiveness among the various schools of psychotherapy. Although some reviews exist, suggesting superior results for cognitive or behavioral approaches over other therapies, these exceptions have often been explained as methodological artifacts (Lambert & Bergin, 1994).

Two studies illustrate the sort of research in this area. First, in a landmark comparative study, Sloane, Staples, Cristol, Yorkston, and Whipple (1975) compared short-term psychodynamic and behavioral therapy. Ninety outpatients, most presenting with neuroses, were randomly assigned to short-term psychoanalytically oriented psychotherapy, behavior therapy, or a minimal treatment wait-list group. Clients were treated by experienced and respected proponents of their respective approaches. Ratings at 4 months indicated that all three groups had improved significantly on target symptoms and that the two treatment

TABLE 2

Meta-Analytic Reviews of Outcome With Depression

Researchers	Diagnosis/treatment	No. of studies	Effect size
Gaffan et al. (1995)	Depression/cognitive therapy	6	0.72
Dobson (1989)	Depression/cognitive therapy	10	2.15
Nietzel, Russell, Hemmings & Gretter (1987)	Unipolar depression	28	0.71
Quality Assurance Project (1983)	Depression	10	0.65
Robinson, Berman, & Neimeyer (1990)	Depression	29	0.84
Steinbrueck, Maxwell, & Howard (1983)	Depression	56	1.22

Note. References available from the authors on request.

groups had improved much more than the wait-list group. No differences obtained between behavioral therapy and psychotherapy groups on any of the target symptoms. At 8 months, there were no differences among the three groups on any measure of change. Treated patients maintained their gains over time, whereas the wait-list patients eventually reached the improvement levels attained by the patients who had undergone either of the active therapies.

Another important comparative study is the National Institute of Mental Health (NIMH) Collaborative Depression Study. This investigation compared imipramine plus clinical management, cognitive-behavioral therapy, and interpersonal psychotherapy. The three treatments were also contrasted with a drug placebo plus clinical management control group. Results of the comparisons have been extensively reported by Elkin et al. (1989) and Imber et al. (1990). For this reason, the methodology and results of this study are only briefly summarized here.

Two hundred and fifty patients who met the research diagnostic criteria for major depressive disorder were assigned to one of the four treatments. Participants were seen at one of three research sites. The therapists were 28 carefully selected and trained psychologists and psychiatrists who provided a clearly defined treatment, guided by treatment manuals. Each therapist saw between 1 and 11 patients, with the total sample averaging 13 sessions. Outcome measures included symptomatic and adjustment ratings from multiple perspectives. In head-to-head comparisons between interpersonal psychotherapy and cognitive-behavioral therapy, little evidence to support significant differential effectiveness was found. This finding held true for more and less severely disturbed patients.

The general finding of no difference in the outcome of therapy for clients participating in diverse therapies has several alternative explanations. First, different therapies can achieve similar goals through different processes. Second, different outcomes do occur but are not detected by past research strategies. Third, different therapies embody common factors that are curative, though not emphasized by the theory of change central to any one school.

No doubt, different therapies require patients to undergo different experiences and engage in different behaviors. Diverse therapies could be effective for different reasons. Yet we do not know enough about the boundaries of effectiveness for each therapy to address the first alternative and its merits. Neither will the second alternative be examined in detail. Many methodological reasons for failing to detect differences in treatments are suggested. For example, Kazdin and Bass (1989) questioned the value of the majority of past comparative studies on the basis of a "lack of statistical power." There are serious problems, too, in accurately measuring behavioral change (Lambert,

Christensen, & DeJulio, 1983). However, the third alternative, emphasizing the role of common factors in different therapies, is the possibility that has received the most research attention and the one that has the clearest implications for practice. It is not only an interpretation of the comparative outcome literature, but also is based on other research aimed at discovering the active ingredients of psychotherapy. The common factors are considered next.

Research Findings on Common Factors

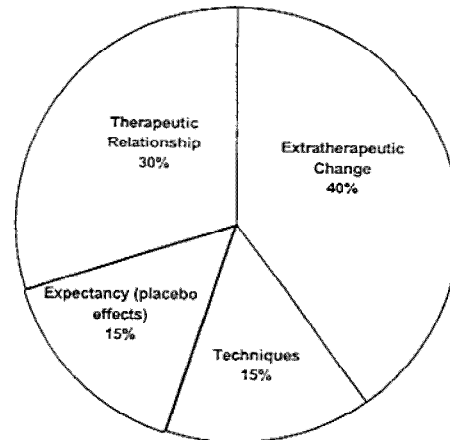
Common therapeutic factors can be divided into four broad areas: client factors and extratherapeutic events, relationship factors, expectancy and placebo effects, and technique/model factors. Figure 3 provides a graphic display, illustrating our current belief about the degree to which each of these classes of variables contributes to outcome. The findings from research regarding each of these common factors is now discussed.

CLIENT VARIABLES AND EXTRATHERAPEUTIC EVENTS

Although some practitioners, especially the inexperienced, imagine that they or their techniques are the most important factor contributing to outcome, the research literature does not support this contention. On the contrary, outcome is determined to a great degree by the client and outside events—not the therapist. On the basis of his review of the extant literature, Lambert (1992) concluded that as much as 40% of the improvement in psychotherapy clients is attributable to client variables and extratherapeutic influences. The subject of client variables and extratherapeutic events and their relation to outcome could fill a volume. In this context, we mention some of the more important client variables and sample the research on extratherapeutic factors.

