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INTRODUCTION

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> It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity.
>
> —Charles Dickens, *A Tale of Two Cities*

Dickens, starting his celebrated novel, used the rhetorical device called *anaphora:* the repetition of a word or words at the beginning of two or more successive clauses or sentences. In so doing, he created a cadence that not only makes the passage more memorable—some might say immortal—in the annals of literature but also intensifies the emotions he intends to evoke in his readers. *A Tale of Two Cities,* as the opening foreshadows is in part a story of dualities, set in a revolution at a defining moment in history. For many, this moment meant opportunity, hope, a promise of change and modernization, and a long-awaited shift in authority and control from the privileged to those disenfranchised. For others, it was nothing more than turmoil, uncertainty, loss of power, folly, the fall of the old order, and financial ruin.

At first blush, citing Dickens's reasoned use of language and the French Revolution might be seen as far removed from contemporary psychotherapy and a singular approach to introducing the second edition of *The Heart and Soul of Change*. Of course, students of the work of the late psychiatrist and prominent exponent of common factors, Jerome Frank (1961, 1973), and that of Frank and his daughter Julia (Frank & Frank, 1991), would not find any reference to rhetoric out of place in the present context. Frank maintained

that psychotherapists and rhetoricians both rely on the stimulation of emotions and additional, shared methods to persuade and influence others to achieve improvements in personal well-being (Frank & Frank, 1991, p. 68). As in the first edition, how therapists, in partnership with their clients, achieve what they do is at the very center of this volume.

The struggles experienced and endured in the profession of psychotherapy hardly compare with the great adventure called the French Revolution. Yet, it is true that in this period of our history, it is the "best of times" and the "worst of times." This is neither a cliché nor a literary technique. Over the past decade, advances in knowledge and social changes congenial to the practice of psychotherapy are contrasted to instability, monetary anxieties, and a crisis of confidence. To date, the solutions proposed to address this dilemma are falling far from the mark. How this state of affairs has come about and what it bodes for our future is a matter of considerable debate. We are at the point that knowing what works in therapy is not enough. Delivering what works, the subtitle of this edition, is the next revolutionary step. In stark terms, taking this step is critical both for the continued success of psychotherapy as a profession and for the clients we serve.

This introductory chapter begins with a summary of the current status of the field of psychotherapy: the encouraging developments (the best of times) and the areas of concern (the worst of times). We then present briefly an integrated model of the common factors. The ensuing chapters elucidate its structure. In so doing, we avoid the dichotomy of common versus specific factors, to the extent possible, to emphasize aspects of psychotherapy that are responsible for the benefits clients experience. Our principal intent in this volume is to focus on what is therapeutic and how to deliver what works for each and every client. It is proposed that practice-based evidence brings accountability to the practice of psychotherapy and improves the quality of services.

THE BEST OF TIMES

A discussion of the circumstances—fortunate or favorable for the field—comes first. It is by no means exhaustive or intended as comprehensive, and the order of the review is not determinative of importance. Rather, it summarizes the major positive changes seen since the publication of the first edition of *The Heart and Soul of Change* (Hubble, Duncan, & Miller, 1999b).

The Decline of "Model Mania"

If anything can be said of psychotherapy, it is maturing. The days when models and theories arrived and were pursued with all the alacrity that only

the latest designer drugs could excite on the streets are over. New therapeutic approaches are still emerging, but the fire for the novel, different, and exotic therapies has for the most part been extinguished.

