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"Common Factors" and "Nonspecific Variables": Clarification of the Two Concepts and Recommendations for Research

Louis G. Castonguay[1]

In the field of psychotherapy, the terms "common factors" and "nonspecific variables" are generally perceived as synonyms. However, the indiscriminate use of these concepts imposes major restrictions on understanding the factors that cut across different forms of intervention: it implicitly confines them to undefined aspects of the therapeutic relationship. In this article, an attempt is made to understand why the association or blending of the two concepts is still predominant. It is argued that the term common factors should be retained, and that it should refer to a large number of elements that are present within different dimensions (e.g., technical, interpersonal, intrapersonal, structural) of the therapeutic interaction. It is also argued that the term nonspecific variables be discarded, although it is acknowledged that the nature and the impact of many variables in the therapeutic process have yet to be specified. Finally, recommendations are made regarding which common factors (specified and not yet specified) should receive further research attention.

KEY WORDS: common factors; nonspecific variables; psychotherapy.

INTRODUCTION

A major impetus for the integration movement in psychotherapy has been the identification of therapeutic ingredients that cut across different forms of psychological intervention (Arkowitz, 1989; Beitman, Goldfried, & Norcross, 1989; Goldfried, Castonguay, & Safran, 1992). Our efforts to understand and study common factors, however, have been limited by the

[1]Behavioral Medicine Program, Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, Stanford, California 94305-5490.

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frequent use of the term "nonspecific variables" to describe them. In this article, an attempt is made to identify the consequences, as well as the source of confusion between the terms "common factors" and "nonspecific variables." To avoid future confusion, suggestions are offered regarding the use of these terms in the psychotherapy literature. Research directions are also recommended to improve our knowledge of therapeutic ingredients shared by different treatments.

COMMON FACTORS AND THE THREE MEANINGS OF NONSPECIFIC VARIABLES

Perusing the writings of some of the most influential authors of psychotherapy, one is tempted to conclude that the terms common factors and nonspecific variables are synonymous. For example, Garfield (1980) argued that in "recent years there has been increased attention paid to the potential importance of common or nonspecific factors in psychotherapy" (p. 134). An identical view was expressed by Sloane, Staples, Cristol, Yorkston, and Whipple (1975) while examining the commonalties between behavioral and psychodynamic treatments: "Acceptance into any kind of treatment arouses hope that tomorrow may be less bleak than today. This is an example of one of these common, nonspecific factors" (p. 49). Commenting on the equivalent effectiveness of different methods of therapy, Luborsky, Singer, and Luborsky (1975) wrote

> The most potent explanatory factor is that the different forms of psychotherapy have major common elements—a helping relationship with a therapist is present in all of them, along with the other related, nonspecific effects such as suggestion and abreaction. (p. 1005)

A number of other writers have implicitly or explicitly equated the two terms (Bergin & Lambert, 1978; Beutler, 1991; Cornsweet, 1983; Frances, Sweeney, & Clarkin, 1985; Frank, 1961; Omer, 1992; Omer & London, 1989; Safran & Segal, 1990; Strupp, 1973, 1992). However, it is both surprising and confusing to note that the term nonspecific variables has been used with three related but distinct meanings. First, it has referred in a very global way to several types of variables that are not specific or unique to one particular form of therapy. These include insight, corrective emotional experience, overcoming apartness, emotional release, acquisition of a sense of mastery, and behavior change (Appelbaum, 1978; Stone, Imber, & Frank, 1966). From this perspective, nonspecific variables correctly refer to factors that are common to many or all forms of intervention.

Second, the term nonspecific variables has also been used to refer to nontechnical elements that are auxiliary to the treatments (Bergin & Lam-

bert, 1978; Strupp, 1973). In this respect, the term primarily refers to interpersonal and/or social factors (e.g., talking to an understanding therapist) that can facilitate the application of therapy, but that remain different from the instrumental (i.e., specific) components of the treatment (e.g., interpretation in psychoanalysis and relaxation in systematic desensitization). These are the variables that researchers attempt to control with the use of placebo groups. As noted by Jacobson and Baucom (1977), placebo groups attempt to include all active ingredients in therapy, except for specific components of the treatment package that are supposed to be responsible for change (see Note 1).

