IMPACT OF COMMON FACTORS ON PSYCHOTHERAPY OUTCOMES

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Thank you for my supervisor, whose generous guidance and support made it possible to work on a topic that was a great interest to me.

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Contents

Introduction

The purpose of this dissertation is to investigate to what extent common factors contribute to the effectiveness of psychotherapies. According to Eysenck (2009, pp. 535), common factors and specific factors are the two main reasons why any given therapy might be effective. Specific factors are aspects of therapies unique to that form of therapy. Common factors are general factors found in most forms of therapy that help clients to recover, such as therapist warmth, therapist empathy and therapeutic alliance.

There are various explanations of common factors, which may depend on from whose perspective it is viewed. Common factors highlighted by Passer and Ronald's (2008, pp. 606-607) are clients faith in the therapist, a reasonable explanation for the client's problems, a protective setting in which clients can experience and express their deepest feelings within a supportive relationship, an opportunity for clients to practice new behaviours, clients achieving increased optimism and self-efficacy. When Cormier and Nurius (2003, pp. 16-42) analysed the basic skills and interventions used in cognitive-behaviour therapy, they described the following common factors: characteristics of effective helpers (self-awareness, interpersonal awareness and critical thinking), other factors affecting helpers (values, diversity and ethics), ingredients of an effective helping relationship (empathy or accurate understanding, genuineness and positive regard) and building an effective helping alliance.

From the very beginning of psychotherapy as a discipline, there was speculation about which therapeutic factors might be responsible for change (Hubble *et al.*, 2009, p. 28). According to Carr (2009, p. 25), common factors are certainly important components of psychotherapies, however, there has been an ongoing debate among

psychotherapy researchers between those who point to the critical role of specific techniques (specific factors) in contributing to the efficacy of psychotherapy and those who point to the importance of common factors. The evidence-based model of psychotherapy (which is similar to the evidence-based medical model) predicts that some types of psychotherapies will be more effective than others because certain ingredients will result in better outcomes (Wampold, 2009, p. 56). Although there is a strong focus on specific treatments for psychological problems, evidence for specific factors remains missing (Hubble et al, 2009, p. 28). Even though the medical model has been quite successfully applied in the context of physical medicine, psychotherapy does not necessarily work in the same way as medicine (Wampold, 2001, pp. 10-19; Hubble et al, 2009, p. 28, Wampold, 2009, pp. 50-53). In contrast, the empirical case for common factors is convincing. Hubble *et al.* (2009, p. 28) suggested that "these shared, curative factors drive the engine of therapy" and they are responsible for the change. Studies in this area support the hypothesis that most forms of psychotherapies work equally well and specific models are not necessarily responsible for outcomes. In the course of identifying the common factor approach, Norcross (2005) has stated:

> The common factors approach seeks to determine the core ingredients that different therapies share in common, with the eventual goal of creating more parsimonious and efficacious treatments based on their commonalities. This search is predicated on the belief that commonalities are more important in accounting for therapy outcome than the unique factors that differentiate among them (Norcross, 2005, cited in Jones-Smith, 2011, p. 589*).*

This investigation of the effectiveness of the common factor starts with the history of common factor approach (see section 1.0), which focuses on several prominent researchers who contributed to the development of this approach. Afterwards, there is a further discussion about approaches in psychotherapy research and practice (see section 2.0), such as the Evidence-Based Practice (EBP) or psychotherapy integration movements. In this section, various other concepts are explained, such as meta-analysis and the hierarchy of evidence, which are necessary to understand studies in this area of research. This section is followed by several studies which are collectively challenging the common factor approach (see section 3.0). However, these pieces of research have many limitations, such as the allegiance effect and the inaccuracy of meta-analyses (see section 4.0). The allegiance effect in this context refers to the belief of a psychotherapy researchers that one therapy is superior to others, which can affect the objectivity of results.In order to further analyse to what extent common factors contribute to the effectiveness of psychotherapies, further meta-analytic studies are being discussed in which common factors were no more effective than placebos (see section 5.0). Nevertheless, these studies are also criticised.

To further analyse the elements of psychotherapy and the relationship between common and specific factors, several studies are being discussed, which estimate the percentages of variance in effectiveness attributable to different therapeutic factors. However, there are various issues with these studies, due to the dynamic and interdependent nature of therapeutic elements (see section 6.0). In the following section (see section 7.0), when the effort is made to identify common factors, three main categories have been identified: client variables, therapist variables and

technique. In each category, a number of the main factors are being explained in detail.

Eventually, the ideas of Fife *et al.* (2014, pp. 20-21) are introduced, who stated that certain common elements account for more variance than others, so they developed *the therapeutic pyramid* (see section 8.0). This pyramid shows the relationship between factors and might be a useful step toward understanding how therapies work and how different psychotherapeutic factors interdepend on each other. Consequently, the therapeutic pyramid could be a solution for several issues in this field of research, which has been researched and discussed for several decades and they have implications for theory and practice.

1.0 History of the Common Factor Approach

1.1The Early History of Psychotherapy

What enables therapies to work has been researched for over 50 years, while different psychotherapies were trying to prove superiority over others (Sparks, Duncan and Miller, 2008, p. 453). Hubble *et al.* (2009, pp. 24-25) noted that in the early stage of psychotherapy, multiplicity of psychotherapeutic orientations (behaviourism, psychoanalysis etc.) was dividing researchers. The competitions and disagreements were among scientists. It was a fertile ground for the development of new therapies and for the inflated assertions of their effectiveness.

1.2 Formulation of the Common Factor Concept

Saul Rosenzweig (1936, cited in Sparks, Duncan and Miller, 2008, p. 480) realised that all approaches appear equal in effectiveness, so he suggested that some potent implicit common factors are perhaps more important than the methods purposely employed. Rosenzweig (1936, cited in Lundh, 2014, pp. 132-133) was probably the first writer who formulated the concept of “common factors” and the so-called "Dodo Bird Verdict" as a label for the hypothesis that most forms of psychotherapy work equally well. The quoting of the dodo bird came from *Alice's Adventures in Wonderland* (Carroll, 1962/1865 cited in Lundh, 2014, pp. 132-133), who said, "Everyone has won and all must have prizes". The Dodo remark was made after a caucus race in which competitors started at different points and ran in different directions for half an hour (Carr, 2012, p. 323). Common factors were also called in the past as nonspecific therapeutic factors or therapeutic relationship variables (Howell, 2012, p. 323).

Sparks, Duncan and Miller (2008, pp. 454-455) noted that shortly after Rosenzweig's publication, an altogether forgotten panel assembled several prominent theorists at the 1940 conference of the American Orthopsychiatric Society and agreed that more similarities existed between approaches than differences. They discussed areas of agreement making sure that the relationship is central, keeping the responsibility for choice on the client and increasing the client's understanding of the self. Rogers emphasised this discussion as a recommended reading in his first book and referenced Rosenzweig's 1936 paper.

1.3 Carl Rogers's Contribution

Carl Rogers' (1957, cited in Sparks, Duncan and Miller, 2008, p. 456) publication proposed that in effective psychotherapy, therapists create core rational conditions of empathy, respect and genuineness, which is "sufficient" for therapeutic change. Later, Rogers's core conditions have been transformed by other theorists and it has become important across various counselling schools. Rogers's relationship conditions or attitudes have changed over time to a more differentiated focus on therapist interventions and techniques and client processes that are associated to change in psychotherapy (Elliott *et al.*, 2013, p. 515).

1.4 Jerome Frank's Contribution

Jerome Frank's (1961, Sparks, Duncan and Miller, 2008, pp. 456-457) book, *Persuasion and Healing* was the first one completely devoted to commonalities cutting across approaches. Frank systematized and expanded Rozenzweig's work, especially the profound effects of hope and expectancy in healing activities. Frank

also categorised four features shared by all effective therapies: an emotionally charged relationship, a healing setting, a rationale or myth providing a plausible explanation for the symptoms and a procedure to resolve them. The procedure or ritual requires the active participation of both therapist and patient, while both believe in the means of restoring the patient's health.

During the 70's theorists picked up Frank's discussion of hope and expectancy (referred to in the literature as placebo effects). They conceptualised the common factors in these terms and empirical arguments about common factors increased.

1.5 The Use of Meta-Analysis to Compare Treatment Outcomes

Smith and Glass (1977, cited in Wampold, 2009, p. 56) examined the relative efficacy of various types of treatments. At first behavioural treatments seemed superior, but when confounding variables were controlled (e.g. allegiance effect), there were no significant differences among treatments. This study fully supported the "Dodo Bird Verdict". A number of meta-analyses conducted after Smith and Glass have found a similar result. For example, Smith, Glass and Miller (1980, cited in Lambert, 2013a, p. 5) and afterwards Shapiro and Shapiro (1982, cited in Carr, 2009, p. 31) made an extensive reanalysis of the psychotherapy literature that dealt with treatment effects and they refined Smith and Glass's (1977) analysis. They found that differences between therapeutic approaches did not reach a level of significance, providing evidence that specific model ingredients could not be primarily responsible for psychotherapy outcomes.

1.6 Lester Luborsky and His Team's Contribution

In a series of papers starting in 1975, Lester Luborsky and his team concluded that there was strong empirical evidence to support the "Dodo Bird Verdict" (Luborsky *et al.*, 1975, 1993, 1999, 2002, cited in Carr, 2009, p. 52). In a quantitative review of 17 meta-analyses, they compared a range of different treatments with each other and Luborsky *et al.* (2002 cited in Carr, 2009, p. 52) concluded that the differences were small and non-significant. When such differences are corrected for the therapeutic allegiance involved in comparing the different psychotherapies, these differences tend to become even more reduced and non-significant.

1.7 Integration Movement and Lambert's Research

According to Sparks, Duncan and Miller (2008, pp. 457-458), the 1970s and the 1980s gave a big prominence to the common factors ideas, particularly in the integration movement. In the 1990s, integrative theoreticians used common factors to provide a conceptual framework for practice across diverse models. This was based in part on Lambert's (1986, cited in Sparks, Duncan and Miller, 2008, p. 457-458) proposal that client-specific variables, therapist empathy, warmth, and acceptance account for the mass of outcome variance. In addition, Lambert (1992, pp. 94-129) estimated the percentage-wise contribution of the therapeutic factors to the outcome of therapies. Lambert's research base was extensive, lasting for decades, dealt with a large collection of adult disorders and a variety of research designs, including naturalistic observations, epidemiological studies, comparative trials and experimental analogues.