When clients come to therapy, they enter with a diverse array of disorders, histories, current stressors, social support networks, and the like. Those client variables that are most important can be organized in many ways. Further, the categories used to describe clients overlap both in their components and presence in a single client. Among the client variables most frequently mentioned are the severity of disturbance (including the number of physical symptoms involved), moti-

FIGURE 3



Percentage of Improvement in Psychotherapy Patients as a Function of Therapeutic Factors. Extratherapeutic change: those factors that are a part of the client (e.g., ego strength and other homeostatic mechanisms) and part of the environment (e.g., fortuitous events and social support) that aid in recovery regardless of participation in therapy. Expectancy (placebo effects): that portion of improvement that results from the client's knowledge that he or she is being treated and from the differential credibility of specific treatment techniques and rationale. Techniques: those factors unique to specific therapies (e.g., biofeedback, hypnosis, or systematic desensitization). Therapeutic relationship: includes a host of variables that are found in a variety of therapies regardless of the therapist's theoretical orientation (e.g., empathy, warmth, acceptance, encouragement of risk taking). From *The Handbook of Psychology Integration* by M. J. Lambert, 1992, p. 97. Copyright 1992 by Basic Books. Reprinted with permission.

vation, capacity to relate, ego strength, psychological mindedness, and the ability to identify a focal problem (Lambert & Anderson, 1996; Lambert & Asay, 1984). It is reasonable to conclude that the nature of some problems (e.g., personality disorders, schizophrenia) and the makeup of some clients (e.g., severe abuse in childhood, interpersonal distrust) affect therapy outcome. As an example, a withdrawn, alcoholic client, who is "dragged into therapy" by his or her spouse, possesses poor motivation for therapy, regards mental health professionals with suspicion, and harbors hostility toward others, is not nearly as likely to find relief as the client who is eager to discover how he or she has contributed to a failing marriage and expresses determination to make personal changes.

The importance of client factors in psychotherapy outcome was highlighted in a series of case studies reported by Strupp (1980a, 1980b, 1980c, 1980d). In each study, two patients were seen by the same therapists in time-limited psychotherapy. In each instance, one of the patients was seen as having a successful outcome and the other was considered a treatment failure. The patients were male college students suffering from anxiety, depression, and social withdrawal. Although each therapist was seen as having good interpersonal skills, a different relationship developed with the two patients. In all four cases, the patients who had successful outcomes appeared more willing and able to have a meaningful relationship with the therapist. The patients who did not improve in therapy did not relate well to the therapist and kept the interaction superficial.

In Strupp's analysis, the contributions of the therapist remained relatively constant throughout therapy. Accordingly, the difference in outcome could be attributed to patient factors, such as the nature of the patient's personality makeup, including ego organization, maturity, motivation, and ability to become productively involved in therapy. Commenting on the results of the study, Strupp (1980a) concluded,

While these findings are congruent with clinical lore, they run counter to the view that "therapist provided conditions" are the necessary and sufficient conditions for therapeutic change. Instead, psychotherapy of the variety under discussion can be beneficial provided the patient is willing and able to avail himself of its essential ingredients. If these preconditions are not met, the experience is bound to be disappointing to the patient as well as the therapist. The fault for such outcomes may lie not with psychotherapy as such but rather with human failure to use it appropriately. (p. 602)

Much of the research on client variables has been summarized elsewhere (see Garfield, 1994). The data suggest that some client variables can change rapidly in psychotherapy (e.g., motivation and expectations for improvement), whereas other client variables are more likely to be immutable in the short run (e.g., personality styles). As already reported, clients who do better in psychotherapy and maintain treatment gains believe that the changes made in therapy were primarily a result of their own efforts.

Other evidence bearing on the role of client or extratherapeutic factors comes from the literature on spontaneous remission. A well-documented finding from research is that a portion of clients improve without formal psychotherapeutic intervention. This phenomenon has been discussed extensively in previous reviews (Bergin & Lambert, 1978; Lambert, 1976; Lambert & Bergin, 1994). The studies examined in these reviews include participants who had minimal treatment, but

not extensive psychotherapy, and untreated participants. The median rate for extratherapeutic improvement was 43%, with a range from 18% to 67%.

Several factors may influence the rate of spontaneous improvement. For instance, the length of time that the disorder has persisted; presence of an underlying personality disorder; and the nature, strength, and quality of social supports, especially the marital relationship, affect change (Andrews & Tennant, 1978; Lambert, 1976; Mann, Jenkins, & Belsey, 1981). Differential rates of spontaneous improvement have also been suggested among differing diagnostic groups, with depression having the highest remission rate, followed by anxiety and hysterical, phobic, obsessive-compulsive and hypochondrical disorders (Schapira, Roth, Kerr, & Gurney, 1972).

The finding that many clients improve without formal psychological intervention highlights the importance of supportive and therapeutic aspects of the natural environment in which clients live and function. In all likelihood, a significant number of people are helped by friends, family, teachers, and clergy who use a variety of supportive and hope instilling techniques. It is interesting that in the study by Howard et al. (1986), the authors estimated that about 15% of clients experience some improvement before the beginning of treatment. Presumably, at least some pretreatment improvement is attributable to clients' reliance on sources of help and support within their environments.

Before ending the discussion of client factors, the influence of self-help literature and self-help groups bears mentioning. These resources often include behavioral, cognitive, and insight-oriented material drawn from a variety of formal psychotherapy systems. Some of this material, such as self-help books, has been shown to reduce symptomatology (Ogles, Lambert, & Craig, 1991). Thus, what is helpful to people—independent of formal psychological intervention—may, in fact, be borrowed from psychological theory and technique. Further examination of client and extratherapeutic factors is found in chapter 4 of this book.