Third, the term nonspecific variables refers to potentially active ingredients whose exact nature and therapeutic effects have not yet been determined, such as client's expectancies and involvement in therapeutic activities (Mahoney, 1977; Shapiro & Morris, 1978; Wilson, 1980).

Except for a few commendable contributions (e.g., Garfield, 1980; Kazdin, 1979), the three meanings assigned to the term nonspecific variables have rarely been presented simultaneously. Kazdin (1979) may well have provided the clearest summary of these different meanings:

> Nonspecific treatment factors have generally referred to variables common to many different techniques. Occasionally, nonspecific factors have also referred to procedural concomitants for a particular treatment technique that are not considered to be sufficient for therapeutic change.... Finally, the term nonspecific factors seems to refer to a nebulous set of variables with unclear methods of influencing behavior. (p. 850)

Of course, it is possible to find some therapeutic variables that simultaneously fit each of these three descriptions. Certain variables (the therapist's attention, for example) are interpersonal in nature, are difficult to define, and are present in most types of intervention. However, because the term nonspecific variables does not refer exclusively to elements present in most or all forms of intervention, it should not be viewed as a mere synonym for the term common factors. In fact, using these two terms synonymously imposes serious restrictions on the type and number of variables that can be considered as common factors. They first become limited to some elements of the therapeutic relationship and/or the therapist's social influence. Moreover, they also become restricted to poorly defined and researched variables. These two implications and the evidence that argues against them deserve close attention.

Procedural/Technical Similarities

As noted above, the term nonspecific variables refers in part to nontechnical (i.e., interpersonal and/or social) variables that are auxiliary to

treatment methods. If one assumes that common factors and nonspecific variables are the same set of elements, then one has to conclude that it is not possible to identify common factors at the level of procedures and techniques. Contrary to this conclusion, however, several authors have identified therapeutic techniques used in various types of therapy (e.g., Bramer, 1979; Eagan, 1986; Harper, 1974; Shectman, 1975; Sloane, 1969; Torrey, 1972). Moreover, common strategies or principles of intervention have been described by Goldfried (1980; Goldfried & Padawer, 1982). Prochaska and DiClemente (1984) have also delineated processes of change that are employed in different therapies. In addition, Tseng and McDermot (1975) have defined several therapeutic operations underlying most approaches to therapy.

Surprisingly, even some of the authors who have referred to common factors as nonspecific variables have identified several therapeutic similarities at a technical level. For example, Garfield (1980) described a large set of common procedures (e.g., interpretation, reinforcement, desensitization, relaxation, confrontation). Further, some procedures common to psychodynamic and behavioral therapy (e.g., evaluation, intervention with patient's family, correction of false beliefs) were noted by Sloane *et al.* (1975). Strupp (1973) also pointed to a number techniques by which therapists of different orientations are able to influence the client's improvement (e.g., encouragement for openness of communication, manipulation of rewards)—despite the fact that he referred to common factors as nonspecific and therefore "noninstrumental" variables.

Well-Defined Therapeutic Similarities

As mentioned earlier, the term nonspecific variables also refers to elements whose exact nature and therapeutic impact are still unclear. Assuming that the terms common factors and nonspecific variables are synonymous implies that all of the elements shared by different approaches have yet to be studied and clarified. Contrary to such a conclusion, however, several common factors have been precisely defined and submitted to empirical investigation. For instance, operant conditioning, an element often described as a therapeutic commonality (e.g., Frank, 1961; Marmor, 1971; Strupp, 1973), has been operationally defined and systematically measured in humanistic (Truax, 1966), psychodynamic (Noblin, Timmons, & Reynard, 1963), and, of course, in behavioral therapies. This is also the case for the therapist's interpersonal skills (i.e., empathy, congruence, unconditional positive regard). The importance of these variables is now recognized by therapists of all persuasions, but they are still sometimes

relegated to the inferior rank of nonspecific variables. Ricks, Wandersman, and Poppen (1976) rightly argued that behavior therapists are particularly to blame for this attitude. The authors condemned:

