The Process of Change in Psychotherapy: Common and Unique Factors

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Andrew A. McAleavey and Louis G. Castonguay

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Abstract

As a field, psychotherapy has long been dominated by the different types (or orientations) of psychological therapies in practice. Though there are hundreds if not thousands of different kinds of psychotherapy, in many ways some are quite similar—they share some common factors. In other ways, each orientation may possess some unique elements, or combinations of elements not found in most other kinds of therapy: unique factors. In this chapter, we describe how the theoretical and empirical discussions of common and unique factors have progressed historically, highlighting major contributions in identifying and organizing the influential components and active ingredients of psychotherapy. It can be shown that both common factors and more unique factors can be reliably identified, and that these factors can be linked with outcome, and may both be necessary to the successful application of any psychological therapy. Ultimately, the distinction between "common" and "unique" factors may be a false dichotomy when comparing many face-to-face psychotherapies, because neither common factors nor unique factors can exist without the other. Common factors rely on specific treatments, and unique factors exist in the context of common variables.

A.A. McAleavey (✉)
Department of Psychology, The Pennsylvania State University, 346 Moore Building, University Park, PA 16802, USA
e-mail: aam239@psu.edu

L.G. Castonguay
Department of Psychology, The Pennsylvania State University, 308 Moore Building, University Park, PA 16802, USA

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15.1 The Process of Change in Psychotherapy: Common and Unique Factors

Over the last century we have seen a proliferation of varieties of psychotherapy, many with vastly different scopes and aims. This proliferation seems to have been both a cause and effect of an equally astounding number of researchers, theoreticians, and clinicians specializing and honing their practices in increasingly diverse ways. The increasing demands from governmental, healthcare, and research organizations in recent years have led to pressure on these many camps to demonstrate that their practices are effective, or else suffer the possibility of limited reimbursement, loss of clientele, or both. Despite this increased scrutiny on individual psychotherapies, it has been noted for several decades that many psychotherapies that are theoretically different (at least according to their proponents) in fact share many attributes. Rosenzweig (1936) is often regarded as one of the first to have addressed this issue, and his short article foreshadowed major themes of comparative psychotherapy research to the present: psychotherapies that are different do indeed have many similar features, and these similar features may be responsible in some way for the fact that proponents of many treatments report success. As he wrote: "besides the intentionally utilized methods and their consciously held theoretical foundations there are inevitably certain unrecognized factors in any therapeutic situation–factors that may be even more important than those being purposely employed" (p. 412). Still today, writers concerned with documenting and explaining the effects of psychotherapy have been faced with a central question: Are the effects of diverse psychotherapies due to those elements that make them unique (or specific), or are they better explained by what these diverse approaches share with one another?

While much can be said about the so-called Dodo bird verdict (Luborsky et al. 1975)—the finding that several kinds of psychotherapy produce roughly equivalent outcomes across a range of disorders—which itself is still a focus of hot debate (e.g., Crits-Christoph 1997; Norcross 1995; Wampold 2001), the subject matter of this chapter is only tangentially related to it. Though many authors view outcome equivalence as the main reason to study common factors in psychotherapy, we cheerfully disagree. Regardless of outcome, it is noncontroversial to say that psychotherapies of many origins share several features of process and content, and it follows that better understanding the patterns of these commonalities may be an important part of better understanding the effects of psychotherapy. That is, irrespective of whether some psychotherapies are equivalent to others in symptomatic outcome, understanding what part of clients' improvement is due to factors that are shared by several approaches appears to us to be a conceptually and clinically important question.

In this chapter we will examine the issue of whether common factors can be viewed as empirically and theoretically valuable, or whether they are epiphenomenal to the real work of psychotherapy. That is, are common factors real, and are they important to the therapeutic effect of psychotherapy? It is our distinct impression that the work that is undertaken in psychotherapy is much too complex and nuanced to describe common and unique factors as being mutually exclusive descriptions of psychotherapy process. Instead, we believe that the common and unique factors most likely work symbiotically (and sometimes parasitically) with one another, and it is likely that in any given psychotherapy both common and unique aspects will be present and potentially relevant. Importantly, studying the interaction of common and unique factors in psychotherapy is likely to be a productive path to improve psychotherapy as it is practiced around the world. Thus, in our opinion, the question of whether common or unique effects are more important than the other forecloses on the very reasonable conclusion that both are significant contributors to the therapeutic process, and both require further understanding.

15.2 Common Factors

15.2.1 Common vs. "Nonspecific" Factors

In this chapter we use the term "common factors" to refer to those elements of psychotherapy that are so frequently present in different psychotherapeutic treatments that they cannot be considered to be restricted to one school of psychotherapy (as discussed later, there are also some who have distinguished between common therapeutic factors and the relatively inert common factors). Though the term "common factors" has become increasingly popular, an alternative has also been present in the field: "nonspecific factors." While some authors have used the terms nonspecific and common interchangeably to refer to the construct we intend, "nonspecific" has additional meanings beyond "common," and at times some authors have used it to mean those elements of psychotherapy that are either somehow unspecified at present, inherently unspecifiable and therefore unobservable, or else elements of therapy that are auxiliary to the technical variables that are primarily responsible for producing therapeutic effects (Castonguay 1993). Many authors have suggested that since these statements are not generally true of the common factors anymore, the term "nonspecific" should be dropped from the lexicon entirely (e.g., Castonguay 1993; Castonguay and Grosse Holtforth 2005; Lampropoulos 2000; Omer and London 1989; Weinberger and Rasco 2007). As we will see, increasing evidence supports several common factors as specific contributors to the therapeutic process which have been identified, isolated, and sometimes manipulated, and the use of the term "nonspecific" to describe them constitutes an undeserved continued belittling of these important therapeutic elements.