RELATIONSHIP FACTORS

Among the common factors most frequently studied are those focusing on the role of the therapeutic relationship. Empirical findings suggest that relationship factors account for approximately 30% of client improvement (Lambert, 1992). Much of the research on relationship factors began with the client-centered tradition in which certain "necessary and sufficient" conditions for client personality change were identified. These critical or core conditions were conceptualized as accurate empathy, positive regard, nonpossessive warmth, and congruence or genuineness. Most schools of therapy accept the notion that these and related therapist relationship variables are important

for significant progress in psychotherapy. In fact, they are considered fundamental in the formation of a working alliance (Lambert, 1983).

Studies showing both positive and equivocal support for the hypothesized relationship between therapist attitudes and outcome are well documented (Gurman, 1977; Howard & Orlinsky, 1986; Lambert, DeJulio, & Stein, 1978; Patterson, 1984). However, strong agreement exists. The therapist–client relationship is critical. Thus, some uncertainty in the research results from findings indicating that client-perceived relationship factors, rather than objective raters' perceptions of the relationship, obtain consistently more positive results. Further, the larger correlations with outcome are often between client process ratings and client self-reports of outcome. One explanation for this may be that clients perceive the therapeutic relationship as more positive than observers and that they are more accurate in their perceptions of the quality of the therapeutic relationship.

In any case, the value of therapist relationship skills has been demonstrated in several studies. For instance, Miller, Taylor, and West (1980) investigated the comparative effectiveness of various behavioral approaches aimed at helping problem drinkers control their alcohol consumption. Although the focus of the study was on the comparative effects of focused versus broad-spectrum behavioral therapy, the authors also collected data on the contribution of therapist empathy to patient outcome. Surprisingly, these authors found a strong relationship between empathy and patient outcome obtained from the 6- to 8-month follow-up interviews used to assess drinking behavior. Therapists' rank on empathy correlated ($r = .82$) with patient outcome, thus accounting for 67% of the variance in the criteria. These results argue for the importance of therapist communicative skills even in behavioral interventions.

In a more recent investigation, Najavits and Strupp (1994) reported on a study in which 16 practicing therapists were identified as "more effective" or "less effective" using time-limited dynamic psychotherapy (TLDP) with outpatients. Therapist effectiveness was determined by patients' outcome scores and length of stay in treatment. Multiple measures of outcome were used and completed by clients, therapists, independent observers, and the therapists' supervisors. Results revealed that more effective therapists showed more positive behavior and fewer negative behaviors than less effective therapists. Positive behaviors included warmth, understanding, and affirmation. Negative behaviors included belittling and blaming, ignoring and negating, attacking and rejecting. Therapists were differentiated almost entirely by nonspecific (relationship) factors rather than specific (technical) factors. On the basis of these findings, the authors suggested that "basic capacities of human relating—warmth, affirmation, and a mini-

imum of attack and blame—may be at the center of effective psychotherapeutic intervention. Theoretically based technical interventions were not nearly as often significant in this study” (p. 121).

In recent years, increasing interest in the therapeutic alliance as an important aspect of the therapist–client relationship has been observed. The therapeutic alliance was first described by Freud (1912, 1913). He underscored both the importance of the analyst’s attachment to the psychoanalyst and the psychoanalyst’s interest in and “asymptomatic understanding” of the patient in the early treatment relationship. Following Freud, the therapeutic alliance was elaborated and revised by many authors (Bowlby, 1988; Fennichel, 1941; Greenson, 1965; Sterba, 1929; Zetzel, 1956).

In an attempt to integrate the various constructs and ideas offered to describe the therapeutic alliance, Gaston (1990) suggested that the following components are measured by some but not all current research rating scales of the alliance: (a) the client’s affective relationship to the therapist, (b) the client’s capacity to work purposefully in therapy, (c) the therapist’s empathic understanding and involvement, and (d) the client–therapist agreement on the goals and tasks of therapy. Bordin (1976, 1989) also identified three components of the therapeutic alliance: tasks, bonds, and goals. Tasks involve the behaviors and processes within the therapy session that constitute the actual work of therapy. Both therapist and client must view these tasks as important and appropriate for a strong therapeutic alliance to exist. The goals of therapy are the agreed on objectives of the therapy process that both parties must endorse and value. Finally, bonds include the positive interpersonal attachments between therapists and clients, shown by mutual trust, confidence, and acceptance.

Most of the empirical work on the therapeutic alliance has been generated by psychodynamic researchers (Gaston, 1990; Horvath & Greenberg, 1994; Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Luborsky, 1994; Luborsky & Auerbach, 1985). Of late, this construct is receiving increasing attention in studies of behavioral therapy (DeRubeis & Feeley, 1991), cognitive therapy (Castonguay, Goldfried, Wisner, Raue, & Hays, 1996; Krupnick et al., 1996), and Gestalt therapy (Horvath & Greenberg, 1989). The alliance is conceived and defined in various ways and has been measured by client ratings, therapist ratings, and judges’ ratings (Horvath & Luborsky, 1993). Reviews of the research on therapeutic alliance (Gaston, 1990; Horvath & Greenberg, 1994; Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Lambert, 1992) reveal a positive relationship between therapeutic alliance and outcome, although there are instances when the relationship is small or insignificant. As an example of research on therapeutic alliance, Horvath and Symonds (1991) conducted a

meta-analysis of 24 studies in which the relationship between therapeutic alliance and outcome was analyzed. They found an average effect size correlation of .26, suggesting a 26% difference in the rate of therapeutic success attributable to the quality of the alliance.