1.8 Bruce E. Wampold's Contribution

Lundh (2014, pp. 132-133) argues that probably the most well-known proponent of the common factor approach in present-day psychotherapy research is Wampold, who questions the assumption that the effects of psychotherapy are due to the specific methods that are used in various forms of psychotherapy. Through the analysis of existing outcome data Wampold (2001, p. 96) concluded that the psychotherapy techniques are accounted only for a small percentage of overall change in psychotherapy, while client factors are predominating.

1.9 Client Directed Outcome Informed (CDOI) Approach

Sparks, Duncan and Miller (2008, p. 458) asserted that most recently a Client Directed Outcome Informed (CDOI) approach takes advantage of the literature on the role of common factors, particularly client variables and engagement via the therapeutic alliance. They noted that as such, it is more about change than about theoretical content. The CDOI is tailoring each treatment as unique situations based on client feedback. This approach represents a rational evolution of the ideas developed by the earliest common factors theorists and offers a progressive perspective on psychotherapy theory, research and practice in the twenty-first century.

2.0 Evidence-Based Model and Contextual Model of Psychotherapy

A major controversy in psychotherapy is whether change is brought by specific ingredients or common factors. According to Howell (2012, p. 323), therapists using the evidence-based model of psychotherapy are suggesting that the specific therapeutic interventions produce the clinical changes. For example, specific ingredients in a therapy include strategies such as cognitive restructuring, empathic reflection, psychoeducation, problem solving, role playing and communication training. This approach is similar to the medical model where a specific treatment is applied to a problem to achieve improvement or cure. Similarly, Wampold (2001, p. XII) noted that the medical model is emphasizing the idea that specific treatments have differential effects on specific disorders (specificity of treatments). As a result, therapists and researchers are focusing on specific ingredients, which are theoretically supported of being necessary for change. In contrast, the contextual model of psychotherapy claims that specific ingredients contained in the treatment are not responsible for positive change (Wampold, 2001, p. XII). The contextual model emphasises the importance of the commonalities among therapies and they consider them as necessary prerequisites to delivering the substantive content or therapy interventions effectively (Howell, 2012, p. 323).

Gurman (2008, p. 23) noted that historically there have been a disconnection and friction between practitioners and researchers, with practitioners claiming that researchers are out of touch with the complex reality of therapy practice and researchers who claimed that practitioners use interventions that are not scientifically supported. In fact, there is a validity to both sides of this argument. According to Wampold (2001, p. XII), this debate between advocates of the medical and contextual model has existed since the origins of psychotherapy. This debate

“separates practitioners and researchers into two camps, each confident that they know how and why psychotherapy works”. However, this statement is somewhat oversimplified, exaggerated and outdated. In fact, as it has already been mentioned earlier (see section 1.9), the Client Directed Outcome Informed (CDOI) approach is increasingly present, which is based on common factors. Also, recent psychotherapy is moving toward an integrated approach and multitheoretical framework (Jones-Smith, 2011, p. 585).

2.1 The Role of Common Factors in Psychotherapy Integration

According to Jones-Smith (2011, p. 586-608), it is believed that psychotherapy integration is necessary to enhance the efficacy, efficiency and applicability of treatments. An important advantage of integrative therapies is that they allow therapists the flexibility to meet clients’ needs who have different presenting issues and who come from a range of cultural contexts. Norcross and Newman (1992, cited in Jones-Smith, 2011, pp. 586-587) have identified eight variables that influenced the growth of integrative psychotherapy. One of these variables are common factors, as researchers recognised that these factors cut across various psychotherapy schools. According to Jones-Smith (2011, pp. 586-608), there are different pathways to integrate different theories or psychotherapies. This includes technical eclecticism, theoretical integration, common factors, multitheoretical psychotherapy and helping skill integration.

2.11 Psychotherapy Integration and the Evidence-Based Model of Psychotherapy.

Jones-Smith (2011, p. 608) suggested that the psychotherapy integration has gradually become tangled with the evidence-based movement in highlighting that various client problems require different solutions. Furthermore, these solutions are increasingly chosen on the basis of empirical outcome research, known as Evidence-Based Studies. Norcross, Beutler and Levant (2006, pp. 5-75) suggested that the Evidence-Based Practice (EBP) is a movement in medicine, psychology and public policy that requires professionals to base their practice on evidence. EBP is considering available scientific evidence about the best practice (what works) on one hand and clients' needs, rights and preferences on the other. It also involves making compassionate and ethical judgments. However, there are elemental controversies and problems in real-life applications of evidence-based practices, such as the transportability of laboratory-validated treatments to practice settings.

2.2 Hierarchy of Evidence

According to Carr (2012, pp. 311-312), when considering scientific evidence for the effectiveness of interventions, scientific evidence is categorised into a hierarchy, from the least to most persuasive (illustrated in Figure 1). In this hierarchy case studies are the least persuasive forms of evidence. The most persuasive evidence for psychological interventions come from meta-analyses. For this reason, researchers increasingly make use of meta-analysis in order to provide an overall estimate of therapeutic effectiveness (Eysenck, 2009, p. 533).

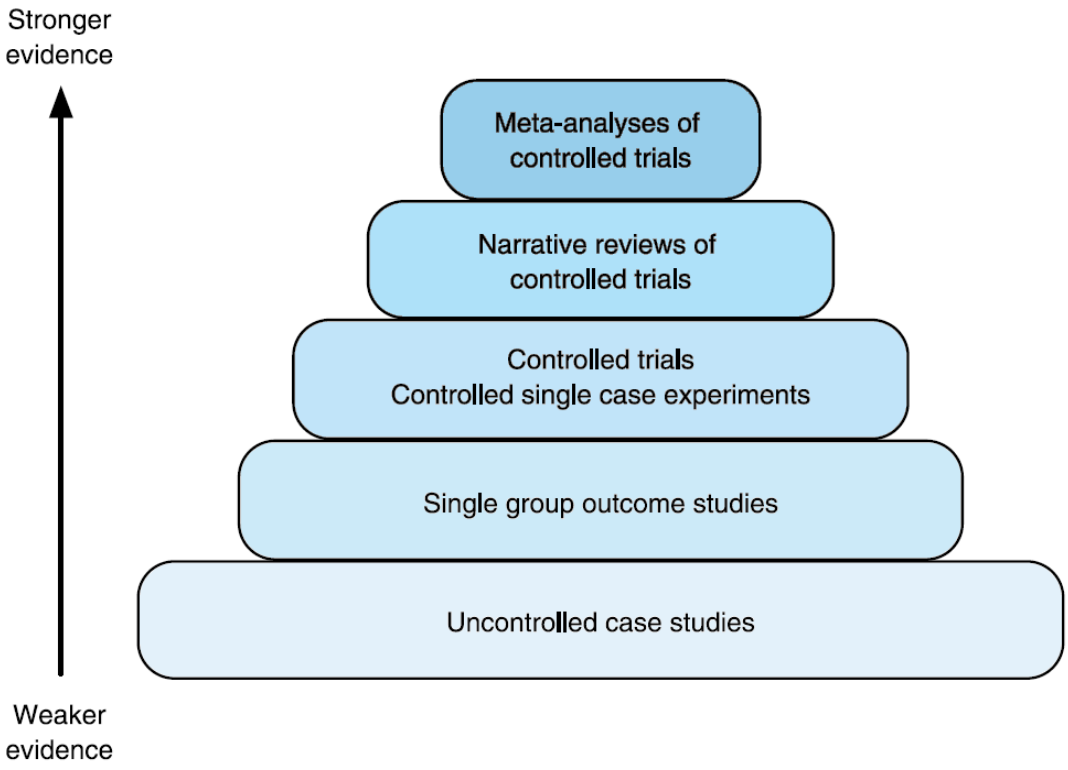

Figure 1. Hierarchy of evidence. Source: Carr, 2012, p. 312.

2.3 Meta-analyses

Meta-analyses combine results from different findings of similar studies into one large analysis. It gives a coherent overall picture of the research findings and helps to identify general trends in research in any given area (Eysenck, 2009, pp. 8-9).

According to Sparks, Duncan and Miller (2008, p. 480), the preferred method for investigating whether one treatment has better outcomes than another is the meta-analysis. Wampold (2001, p. 75) asserted that meta-analysis can be used to examine the relative efficacy of treatments. Meta-analyses can test the hypothesis that treatments are equally effective versus the alternative that they differ in effectiveness. Meta-analyses provide a precise quantitative measure of differences in effect size across similar studies. When meta-analyses are reviewing evidence from multiple

trials, the effect sizes of each trial are averaged across all trials, which is an index of a degree to showing how treated groups improved more than control groups − see Figure 2 for the graphic explanation of the calculation of an effect size (Carr, 2012, p. 314-315). According to Conn *et al.* (2012, pp. 182-190), meta-analysis is a valuable form of comparative effectiveness research because it emphasises the magnitude of intervention effects rather than relying on tests of statistical significance of primary studies. Although meta-analysis is a great comparative effectiveness strategy, methodological challenges and limitations must be acknowledged to interpret research findings.