15.2.2 Identification of Common Factors

Several attempts have been made to describe common factors of psychotherapy, based on the experience and expertise of preeminent researchers and clinicians. These attempts have been made by leaders from all orientations and schools of psychotherapy and differ in terms of scope and detail. Rosenzweig (1936) was certainly one of the first, and in his brief article he identified several possible factors that may operate across diverse therapies, including therapist adherence to a system of treatment, client developing some new understanding based on a coherent model of personality, and several "implicit" factors such as the therapist's personality and catharsis. Since Rosenzweig, several avenues of study regarding common factors have been followed.

In particular, a great debt is owed to several individuals who generated early lists and/or categories of common factors that have influenced later conceptual and empirical efforts. Though we refer later to a few works that have attempted to integrate and synthesize common factors into a single comprehensive and coherent framework, it is important to recognize the contributions of such influential figures as Frank (1961), Marmor (1976), Garfield (1980), Marks and Gelder (1966), Karasu (1986), Prochaska and DiClemente (1984), Sloane (1969), Masserman (1980), and Strupp (1973). These lists stimulated research and theory, with each taking a different approach to the common factors. Frank (1961) and Frank and Frank (1991) contributed a particularly influential list of several common factors and provided a rationale for their effects. Though few contemporary writers have maintained this distinction, Frank usefully divided the common factors into the common features (aspects of the situation,

observable components behaviors of the participants, and so on) and common functions (impacts on the client; what the therapy does to the client that is different than ordinary life) of psychotherapy. This distinction itself is an important clarifying element in dialogue regarding common factors, since it highlights what has already been discussed: while many psychotherapeutic treatments share components or observable features (e.g., a helping relationship, a socially sanctioned healing setting), the debates surrounding common factors more frequently surround the question of common functions or impacts (e.g., the significance of corrective experiences and behavior change across treatments). Frank's four common features were a helpful relationship, a healing setting, a rationale or "myth" explaining the client's problems, and a "ritual" implied by the myth that is believed to help solve the problem. The six common functions that he proposed include a decrease in alienation through the therapeutic relationship, expectations of improvement, providing new learning experiences, emotional arousal, enhancing a sense of mastery and self-efficacy, and providing opportunities for practice (Frank and Frank 1991). Although published in a book that is now more than 50 years old, Frank's list has helped to spur one of today's zeitgeists in psychotherapy: identifying, exploring, and explaining factors that cut across different theoretical orientations.

15.2.3 Integration of Common Factors

As the number of lists of common factors has increased, perhaps to the point that these "lists of lists" have become unwieldy (Castonguay 2009), several authors have attempted to organize and understand the common factors by integrating them using empirical and theoretical means. In this chapter we will focus our discussion on a few empirical approaches to documenting common factors and then describe two particularly important systems for understanding common factors that have influenced the field greatly.

One important empirical contribution is the work of Grencavage and Norcross (1990), who systematically reviewed the literature for any mentions of common factors and then divided them into thematically similar categories of common factors. These authors identified 89 distinct factors in 50 published works, which they divided into five categories: client characteristics, therapist qualities, change processes, treatment structure, and therapeutic relationship. These categories were derived from the authors' reading of the theoretical literature and are therefore quite consistent with much of the extant literature itself. Interestingly, only one of these five categories clearly corresponds with Frank's (1961) common functions of psychotherapy, while the rest may be defined as primarily common features.

Tracey et al. (2003) reported a different attempt to understand the varieties of common factors that have been identified, and in this study they used statistical dimension-reduction strategies. These authors took as their starting point the 35 commonalities identified by at least 10 % of the sample reported in Grencavage and Norcross (1990), and they then had experienced professionals and expert researchers rate these common factors for similarities. The resulting data was amenable to scaling and cluster analysis, and rather than the five categories identified by Grencavage and Norcross (1990), Tracey et al. identified three distinct clusters of common factors: bond, information, and structure. This suggests that, in terms of how psychotherapy experts think of common factors, there are essentially three different types of common factors: those related to the therapeutic relationship (e.g., warmth), those related to specific information and conceptual knowledge (e.g., direct feedback), and those related to the roles of psychotherapy (e.g., being a healer). This is a stark departure from the 89 initially found by Grencavage and Norcross (1990) and even compared to the five superordinate categories that they identified. It should be noted that this study suggests that these clusters share features in common, not that they are the same factors.