In the National Institute of Mental Health Treatment of Depression Collaborative Research Program, Krupnick et al. (1996), using a modified version of the Vanderbilt Therapeutic Alliance Scale, investigated the role of the therapeutic alliance in the psychotherapeutic and pharmacological treatment of depressed individuals. Results indicate that the therapeutic alliance had a significant impact on outcome for both psychotherapies and for active and placebo pharmacotherapy. Both early and mean client ratings of alliance were significantly related to treatment outcome. However, therapist contribution to the therapeutic alliance was not significantly related to outcome on any measures. The lack of variability among the carefully selected therapists used in the study was proposed to explain this latter finding. In summarizing the outcomes, the authors concluded, "These results are most consistent with the view that the therapeutic alliance is a common factor across modalities of treatment for depression that is distinguishable from specific technical or pharmacological factors within the treatments" (p. 538).

In yet another study, Castonguay et al. (1996) examined the therapeutic alliance in cognitive therapy. The researchers compared the impact of a treatment variable unique to cognitive therapy (the therapist's focus on distorted cognitions in depressive symptoms) and two variables common with other forms of treatment (therapeutic alliance and client's emotional involvement) on treatment outcome. Subjects were 30 patients with major depressive disorder receiving either cognitive therapy alone or cognitive therapy with medication over a 12-week period. The patients were treated by four experienced therapists who conducted cognitive therapy according to the guidelines of manualized treatment. Outcome was assessed through patient ratings and with independent evaluators.

Results revealed that the two common variables, therapeutic alliance and patient's emotional experiencing, were both related to improvement. At the same time, the variable considered unique to cognitive therapy, linking distorted thoughts and negative emotions, was positively related to depressive symptoms after therapy. Castonguay et al. (1996) suggested that the latter finding was likely attributable to the therapists' attempts to repair strains in the therapeutic alliance by (a) increasing their efforts to persuade the patient to accept the validity of the cognitive therapy rationale or (b) treating alliance strains as manifestations of the patient's distorted thoughts that needed to be challenged.

Beyond the research on client-centered relationship factors and the therapeutic alliance, several other studies have illuminated the importance of the therapist-patient relationship in psychotherapy. For

example, Lorr (1965) asked 523 psychotherapy patients to describe their therapists on 65 different statements. A factor analysis of these data identified five factors: understanding, accepting, authoritarian (directive), independence encouraging, and critical hostile. Scores on these descriptive factors were correlated with improvement ratings; patient ratings of understanding and accepting correlated most highly with patient and therapist rated improvement.

The role of relationship factors has also been emphasized in group treatment. Glass and Arnkoff (1988), for instance, examined common and specific factors in patient descriptions and explanations of change. With a presenting complaint of shyness, clients were treated in one of three structured group therapies or an unstructured therapy group. The approach in each group was based on a different theory of change and differed in both content and focus. Notwithstanding theoretical differences, content analysis revealed that, besides specific treatment factors, all groups placed considerable emphasis on group process and relationship factors (e.g., support). The authors suggested that the role of common group process factors was at least as important to the clients as the specific therapy program (p. 437).

As this introductory survey shows, the empirical evidence on the impact of relationship factors in psychotherapy is substantial. These factors play a significant part in psychotherapeutic change and outcome. The role of relationship factors is covered more in depth in chapter 5 in this book.

EXPECTANCY AND PLACEBO EFFECTS

Research on psychotherapy outcome over the past three decades has addressed the importance of expectancy and placebo effects in client change. For example, Lambert (1992) suggested that this factor, which accounts for 15% of the variance in client change, is as important to the change process as technique factors. A pioneer in researching client expectancies and their relationship to outcome is Jerome Frank. In his classic work *Persuasion and Healing*, Frank (1973) argued that the therapeutic enterprise carries the strong expectation that the client will, in fact, be helped. He suggested, too, that an underlying factor unites all the seemingly different approaches to psychotherapy and even other forms of healing, such as the placebo in medicine and various types of religious cures. Namely, people are offered hope that something can be done to help them.

Frank, Gliedman, Imber, Stone, and Nash (1959) produced evidence indicating that the expectations that the client brings into therapy have an important influence on the outcome of therapy. They also found that the greater the felt distress, the greater the likelihood of

improvement. More recent research on client expectations has suggested a positive relationship between expectations and improvement, especially in the early phases of treatment (Garfield, 1994).

The role of placebo effects in psychotherapy has also received considerable research attention in studies comparing the effects of a particular type of psychotherapy or psychotherapeutic intervention with a placebo or minimal treatment group and a no-treatment control group. Although placebo effects and the use of placebo controls in psychotherapy research are controversial (Lambert & Bergin, 1994), it is clear from the existing research literature that placebo effects do have an important impact on psychotherapeutic change. For example, Lambert, Weber, and Sykes (1993) summarized studies comparing the effect sizes of psychotherapy, placebo, and no-treatment controls. The results of this summary are depicted in Figure 1 and can be expressed in percentage-improvement rates. Specifically, the average client undergoing a placebo treatment is better off than 66% of the no-treatment controls. On the other hand, the average client undergoing psychotherapy is better off than 79% of the no-treatment controls.

The impact of placebo effects was clearly demonstrated in the NIMH Collaborative Depression Study discussed earlier (Elkin et al., 1989). Of the many comparisons reported in the study, two stood out as particularly pertinent to this discussion. First, in head-to-head comparisons of cognitive behavioral therapy and interpersonal psychotherapy, no significant differences in treatment effects were found. Second, there was little evidence supporting the superiority of the two psychotherapies in contrast to the placebo plus clinical management. Both of the therapies were effective, but placebo plus clinical management patients also improved. While the placebo used in this study was admittedly a potent one, these findings nevertheless support the existing evidence on the impact that placebo and expectancy have in treatment outcome.