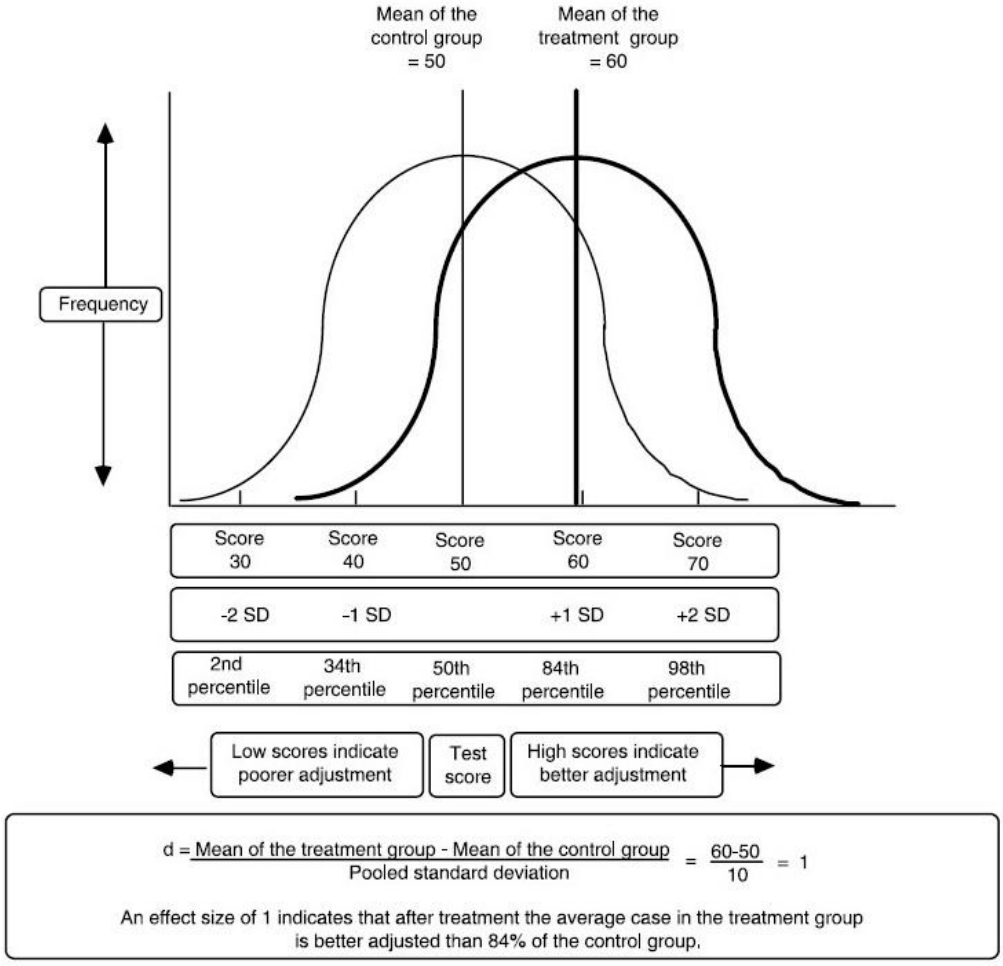

Figure 2. Graphic representation of an effect size of 1. Source: Carr, 2012, p.315.

3.0 Studies That Support the Evidence-Based Model of Psychotherapy

Not all researchers agree with Rosenzweig's and Luborsky's ideas. There are a plenty of studies that provide significant evidence that some psychotherapy treatments are significantly more effective than others. These studies support the evidence-based model of psychotherapy and they question the validity of the "Dodo Bird Verdict". For example, Weisz *et al.* (1995, cited in Carr, 2009, p. 52-53), in a meta-analysis of 150 studies conducted between 1967 and 1993 with two–eighteen-year-old children and adolescents, found that the mean effect size on non-reactive measures for cognitive behavioural treatments was .52, which was significantly greater than the mean effect size of .25 for client-centred and insight-oriented therapies. Weisz *et al.* (2006, cited in Carr, 2009, p. 52-53), in a further meta-analysis of 32 randomized controlled trials, largely involving youngsters with conduct problems and drug abuse, found that evidence-based cognitive behavioural and systemic treatments were more effective than usual care. The average adjusted effect size after treatment was .3 and at one-year follow-up was .38. These small to medium effect sizes indicate that the average client who received an evidence-based treatment fared better than 62% of those who received usual care after treatment and 65% at follow-up.

In another comparison meta-study, Reid (1997, pp. 5-16) reviewed results of 42 focused meta-analyses of specific treatments for specific problems such as depression, panic disorder, bulimia and so on. He concluded that 74% of the meta-analyses showed evidence of differential treatment effects. Cognitive behavioural treatments led to better outcomes for many problems. A similar conclusion was drawn in major broad meta-analyses of both child and adult problems. However, Reid

argued there could be a possibility of confounding variables which may account for the differences. Meta-analyses or within-study comparisons are not adequate and well-controlled in any given problem to be definitive.

Similarly, Shadish *et al.* (2000, pp. 512–529) conducted a meta-analysis of 90 studies in which clients, treatments and therapists were representative of typical clinical settings. They found that treatment effect sizes were larger for cognitive behavioural than traditional approaches to psychotherapy. They also noted that effect sizes were higher (a) when the dose of therapy was greater, (b) when highly specific measures were used, (c), when passive controls were used and (d) when therapy occurred in a clinical setting.

Roth and Fonagy (2005, cited in Eysenck, 2012, p. 534) systematically analysed different forms of therapy for different disorders. For each disorder, they managed to identify those types of treatments that have been found to be clearly effective. They identified for each disorder those forms of treatments which had limited support for efficacy as well. For example, family intervention programmes were identified effective in treatment of schizophrenia. However, there was a significant evidence for the effectiveness of other forms of therapy not emphasized by them − e.g. psychodynamic therapy (Eysenck, 2012, pp. 534-535). Carr (2012, p. 327) also suggested that there was a significant evidence that some psychotherapy treatments are more effective than others. Broad reviews of the literature on the effectiveness of psychotherapy provided evidence that effective evidence-based psychological interventions had been developed for a range of problems such as mood, anxiety, eating, substance use and sleep disorders, family relationship problems, pain management and adjustment to illnesses, psychological and intellectual disabilities in children and adults.

4.0 Limitations in Assessing Therapeutic Effectiveness

4.1 Nature and the Seriousness of the Disorder

There are several issues in assessing therapeutic effectiveness. When Matt and Navarro (1997, pp. 1-32) addressed the issue of therapeutic effectiveness, they reported differences in the effectiveness of different therapies; they found that behaviour therapy and cognitive therapy are more effective than psychodynamic and client-centred therapy. Nevertheless, they argued that the differences were not clear, because clients treated by behaviour or cognitive therapy often had less serious symptoms than those treated by psychodynamic or client-centred therapy; the effectiveness of psychotherapies may depend on the nature and the seriousness of the disorder and patient characteristics, which can prevent generalised conclusions about the magnitude of the effects and variables that mediate therapy effects. Eysenck (2012, p. 534) criticised Matt and Navarro's research concerning the lack of standardisation. Besides, Eysenck highlighted that a much lengthier approach with follow-up would be needed to determine specific conditions and individual cases that are vital in determining the effectiveness of therapy. However, this cannot be discovered in Matt and Navarro's study.

4.2 Perspectives of Therapeutic Effectiveness

There are several ways of assessing therapeutic effectiveness, which are important unsolved problems in the assessment of therapeutic change. Eysenck (2012, p. 532) stated that one of the reasons is that different therapies have different goals. For example, a psychodynamic therapist is working on resolving inner conflict, while a behaviour therapist is trying to produce desirable changes in overt behaviour. Also,

therapists differ in what they regard as suitable outcome measures. According to Strupp (1996, pp. 1017-1027), the effectiveness of any therapy can be considered from three different perspectives:

1. Society perspective − the individual's ability to function in society; compliance with social norms.
2. Client's own perspective − the client's overall sense of wellbeing and ability to function effectively.
3. Therapist's perspective − the client's thinking and behaviour related to the therapeutic framework underlying the therapy used by the therapist.

4.3 Issues with Efficacy and Effectiveness Studies

According to Eysenck (2012, p. 532), there is a conflict of measuring therapeutic effectiveness, which involves the decision, whether to adopt a scientific approach (efficacy studies) with more control or to adopt a more realistic approach rooted in clinical practice (effectiveness studies). Both studies are worthwhile, however, it is seldom possible to be scientific and realistic at the same time. Carr (2009, p. 18) asserted that in efficacy studies carefully selected clients with a specific type of problem are randomly assigned to treatment and control groups. The treatment group receives a specific type of therapy from a specialist psychotherapist in practice centres. In effectiveness studies, in contrast, ordinary clients are getting treatments from typical therapists in routine clinical settings. The therapy manuals and supervision are used more flexibly than in efficacy studies. Eysenck (2012, p. 532) noted that efficacy studies allow us to identify factors responsible for the benefit to clients and to interpret the finding with confidence, however, it is difficult to generalise

studies to clinical practice. While the outcomes in effectiveness studies are more informative, on the other hand, the uncontrolled nature of such studies makes it hard to be sure about the finding reported.

4.4 Self-Generated Change, Spontaneous Recovery and Nontherapist Source of Assistance

Bohart and Talman (2009, pp. 85-86) noted that studies had repeatedly demonstrated that people overcome significant problems without the benefit of professional intervention. For instance, many individuals overcome problems considered chronic, such as antisocial behaviour and substance abuse without formal treatment. In addition, both waiting-list (untreated) clients and clients who are receiving treatment are actively seeking informal help from other people (Wills, 1987, p. 39). Self-generated change, spontaneous recovery and nontherapist source of assistance are interfering factors, which have implications for psychotherapy outcome research.

4.5 Weaknesses of Meta-analyses

Although, the most persuasive evidence for psychological interventions comes from meta-analyses and they are the most often used methods to assess the effectiveness of therapies, they have weaknesses as well. Sharpe (1997, p. 882) identified three different problems with meta-analyses. First, there is the "Apples and Orange" problem; not very similar studies might be included within a single meta-analysis. Second, there is the "File Drawer" problem; failure to obtain all studies on some topic, so studies are not representative of all the studies on a given topic.

Third, there is the "Garbage in − Garbage out" problem; methodologically poor studies are often included along with good ones. Apart from comparisons of unequal treatments, comparative studies can also be compromised by Type I error (incorrect rejection of a true null hypothesis − a "false positive"), by reactive measures (any measure with the action of altering a response under examination) and by allegiance effects (Wampold, 2001, pp. 75-86). Eysenck (2009, p. 534) noted that as it is difficult to determine the accuracy of meta-analyses and in many cases the case-study-centred approach would be more useful. However, the cost and time implications mitigate against this more focused type of study.