The University of Chicago's David Orlinsky has provided insight into the reasons for a downturn in model development. Citing Thomas Kuhn, author of *The Structure of Scientific Revolutions* (1970), Orlinsky (2006) suggested that psychotherapy has moved from the earliest stage of science, termed *pre-paradigmatic*, to the next, termed *normal science*. Thirty years ago, Orlinsky and Howard (1978) tendered that "the difficulties encountered in [the] earliest stage of science arise not from the absence of a model for research, but from the multiplicity of basic models dividing the allegiances of researchers" (p. 283). When the foregoing observation was made, *schoolism*—that is, immersion in and loyalty to a therapeutic orientation (be it psychoanalytic, behavioral, cognitive, etc.)—was the rule of the day. Those entering the field at that time tended to "work within one or another of these competing orientations, according to personal preference and the historical accidents of their training and work environs" (Orlinsky & Howard, 1978, p. 283). It is not surprising that debates were rampant and discourse was of the puerile "mine's better" sort. In this period, Strupp (1978) suggested that a newcomer's first impression of modern psychotherapy was bound to be bewilderment. One would observe "a welter of theories and practices that seemingly have little in common . . . ; a mélange of practitioners whose philosophical leanings, training, and activities are grossly divergent . . . ." (p. 3). So much disagreement provided fertile ground for the sincere, the ambitious, or the merely narcissistic to advance new therapies and inflate assertions of their effectiveness.

Gradually, the field of psychotherapy has "settled down," for lack of any better way to characterize this change. In particular, with the great "battle of the brands" (Hubble, Duncan, & Miller, 1999c, p. 5) waning, Orlinsky (2006) posited that the profession has entered a stage of "normal science":

> Research by and large has become devoted to incrementally and systematically working out the details of a general "paradigm" that is widely accepted and largely unquestioned. The research paradigm or standard model involves the study of (a) manualized therapeutic procedures (b) for specific types of disorder (c) in particular treatment settings and conditions. This is very different from the field that I described three decades ago (Orlinsky & Howard, 1978) as "pre-paradigmatic."(p. 2).

His assessment of this evolution, however, does not imply endorsement. Orlinksy (2006) made abundantly clear in his essay that despite an "implicit paradigmatic consensus," as the turnaround in the science might imply, the field is at risk of trapping itself in a "constricted and unrealistic model" (p. 2). For the purposes of the present discussion, it is sufficient to say that this phase or

current instantiation of normal science has helped quash model propagation. (Further elaboration and critiques of this "unrealistic model"—as embodied in much of the empirically supported treatment movement—are found throughout this volume, with a pointed and detailed evaluation provided by Wampold in chap. 2.) Even so, the attenuation of proliferation does not reduce the threat that one existing model, say cognitive–behavioral treatments, might be privileged over other, well-established treatments, such as humanistic and psychodynamic approaches (Wampold & Bhati, 2004).

No More Stigma

Concomitant with the profession standing down from its faddist pursuit of new treatments, another welcome change has come about. Specifically, the stigma associated with psychotherapy and psychological complaints has significantly decreased (Slife, Williams, & Barlow, 2001). A recent survey by the American Psychological Association (APA) attests to this fact (Penn, Schoen, & Berland Associates, 2004). When queried in the APA's 2004 poll, more than 9 in 10 Americans (91%) said they were likely to consult a mental health professional or recommend that a family member do so if they or a family member were experiencing a problem. The same percentage stated they would opt for a mental health professional who would emphasize talk therapy as a first course of action rather than medication. Of the respondents, 30% said they would be concerned about others finding out if they had consulted with a mental health professional, and only 20% identified stigma as a very important reason for not choosing to seek assistance. Of 12 possible reasons for not seeing a mental health professional, stigma and concerns about others' opinions ranked, in order, 11th and 12th. Lack of insurance coverage and cost of treatment were at the top of the list.

The "Therapy in America 2004" Harris Poll, acclaimed as the first of its kind to examine consumer trends and attitudes toward mental health treatment in this country, yielded similar findings (Harris Poll, 2004). On the basis of these results, the sponsors (*Psychology Today* and PacifiCare Behavioral Health) concluded that psychologically informed treatment had become an important part of American life. In effect, psychotherapy had gone mainstream, as evidenced by the following results. First, more than 1 in 4 American adults (27% of adults, or an estimated 59 million people) had received treatment for a mental health problem in the 2 years preceding the poll, through talk therapy, medication, or a combination of the two. Almost half of those surveyed (49%) knew someone who has been in treatment, and approximately two thirds (61%) said they did not view the choice to receive therapy as a mark of character weakness. Close to 4 out of 5 (79%) respondents believed that if a coworker were in therapy it would make no difference

in his or her ability to do the job, and 7% of respondents said it would actually make the coworker better able to do the job. Forty percent of adults thought that their parents would have benefited from therapy. As to stigma, just 22% expressed the fear that therapy would go on their "record," and 19% were concerned that family or friends could find out if they attended therapy.