Placebo effects look to be less powerful in clients with more severe disorders and in studies where more experienced therapists are used (Barker, Funk, & Houston, 1988). However, placebo, hope, and expectancy factors play an integral enough role in change to deserve careful consideration by therapists interested in maximizing the effects of treatment. Chapter 6 continues discussion of the role of placebo, hope, and expectancy in therapy.

Technique and Model Factors

Although some researchers adhere to the argument for common factors as the principal mediators of change, most research studies have

aggressively investigated the role of model-based, technical interventions (Jones, Cumming, & Horowitz, 1988). The enthusiasm for researching the effects of specific schools or interventions exist because of clinicians' allegiance to school-based approaches and because the most suitable control group for past, as well as future studies, is the best alternative treatment. Therefore, specific interventions are often studied in the context of comparative outcome studies. Comparative studies also avoid the ethical and methodological problems in no-treatment, wait-list, and placebo controls, while providing information about the effectiveness of one technique or orientation in relation to others.

For those convinced of the singular abilities of their models and related interventions, the results have been disappointing. Overall, in the many comparative studies completed to date, little evidence to suggest the superiority of one school or technique over another has been obtained. While exceptions occur in the research literature (some of which are discussed below), specific techniques are estimated to account for only about 15% of the improvement in psychotherapy clients (Lambert, 1992).

Examples of Specific Effects

Comparative studies have shown the potent effects of some behavior therapies on certain problems. The treatment of phobic disorders with behavioral techniques incorporating systematic "exposure," has been found highly effective and superior to other forms of intervention. These procedures involve selecting patients with clearly identified fears evoked by specific stimuli. In addition to identifying the evoking stimuli, the patient must be motivated to seek and complete treatment. Exposure also requires the client's willingness to "make contact" with the evoking stimuli until their discomfort subsides (Emmelkamp, 1994; Marks, 1978).

To ameliorate phobic anxiety with exposure, several conditions must be in place. Specifically, the most useful therapeutic strategy, supported by numerous studies, includes the following elements: identify the provoking stimuli, encourage exposure, help the patient remain exposed until the anxiety subsides, and assist the patient in mastering thoughts and feelings linked with the fear-evoking stimuli. The bulk of the evidence suggests that achieving lasting reductions in fears and compulsive rituals is, indeed, a function of exposure.

It is noteworthy that limits to the effectiveness of exposure have been found. Exposure treatments, though effective with agoraphobia, simple phobias, and compulsions, are not as or uniquely effective with social phobias, generalized anxiety disorders, or a combination of these difficulties (Emmelkamp, 1994). Nevertheless, given a circumscribed

anxiety-based problem, specific interventions are available that are likely to help the majority of patients.

Additional research suggests that the treatment of panic disorder may be more successful when a cognitive-behavioral intervention is used (Barlow, Craske, Cerny, & Klosko, 1989; Murphy, Cramer, & Lillie, 1984). Barlow et al. (1989) compared relaxation training (RT), imaginal exposure plus cognitive restructuring (E+C), and a combined modality (RT+E+C) versus a wait-list control condition (WL). Differential outcome was evidenced by those patients experiencing panic attacks. Results indicated that 36% of WL, 60% of RT, 85% of E+C, and 87% of the RT+E+C patients were panic free at posttreatment.

Nevertheless, Milrod and Busch's (1996) recent comprehensive review of long-term outcome data for treatments of panic disorder calls for a less sanguine appraisal of Barlow's work. These reviewers concluded, "questions remain as to what is the best type of initial treatment for panic disorder . . . and what types of interventions may be most useful to reduce symptoms in patients whose symptoms are persistent or recurring" (p. 729).

The State of Current Knowledge

Exemplified by the research on exposure, evidence for the effectiveness of specific techniques for particular problems has been gradually accumulating. For this reason, "hope springs eternal"—optimism is expressed that more "treatments of choice" or prescriptive therapies will be found for specific disorders. The preponderance of evidence, however, supports the conclusion that little difference exists between the various schools of therapy in their ability to produce effects. Again, older reviews that analyze studies comparing a wide range of psychotherapies (Bergin & Lambert, 1978; Bergin & Suinn, 1975; Beutler, 1979; Goldstein & Stein, 1976; Kellner, 1975; Meltzoff & Kornreich, 1970) as well as more recent meta-analytic reviews suggest similar conclusions: Typically, there is little or no difference between therapies and techniques.

Curiously, the findings of no difference between treatments go largely unheeded. The debate continues over whether one technique is significantly different from and more effective than another. For example, Hollon and Beck (1986) predicted the continual success and superiority of cognitive therapy as a treatment for depression. In contrast, results from the NIMH Collaborative Depression Study (Elkin et al., 1989), to date the most comprehensive comparative study ever completed, revealed little evidence for the differential effectiveness of cognitive-behavioral therapy and interpersonal psychotherapy with depressed individuals.

Some also anticipate that future research may reveal greater distinctiveness between approaches as the use of therapy manuals becomes more important and more frequently applied. There is, for instance, evidence to suggest that the use of manuals to specify treatment techniques results in objectively discriminable therapist behaviors (Luborsky & DeRubeis, 1984; Rounsaville, O'Malley, Foley, & Weissman, 1988). In addition, the use of treatment manuals (and more experienced therapists) has been shown to reduce the variability in outcome due to the therapist, allowing for more accurate comparisons in comparative outcome studies (Crits-Christoph & Mintz, 1991). The use of and adherence to treatment manuals also helps enhance the effects of specific therapy procedures (Crits-Christoph, 1992).

Yet problems associated with the use of treatment manuals call into question their value in psychotherapy training and research (Strupp & Anderson, 1997). In this regard, Henry, Strupp, Butler, Schacht, and Binder (1993) found that the use of treatment manuals produced negative effects on therapeutic behavior among therapists, including a tendency for therapists to become less approving and supportive, less optimistic, and more authoritarian and defensive.