According to Conn *et al.* (2012, pp. 182-190), the narrow inclusion criteria of meta-analyses may exclude studies conducted in a practice setting that would provide valuable evidence for changing practices. Including studies with varied methodological difficulties can be valuable and challenging. Combination of different approaches in the inclusion criteria may be more effective while testing connections between methods and effect sizes. Conn *et al.* noted that reporting bias (tendency to report significant findings and not to report findings that are not significant) and publication bias (tendency to publish statistically significant findings) can also alter meta-analyses in unknown ways. They concluded that only rigorously conducted meta-analyses can compare interventions to find out which approach works the best.

5.0 Common Factors and Specific Psychotherapies

5.1 Comparison of the Overall Effect of Psychotherapy

According to Carr (2012, pp. 319-322), meta-analyses of psychotherapy trials have moderate to large effect sizes that range from .65 to 1.02, which means that 65-72% of people benefit from psychotherapy. A striking feature of the evidence-based psychotherapy is the similarity in outcomes of diverse approaches with a range of populations − see Figure 3.

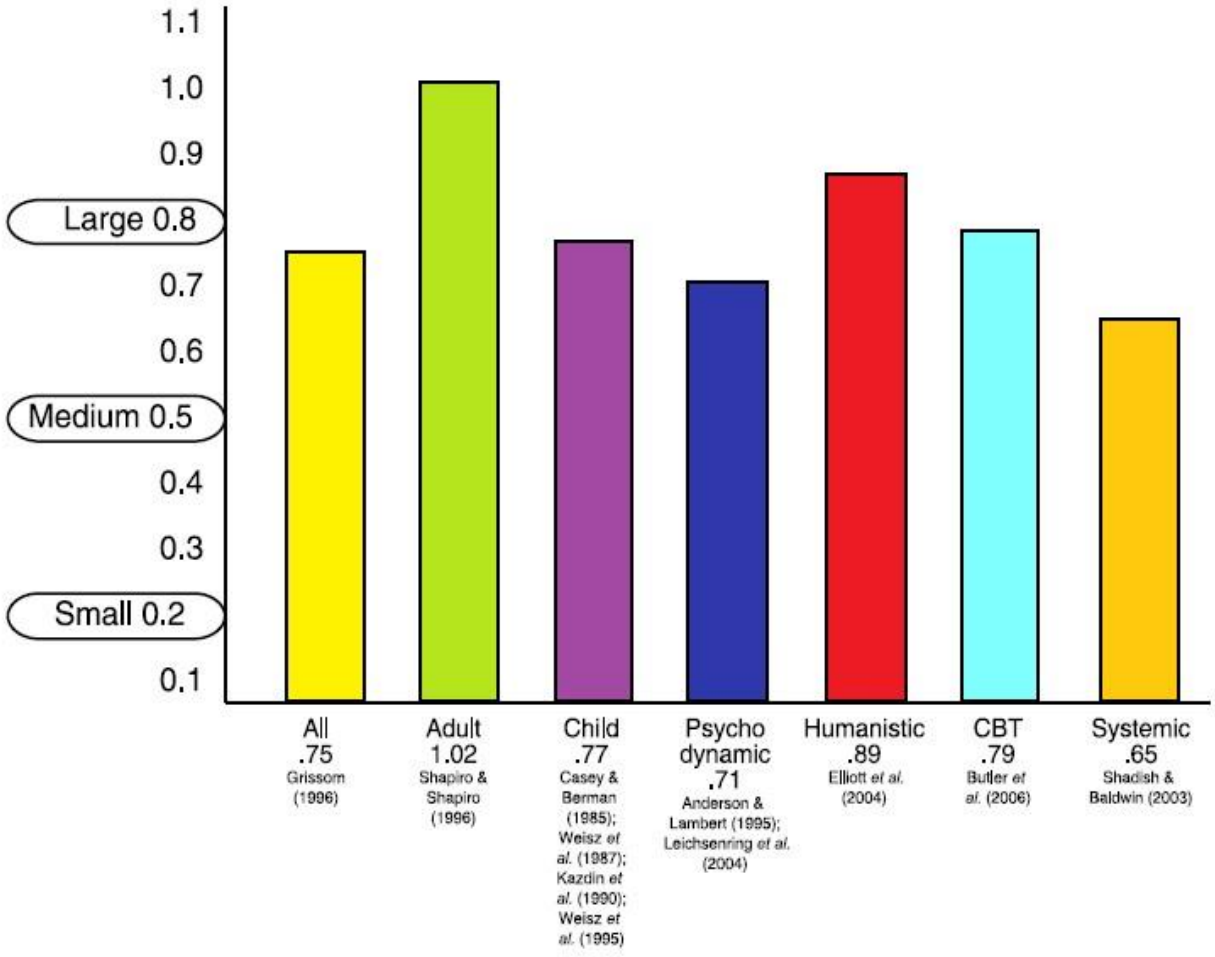

Figure 3. The mean effect sizes from meta-analyses of psychotherapy with adults and children from different traditions. Adopted from: Carr, 2012, p. 320.

When therapies are compared, differences rarely exceed an effect size of .2 as shown in Figure 4, which is based on Grissom's (1996, cited in Carr, 2012, pp. 322-323) synthesis of many meta-analyses. These results support the hypotheses that different psychotherapies lead to similar effects and that a set of common factors may underpin all effective psychotherapies.

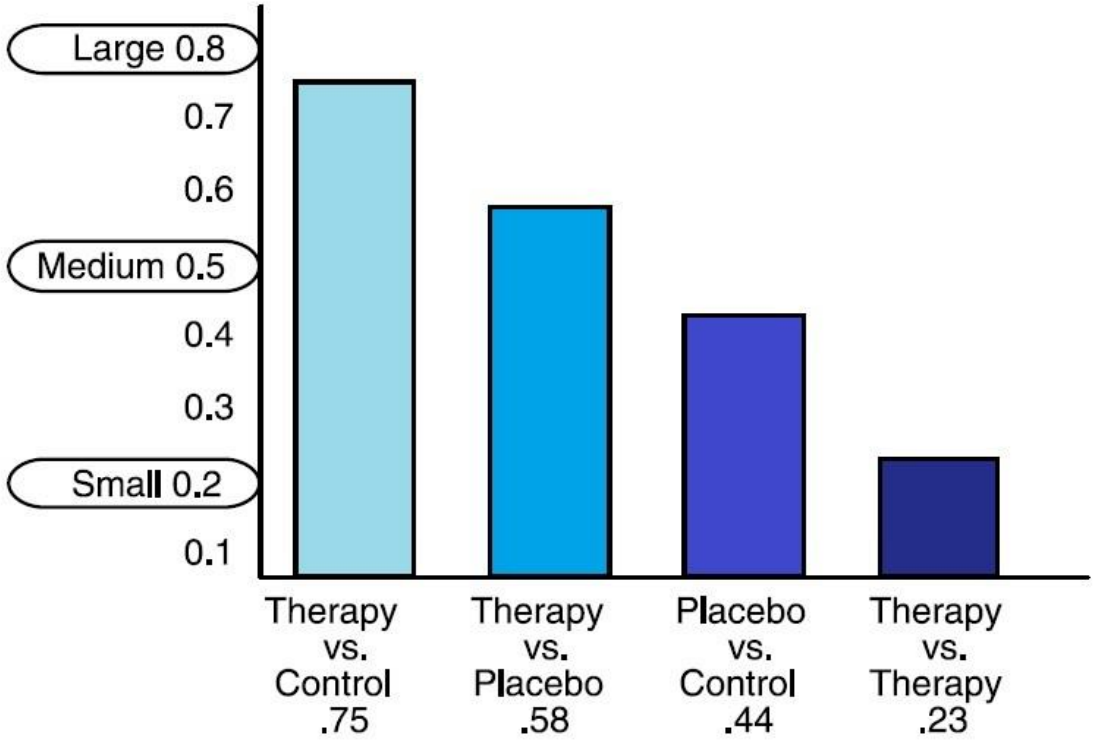

Figure 4. The effects of psychotherapy compared with placebo control groups. Based on Grissom (1996). Adopted from: Carr, 2009, p. 50.

5.2 Investigation of Placebo Effect

According to Bohart and Tallman (2009, p. 86), one way of understanding the placebo phenomena is that the client's expectation for change stimulates innate self-healing capabilities. They also noted that the placebo effect is an evidence of the significant role that clients play. According to Carr (2012, p. 323), it is possible that the underlying common factor and the placebo effect are the same. So

psychotherapy may be no more than a placebo that gives clients hope and creates the expectation of improvement.

In order to evaluate this hypothesis, researchers have conducted studies in which a specific form of psychotherapy is compared with a psychological or a pharmacological placebo condition (see Figure 4). In Grissom's (1996, pp. 973-982) synthesis three types of groups were compared:

1. Specific therapy groups − for whom any benefits may depend on specific effects or common effects
2. Placebo control groups − for whom any benefits are likely to depend on common factors
3. Waiting-list control groups − for whom no benefits are expected

The effect size of psychotherapy compared to placebos was .58, so the average treated case fared better than 72% of cases in control groups who received placebos. This indicated that psychotherapy is not just a placebo, but a set of procedures that influences the recovery process. Figure 4 demonstrates that the effect size of therapy versus waiting list control groups (.75) is larger than the effect size of placebo versus waiting list control groups (.44). This indicated that the effects of psychotherapy are much larger than those of placebos.

Both Lipsey and Wilson (1993, cited in Lambert, 2013b, p. 179) and Matt and Navarro (1997, pp. 1-32) addressed the placebo issue as a part of their meta-analyses. Their result was similar to Grissom's results. They concluded that there are likely some generalised placebo effects that contribute to the overall effects of psychological treatment, but their magnitude does not seem sufficient to fully account for overall effects.