> the continued use of the global term "nonspecific factors" to describe the therapist's personal contribution to psychotherapy. Since the humanistic therapists have been able to be quite specific and operational about what they mean by warmth, empathy, genuineness, transparency, etc., behavior therapists should now follow their lead, discard this tired old umbrella term, and try to be as precise about the person of the therapist as they are about his methods. (pp. 385–386)

A number of other common variables have been empirically studied, and their link with client improvement documented. Among these variables are the therapeutic alliance (Gaston, 1990) and therapist feedback (Kerr, Goldfried, Hayes, Castonguay, & Goldsamt, 1992). In addition, some authors have provided fairly precise definitions of common factors, such as the therapist's modes of influence (Pentony, 1981) and the rules of communication in psychotherapy (Bandler & Grinder, 1975). It is significant that some authors who have referred to common factors as nonspecific variables have conducted and/or reported studies about the link between common factors (e.g., empathy, catharsis, alliance) and therapeutic outcomes (e.g., Frances, Sweeney, & Clarkin, 1985; Luborsky *et al.*, 1971; Sloane *et al.*, 1975).

In summary, defining common factors as nonspecific variables prevents a fair and comprehensive understanding of these factors. To be sure, such a definition implies that they are not unique to a single orientation. However, it also implies that neither their nature nor their impact have yet been determined. Moreover, such a definition constrains common factors to a set of auxiliary variables that are confusingly regrouped under the general category of "interpersonal and social factors." Such implications and restrictions are clearly arbitrary and do not respect the different types of therapeutic similarities that have been identified in the literature.

It should be noted that not all authors in the psychotherapy literature have used the two terms interchangeably. In describing the points of similarity between psychodynamic and behavioral methods, Marks and Gelder (1966) have discriminated between nonspecific common variables (e.g., placebo, client expectancies, suggestion) and "more specific common variables" (e.g., encouragement, manipulation of the environment, identification of sources of stress, identification of repetitive patterns of behavior). As noted previously, however, most authors in the field have not differentiated between the two terms.

SOURCE OF CONFUSION BETWEEN COMMON FACTORS AND NONSPECIFIC VARIABLES

The lack of a clear and accepted distinction between these two terms seems to derive from an implicit but predominant assumption that the ingredients responsible for therapeutic change can be divided into two categories of variables: the specific vs. the nonspecific variables (e.g., Arnkoff, 1983; Bergin & Lambert, 1978; Elliot & James, 1989; Jacobson, 1978; Jones Cummings, & Horowitz, 1988; Kazdin & Wilcoxon, 1976; Omer & London, 1989; Strupp, 1973, 1992). As noted by several authors, this dichotomy has been derived from the pharmacotherapy literature (e.g., Wilkins, 1985), corresponding to a crucial aspect of what Stiles and Shapiro (1989) have called the "drug metaphor." Described as an investigating paradigm adopted by most process-outcome researchers, this metaphor "views psychotherapy as comprising active ingredients, supplied by the therapist to the client, along with a variety of fillers and scene-setting features" (Stiles & Shapiro, 1989, p. 522). Within this context, the specific variables represent the techniques (or active ingredients) used by the therapist, such as interpretation of resistance or exposure to feared situations. Because the application of these techniques has been extensively described in clinical textbooks, it is assumed that their nature and impact are known; these techniques, in other words, are assumed to be *specified*. Furthermore, since most of these techniques have been defended by one orientation (and very often rejected by other approaches), they are considered to be *unique* to a single treatment approach.

This division into specific vs. nonspecific therapeutic ingredients implies that all techniques are specific (i.e., unique) to one school and generally well defined (i.e., specified). Conversely, every factor that is not a technique inevitably becomes a noninstrumental variable that is considered to have an undefined effect in all forms of treatment. Hence, from this arbitrary division of process variables, it is incorrectly deduced that all common factors are nonspecific (i.e., nontechnical and nonspecified) and that all nonspecific variables are common to all approaches.