Owing to the historical and continuing emphasis on specialized models and techniques in graduate and professional training, continuing education seminars, publications, and professional discussions, the impression is easily created that they represent the "big guns" of therapeutic change. That they are not is admittedly frustrating. The often uncertain work of therapy would be simplified if special techniques uniformly exerted powerful main effects for particular complaints. Therapy could then be applied in this manner: "When faced with problem _____, administer technique _____."

At this stage in our understanding of what matters in therapy, the most that can be concluded about the role of techniques is that, like the other common factors, they contribute to positive treatment outcomes. Specific techniques may provide an extra boost to change, depending on the client population. This fact, nonetheless, does not contradict the evidence regarding the significant role of the other common factors—client, relationship, placebo, and expectancy. Rather, it suggests that unique or special variables at times may be important as well (Lambert & Bergin, 1994).

In all, specific techniques and the other common factors are not mutually exclusive as determinants to treatment outcome. As some authors have suggested (Butler & Strupp, 1986), separating specific techniques from common factors is of limited value anyway because techniques can never be offered in a context free of interpersonal meaning. From this perspective, models and their associated techniques

are part of a human encounter. They constitute interpersonal events inexorably bound up in the expectations and beliefs of the participants (Lambert & Bergin, 1994). Chapter 7 provides further review and commentary on the part that models and techniques play in therapy.

Implications for Practice and Training

Our brief examination of the empirical research on psychotherapy reveals important and useful findings for clinical work. For the practitioner, the challenge left is to integrate these results into practice. To promote this integration, several conclusions with implications for practice and training are offered. The general implications from psychotherapy outcome research are first discussed and then recommendations arising from research on the common factors are presented.

1. The effects of therapy are positive at treatment termination. Therapists can feel confident that they have something valuable to offer their clients. If clients or others raise questions about the benefits of undergoing treatment, they can be reassured. This knowledge may sustain both therapist and client through any difficult phase that may arise during treatment.

2. The beneficial effects of therapy can be achieved in short periods (5 to 10 sessions) with at least 50% of clients seen in routine clinical practice. For most clients, therapy will be brief. This is not meant to be an endorsement of brief therapy. It is simply a statement of fact. In consequence, therapists need to organize their work to optimize outcomes within a few sessions. Therapists also need to develop and practice intervention methods that assume clients will be in therapy for fewer than 10 sessions.

3. A sizable minority of clients (20% to 30%) requires treatment lasting more than 25 sessions. This group may need alternative interventions or more intensive, multifaceted treatment approaches. Even when intensive efforts are required, clients will improve to a significant degree. Further, clients most likely to fail at brief therapy are those poorly motivated and hostile, who come with a history of poor relationships and expect to be passive recipients of a medical procedure. Therapists need to identify these clients early and attempt to modify their unproductive expectations and behavior.

4. The effects of treatment are lasting for most clients, with follow-up studies suggesting little decline 1 to 2 years after termination. Relapse can be reduced by encouraging and reinforcing the clients'

belief in their ability to cope with the inevitable, temporary setback likely to be experienced after therapy.

Therapists also need to adopt methods for enhancing the maintenance of treatment gains. In this respect, facilitating two general beliefs in the client is necessary. First, clients can be encouraged to see the gains they make as a consequence of their own best efforts, rather than of the clinician, medication, or therapy. Second, clients need to know that they are not inoculated against future problems. Without such preparation, when setbacks occur, clients might become demoralized and underrate their newly developed ability to cope. Symptoms can recur without the client interpreting them as evidence of failure.

5. Client outcome is principally determined by client variables and extratherapeutic factors rather than by the therapist or therapy. Clinicians are not yet blessed with the wisdom to know which client will not profit from therapy, nor do they wish to exhibit the inhumanity of telling them so. Yet certain client characteristics consistently predict better outcomes across studies, types of therapy, and clinical settings. These include indices of severity, chronicity, and complexity of symptoms; motivation; acceptance of personal responsibility for change; and coping styles (Anderson & Lambert, 1995; Safran, Segal, Vallis, Shaw, & Samstag, 1993). Therapists should be familiar with client variables that have been shown to affect outcome and develop the skills to evaluate the suitability of a given client for the intervention offered. In addition, as a supplement to their own psychotherapeutic skills, it behooves the therapist to become familiar with the social support networks and community resources available to their clients and to help them in identifying and using these resources.

6. Outside client and extratherapeutic variables, the best predictors (and possibly causes) of success are clinician-client relationship factors. Therapist relationship skills, such as acceptance, warmth, and empathy are absolutely fundamental in establishing a good therapist-client relationship. They are related to positive outcomes (Lambert & Bergin, 1994). Consequently, keeping a focus on the importance of including these skills or qualities in the therapeutic process is essential for successful treatment. Training in relationship skills is crucial for beginning therapists because they are the foundation on which all other skills and techniques are built.

Reassessing periodically their incorporation and effective use of these skills may also be prudent for more seasoned practitioners. In particular, the increasing influence of managed care, with the accompanying emphasis on symptom reduction, may serve to erode a therapist's capacity to understand and empathize with clients' internal experiencing and, consequently, inhibit their affective expression and processing. This may interfere later with the development of a posi-

tive therapist–client relationship or alliance, thus undermining therapeutic effectiveness. It also follows that when therapists become overstressed, fatigued, or “burned out,” the first skill that suffers is their ability to empathize with the client and express warmth and understanding. Deterioration in these skills not only reduces therapeutic effectiveness, but also may constitute a “red flag” for the therapist. That is, it may signal the need for clinicians to focus on their personal circumstances and attend to factors that may be impinging on their therapeutic abilities.