Stevens, Hynan and Allen (2000, pp. 273-290) made a similar research by analysing 80 outcome studies in which specific therapy groups, placebo control groups and waiting-list control groups were compared. Interestingly, they found that the impact of specific and common factors depends on the severity of the mental disorders. With the less severe disorders (e.g. chronic and characterological disorders), common factors and specific factors were similar, but with the more severe disorders (acute and circumscribed disorders), in contrast, only specific factors influenced the outcome. They stated that, with the less severe disorders, a therapist only needs to be friendly and sympathetic. However, to help patients with more severe disorders being sympathetic is insufficient.

Bohart and Tallman (2009, p. 86) came to a totally different conclusion about meta-analytic studies where placebo effects were investigated. In order to highlight the existence of placebo effects, they only mentioned a fraction of Grissom's (1996) study, which states that the effect size (ES) of placebo conditions was 0.44 compared with no-treatment control groups. Also, Bohart and Tallman (2009, p. 86) argued that, in two other large randomised clinical trials ever conducted − the Treatment of Depression Collaborative Research Project (Elkin, 1994) and the Collaborative Cocaine Treatment Study (Crits-Christoph *et al.*, 1999) − researchers found that "the placebo and minimal clinical management conditions achieved outcomes roughly equivalent to those in psychotherapy".

5.3 Criticism of Placebo Related Comparison Studies

Wampold, (2009, pp. 61-62) highlighted three critical issues that claim that placebo related comparison studies are problematic. The first issue is that psychotherapy

trials cannot be blinded. The therapist's belief in the effectiveness of the placebo-type treatment is compromised and clients are also likely to know that they are receiving the less desirable treatment. The second issue related to placebo-type treatment is the lack of delivery of a treatment of some kind; a treatment that has a cogent and convincing rationale. Without a treatment, there can be no collaborative effort to establish goals, interventions and therapy processes (Sparks, Duncan and Miller, 2008, p. 461); a specific form of therapy is needed for common factors to have a medium through which they operate (Carr, 2012, p. 327). The third issue that Wampold, (2009, p. 62) highlighted is that, in studies comparing a specific treatment with placebo-type controls, treatments are not structurally equivalent. Structural equivalence refers to the similarity of two treatments in terms of therapist training, number and length of sessions, format (group vs. individual) and the degree to which clients are allowed to discuss the topics of their treatment.

According to Wampold (2001, pp. 159-183), the allegiance is relatively unimportant in the medical model and it is often ignored when control groups (placebos or alternative treatments) are designed. Allegiance appears to have an extremely large impact on the outcome. So if they are not taken into account, they affect the conclusions that are made about various treatments. In contrast, allegiance is a critical factor in the contextual model of psychotherapy. This model emphasizes the person of the therapist and the therapist's belief that the therapy is beneficial for the client. When the therapist believes that the treatment is efficacious, he or she will communicate that belief to the client.

Among the controversies about placebo controls is the question of what composes the placebo group. Baskin *et al.* (2003, p. 976) noted that the placebo term suggests deception because these placebo controls rarely include all the components of

common factors, therefore the difference between active treatments and control treatments are often overestimated. Baskin *et al.* found that when the placebo controls were structurally equivalent the outcomes for them and the comparison group were very similar (*d* = .15) while the structurally nonequivalent control versus the active treatment favoured the active treatment (*d* = .46). Baskin *et al.* concluded that the validity of placebo design in psychotherapy is arguable, although many researchers continue to believe in such designs.

5.4 Component Design

According to Wampold (2009, p. 62), a precise way to examine the specificity (the idea that specific treatments have differential effects on specific disorders) that avoids many of the problems related to placebo-type controls is either to remove a critical ingredient or to add a theoretically important component to the treatment. These are called component designs and they are used occasionally to test for specificity. An outstanding component study was carried out by Jacobson *et al.* (1996, pp. 295-304), who compared CBT with behavioural treatment (BT). CBT and BT were structurally equivalent, except that BT lacked the cognitive components that are thought to be essential for the effectiveness of CBT. The results revealed that the treatments with and without the cognitive components were equally effective (in short and long term), which may question the specificity of CBT for depression. Similarly, Ahn and Wampold (2001, pp. 251-257) examined 27 component studies and they found no evidence to support the claim that removing or adding a specific component to a treatment altered the outcomes. They stated that component studies produced no evidence that specific ingredients of psychological treatments are accountable for the beneficial outcomes of psychotherapies.

Wampold (2009, pp. 63-71) suggested that in contrast to medical research, in psychotherapy, it is difficult to design trials to establish specificity. A rigorous examination of placebo- type control research and component studies provides little evidence for specificity of any psychological interventions, thus suggesting that the common factors are the potent aspects of the treatment. However, the evidence that can support the common factor approach became quite diffuse, because studies of integrated models of the common factors were not emphasised. On the other hand, there is a collection of evidence that suggests that therapists differ in the outcomes produced and that these differences are due to common factors, such as the therapist's ability to form an alliance with their clients.

5.5 Criticism of Evidence-Based Practice (EBP)

Straus and McAlister (2000) developed an argument of Evidence-Based Medicine (EBM) and EBP and they classified various limitations and misconceptions of EBP (see Table 1).

Common Limitations and Misperceptions of EBP	
Limitations	**Misperceptions**
Shortage of coherent, consistent scientific evidence	Evidence-based medicine denigrates clinical expertise
Difficulties in applying evidence to the care of individual patients	It ignores patients' values and preferences
Barriers to the practice of high-quality medicine	It promotes a "cookbook" approach to medicine
The need to develop new skills	It is simply a cost-cutting tool
Limited time and resources	It is an ivory-tower concept
Paucity of evidence that evidence-based medicine "works"	It is limited to clinical research

Table 1. Limitations and Misperceptions of EBP. Adapted from Straus and McAlister (2000).

Similarly, Sparks, Duncan and Miller (2008, p. 468-474) intensively criticised EBP, but through the lens of the common factor approach. They argued that studies that are considered "evidence-based" lack the evidence due to the lack of validity and reliability of studies. Psychotherapy has demonstrated its superiority over placebo, but demonstrating efficacy over placebo is not the same as demonstrating efficacy over other approaches. Psychotherapy techniques are often sequentially arranged in EBP, which assumes that specific ingredients of a certain approach account for change and these strategies result in better outcomes. As a result, the creation of manuals detailing the precise model-specific steps is often believed to be a "silver bullet" for an effective psychotherapy. Technical procedures may interfere with the outcome, however, many controlled studies suggest the opposite. In addition, therapists who do the therapy by book develop a better relationship with their manuals than with clients and seem to lack the ability to respond creatively. The EBP is restricting therapists and clients in creating an active and evolving partnership that is the essence of every successful therapy. The EBP debate may create a situation that distracts attention from the effort to take advantage of the known evidence of what makes therapy effective.

6.0 Studies Describing Percentages of Variance in Effectiveness Attributable to Different Factors

In order to further analyse the relationship between common and specific factors and to find out their contribution to psychotherapy outcome, researchers attempted to estimate the percentages of variance in effectiveness attributable to different therapeutic factors.

Lambert (1992, pp. 94-129), following an extensive review of outcome research spanning decades, identified four therapeutic factors and ranked their importance on the basis of their estimated percentage-wise contribution to the outcome (see Figure 5). Lambert stated that 40% of the outcome was due to extratherapeutic variables. These are factors that clients bring to therapy, such as knowledge base, life experiences, strengths and abilities, and readiness to change. Further 30% was due to common factors, 15% was due to model or technique and 15% was accounted for hope, expectancy and placebo. Conceding that the percentages were not derived from a strict statistical analysis, Lambert suggested that percentages represent what studies indicated at the time about treatment outcome

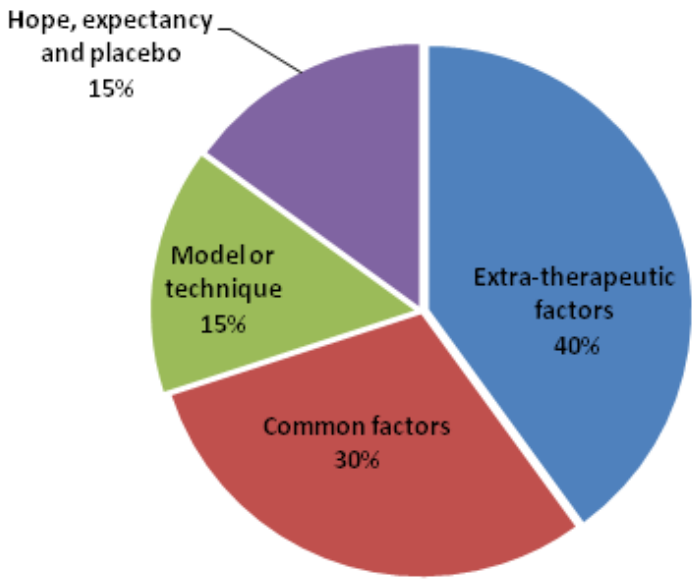

Figure 5. The percentages of all factors that are contributing to the outcome of the psychotherapy. Adopted from Lambert (1992) data

Wampold (2001, pp. 135-207) conducted a quantitative review of more than a dozen meta-analyses in which the focus was on the effectiveness of different forms of psychotherapy for specific problems such as depression and anxiety. The effects of therapies were studied on a wide variety of populations. Similarly to Lambert (1992), Wampold (2001) concluded that common factors have a greater impact than specific factors in determining the outcome of psychotherapy, but the results of his analysis led to a far more extreme statement; he dramatically reduced Lambert's (1992) estimate of the contribution of specific effects (see Figure 6). Wampold (2001) estimated that common factors are nine times more influential than specific factors in determining the outcome of psychotherapy. He concluded that only 13% of the variance of the outcome for psychotherapy clients is due to psychotherapy (including common, specific, and other factors). The result of this conclusion was that the

remaining 87% of the variance of the outcome for psychotherapy clients is due to extratherapeutic factors, error variance and unexplained variance. Wampold estimated that from the variance of the outcome 9% (4% from placebo effects and 5% from working alliance) was accounted for common factors, 3% was due to unexplained therapy factors (probably client characteristics) and only 1% was due to specific factors.