The Profession Grows and Diversifies

Hand in hand with psychotherapy's greater acceptance in society, more and more people are entering the mental health professions. Since the publication of the first edition of this volume, the number of mental health practitioners has nearly doubled. The latest estimate pins the total at more than 800,000 (see chap. 9, this volume), with an additional 200,000 in the substance abuse field (Mulvey, Hubbard, & Hayashi, 2003). With this increase, the demographics are changing. In psychology, for example, women are becoming the majority, a development seen in other mental health professions and not only in the United States but also in Europe and Latin America. The entry of minorities into psychology and the other professions has grown as well, which reflects a change to be more representative of the culture at large. For example, the 2008 report from the APA Commission on Ethnic Minority Recruitment, Retention, and Training in Psychology indicated that between 1998 and 2003, minority student affiliate membership increased by 28.7% (APA, Office of Ethnic Minority Affairs, 2008). Additionally, between 1996 and 2004, ethnic minority recipients of master's degrees in psychology increased by 90.8%, and ethnic minority doctoral recipients in psychology increased by 16.6%. Whether these changes in the overall numbers of clinicians, including the composition of the workforce, speak to an affirmation of psychotherapy or to perceived opportunities for a career, we see here further evidence of therapy viewed as a viable and vital profession.

It Works

More good news: Psychotherapy continues to prove its effectiveness. The weight of quantitative studies consistently produces an effect size of about 0.8 standard deviations, which means the average treated person is better off than 80% of those who do not have the benefit of treatment (see chap.2, this volume; Lambert & Ogles, 2004; Wampold, 2007). These substantial benefits extend from the laboratory to everyday practice. For example, Minami et al. (2008) found clinicians in a managed care context attained effects that were comparable with those reported in randomized clinical trials for the treatment of depression. Furthermore, a real world study in the United Kingdom (Stiles, Barkham, Mellor-Clark, & Connell, 2008) comparing cognitive–behavioral

therapy (CBT), psychodynamic therapy, and person-centered therapy as routinely practiced reported large effects comparable to those attained in clinical trials.

When such findings are contrasted with results widely heralded as advances in the medical arena, psychotherapy yields significant benefits hand over fist. Rosenthal (1990) pointed out, for instance, that the large-scale clinical trial of aspirin as a prophylaxis for heart attacks produced an effect size of .03 (compared with .80 for psychotherapy as a treatment for mental health problems). It is interesting that the magnitude of the effect was thought to be so astonishing that the trial was stopped prematurely because it was decided that delivering the placebo was unethical. Such findings are not the result of cherry-picking studies from the literature. In medicine, comparatively meager outcomes are the rule rather than the exception (e.g., statins for reducing heart attacks; Carey, 2008; Lambert et al., 2003; see also Wampold, 2007, and chap. 2 of this volume).

Common Factors Come of Age

From the very beginning of psychotherapy, speculation has abounded on what causes change. With some notable exceptions (e.g., Allen Bergin, Jerome Frank, Sol Garfield, Michael J. Lambert, Saul Rosenzweig), most of the discourse has championed methods derived from theoretical approaches. The abiding faith that specific treatments that target particular psychological disorders—a kind of psychological formulary—have been or will be developed is remarkably strong. And why not? The prospect of having on hand a special psychological intervention for a given problem is very appealing (Hubble & Miller, 2004). Also, that therapists might possess the equivalent of a pill for emotional distress is one that resonates with the public and policymakers, both in government and in the insurance industry. Notwithstanding, after more than 40 years of research, evidence that specific ingredients are needed for resolving particular disorders remains conspicuously missing. The conclusion is inescapable: "Psychotherapy does not work in the same way as medicine" (Miller, Duncan, & Hubble, 2005, p. 22; see also Wampold, 2001, 2007; and chap. 2, this volume). Bluntly put, the existence of specific psychological treatments for specific disorders is a myth.