Common factors have also been identified using methods of factor analysis and self-report measures. In one recent example, McCarthy and Barber (2009) reported the development of the Multitheoretical List of Therapeutic Interventions (MULTI), which is a self-report and observer-rated measure of therapist behaviors. They developed the instrument using input from experts in several orientations of psychotherapy and showed that the subscales of this measure differentiate between seven orientations of psychotherapy and common factors in terms of the reported therapist techniques. On the MULTI, the common factors subscale comprises items on basic helping skills and relationship maintenance behaviors like focused listening and general warmth. Interestingly, in their studies and that of Boswell et al. (2010), the common factors subscale of the MULTI has been rated as more prevalent than any theory-specific subscale across several therapeutic orientations—that is, therapists in these samples typically use common factors as much or more than other techniques, when measured on the MULTI. Similarly, Larsson et al. (2010) reported another effort that identified common factors based on therapist self-report, but rather than reported or rated therapist behaviors, the Valuable Elements in Psychotherapy Questionnaire (VEP-Q) which these authors developed is based on therapists' attitudes about what is most helpful in therapy. The authors showed that the VEP-Q differentiated between cognitive-behavioral and psychodynamic therapists in terms of how much they value orientation-specific mechanisms, but these psychotherapists did not differ on how much they valued the common factors items included in the VEP-Q (which include items on the alliance, empathy, positive regard, and goals of therapy). Interestingly, psychotherapists who were treating more clients valued common factors more, holding all other variables constant. Other studies have also identified commonalities across types of psychotherapy using therapist self-report, for instance, in terms of therapists' intentions across treatment types (e.g., Hill and O'Grady 1985). Such quantitative measures provide evidence that common factors can be empirically identified as specific therapeutic interventions that cut across therapies and that, on the whole, therapists of different orientations seem to value them roughly equally.

Thus, while the number of essential common factors is in question, empirical evidence appears to support that certain aspects of psychotherapy, including both circumstances and processes of therapy, are present in many types of psychotherapy. How we understand these common factors and their operations in psychotherapy, however, is a more difficult question than whether we can simply observe them. Although several authors have offered reviews of common factors and/or models of psychotherapy based on these factors (e.g., Castonguay 2006; Weinberger 1995), two particular systems of understanding have inspired much of the theoretical and empirical work on common factors in recent decades: the Generic Model of Psychotherapy and principles of change.

15.2.3.1 The Generic Model

The work of David Orlinsky, Ken Howard, and their colleagues has been indescribably important to the study of common factors and psychotherapy process more broadly. These authors produced some important early empirical research on sessions of psychotherapy (e.g., Orlinsky and Howard 1967) and have developed a unifying framework by inductively reading the psychotherapy process research literature, known as the Generic Model of Psychotherapy, that has been applied around the world. Since one of the original purposes of this model was to organize the results of psychotherapy research studies, this model has been designed and revised so as to be inclusive of all psychotherapy events as well as extra-therapeutic environments and conditions. Recently summarized by Orlinsky et al. (2004) and Orlinsky (2009), the Generic Model categorizes processes of psychotherapy into six categories: therapeutic contract, therapeutic operations, therapeutic bond, self-relatedness, in-session impacts, and temporal patterns. While these categories are broad, they are designed to describe and organize a complex system of interconnected events, personalities,

and interactions. One of the impacts of attempting to inclusively describe all therapeutic context and activities is that the Generic Model inherently provides a framework for both identifying common factors of psychotherapy and identifying ways that theoretical orientations differ from one another. For instance, the therapeutic contract is seen in the Generic Model to be a common factor of psychotherapies. The contract itself may be quite different between a CBT and a psychodynamic treatment for depression, for instance, because in CBT the therapist is typically more didactic and directive than most psychodynamic treatments for depression (as in, for example, Jones and Pulos 1993). From a common factors perspective, however, the fact that the two treatments both create an unwritten contract regarding the role of the participants in therapy may be more significant than the differences between the two: the socialization process required by establishing a therapeutic contract in any particular model of therapy is a useful and necessary component of treatment.

The Generic Model has also inspired empirical research, such as the work of Kolden (1991, 1996) on process (e.g., client openness, therapist interventions, and therapeutic bond) and outcome (e.g., session progress). In addition, several other lines of research inspired by the Generic Model are worth noting, including dose effect and phase models of change in therapy (e.g., Howard et al. 1986, 1993) as well as patient-focused research (e.g., Lambert et al. 2001) and research on therapist effects (e.g., Lutz et al. 2007).

15.2.3.2 Principles of Change

A conceptually different paradigm for understanding common factors was put forward by Goldfried (1980), who suggested the organizing framework of *therapeutic principles* or *strategies of change*. Principles of change are likely, Goldfried suggests, to reveal more commonalities between psychotherapies because they occupy a conceptual middle ground between theories of change (how therapists suppose that meaningful change comes about, which varies widely between therapeutic approaches) and psychotherapy techniques (the interventions derived from or prescribed by the theories of change, which may also vary widely across orientations). Principles, Goldfried suggests, represent somewhat more universal aims of psychotherapies: short-term goals of therapists of nearly all orientations. This is similar to the distinction between tactics and strategies: the former representing the small-scale constituent steps (techniques) which are contextually dependent and different in every situation, whereas the latter represent general intentions or goals in the absence of any specific context (principles) but which may be applied to a situation by using any number of tactics.

Goldfried proposed five common strategies, based on clinical reasoning and a broad reading of the theoretical and empirical literature: providing the possibility of corrective experiences and new behaviors, feedback from the therapist to the client to promote new understanding in the client, promoting an expectation that psychotherapy can be helpful (that is, hope and expectancy that the client will get better), establishing the desired therapeutic alliance and relationship, and promoting ongoing reality testing by the client (Goldfried 1980; Goldfried and Padawer 1982). These principles are not meant to be inclusively descriptive of the events in psychotherapy as the Generic Model is but instead provide two noteworthy contributions with regard to the process of change. First, and as described in more detail later, they challenge the false dichotomy between common factors and unique variables by showing that some elements of therapy can be both transtheoretical (as general strategies of intervention) and unique (as when they manifest in particular ways within specific approaches). Second, they allow therapists to broaden their clinical repertoire by informing them that they can use a wide range of therapeutic procedures to achieve important therapeutic goals such as improving clients' interpersonal functioning. Thus, therapists may be more easily able to assimilate interventions that are not typically emphasized in their preferred theoretical orientation.