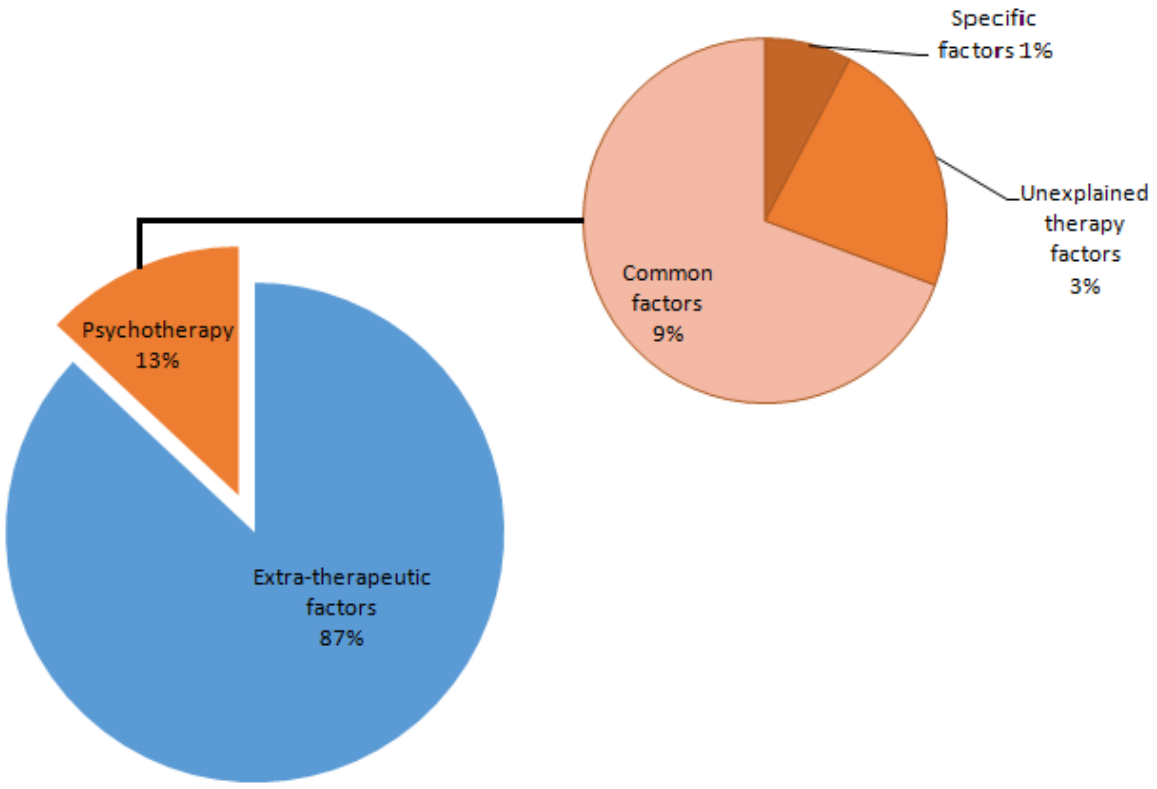

Figure 6. The percentages of all factors that are contributing to the outcome of the psychotherapy. Adopted from Wampold (2001) data.

Wampold (2001, p. 204) reported that research designs that are able to isolate and establish the relationship between specific ingredients and outcomes "failed to find a scintilla of evidence that any specific ingredient is necessary for therapeutic change". However, Fife *et al.* (2014) noted that many findings like Wampold's (2001) are often interpreted in a way as if technical skills were not necessary for a successful therapy

and therapists could follow their intuition or using their own perceptions. In fact, studies do not support this conclusion (Fife *et al.*, 2014, pp. 22-23).

Carr (2009, p. 52) stated that Lambert's and Wampold's findings represent extreme interpretations of the available data. However, they both came to the same conclusion that common factors have a far greater impact than specific factors in determining whether or not clients benefit from psychotherapy. Carr also noted that this significant impact of common factors on the outcome of psychotherapy provides a possible explanation for the similarity in the outcome of different psychotherapy approaches.

Martin *et al.* (2000, cited in Carr, 2009, p. 58) investigated the alliance-outcome correlation in a meta-analysis of 79 trials of a range of different types of psychotherapy with a variety of adult psychotherapy populations. They found that the therapeutic alliance is 5% of the variance in outcome for psychotherapy clients. Shirk and Karver (2003, cited in Carr, 2012, p. 326) investigated a range of different types of psychotherapy with children and adolescents with a wide variety of psychological problems and they found precisely the same result as Martin *et al.* (2000) and Wampols (2001). This 5% is a very large contribution to the outcome, in light of Wampold's (2001) estimate that overall psychotherapy accounts for 13% of the outcome for psychotherapy clients (as shown in Figure 6). When the effect of the alliance is expressed as a fraction of the overall effects of psychotherapy, it amounts to 5/13, or 38%. Obviously, the therapeutic alliance is an important factor contributing to the outcome of all forms of psychotherapy.

Wampold (2001, p. 200) in a review of major meta-analyses and large controlled psychotherapy outcome studies concluded that approximately 6-9% of the outcome is due to the therapist effects (including therapist training, capacity to form an

alliance). This is also a large contribution to the outcome, in light of Wampold's (2001) overall estimation. When the effect of the therapist is expressed as a fraction of the overall effects of psychotherapy, it amounts from 6/13 to 9/13, or 46-69%. Clearly, the person of the therapist is the most important factor contributing to the outcome of psychotherapy.

Stein and Lambert (1995, pp. 182-196) investigated the relationship between therapist training and outcome. They found that therapists with more training have less clients dropped out of therapy and their clients reported greater symptomatic improvement and greater satisfaction with therapy. They concluded that the therapist training accounts for about 2% of the outcome. When the effect of therapist training is expressed as a fraction of the overall effects of psychotherapy, it amounts to 2/13 or 15%, which is an important factor contributing to the outcome of psychotherapy.

Hubble *et al.* (2009, pp. 33-34) criticised the idea of depicting the relationship among the factors using a simple pie chart. He stated that the relationship among the factors implied that the factors were independent and the percentages additive. This apportionment of percentages suggested that the factors could be rendered as discrete elements and thus individually operationalised. Hubble *et al.* noted that in reality, common factors are not invariant, proportionally fixed, or neatly additive. They are interdependent, fluid and dynamic. Although presented sequentially, they cause and are caused by each other over the course of therapy. The role and degree of the influence of any one factor are dependent on the context: who is involved, what takes place between therapist and client, when and where the therapeutic interaction occurs and from whose point of view these matters are considered.

7.0 Categories of Common Factors

Passer and Ronald (2008) noted that there are three sets of common variables that influence treatment outcome: client variables, therapist variables and technique. Whereas Carr (2012, p. 325) suggested that it is useful to distinguish between client factors, therapist factors and factors associated with the therapeutic context (see Table 2).

Therapy, client and therapist 'common factors' that affect positive psychotherapy outcome		
Therapeutic context factors	**Client factors**	**Therapist factors**
Dose of 20-45 sessions Positive therapeutic alliance Empathy Collaboration and goal consensus Positive regard and genuineness Relevant feedback and relevant self-disclosure Repair alliance ruptures Manage transference and countertransference Common procedures Problem exploration Credible rationale Mobilising client Support and catharsis Reconceptualising problem Behavioural change Combining psychotherapy and medication	High personal distress Low symptom severity Low functional impairment Low problem complexity, chronicity and comorbidity Readiness to change and lack of resistance Early response to therapy Psychological mindedness Ego strength Capacity to make and maintain relationships Social support High socio-economic status	Personal adjustment Therapeutic competence Matching therapy style to patients needs Over-controlled patients − facilitate insight Under-controlled patients − build symptom management skills Positive past relationships − facilitate insight Negative past relationships − provide support Compliant clients − use directive interventions Resistant clients − use self-directed interventions Credibility of rationales Problem-solving creativity Specific training Flexible manual use Supervision and personal therapy Feedback on client recovery

Table 2. Common factors that contribute to the effectiveness of the psychotherapy**.** Adopted from: Carr, 2012, p. 325.

7.1 Therapeutic Common Factors

7.11 Dose of sessions.

Sparks, Duncan and Miller (2008, p. 481) argued that studies indicate that change in successful therapy is highly predictable, with most occurring early in the treatment process. The client's experience of change early in the treatment is predictive of outcome and the client's early ratings of the therapeutic alliance is highly correlated with the outcome. Lambert, Hansen and Finch (2001, pp. 159-172) conducted a number of dose-effect relationship studies. They found that for most acute and chronic symptoms up to 21 therapy sessions are required for 50% of clients to recover. But more than 40 treatment sessions were required for 75% of clients to make a clinically significant improvement (see Figure 7). According to Carr (2009, p. 56), different amounts of therapy are necessary for recovery from different types of problems. Patients with more chronic or pervasive problems are requiring more therapy sessions. For example, for optimal benefit to be achieved, chronic problems, like those associated with personality disorders, require more sessions than acute problems, like depression or anxiety.

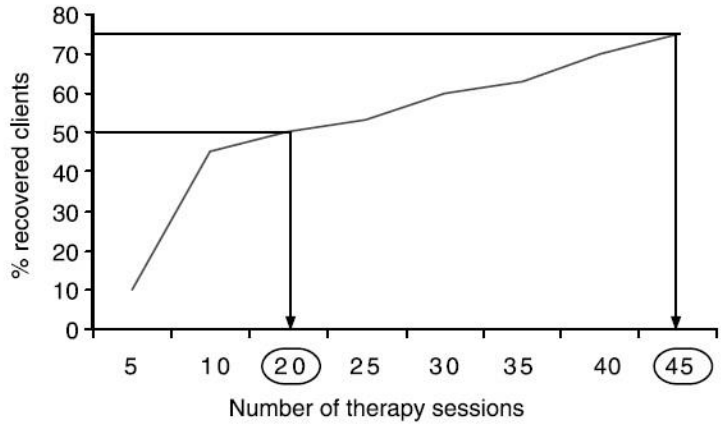

Figure 7. Psychotherapy dose–effect relationship. Adopted from Lambert, Hansen and Finch, 2001, p. 164.