This categorization of process variables, however, is intrinsically flawed. As mentioned previously, some techniques and procedures are not unique to one orientation. Moreover, the mechanism of change and the therapeutic impact of some techniques have yet to be specified. Humanistic therapists have developed many techniques to facilitate the exploration of client's inner experience (e.g., Gendlin, 1978), but they have generally not been eager to conduct empirical research that could clarify the nature and impact of their interventions (Wolfe, 1983). Furthermore, some nontech-

nical or interpersonal phenomena may well represent a unique aspect of a single mode of treatment. For instance, although transference has been identified in several orientations, the concept "transference neurosis" may be relatively unique to orthodox psychoanalysis.

Other authors have also pointed to flaws inherent in the specific vs. nonspecific dichotomy of therapeutic variables. Omer and London (1989) have challenged the independence assumption underlying these two types of variables. They cogently argue that, by their nature, nonspecific variables (such as the therapeutic relationship and client's expectancies) can only take place in the application of specific (i.e., technical) interventions. For these authors, any attempt to control nonspecific variables through the use of attention-control or placebo groups is logically and methodologically impossible. Unfortunately, because Omer and London (1989) explicitly equate nonspecific variables with common factors, and because they specifically refer to these variables as nontechnical (as opposed to specific variables, such as therapist's interventions), they implicitly restrict the range of possible common factors. Hence, their view precludes any consideration of similarity at the level of techniques, procedures, and intervention strategies.

The specific vs. nonspecific dichotomy was also sharply questioned in a landmark contribution by Butler and Strupp (1986). They argued that specific variables cannot be applied without the presence of nonspecific variables:

> ...psychotherapeutic techniques have no meaning apart from their interpersonal (social-symbolic) context. It is thus conceptually impossible to separate specific, active ingredient factors from interpersonal, nonspecific ones.... Indeed, psychotherapeutic technical (specific) factors must be defined with reference to the same symbolic and interpersonal realm which defines the relationship (nonspecific) factors. (Butler & Strupp, 1986, p. 33)

Like most authors in the field, Butler and Strupp (1986) implicitly suggest that nonspecific (interpersonal) variables and common factors are the same set of therapeutic elements. Again, this imposes unnecessary restrictions on the type of variables that can be described as common factors. Nevertheless, their sophisticated description of the therapeutic process is in other ways extremely relevant to the conceptualization of common factors. In particular, their recommendation to abandon the specific vs. nonspecific dichotomy implies that technical factors cutting across different approaches should be viewed as operations that take place in meaningful, interpersonal contexts. The understanding of such technical factors, therefore, requires a contextual and clinically sensitive analysis of the therapist–client interaction.

COMMON FACTORS AND NONSPECIFIC VARIABLES: WHICH TERM SHOULD WE USE?

Considering the confusion that has been created by equating common factors with nonspecific variables, one may be justified to wonder whether or not we should continue using either of these terms. It might be useful to preserve the term common factors as a generic term referring to ingredients of the therapeutic process that cut across several orientations, provided that two conditions are agreed upon. First, it should be clear that some common factors are well defined and researched, but that others need to be better understood and carefully studied. Second, it should be recognized that common factors include both technical and interpersonal variables. Even the dichotomy between technical and interpersonal is too restrictive since still other types of variables have been identified in different forms of therapy, such as numerous structural (e.g., stages of therapy) and intrapersonal (e.g., client's experiencing) factors (Castonguay, 1987; see Note 2). Hence, common factors should be defined solely as a set of variables that are present in more than one form of therapy, rather than being described as noninstrumental variables that are poorly defined.

On the other hand, the viability or utility of nonspecific variables is much more questionable. Several authors (e.g., Kazdin, 1979; Wilkins, 1979a,b) have recommended that we eliminate this concept from our scientific and professional vocabulary. Wilkins (1987a), for instance, has argued that its negative form prevents a clear conceptualization of "what is and what is not a nonspecific event." He suggested that it be replaced by the positive description of the different variables (e.g., expectancies, therapist credibility) that are generally included under the term "nonspecific." Abandoning the concept of nonspecific variables once and for all may well be an important step for psychotherapy research, as it may encourage a fine-grained analysis of all potentially crucial factors of change.