Goldfried showed that using principles of change, it is possible to understand why different techniques may have similar (and similarly beneficial) effects. In some ways this is the opposite side of what Messer (1986) described as "choice points" that distinguish the techniques of various therapy orientations. Messer suggested that psychotherapists of different orientations elect interventions in order to pursue theory-specific goals, whereas Goldfried's (1980) concept of principles of change suggests that sometimes the goals that therapists pursue (the clinical strategies) are the same across orientations, but it is the techniques and theory of change that are distinct to a given theory. Goldfried gives the example of psychoanalysts and behavior therapists who have noticed that the simple process of paying close attention to one's thoughts or behaviors often leads to new understandings on the parts of their patients (p. 995). Here, the intention and effect can be identical across two overtly different psychotherapy orientations, whereas the techniques that these psychotherapists use are effectively quite varied (free-associative analysis and daily monitoring of explicit behaviors). Thus, the common factors between psychotherapies may not be obvious on the level of techniques but may emerge when studying a deeper level of strategies and principles.

In fact, one of the lasting legacies of Goldfried's (1980) work has been an increase in empirical investigations of the process of change. The introduction of principles was partially responsible for a de-emphasis on technique as the only relevant process variables, including an increase in the study of the therapist's focus of intervention (Hill 2009). For instance, the Coding System of Therapist Feedback (CSTF, Goldfried MR, Newman CF, Hayes AF (1989) The coding system of therapeutic focus. Unpublished manuscript, State University of New York at Stony Brook) was developed and has been used to rate therapist comments across a range of psychotherapy orientations. Goldfried et al. (1998) used the CSTF to rate pre-defined high- and low-significance segments of psychotherapy sessions by master therapists of either cognitive-behavioral (CBT) or psychodynamic-interpersonal (PI) psychotherapy. They found that orientation was only significantly related to a few foci of intervention (e.g., CBT therapists focused more on between-session experiences, while PI therapists focused more on the therapist themselves) but that clinical significance of the segment was related to many differences. For instance, compared to the nonsignificant segments, during segments they identified as being highly significant therapists focused more on themselves, connections between time periods and people in the clients' life, new information, and the future. There were very few significant interaction effects, which in sum suggests that these therapists did not select different foci of intervention on the basis of their therapeutic orientation alone, but rather, the moments of psychotherapy identified as significant by both groups of therapists tended to have different foci than the less-significant segments. That is, master therapists from different orientations appear to focus on similar topics in general, but in moments of clinical significance, they focus on different topics than their usual while continuing to appear similar to one another. In part because of findings like this, Goldfried's work on principles of change has also been regarded as one of the key catalysts of the psychotherapy integration movement (e.g., Wachtel 2009), which has certainly come to define a major trend in psychotherapy for the last 30 years (Castonguay 2009).

15.2.4 Common Factors and Outcome

While it is clear that common factors of psychotherapy can be identified and studied empirically, the fact that diverse psychotherapies share certain features does not necessarily mean that these features actually promote positive outcomes in psychotherapy. Lampropoulos (2000) discussed this issue in some depth in a thoughtful summary of the difference between "common factors" and "common therapeutic factors," the latter of which is a label he reserved for those commonalities that have been shown to be important to the process of change. Some

common factors of psychotherapy may be ubiquitous for reasons other than their efficacy, one example being the typical length of psychotherapy sessions (frequently 45 or 50 min long), which may have started as early as psychotherapy itself but now is often perpetuated more by expectations and demands on participants' time from other activities rather than because it has been clearly demonstrated that 50 min represents an optimal dose of psychotherapy. Though 50 min is a common time, there is no sufficient evidence to say that this common factor produces psychotherapeutic change itself.

Although many common factors now have at least some empirical support as correlates or facilitators of change, many (or possibly most) have not been the focus of enough empirical research to either support or refute the significance of their role. Weinberger and Rasco (2007) provide a similar distinction and concept in what they call "empirically supported common factors." They discuss five such empirically supported common factors: the therapeutic relationship, expectations of treatment effectiveness, confronting the problem (exposure), mastery or control experiences, and attribution of therapeutic outcome. This list is hardly intended to be inclusive but rather to capture those elements of therapy that have been found to be generally beneficial and organize them in a coherent way. Lambert and Ogles (2004) provide a longer list of 32 common factors, divided into three presumed phases of treatment (p. 173). These authors contend that each of these factors has received empirical support in relation to outcome and that the process of therapy progresses in part by the provision of these common factors.

While it is clear that there are numerous reasonable approaches to this topic, in this chapter we will limit our discussion to a less-than-comprehensive discussion of the empirical support for common factors in order to accommodate a discussion of their context. Therefore, we will focus on a subset of the factors that have received recent support and accept the fact that we cannot do justice to certain common factors, despite their importance. The factors that we will touch on are Rogers' facilitative conditions and the therapeutic alliance.