7.12 The therapeutic alliance.

Apart from client factors, the therapeutic alliance is responsible for the most of the gains resulting from therapy (Bachelor and Horvath, 1999, cited in Sparks, Duncan and Miller, 2008, p. 461). As it was mentioned previously, when the effect of the alliance is expressed as a fraction of the overall effects of psychotherapy, it amounts 38% (see section 6.0). Horvath (2001, p. 365) suggested that "the therapeutic alliance refers to the quality and strength of the collaborative relationship between client and therapist", which is essential for optimal client outcomes regardless of the therapy model used. The therapeutic relationship is the most studied aspect of psychotherapy process. More than 1000 studies are supporting the importance of the therapeutic alliance on treatment outcome, especially if it is measured from clients' perspective (Orlinsky, Grawe and Parks, 1994, cited in Ursano, Sonnenberg and Ursano, 2015, p. 27*)*.

Although Freud advocated engaging collaboration with patients, Rogers (1957, cited in Fife *et al.*, 2014, p. 23) was the first to draw attention to the relationship issue and highlighted the importance of the therapist’s facilitative conditions of empathy, warmth, genuineness (also called congruence) and positive regard. Norcross (2009, p. 124) noted that studies support Roger's original conviction that these facilitative conditions work together and they cannot be easily distinguished. Passer and Ronald (2008, pp. 606-607) emphasised, that when therapists do not manifest these qualities, the effects of the therapy are null or clients can get worse.

Bordin (1979, cited in MacEwan, G. H., 2008, pp. 3-4) presented three elements that supposed to be critical to the development of a positive alliance:

1. The *goal* component - relies on a mutual agreement concerning what constitutes the client’s stressors, frustrations and dissatisfactions.

2. The *tasks* of therapy - mutually agreed means of approaching the treatment. The specific tasks assigned will depend upon the type of treatment.
3. The *bond* - connection between the client and therapist that represents a level of trust that must be established between the two participants.

Fife *et al.* (2014, pp. 23-24) noted that the scientific literature describes various features that contribute to the therapeutic alliance (e.g., therapist's attributes of being flexible, respectful, trustworthy, confident, interested, affirming, relaxed, genuine, open, kind, mindful, etc.). The therapeutic relationship has many overlapping features and has multiple conceptualizations and it is clear that some of its components are innately personal. The therapeutic relationship is something that can be created by the correct application of relationship-building skills and techniques, however, they can be described by at least three components:

1. The client's characteristics and personal attributes.
2. The relationship between therapist and client, including the working alliance.
3. The person of the therapist, together with the therapist's interpersonal attributes, style and therapist's facilitative conditions.

7.13 Common Procedures.

Carr (2012, p. 327) asserted that there are common procedures that are common to most forms of therapies, that contributes to clients' recovery. For example, exploration and reconceptualisation of clients' problems, provision of a credible rationale for conducting therapy, generating hope and expectation of improvement and mobilizing clients to engage in problem solving. These procedures may involve techniques such as providing support and encouraging emotional expression. Moreover, there is a developmental sequence common in most psychotherapies that

facilitates new ways of viewing problems, promotes learning and new forms of behaviour.

7.2 Client Factors

According to Hubble *et al.* (2009, p. 35), clients' factors cover all that affects improvement independent of treatment. Clients come to therapy with varying degrees of motivation and with varying degrees of internal and external resources. Sparks, Duncan and Miller (2008, p. 460) suggests that clients are the most neglected therapeutic factor in studies of psychotherapy. Theories of personality and psychopathology traditionally have viewed clients as deficient − possessing more or less stable core traits that require remediation. They also argued that, while client pathology continues to provide the basis of most psychotherapeutic theories and practices, research refutes the idea of the "unheroic" client (sic).

Lambert (1992, pp. 94-129) stated that 40% of the outcome was due to extratherapeutic factors, while Wampold's (2001) meta-analysis ascribes an even greater proportion of outcomes due to factors apart from therapy − 87% to extratherapeutic factors, error variance and unexplained variance, which indicates the importance and effectiveness of client's factors (see section 6.0).

Carr (2009, p. 65) noted that, clients with multiple complex co-morbid problems from problematic families with much stress and little support respond less well to therapy. While Carr (2012, p. 326) stated that distressed clients with problems of low severity with low functional impairment who are ready to change and who show an improvement early in treatment, respond well to psychotherapy. Psychological mindedness, ego strength, the capacity to make and maintain relationship, social

support and high socio-economic status are other client attributes associated with positive psychotherapy outcome. Psychologically minded individuals understand their problems as internal psychological processes, rather than blaming external factors. Ego strength is the capacity to tolerate conflicts and distress, while showing flexibility and persistence in pursuing valued goals.

Hubble *et al.* (2009, pp. 35-36) suggested, it is critically important to adjust therapy to the client: who they are, what they want and what influences the circumstances of their lives. It also means that assessments of the quality and the outcome must come from the client. The field can no longer assume that therapists know what the best is for their clients independently of them. Therapies that include the clients' ongoing evaluation of progress and feedback to the participants with that information, achieve significantly superior results (Hubble *et al.*, 2009, pp. 35-36). As the Client Directed Outcome Informed approach (CDOI) is increasingly present in therapeutic environments (see section 1.9), the idea of neglected clients might be questioned.

7.3 Therapist Factors

According to Hubble *et al.* (2009, p. 38), the therapist factors were also previously overlooked. This turns out to be a particularly remarkable error. Wampold (2006, pp. 204) found that the therapist is one the most robust predictor of outcomes of any factor studied. Wampold stated that "the variance of outcomes due to the therapist (8%-9%) is larger than the variability among treatments (0%-1%), the alliance (5%), and the superiority of an empirically supported treatment to a placebo treatment (0%-4%)".

Hubble *et al.* (2009, p. 38) noted that evidence suggests that some therapists are more effective than others. Clients of the most effective therapists, for instance, experience 50% less dropout and 50% more improvement than those seen by average clinicians. Najavits and Strupp (1994, pp. 114-123) investigated the behaviour of effective and ineffective therapists during therapy. They distinguished between positive behaviours (e.g., warmth, helping and alliance) and negative behaviours (e.g., ignoring, blaming and attacking). Effective therapists displayed more positive behaviours, fewer negative behaviours and more self-criticism than ineffective therapists. According to Carr (2012, p. 326), effective therapists are technically competent, credible and creative in their approach to help clients solve problems. Also, they are engaged, well adjusted, well trained, use therapy manual flexibly and use feedback to match their therapeutic style to client needs (see the underlined text in Table 2 for client types). Carr (2009, p. 62) highlighted that the therapist supervision is important as well. It has a beneficial impact on alliance formation, on the use of technical skills, on therapist performance and on the quality of the service that psychotherapists offer to clients.

Hubble *et al.*, 2009, pp. 38-39) asserted that the characteristics or actions of the most effective therapists are not really known, nevertheless, the evidence suggests that better therapists use common factors to achieve better outcomes. For example, Baldwin *et al.* (2007, cited in Hubble *et al.*, 2009, pp. 38-39) found that variability among therapists in terms of outcome was explained by the therapists' contributions to the alliance; better therapists formed better alliances with a range of clients. However, a paradox is created if someone attempts to operationalise common factors (Sparks, Duncan and Miller 2008, pp. 480-481). Studies show that training

therapists to focus on the alliance in the combination with the use of a manual has not been productive (Horvath, 2001, p. 370).

7.4 Consequences of Misconceptions in Identifying Therapeutic Factors

There could be problems in the interpretation of different factors and there are limitations in identifying common factors. Common factors are not fixed, they are often inseparable and they depend on the context, as Hubble *et al.* (2009) noted previously (see section 6.0). Lampropoulos (2000, p. 416) pointed out that there is a misconception and confusion between the concepts and terms of ‘‘common factors’’ and ‘‘therapeutic factors’’. Another area of confusion is the inappropriate mixing of different kinds and levels of commonalities in the study of common factors. Both misconceptions can represent sources of confusion in theory, practice and research and obstruct the development of the common factor approach.

8.0 The Therapeutic Pyramid

As many others have stated before, Fife *et al.* (2014, pp. 20-21) asserted that common factors in therapy have been found to account for more changes than therapy models. Common factors have been critiqued that they are just variables that suggest little practical guidance. Each factor has a varying degree of empirical support. So understanding the clinical and training implications is challenging, because common factors are not independent identities and investigating one factor without implicating others is impractical or impossible. However, a number of researchers have confirmed, certain common elements account for more outcome variance than others, suggesting that some factors should be emphasized over others. As a result, Fife *et al.* (2014) suggested a meta-model, which visually shows the relationship between the factors. This model focuses on how common factors interact and produce change in therapy regardless of the model used (see Figure 8). In this is a hierarchical model, techniques rest upon the quality of the therapist-client alliance, which is grounded in the therapist's way of being, which is fundamental to most aspects of effective therapy. This suggests that the effectiveness of each level depends upon the level below it and the therapist should emphasise the lower levels (Fife *et al.*, 2014, pp. 20-21).

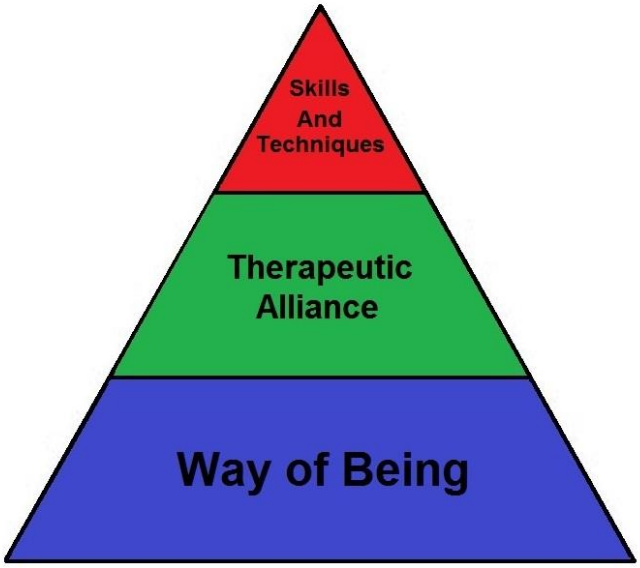

Figure 8. *The therapeutic pyramid*. Adopted from: Fife *et al.*, 2014, p. 22.