The development of a therapeutic or working alliance has been shown to relate positively to outcome (Horvath & Symonds, 1991). Therefore, therapists must engage in behaviors that have been found to facilitate the development of a positive alliance. We have already discussed the value of therapist relationship skills in this process. In addition, the element of collaboration between therapist and client, including the consensual endorsement of therapeutic procedures, has been shown to be an essential part of the development of a strong therapeutic alliance.

We also wish to emphasize the necessity for therapists to avoid communications and behavior that have been shown to be disruptive to the therapist–client relationship. Specifically, behaviors that are critical, attacking, rejecting, blaming, or neglectful have been associated with less effective treatment (Najavits & Strupp, 1994). Therapist sensitivity to the deleterious effects of this type of behavior is critical in avoiding pitfalls that would compromise the therapy. This is especially true in work with certain groups of clients (e.g., those diagnosed with borderline or paranoid personality disorders). In these cases, untoward interpersonal pressures and the vicissitudes of the treatment may tempt the therapist to engage in behavior that is critical, attacking, or abusive.

A final recommendation is for therapists to make weekly assessments of client progress before each session to help the client communicate their psychological status. Simply reviewing with clients their progress in therapy may help to facilitate and solidify treatment gains. Clinicians can accomplish this by creating their own forms, or using formal questionnaires from the literature (see Ogles, Lambert, & Master, 1996).

7. Therapists can contribute to the therapeutic process by enhancing the effects of client expectations and placebo factors in their approach. Positive expectations about treatment include the belief that there is hope for overcoming problems and feeling better. As Frank (1973) pointed out, clients come to therapy because of lost hope or depleted morale. It is more than just being demoralized about having problems—clients have lost hope about being able to solve them. In the early phases of treatment, therapists can instill hope by directly

communicating to clients both their hope for change and reasons for being hopeful. It is assumed that a therapist would not work with the client if she or he felt there was no hope for improvement. Making this assumption explicit and clear for the client is key.

Successful negotiation and acceptance by the therapist and client of the tasks, techniques, or rituals of therapy, as well as the therapist's communication of belief about the efficacy of these tasks, naturally lead to increased morale and hope in the client. One way a therapist can communicate his belief in the value of a particular approach is by monitoring client change either through the client's own report or using a variety of accepted measures and questionnaires (Ogles et al., 1996). Finally, positive outcomes can be enhanced by keeping the treatment focused on the future, particularly on the client's ability to overcome in the future what has happened to them in the past, and by facilitating the client's sense of personal control (See Miller, Duncan, and Hubble, 1997, for a detailed discussion of these factors).

8. Some specific techniques look to be especially helpful with certain symptoms and disorders. Reviews of the psychotherapy outcome literature suggest that specific behavioral techniques have been found efficacious in the treatment of anxiety disorders, particularly circumscribed phobic disorders.

The practicing clinician is well served by reading the research literature and attending to the efforts of the American Psychological Association Task Force on Empirically Validated Treatments for guidelines regarding interactions between outcome and techniques (Task Force, 1995). In addition, many treatment manuals (Barlow, 1993) are available that can be used by the experienced therapist to supplement existing skills. These manuals provide session-by-session steps for assessment of and intervention in specific disorders, ranging from eating disorders to personality disorders.

Certainly, the therapist who intends to offer the highest level of treatment to clients will make every effort to stay abreast of developments and emerging empirical findings. Concurrently, one should remember that serious criticisms have been leveled against the research on "empirically validated treatments" (Silverman, 1996) and the use of treatment manuals (Strupp & Anderson, 1997). Keeping an open mind, but a balanced perspective, in considering the use of treatment manuals and empirically validated treatments will give clinicians more options. It is also helpful to remember that common factors and technical interventions are not mutually exclusive; all therapies use models and techniques. Our hope is that these technically based interventions will not be assumed to be so well established that their application will become mandatory. "Painting-by-numbers" can produce good results with certain clients, but rigid

adherence to manuals and guidelines is not a proven way to get the best results.

The current brief review touches the surface of the rich assortment of information available to the practicing clinician on the importance and value of common factors in psychotherapy. As this body of knowledge grows, so will clinicians ability to implement pragmatically and effectively the findings from research on this often overlooked but extremely important aspect of psychotherapeutic change.

Questions From the Editors

1. *Bergin and Garfield (1994), in the final chapter of the fourth edition of the Handbook of Psychotherapy and Behavior Change wrote, "As therapists have depended more upon the client's resources, more change seems to occur" (p. 826). This statement, in concert with your report on the importance of client factors in determining treatment outcomes, suggests a pivotal role for clients' strengths and abilities in fostering therapeutic change. The tradition, however, of most therapeutic schools has been to emphasize psychological weakness, incompetence, and pathology. What practical steps can be taken to enable our clients' resources in day-to-day practice?*

Outcomes, both positive and negative, are largely dependent on what the patient brings to the therapeutic encounter. Whereas psychological assessments and personality theories themselves rely heavily on identifying and labeling what is "wrong" with the patient, therapists of necessity rely heavily on the patient's positive coping mechanisms. Psychodynamic theorists, for example, pay close attention to patient ego strength in making treatment assignment decisions and in guiding in-session behaviors. Behaviorally and cognitively oriented therapists often assign homework, demonstrating their confidence in the patient's ability to self-monitor, recognize patterns, and instigate behavioral changes. Person-centered therapy makes trust in the clients' positive directional tendencies the hallmark of theory and practice. In general, therapists do a good job of enabling clients to call on their own resources in solving problems.