15.2.4.1 Rogers' Facilitative Conditions

One of the most significant conceptualizations of the therapeutic relationship is Rogers' (1957) assertion that genuineness (congruence), accurate empathy, and unconditional positive regard are the necessary and sufficient conditions of therapeutic change (see also Chap. 11). Since this assertion, these facilitative conditions have been the focus of much research. When the American Psychological Association's Division of Psychotherapy Task Force on empirically supported therapeutic relationships organized their findings (Norcross 2002), the significance of Rogers' contribution was clear, as this task force devoted separate reviews to the effects of empathy (Bohart et al. 2002), positive regard (Farber and Lane 2002), and congruence (Klein et al. 2002). Based on these and other literature reviews (e.g., Asay and Lambert 1999; Lambert et al. 1978; Orlinsky et al. 1994), Rogers' (1957) facilitative conditions have been linked to outcome across therapeutic orientations and numerous clinical problems.

These findings have been supported by recent meta-analyses. Specifically, Elliott et al. (2011) reported a meta-analytic effect size (r) of .31 for empathy, Farber and Doolin (2011) reported $r = 0.27$ for positive regard, and Kolden et al. (2011) reported $r = 0.24$ for congruence/genuineness. Conventionally, an r value of 0.10 is considered small, 0.30 is considered medium, and 0.50 is considered large, in the psychological sciences. At first glance, therefore these effect sizes may be unimpressive—they are small to medium sized. However, aside from the fact that numerous factors impact psychotherapy outcomes, creating very "noisy" data, small correlations between process and outcome may be obtained even when the processes under investigation are important to therapy outcome. Stiles (1988) clearly described the confound of therapist responsiveness: a nonsignificant correlation between process and outcome would be expected if the process being investigated was

consistently being started and stopped in good outcome cases, modulated by the therapist to fit the client's needs and resources. This is consistent with what Horvath and Luborsky (1993) suggested regarding the alliance (which is discussed below): small overall correlations between the alliance measured at several times in therapy might be small, even smaller than the correlation would be with some specific early sessions, due to the hypothesized rupture-repair cycle that is thought to characterize successful cases of therapy. Thus, though the effect sizes of these correlations are often low, there may be reason to believe that the relatively consistent positive correlations reflect meaningful relationships between therapist facilitative conditions and outcome.

As an example, one prominent study that has influenced much of the subsequent psychotherapy research was that of Sloane et al. (1975), who conducted retrospective assessment with clients of psychodynamic psychotherapy and cognitive-behavioral therapy. Part of this process included asking clients about what aspects of their therapy they perceive to have been most beneficial to their treatment. Perhaps surprisingly, clients in both treatments identified many similar aspects of treatment as useful, nearly all of which were related to the therapy relationship and provision of basic conditions such as an understanding therapist to talk to. This suggests that, at least from the clients' perspective, relationship factors are particularly important to the process of successful therapy across treatments. Since the publication of this investigation, numerous other studies have produced similar findings, suggesting that relationship variables like empathy are related to outcome across many kinds of psychotherapy (e.g., Burns and Nolen-Hoeksema 1992).

More recently, Hoffart et al. (2009) conducted a study of residential group and individual psychotherapy for social phobia. In this study the authors had patients and therapists rate several common factors (including therapist empathy, alliance, and patient expectancies) at multiple times during treatment and also assessed symptomatic outcomes during treatment simultaneously. Using advanced statistical techniques, the authors concluded that there is general support for several common factors influencing subsequent symptomatic improvement, as evidenced for the fact that change in the common factors predicted subsequent decrease in symptoms. The authors also found some support for certain feedback loops from improved symptomatic functioning to stronger ratings of common factors, suggesting that positive therapeutic processes are self-perpetuating with improved outcome.

Drawing conclusions about direct or indirect causation between these relationship variables in psychotherapy is often difficult or impossible due to the frequency of correlational rather than experimental designs in this literature. However, some noteworthy studies have provided the empirical background for such a position. In an early attempt to assess its effect, Morris and Suckerman (1974) conducted an experimental study of therapist warmth. These authors found that systematic desensitization was more effective at reducing snake phobia when conducted by a warm therapist (speaking softly, expressing concern) than by a cold therapist, though the technique itself was delivered in both instances. Interestingly, these results were not consistent across all behavioral techniques tested using similar methods, for instance, Morris and Magrath (1979) reported opposite results for contact desensitization. Unfortunately, very few true experimental studies like these one have been conducted on common factors of therapy, and the reasons for the observed differences are not clear. Despite some limitations in the literature, these and other studies certainly suggest that the continued emphasis on basic therapeutic relationship variables in the clinical and research literature is likely appropriate.

15.2.4.2 The Therapeutic Alliance

Perhaps the most prominent common factor investigated in psychotherapy research is the therapeutic alliance, a multifaceted construct that has been the subject of over 1,000 empirical findings (Orlinsky et al. 2004) and several volumes (e.g., Barber and Muran 2010; Horvath

and Greenberg 1994) (see also Chaps. 11 and 16). The therapeutic alliance is clearly related to the provision of the facilitative conditions discussed above, but it has a distinct theoretical history and meaning. The alliance is often defined by Bordin's (1979) tripartite model, encompassing the bond between client and therapist, agreement on the goals of treatment, and agreement on the tasks of treatment. While the alliance is derived from psychoanalytic theory and research (Constantino et al. 2002), in recent decades proponents of most, if not all, psychotherapy orientations have adopted the alliance in some way (Castonguay et al. 2006). The adoption of the therapeutic alliance across psychotherapeutic orientations has come in tandem with two facts: first, that the alliance has been operationalized and studied empirically in many treatments and settings, often correlating with outcome in diverse treatments; and second, the recognition that the therapeutic alliance may differ across therapies both in terms of its role in promoting change and the way that a "good" alliance may appear.