The development of *The Therapeutic Pyramid* was influenced by *The Parenting Pyramid*^{TM} (Arbinger, 1998), which suggests that there is a connection between who we are (parental way of being), our interpersonal relationships and our parenting behaviour (Fife *et al.*, 2014, pp. 21-22).

8.1 Skills and Techniques

Throughout history, the understanding of the role of models and techniques has evolved and effective specific treatments have been developed for each disorder. Nevertheless, Hubble *et al.*, (2009, p. 36) argued that the search for what works is limited to a handful of specific treatments for a circumscribed set of disorders. Since the formulation of the common factors, the discussion of models was considered separately from the contribution of hope, placebo and expectancy. Research evidence indicate that this division is not justified as models achieve their effects largely through the activation and operation of placebo, hope, and expectancy.

Hubble *et al.*, (2009, pp. 36-37) asserted that, since the comparisons of therapy techniques have found little differential efficacy, they could all be understood as healing rituals, technically inert, but nonetheless powerful methods for enhancing expectations of change. Techniques are not specifically curative, nevertheless, the packaging is important. In fact, studies have indicated, the lack of structure and focus on treatment predicts a negative outcome (Lambert and Bergin, 1994; Mohl, 1995; Sachs, 1983, cited in Hubble *et al.*, 2009, p. 37). This idea is supported by Wampold (2001) who concluded that only 1% of the psychotherapy outcome is due to specific effects, however, as it has earlier been noted (see section 6.0), a specific form of therapy is always necessary for psychotherapy in order to deliver a treatment of some kind. On the other hand, Fife *et al.* (2014, p. 23) argued that, although technical skills are necessary for a successful therapy, clients need a human being more than they need a technician. Therefore, they suggest that the theoretical knowledge and technical skill is therapeutic when it is based on factors related to the therapeutic alliance and the therapist's way of being.

8.2 Therapist's Way of Being

Interestingly, the therapist's way of being is absent from most psychotherapy literature or it is conceptualised within other factors (which might cause confusion of terminology − see also section 7.4). Nevertheless, many therapists have indirectly referred to the way of being, such as Rogers (1957), who advocated the unconditional positive regard. Fife *et al.* (2014, pp. 25-27) suggested that effective therapy involves not only what therapist do, but who they are and how they regard their clients. Way of being is a concept that reflects a therapist's in-the-moment stance toward clients and it represents an attitude that therapists have toward clients,

which provides a foundation for the therapeutic alliance. This attitude can be genuine and open to the humanity of the client or it can be impersonal and objectifying. The way of being is developed and demonstrated through relationships, which change from moment to moment and person to person.

Anderson (2006, p. 43) noted that the personal and professional way of being cannot be separated. It means there is a resemblance in the way that the therapists think about and relate to people in their private and professional life. The way of being describes how a therapist “conveys to the other that they are valued as a unique human and not as a category of people; that they have something worthy of saying and hearing; that you meet them without prior judgment". This is communicated to clients through attitude, tone, body gesture, word choice and timing.

According to Fife *et al.* (2014, pp. 25-27), therapists who value clients as individuals and put their needs first are demonstrating a way of being that is contributing to a good therapeutic relationship. For therapists who are open and feel compassion or concern for the clients' distress, the client is primary and the model or plan for the session is secondary. They are willing to modify or abandon the plan if their sense of the clients’ needs indicates to do so. Fife *et al.* (2014) highlighted that some researchers write in objectifying ways and clinical literature is often focussed on reliability, which results in scholarly precision, but strips some of the humanity from therapeutic discourse. Therefore, it is important for therapists to increase their awareness of their way of being during clinical work and training.

Conclusion

In order to find out to what extent common factors contribute to the effectiveness of psychotherapies, both the evidence-based model and the contextual model of psychotherapy have been investigated. The evidence-based model of psychotherapy focuses on specific ingredients, which are theoretically supported of being necessary for change. There are many studies that support the evidence-based model of psychotherapy − see section 3.0. These studies support the idea that some treatments are significantly more effective than others. However, due to the lack of validity and reliability of comparison studies, this hypothesis can be questioned (see section 4.0). While the medical model is popular and has been successfully applied in the context of physical medicine, the predictions of the medical model are often inconsistent with psychotherapy outcome research which brings into question the validity of Evidence-Based Practice (EBP) − see section 5.5.

On the other hand, studies that support the contextual model of psychotherapy are convincing. A series of studies indicate that approaches appear similar in effectiveness, so common factors are perhaps more important than the methods purposely employed (see section 1.0). Component studies produced no evidence that specific ingredients of psychological treatments are responsible for the beneficial outcomes of psychotherapy (see section 5.4). In addition, researchers were able to estimate the percentages of variance in effectiveness of different therapeutic factors. Both Lambert (1992, pp. 94-129) and Wampold (2001, pp. 135-207) concluded that the contribution of specific effects to the outcome of psychotherapy is small in contrast to common factors (see section 6.0). Nevertheless, it has been found that technical procedures may interfere with the outcome and a specific form of therapy is always necessary to deliver a treatment of some kind (see section 8.1).

It is worth mentioning that, although the evidence-based medical model is more popular than the contextual model of psychotherapy, the Client Directed Outcome Informed (CDOI) approach is present in contemporary research and practice, which represents the common factor approach (see section 1.9). In addition, common factors were one of the variables that influenced the growth of the integrative psychotherapy (see section 2.1). Therefore, it can be concluded that the common factor approach is partially accepted in the current psychotherapy research and practice. However, common factors might need more practical consideration, due to their effectiveness.

The limitations in outcome studies and in meta-analytic reviews prevented generalised conclusions about the magnitude of the effects and variables that mediate therapy effects. Studies employing both the evidence-based medical and the contextual model of psychotherapy are affected by limitations. There are problems with the experimental design. For instance, comparisons of different psychotherapy treatments with non-equal nature and seriousness of the disorder and patient characteristics (see section 4.1) and differences in measuring therapeutic effectiveness (see section 4.3). Also, there are confounding factors such as clients' self-generated change, spontaneous recovery and nontherapist source of assistance (see section 4.4). Besides, meta-analyses have many weaknesses, such as problems with appropriate selection of studies and Type I error (see section 4.5). Nevertheless, precise design, the careful selection of studies and rigorously conducted meta-analyses can overcome many limitations, which would provide a better picture of the effectiveness of common factors.

Although most weaknesses of comparison studies affect research foregrounding of both models, the medical model is more likely to take advantage of some of these

weaknesses in order to prove its hypothesis. For example, it has been found that when allegiance is not taken into the account, there are some differences between psychotherapy treatments, but when the therapeutic allegiance is corrected, differences between treatments disappear (see section 1.5, 1.6 and 5.3). In placebo related comparison studies, the effectiveness of the placebo treatment is compromised, because these trials cannot be double-blinded. Also, placebo controls rarely include all the common factors, so they appear less effective than other specific forms of psychotherapy treatments. In addition, EBP debate may create an unfortunate dichotomy that distracts attention from the effort to take advantage of the evidence of what makes psychotherapies effective.

There are various reasons why common factors have been critiqued and their effectiveness has been questioned. Common factors are variables that suggest little practical guidance. They are not fixed; they are interdependent, fluid, and dynamic. They cause and are caused by each other, so they constantly vary according to the context. For this reason, their effectiveness is difficult to assess and they cannot be individually operationalised. Common factors are insufficient to establish the goals of therapy, specific factors are needed for common factors to have a medium through which they operate. Consequently, even if the placebo comparison studies lack other limitations, placebo control groups might be not suitable for comparison studies because they cannot function properly without specific factors. In addition, as Baskin *et al.* (2003, p. 976) noted, in these studies, placebo controls rarely include all the components of common factors, so the validity of placebo design in psychotherapy is questionable.

Fife *et al.* (2014, pp. 20-21) also noted that common factors are not independent identities and investigating one factor without another is impossible, however, some

factors should be emphasized over others. As a result, the researchers in question developed a hierarchical model where techniques rest upon the therapist-client alliance, which is grounded in the therapist's way of being (see section 8.0). Although this model does not state the variance of percentages contributing to the effectiveness of different factors, it suggests that the effectiveness of specific factors may depend upon common factors. In addition, this hierarchical model can help pointing out some of the limitations of comparison studies and it can explain some contradictory findings in research and practice. For example, evidence shows that the therapeutic alliance makes a large contribution to the psychotherapy outcome. Therapists are more effective if they are able to form better alliances with their clients, however, as Horvath (2001, p. 370) argued, studies show that therapist training on the alliance is not productive. Nevertheless, if the therapist's capacity to help clients is observed through the structure of the therapeutic pyramid, it can be concluded that the capacity to form an alliance depends on the way of being. Therapists need to make a constant effort to focus on their way of being (in private life and practice) to increase the effectiveness of the psychotherapy they provide. In addition, the top of the pyramid can be trained (communication training, problem-solving, training in specific techniques etc.). This more holistic perspective may explain why therapists training to focus on the alliance have not been productive.

The therapeutic pyramid is a way of explaining how therapies work, however, it does not address most components of common factors (mentioned in section 7.0). For example, it ignores client factors, which perhaps accounts for the largest proportion of the psychotherapy outcome apart from therapy. It would be useful to construct a model that shows how common factors interdepend and amplify each other's effect. Nevertheless, this would be a very challenging, perhaps impossible task.

Nevertheless, as a first step, it would be useful to address some of the misconception and terminology confusion regarding common factors. In addition, more rigorous meta-studies should be conducted to have a reliable and more precise picture regarding the differences among psychotherapy treatments, while the nature and seriousness of the disorder treated should be also considered. However, perhaps the most important task is to always consider the therapist's beliefs, which affect the client's beliefs and the outcome of the therapy. In order to accomplish all these challenges, perhaps decades of research are needed and fundamental changes in psychotherapy research.

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