There are still a significant number of therapeutic variables whose nature and impact have not yet been clearly defined or specified. However, it is important to avoid using a general and misleading term such as nonspecific to designate these heterogeneous variables (Wilkins, 1979a). It would also be wrong to automatically assume that variables not yet specified are common to most orientations. As Wilkins (1979b) pointed out, it is possible that future studies will more clearly determine the mechanisms of change involved in so-called nonspecific variables (e.g., treatment expectancies) and may reveal that some of them represent unique aspects of a single method. Similarly, it would be incorrect to assume that the elements of psychotherapy that are still unspecified are all interpersonal in nature.

COMMON FACTORS: SUGGESTIONS FOR RESEARCH

Although therapeutic similarities have been recognized in different dimensions of the therapeutic interaction (Castonguay, 1987), not all of the common factors identified at a conceptual level have been the object of thorough empirical investigation. In this section, I will suggest some directions for future research. Although they are not meant to be exhaustive, the following suggestions concern factors that have been relatively well defined and researched as well as those for which our knowledge is still very limited.

Client's Involvement in Therapy

Among the variables that need to be better understood are the cognitive, emotional, and behavioral aspects of client's involvement in therapy. In particular, it would be important to compare specific aspects of client's experience that occur in exploratory (e.g., psychodynamic) as opposed to directive (e.g., behavioral) treatments. Factors such as client's discharge of intense emotion, expression of negative feelings, experiencing (i.e., client's immediate awareness of inner referents), and acquisition of new understanding, have all been linked to a positive outcome in exploratory modes of therapy (Orlinsky & Howard, 1986). Although they have been frequently observed in behavioral treatments (e.g., Bohart, 1982; Breger & McGaugh, 1965; Evans & Robinson, 1978; Goldfried & Davison, 1976; Levay, Weissber, & Blaustein, 1976; Locke, 1971; Segraves & Smith, 1976; Sloane, 1969; Weitzman, 1967), these factors have not been the object of much empirical research. In one noteworthy exception, Wiser and Goldfried (in press) have shown that clients in cognitive-behavior therapy are able to obtain the same level of experiencing as those in psychodynamic therapy. It is not known, however, if the clients' experiencing is differentially related to outcome in the two treatments, or if the procedures used to facilitate the experiencing level are the same in each form of therapy.

The client's experience of therapy that has been described by psychodynamic authors as transference has recently infiltrated the clinical writings of several behavioral and cognitive-behavioral therapists (e.g., Arnkoff, 1983; Kohlenberg & Tsai, 1991; Koerner & Linehan, 1992; Safran & Segal, 1990; Wright & Sabourin, 1987). Aside from anecdotal evidence, it is not clear how frequently most behavior therapists focus on the emotional reactions that the client has toward them, how helpful the exploration of such reactions is with respect to challenging of maladaptive interpersonal schemas, and how effective this type of intervention is or could be for clients' behavioral change. Although it would represent an impressive methodological challenge, it might prove fruitful to adapt an instrument such as Luborsky's Core Conflictual Theme in a way that the presence and impact of transferential reactions can be measured simultaneously in psychodynamic and cognitive-behavior therapy.

The client's lack of involvement, often referred to as resistance, has recently been identified by several authors as a transtheoretical phenomena (Arkowitz, 1992; Lecomte, 1987; Wachtel, 1982). Although previous research has shown that the client's defensiveness tends to be negatively related to outcome (Orlinsky & Howard, 1986), studies comparing different orientations have yet to be conducted on the different forms of client resistance, the various strategies and interventions used to address resistance, and the effects of such interventions.