The first fact, that the alliance has been found to be empirically related to outcome in many forms of psychotherapy, has been the subject of the majority of discussion of the alliance. Most studies and meta-analyses in this topic have found that there is a relatively small but significant positive correlation between alliance measured early in therapy and overall symptom outcome: for instance, Martin et al. (2000) found the average correlation to be $r = 0.22$ across the samples they included, and Horvath et al. (2011) found an aggregate effect of $r = 0.275$. This effect size is not overwhelmingly large, but it appears to be a robust and consistent finding in such meta-analyses.

However, there continues to be considerable controversy about what this correlation means. Several authors have pointed out that since the alliance is often measured a few sessions into psychotherapy treatment, whereas outcome is typically assessed by comparing overall change from pre- to post-treatment, it may be the case that the alliance is partially a result of early symptomatic change (e.g., Barber et al. 2010). The intricacies surrounding this issue are complex and deserve attention on their own, but suffice it to say that when researchers have attempted to statistically control for prior symptom change in interpreting alliance-outcome correlations, results have been inconsistent (Barber 2009). This has sparked perhaps the most substantial debate surrounding the alliance: whether it is a cause of therapeutic change, an epiphenomenal result of productive therapy, or a combination of useful precursor and marker of productive psychotherapy. Because of the volume of work on the alliance as it relates to outcome, the equally important investigation of the different roles of the alliance across therapy orientations has been relatively obscured.

Nevertheless, it is worth nothing that proponents of many psychotherapy orientations have reported that the alliance is an important therapy process variable in their preferred orientation, including psychodynamic (Messer and Wolitzky 2010), cognitive-behavioral (Castonguay et al. 2010), and humanistic (Watson and Kalogerakos 2010) psychotherapies. Interestingly, particular orientations also emphasize and use the alliance slightly differently. For instance, Castonguay et al. (2010) and Watson and Kalogerakos (2010) both note that the development of more directive forms of their orientations has required that the relationship and alliance be used by therapists to facilitate adherence to the prescribed processes of the treatment, but these different authors also describe the unique mechanisms through which the alliance may itself be useful in CBT (e.g., as a vehicle for social learning and in vivo behavior-modification techniques) and in humanistic psychotherapy (e.g., facilitating the client's exploration and processing of emotions).

Thus, the relationship variables in diverse psychotherapies share much in common and also differ in meaningful ways. This dynamic interplay between common and unique factors is frequently overlooked, though it has become the focus of research in more recent years (Horvath and Bedi 2002). Because of their constantly and intrinsically enmeshed effects, no discussion of common factors is complete

without a discussion of orientation-unique factors as well.

15.3 Unique Factors

Unique factors are those elements of a given type of psychotherapy that are uncommon, absent, or inert in other types of psychotherapy. Like common factors, unique factors can be divided into many different categories, including techniques (e.g., the provision of daily thought records in cognitive therapy), impacts (e.g., insight into the developmental roots and conflictual reproductions of maladaptive patterns in traditional psychoanalysis), mechanisms of change (e.g., increase in reflective functioning in certain psychodynamic approaches), and others. Since unique factors tend to be paid substantial attention in the literature, we will only provide a limited overview of this important topic here. It should be noted first that neither common nor unique factors of psychotherapy operate in the absence of the other (at least in the context of any bona fide psychotherapy), and it will be clear that this distinction between common and unique factors represents a false dichotomy. For example, an important part of the construct of the alliance is a sense of shared goals between client and therapist, but there are no goals without a theoretical forecast (most frequently based on a particular model of change) of what the immediate and long-term objectives ought to be to improve functioning and reduce symptoms.

That being said, it is clear from empirical research that a number of factors emphasized in some psychotherapeutic treatments do have support. One example of an empirically supported unique variable is homework. The incorporation of explicit and cooperatively assigned homework into psychotherapy is largely unique to cognitive-behavioral therapy (though it must be noted that integrative work in other orientations has sometimes incorporated this as well; Nelson et al. 2005). Burns and Nolen-Hoeksema (1991) have shown that client rates of completion of therapist-suggested self-help homework predict outcome of therapy in cognitive therapy for depression. Building on this, Burns and Spangler (2000) used structural equation modeling (SEM) in an attempt to separate the effects of homework on symptoms from the reverse effects and found that homework compliance was generally a more powerful predictor of symptomatic improvement than the other way around in CT for depression. This finding is consistent with theoretical formulations of CBT that suggest that homework assignments can provide opportunities for application of new skills, new opportunities for mastery experiences, generalization of learned behavior outside of the therapy hour, and increased interactions with positively reinforcing stimuli.