Helping clients to marshal their abilities and resources in the therapeutic enterprise begins with the therapist's attitude about the client's role in the change process. Communicating a belief and hope in the client's ability to change and an optimistic expectation that change will indeed occur is essential, especially in the beginning phases of treatment. Likewise, communicating the expectation that clients will be active participants in the therapeutic process who share responsibility for the type and amount of change implies that they are

taken seriously by the therapist and are viewed as competent and capable of change.

The client's sense of efficacy is also enhanced as improvements in functioning are identified and highlighted. This process is facilitated when therapists make a point of actively inquiring about changes that the client may have noticed within sessions and between sessions and how these changes may be related to the client's efforts in therapy. Therapists should also feel free to point out the positive changes and differences that they see in their clients and continue to communicate the expectation that more change is likely to occur. Some therapists have found success in having clients fill out questionnaires or rating scales at the beginning of each session that document client progress. This helps to reinforce the clients' faith in their ability to improve. Finally, keeping in mind that extratherapeutic factors have a significant impact on client change, it is important for therapists to assist clients in becoming aware of and using extratherapeutic resources, including support networks, self-help materials, and community programs that are available to them.

2. When therapy succeeds, the convention is to attribute the positive outcome to the therapy or ministrations of the therapist. In contrast, when therapy goes awry, or at least yields disappointing results, it has been customary to place the failure in the client or the client's personality. As reported in your chapter, Strupp's (1980a, 1980b, 1980c, 1980d) conclusions from his case studies represent this tendency. On the basis of your review of the empirical outcome literature, how much responsibility actually lies with clients or with therapists' difficulty in creating the necessary conditions for the development of the alliance?

The research literature on treatment effects underscores the important role that client factors play in outcome. As we have summarized in this chapter, client variables account for the largest portion of variance in psychotherapeutic change. It follows that what the client brings into the therapy situation is going to have the most influence on what happens in the treatment. However, it is also clear that therapist variables play a critical role in client change and that there is significant variability in therapist's effectiveness.

How therapy proceeds will be determined, to a large extent, by the type of therapeutic relationship or alliance that is formed. Therapists make an important contribution to the alliance and it is probable that the difference between effective and less effective therapists is their ability to form and maintain a therapeutic alliance with the client, particularly in treating more difficult or challenging clients. Therapists who are able to communicate warmth, understanding, and positive feelings toward the client and can facilitate a reasonable dialogue leading to understanding and agreement about therapeutic goals, techniques, and roles will be more likely to effect

a positive treatment alliance. It is also important that the therapist be able to respond to negative feelings and expressions from the client about the therapy or the therapist without becoming defensive and resorting to antitherapeutic reactions, such as becoming authoritarian, defensive, critical, rigid, and dogmatic. If handled properly, negative client reactions can ultimately strengthen the therapeutic alliance.

There are usually multiple causes when a workable alliance is not achieved and the treatment is unsuccessful. In many cases the problem may justifiably be laid at the feet of the therapist who is lacking in maturity, skill, or interest, rather than reflexively attributing the failure to the client. Many therapists' behaviors can be linked to negative responses from the client. These include interpretations, passivity, negative confrontations, attempts at humor, mechanical responding, ignoring of patient feelings, and the like. Therapists can always increase the degree to which they attempt to concentrate on the alliance. In training student therapists it is clear that trainees can learn (in a relatively short period of time) how to be attuned to patients' feelings. But it is also clear that they fail routinely and persistently to offer high levels of empathy once they are not monitored. Clients and therapists work together to produce outcomes. When progress is insufficient it makes sense to attribute this failure to ourselves. It does not help to attribute alliance failures to patients because it does not, as readily, lead to changes in our own behaviors, including the need to be flexible in our approach.

Research suggests that the relationship offered by some therapists remains constant across patients (easy and difficult) whereas the quality of the relationship may be much more unstable in other therapists. This finding suggests that there is a sizable subset of therapists who need feedback and work on providing high levels of understanding with the most negative cases.

3. Despite the impressive research support, your position on the common factors is not a popular one. The field remains enamored with psychological theories and technical prowess. What might be done to disseminate information on the role of common factors in effective therapy? And, assuming that the "word gets out," how do you see psychotherapy as a profession changing?

About 70% to 80% of outpatients show significant benefits as a result of a wide range of therapies that use very different techniques. The controversy over causative agents in this behavior change is a natural and healthy phenomena.

Those who are committed to particular theories quite naturally argue for specific techniques and are often in the center of movements to encourage the use of "empirically supported treatments." The American Psychological Association and similar associations that pro-

vide accreditation to graduate training programs would do well to make sure that they provide support and encouragement for the development of training modules aimed at fostering relationship skills in addition to empirically supported psychotherapies.

There is no reason for those who are devoted to the development and testing of specific techniques to discount the obvious benefits of common factors and particularly the importance of therapist attitudes of respect, caring, understanding, and concern. By the same token, those of us who are convinced of the primary importance of the therapist, as a person, would be well served by remaining open to the likelihood that specific techniques, when offered within the safety of the therapeutic relationship, will appreciably add to the therapeutic encounter. We are, in fact, excited by efforts that derive their impetus from psychological theories that emphasize technique operations. Psychotherapy will be most effective when it includes high levels of positive attitudes as well as activities that are specific to patient problems.

Changing the emphasis in graduate training toward the development of the therapist as a person who prizes others can only make the enterprise of therapy more valuable, meaningful, and effective. The practice of psychotherapy appears to be moving toward an integrative eclecticism that is fostered by the assumption that there are specific techniques for specific problems. Like Carl Rogers, we believe that the "facts are always friendly." Future research will reveal the degree to which an emphasis on techniques will enhance the outcomes of treatment for the patient.

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