Therapist's Involvement in Therapy

More research is also needed on different aspects of the *therapist's* involvement in therapy. Recently, the cognitive activity of therapists (e.g., inferences, intentions) has received considerable attention (see Hill, 1990; Lecomte, 1987). Kelly, Smith, Hall, and Miller (1989), for instance, have shown that the clarity of the therapist's intention is linked with client improvement. Although there is evidence that therapists of differing orientations tend to be guided by different therapeutic intentions, it would be interesting to determine if the clarity of the intention is related to the success of most forms of treatment. On a related issue, several psychodynamic research teams have demonstrated that therapist's interventions that are consistent with a case formulation are predictive of better outcome (Crits-Christoph, Cooper, & Luborsky, 1988; Silberschatz, Fretter, & Curtis, 1986). Interestingly, the exact theoretical framework guiding the elaboration of case formulations differed from one research group to another, suggesting that the veracity or comprehensiveness of the therapist's interpretations may be less important than the consistency of his/her intervention with the therapeutic conceptualization—a hypothesis that appeared many years ago in earlier work on common factors (Garfield, 1957; Marmor, 1971; Rosenzweig, 1936), and that is consonant with the current interest in constructivism and hermeneutics in psychotherapy (Bouchard & Guerette, 1991). Considering the recent emphasis given to case formulation in cognitive therapy (Persons, 1989), it might be interesting to submit this hypothesis to an empirical test employing groups of therapists of different orientations.

Therapists from most orientations acknowledge the importance of being aware of their own reactions to their clients, for both assessment and treatment purposes. Even several behavioral oriented therapists have de-

scribed as invaluable the therapeutic utility of their own reactions to clients' behavior in treatment (e.g., Arnkoff, 1983; Goldfried, 1982; Goldfried & Davison, 1976; Kohlenberg & Tsai, 1989; Safran & Segal, 1990). However, with the exception of a few recent efforts (Bouchard, Normandin, Lecours, & McNulty, 1991; Van Wagoner, Gelso, Hayes, & Diemer, 1991; see also Kiesler, 1992) not enough empirical attention has been given to the nature and impact of the therapist's reactions to the client within various forms of therapy.

Whether or not they are related to the notion of countertransference, some aspects of the therapist's cognitive, emotional, and/or behavioral involvement have the potential to jeopardize therapeutic progress. Dumont (1991), for instance, has argued that expert therapists from any orientation are prone to commit cognitive errors that prevent an adequate representation of the client's situation (e.g., failure to observe or uncover clinical data not consistent with preferred theoretical model). Are therapists of different orientations committing the same type or numbers of errors? Are some of these errors more detrimental for certain types of clients, independent of the treatment used? Can a more comprehensive or eclectic model of change decrease the probability of falling into most of the common cognitive fallacies? These questions deserve empirical attention in the near future.

Henry, Schacht, Thomas, and Strupp (1990) demonstrated that clients who were treated by hostile and critical psychodynamic therapists tended to show no positive change, or even deterioration. As noted elsewhere (Goldfried & Castonguay, 1992), there is no reason to believe that such a negative attitude would lead to different results in behavior therapy, or any form of treatment for that matter. Considering that what is directly at stake is the welfare of our clients, it is imperative to conduct research on negative interpersonal behaviors with therapists of different theoretical orientations.

Intervention Methods

As mentioned previously, several common factors have been identified at the level of therapeutic techniques (e.g., reflection, interpretation, confrontation). Wolfe and Goldfried (1988) have recommended that while it may be useful to conduct more research on the techniques that are shared by different approaches, it may be more fruitful to study therapeutic commonalities at a more global level of intervention. In this regard, Goldfried (1980; Goldfried & Padawer, 1982) has identified some general strategies or principles of intervention, such as the provision of a more realistic view of self and the world, the facilitation of corrective experiences, and the continuous testing of reality. Although these general intervention strategies are perceived as "robust clinical phenomena" (Goldfried & Padawer, 1982), they have received little attention from researchers. For instance, no study has been conducted on the potential impact of corrective experiences and reality testing in psychodynamic, behavioral, and humanistic therapies.

A strategy of intervention that has received some empirical attention is the therapist's efforts to provide the client with a more realistic perception of self and others (Goldfried, 1991). In one study, Kerr, Goldfried, Hayes, Castonguay, and Goldsamt (1992) found that when attempting to increase client's awareness, psychodynamic-interpersonal and cognitive-behavioral therapists did not differ in their degree of focus on the client's interpersonal functioning. Such a finding is consistent with the recent tendency within each major orientation to give more emphasis to interpersonal factors in their conceptualization of psychological problems (Goldfried, Castonguay, & Safran, 1992). The results of Kerr *et al.* also suggest, however, that when psychodynamic therapists focus on interpersonal issues they are more effective than when cognitive-behavioral therapists do so. Moreover, Hayes, Castonguay, and Goldfried (1992) have found that a focus on interpersonal functioning in cognitive therapy may actually interfere with client's improvement. Taken together, these findings suggest that behavior therapists can potentially learn how to address interpersonal issues in therapy from their psychodynamic colleagues, especially since many of them are beginning to pay more serious attention to the complexity of the client's interpersonal reality (see Goldfried & Castonguay, 1992).