However, one of the best experimental designs to test any specific or unique factor in a particular therapy may be a dismantling or component analysis design, rather than the quasi-experimental designs described above. Jacobson et al. (1996) provided an excellent example of such a design, in which they treated major depressive disorder with either complete cognitive therapy or two of its components: cognitive processes aimed at changing automatic thoughts (ATs) or treatment focused solely on behavior activation (BA), which primarily consisted of activity monitoring and planning. In the Jacobson et al. study, as well as a number of subsequent explorations (e.g., Dimidjian et al. 2006), the behavioral activation treatment has been shown to be as effective in treating depression as the full CT treatment. This line of research helps support the notion that increasing enjoyable and therapeutic behaviors in the treatment of depression is an efficacious part of the CBT protocol and therefore that the techniques of providing clients with behavioral homework is a viable unique factor (though, of course, other factors in the BA treatment, including a strong therapeutic relationship, may be active as well).

While much of the published and well-controlled empirical research on psychotherapy has been conducted on cognitive-behavioral therapy, there is also support for certain unique factors from other therapies. For instance, psychodynamic researchers have focused on the technique of interpretation (especially

transference interpretations), and a body of work now suggests that interpretations are valuable unique interventions in this orientation. Interestingly, two elements of this intervention have been highlighted in the literature: frequency and accuracy.

There is some evidence suggesting that the overall frequency or concentration of interpretations is either negatively related or unrelated to outcome. Using correlational methods, both Piper et al. (1993) and Schut et al. (2005) found that the overall frequency of interpretation was not positively linked to outcome in psychodynamic psychotherapy. In addition, a recent experimental study of psychodynamic psychotherapy with and without moderate levels of transference interpretations (Hoglend et al. 2006) failed to find differences in outcome between the low transference interpretation and moderate transference interpretation groups. However, they did find that some patient variables moderated the relationship between interpretation and outcome, and subsequent analysis has suggested that, as would be expected by theory, insight mediated the effect of transference interpretations on outcome (Johansson et al. 2010). This finding suggests that interpretations are not always beneficial (so just doing more is not recommended), but when they are used in an appropriate context (and/or with attunement to the client's needs), they can be helpful.

Crits-Christoph et al. (1988) conducted an important study on interpretation accuracy, a variable that would be expected to improve the chances that an interpretation would be effective. These authors found that in cases in which therapists used more accurate interpretations (meaning that the interpretation was relevant to an important conflictual relationship theme, as rated by an independent observer), treatment outcome was better than when interpretations were less accurate. This finding held true when alliance scores were statistically controlled, which is important considering that the interpretations assessed were early in treatment but the outcome was assessed much later. Using similar methods, Crits-Christoph et al. (2010) found that accuracy of interpretation was positively related to outcome in interpersonal therapy for depression but that the opposite was true in cognitive therapy.

Andrusyna et al. (2006) also found support for the use of accurate interventions in a psychodynamic psychotherapy, but in this study the authors examined changes on shorter time spans: large intersession reductions of symptoms, or rather sudden gains. These authors found that in sessions prior to sudden gains (pregain sessions), interpretation accuracy was significantly higher than control sessions. In addition, they found a higher number of accurate interpretations in pregain sessions as compared to control sessions. Taken in total, it seems that accurate interpretation is empirically related to outcome in psychodynamic psychotherapy (but not in cognitive therapy), though the raw frequency of interpretation is less important.

It is clear from these examples that certain psychological treatments contain theoretically identified elements that can be empirically assessed, manipulated, and linked to outcome within their respective treatments and deserve the term "unique factors."

15.4 Common and Unique Factors in Context

While the evidence reviewed here suggests that both unique and common factors operate in psychotherapy, much of the discussion on this topic has either subtly or overtly assumed that only one of these groups of effects is actually essential or that one of them is inherently more important than the other. A closer examination of the issues suggests that even the conception of common and unique variables as separate entities is misguided. As Castonguay (2000) has discussed, this is a false dichotomy. That is, several theoretically unique factors operate in treatments other than the one in which they were developed, and it is more than likely that common factors *always* operate within the context of a unique psychotherapy orientation. Castonguay pointed out the necessity of understanding common factors from

an established theoretical orientation, as the case formulation derived from this orientation provides the necessary context for implementing any effective interventions, common or unique. Some empirical basis for this statement has been found. In a recent paper, Tschacher et al. (2012) used results of a survey of psychotherapy research experts to identify potential relationships between common factors and specific psychotherapy techniques. These authors found that each of the 22 common factors they included in their survey was significantly related to orientation-specific techniques in practice, suggesting that the common and unique processes of psychotherapy are systematically linked. Thus, discussing common and unique factors in absence of each other fails to reflect the complex reality of therapeutic change. Castonguay (2011) suggested that the study of two concepts could provide a useful integration of common and unique factors: faux-unique variables and change principles.

Faux-unique variables are those psychotherapeutic processes that are expected to operate within one orientation but may also be present in others, even though the theoretical framework of the other orientations may not account for them. That is, any component of psychotherapy that is claimed to be a "unique" part of a certain psychotherapy orientation may actually be found outside its orientation of origin. These faux-unique variables are not specific or intentional integrations or the result of eclectic practice but rather represent commonalities between treatments that are either not anticipated by theory or are not explicitly included within a therapist's explanation of change. The identification of faux-unique variables has been a hallmark of the integrative movement in psychotherapy for many years. There may be countless examples of identified faux-unique variables in psychotherapy. For instance, Murray and Jacobson (1971) summarized that clear processes of social influence operate in the therapeutic work of Carl Rogers, despite his original theory that his work was explicitly nondirective and exclusively enacted clients' change mechanisms. In addition, the presence (and importance) of transference in behavior therapy has been noted for many years, in spite of many behavior therapists' sense that psychoanalytic constructs are not applicable to their practice (e.g., Rhoads and Feather 1972). Several studies have also shown that emotional deepening and exploration of the past (techniques clearly associated with humanistic and psychodynamic treatments) have been linked with outcome in CBT (see Castonguay 2011).