Behavior therapists, on the other hand, may provide helpful insights to psychodynamic therapists on the general strategy of reality testing (i.e., therapists' attempts to help clients change distorted beliefs and maladaptive patterns of behaviors as they occur between sessions). A major strength of behavior therapy has been the development of techniques and procedures to facilitate the acquisition of behavioral skills and the generalization of the therapeutic learning to the client's "real life" (Goldfried & Castonguay, 1992). In a recent study, Messer, Tishby, and Spillman (1992) have developed a sophisticated coding system based on a psychodynamic formulation of change processes. This system enabled them to identify some important aspects of the therapist's interventions that facilitate client's progress at the beginning and the middle stages of therapy. This system, however, did not capture the processes of change that may have prevailed in the last stage of treatment. A behaviorally oriented therapist might suggest that in later phases of treatment, effective psychodynamic therapists implicitly or explicitly encourage their clients to try out new ways of behaving outside of the therapy office. Such encouragement, a behavior therapist would argue,

could lead to increased self-efficacy expectations, increased self-esteem, reduced depression and anxiety, and an improved sense of fulfillment at work and in relation to others.

Methodological and Epistemological Developments

Researchers should not only be concerned with what common factors should be studied in the near future, but also how we should study them. Within the last decade, psychotherapy research has been strongly criticized (Elliot, 1983; Gendlin, 1986; Safran, Greenberg, & Rice, 1988) and methodological problems associated with traditional investigations of the therapeutic process have been blamed for clinicians' lack of enthusiasm concerning the empirical findings reported in journals (Goldfried *et al.*, 1992). In reaction to such difficulties, humanistic and psychodynamic therapists have developed sophisticated qualitative methodologies to capture some of the most subtle and complex patterns of change (see Rice & Greenberg, 1984; Greenberg & Pinsof, 1986). These research methods (e.g., task analysis and interpersonal process recall) are aimed at an intensive, sequential, and contextual analysis of the therapeutic interaction, and have already led to the discovery of effective therapist tasks, as well as the intrapersonal operations performed by clients in the process of change. Because of the time required by such intensive analyses, however, most qualitative studies have been restricted to a limited number of cases, and none of them (to the author's knowledge) have presented a comparative analysis of different forms of treatments. It would be interesting to determine whether some of the processes uncovered within these approaches, such as the unfolding of problem resolution in client-centered therapy (Rice & Pila Saperia, 1984), are manifested in one form or another across different orientations. As noted elsewhere (Goldfried & Castonguay, 1992), it would be particularly important for cognitive-behavior therapists to invest more energy in developing and applying such research methodology. Although they have led the way in the evaluation of therapy outcome, cognitive-behavior therapists have much to learn from their nonbehavioral colleagues regarding process research.

Encouraging qualitative research in no way implies an abandonment of quantitative methods to study common factors. These two methodological approaches are in many ways complementary to one another (Greenberg, 1986; Mahrer, 1988). The qualitative assessment of single cases can facilitate the discovery and greater understanding of mechanisms of change, whereas the quantitative evaluation of a larger number of subjects may confirm the validity and reliability of the findings. On other hand, qualitative analyses may soon be perceived as a necessary sequence in a research program—a sequence that would facilitate the specification of the processes that are involved in the therapeutic action of any variable that has been empirically found to be related to improvement. For instance, an impressive number of quantitative studies have confirmed the predictive power of the therapeutic alliance (Gaston, 1990). Understanding the specific ways in which the therapist and client prevent or repair strains in the alliance, however, seems to necessitate an intense and fine-grained investigation of the therapeutic interaction. Although this type of research has been applied to one intervention method (Safran, Muran, & Wallner Samstag, in press), no studies have yet attempted to determine whether the contexts and sequences of the therapist and client interaction within which alliance problems emerge and get resolved are similar across orientations.

It may not be long before the application of qualitative methods provides a much deeper understanding of the mechanisms by which the active ingredients in psychotherapy, such as the alliance, permit change. Moreover, these methods may soon clarify the way in which different therapeutic elements, such as the therapist's techniques, the client's level of experiencing, and the therapeutic alliance optimally interact in the course of diverse forms of therapy. Perhaps more importantly, however, qualitative methods may soon lead to significant changes in the way psychotherapy research is conducted. By becoming acquainted with qualitative analyses, psychotherapists will undoubtedly be invited to consider methods of knowledge acquisition that are quite different from the empirical epistemology that currently dominates the field. For instance, qualitative methods as practiced in psychotherapy research are based on assumptions that are in many ways consonant with a hermeneutic epistemology—an epistemological approach based on interpretation, which attempts to understand the meaning and intention of human actions rather than explain facts (see Bouchard & Guerette, 1991; Frank, 1987; Stiles, 1991). The integration of a hermeneutic perspective (e.g., Gadamer, 1975) in our search for knowledge may well provide a more global understanding of the sociological, historical, cultural, and personal factors involved in the experience of those who participate in the act of psychotherapy, as well as those who try to make sense of it.

As cogently illustrated by Woolfolk (1992), a hermeneutic approach may well be suited to the complexity of psychotherapy, which "is part technology, part values clarification, and part the pedagogy of self-discovery and self-interpretation. It is a form of human practice that partakes of science and technology, but encompasses other forms of life as well" (p. 222). Hence, a hermeneutic approach may help us better understand some variables that, as Woolfolk aptly mentioned, are very difficult to define and

measure: clinical know-how, wisdom, and perceptiveness. There is no doubt that such factors are common to all approaches, but they may well remain unspecified if we try to understand them only from an empirical perspective.

CONCLUSION

In this paper, I have attempted to demonstrate that because common factors have been confused with the so-called nonspecific variables, they have often been relegated to the status of nebulous aspects of the therapeutic relationship. It was shown, however, that several commonalities have been identified in different dimensions of psychotherapy, and that the nature and impact of some of them have been relatively well defined. The source of confusion between the terms common factors and nonspecific variables has been traced to a predominant but flawed categorization of therapeutic elements into specific vs. nonspecific variables. It has been recommended that the term nonspecific variables be eliminated from the psychotherapy literature. Such a step would facilitate an empirical investigation of several potentially active variables that have traditionally been grouped together under an all-encompassing and confusing concept. It has also been noted that many common factors have yet to be specified. In order to better understand the nature and impact of common factors, research directions have been suggested, both in terms of factors to study and methodologies to employ.

In part, this article is a plea for a more positive consideration of the role and status of common factors in psychotherapy theory and research. However, it is far from being a call for complacency to clinicians and researchers who believe that therapeutic change should be conceptualized primarily on the basis of these variables. More work (empirical and hermeneutic) is needed to improve our knowledge of how common factors operate in various therapeutic contexts, at different phases of therapy, and for different forms of clinical problems.

ENDNOTES

1. When the placebo or attention-control groups were first developed, interpersonal and/or social variables such as the therapeutic relationship were perceived as necessary but not sufficient for change. Ironically, considerable evidence now suggests that such factors are at the core of psychotherapy effectiveness (Kazdin, 1986). To use Omer and London's (1989) methaphors, whereas nonspecific (i.e., interpersonal) variables were previously considered as "noise" to be controlled for in research designs, they now represent crucial "signal events" in treatment. As for techniques, it is now estimated that they account for a relatively small percentage of the outcome variance in psychotherapy (Lambert, 1992).

2. The categorization "technical vs. interpersonal" is not only too restrictive for an appropriate description of common factors, but it may also be inherently flawed (cf. Butler & Strupp, 1986). In this respect the technical, interpersonal, structural, and intrapersonal dimensions of psychotherapy are arbitrary distinctions that simply attempt to make sense of different therapeutic elements that are in constant interaction with one another.

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