The near ubiquity of these faux-unique variables provides both promise and disillusionment to psychotherapy researchers: On the one hand, it suggests that if we look close enough, we will find important and nearly universal processes underlying psychotherapeutic change (ultimate common factors). On the other, the observable differences between orientations would be obscured beyond recognition in this exclusively common factors description, and this may not be sufficient to guide the process of psychotherapy, as discussed above. It is difficult to conceive the provision of a stand-alone treatment that comprises all of the common and faux-unique factors of psychotherapies without incorporating any factors that could be identified as truly unique. It is just as hard to believe that any psychological treatment can be accurately described as devoid of any common factors of psychotherapy.

One path forward is provided by the second concept advocated by Castonguay (2000, 2011): Goldfried's (1980) concept of change principles. Focusing on principles can often help delineate *both* the shared and distinct features of an intervention or therapeutic process. For instance, one principle of change identified by Goldfried and Padawer (1982) is the provision of alternative views of self. While therapists from various theoretical orientations have identified this as an important task and/or goal of therapy, the technical procedures that are prescribed to achieve it vary from one orientation to another (e.g., cognitive restructuring, transference interpretation, etc.). Thus, these principles can identify empirically testable and clinically useful commonalities between treatments while simultaneously accounting for real differences between treatments in terms of both the rationale for

understanding the principles and the implementation of principles in practice.

Castonguay and Beutler (2006) provide one example of an initiative demonstrating the potential of these principles of change in improving our understanding of the process of change in the context of evidence-based practice. Castonguay and Beutler brought together many influential researchers from diverse orientations to review the research on psychological treatments for four major types of psychopathology (dysphoric disorders, anxiety disorder, personality disorders, and substance use disorders) and develop empirically anchored principles for their treatments. Of the 61 identified principles of change, the task force identified 26 of these principles that may not only cut across treatments for specific disorders but also cut across disorders—that is, principles that are likely to be beneficial when used by therapists of different orientations and when implemented for clients with diverse clinical problems. Some examples include: "Positive change is likely if the therapist provides a structured treatment and remains focused in the application of his/her interventions," and "Therapists should be able to skillfully use "nondirective" interventions" (Castonguay and Beutler 2006, p. 361). These principles are precise enough to provide clinicians with effective guidelines and/or focus of intervention, yet they also reflect strategies that are general enough that they could be implemented by various technical procedures. In doing so, they avoid the "either/or" trap of common versus unique factors and allow for a large repertoire of interventions, fostering a flexible approach to evidence-based practice.

Conclusion

The process of change in psychotherapy is extraordinarily complex. While it is important that we seek to identify the mechanisms of this change, it is equally important that we not lose sight of the variety of factors (and their interactions) involved in therapy, so that we do not oversimplify and unnecessarily limit our ability to both understand why therapy is helpful (when it is) and to further develop and improve our existing treatments as much as possible. There is good evidence to support the assertion that certain common features of several different psychotherapies are beneficial to the process of change across disorders and treatments. Similarly, there is good evidence that some treatments differ meaningfully from others and that certain productive elements of some treatments may be viewed as unique contributions from particular types of psychotherapy.

Based on this, it seems that one important goal of psychotherapy research over the next several years and decades will be to better understand how common and unique processes operate simultaneously, rather than to determine which one is the "true" or best mechanism. Several patterns and conventions may need to change in order to accomplish this goal. For instance, there is a need for more empirical studies that evaluate both common and unique effects in the same cases of psychotherapy, and it is important that we conduct more studies on the same variables in the process of different psychotherapies. Readers may have noted that many of the studies cited in this chapter have been primarily quantitative studies rather than qualitative. This represents another important area for future research: increasing the use of qualitative research methods to investigate common factors, unique factors, and their interactions. Qualitative methods (see Chap. 20) allow for a unique set of research questions and provide researchers with the opportunity to discover new phenomena that may not be easily described in quantitative studies. As an attempt to begin addressing this gap of research, a number of qualitative analyses have recently been published as part of two books focusing on specific common factors: insight or the acquisition of new understanding (Castonguay and Hill 2007) and corrective experiences (Castonguay and Hill 2012).

Future empirical studies, both quantitative and qualitative, are likely to provide the field with helpful information to improve explanatory theories of how and why different factors

of psychotherapy are beneficial. In our view, new theories are likely to be most useful if they are based on (and provide expansions to) existing theoretical structures, such as the models of personality and psychopathology that drive our major orientations at present: cognitive-behavioral, humanistic, and psychodynamic theories. That is, in our minds there is no reason to create new models of human functioning from scratch, to prevent reinventing the therapeutic wheel. Using these theories as the lenses through which we view commonalities of psychotherapy, it may be possible that we can better understand how best to help a given client that seeks treatment. In the long run, this is the most important outcome of our collective work as psychotherapy researchers, and the task is monumental. However, by proceeding in ways that will not obscure real differences between treatments while also permitting the recognition of the valuable commonalities, it is our hope that we will be able to achieve this goal sooner rather than later.

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