By contrast, the empirical case for the common factors is compelling. In professional parlance, *common factors* refer to ingredients or elements that exist in all forms of psychotherapy. These shared, curative factors drive the engine of therapy. The body of research amassed on the subject since the publication of the first edition of *The Heart and Soul of Change* affirms that a core group of factors shared by all treatment approaches is responsible for change. It also calls

for a major reconceptualization of psychotherapy, with particular emphasis on what constitutes the pantheoretical ingredients, how they are structured, and the way in which they interact to foster positive outcomes. Owing to the importance of these developments, an entire section (What Works in Therapy Redux) is devoted to their discussion later in this chapter.

Evidence-Based Practice Defined

Amid the evidence-based practice movement in medicine and other health professions, APA President Ronald Levant appointed the Presidential Task Force on Evidence-Based Practice (hereafter Task Force) in 2005. The Task Force (2006) defined *evidenced based practice* in psychology as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273). The APA policy reflected the "best of times" because it recognized the importance of clinical expertise, defined *evidence* broadly, and considered the client's contribution.

The first part of the definition regarding best research evidence was constructed to include "scientific results related to intervention strategies, assessment, clinical problems, and patient populations in laboratory and field settings as well as to clinically relevant results of basic research in psychology and related fields" (Task Force, 2006, p. 274). Of importance, primacy was not given to randomized clinical trials aimed at establishing the superiority of a particular treatment, as has been the standard in establishing empirically supported treatments, and the types of research that are used to investigate the importance of the common factors were honored.

Evidence-based practice recognizes the therapist as a critical element in the therapeutic equation through the importance of clinical expertise. That is, interpersonal skill—combined with the competence attained through education, training, and experience—forms an essential part of psychotherapy. Clinical expertise also includes using the best research evidence in practice. One purpose of this volume is to show how research evidence can lead to better outcomes in psychotherapy.

The third component of the definition recognizes the importance of the client's characteristics, culture, and preferences. This entails what the client brings to the therapeutic stage, as well as the fit of any intervention with the client's expectations. As indicated in the APA policy, "Services are most effective when responsive to the [client's] specific problems, strengths, personality, sociocultural context, and preferences" (Task Force, 2006, p. 278). As in the prior edition, this volume emphasizes the client as a critical part of the equation. The Task Force added that "the application of research evidence to a given patient always involves probabilistic inferences. Therefore,

ongoing monitoring of patient progress and adjustment of treatment as needed are essential" (Task Force, 2006, p. 280).

Proponents representing both sides of the common versus specific factors debate recognized that outcome is not guaranteed, regardless of evidentiary support of a given technique or the expertise of the therapist. Monitoring outcome and adjusting accordingly on the basis of client feedback—practice-based evidence—must become routine. Monitoring and feedback are primary emphases of this volume.

THE WORST OF TIMES

The suggestion that something could be amiss for professional psychotherapy must strike the reasonable person as preposterous. The field's compulsive fascination for the new and different has ended, and for many, the stigma associated with using mental health services is a relic—gone and mostly forgotten. The ranks of the profession are growing. Therapy works as well, if not better, than any other intervention aimed at promoting health and well-being. All who do therapy, or consider themselves friends of the profession, should feel buoyant, flushed with optimism, and proud of the many accomplishments of psychotherapy as a profession.

Owing to these encouraging developments, is it right to conclude psychotherapy has entered a golden age? Surely, with the discipline's greater maturity and certainty about the results of therapy and, for that matter, what works, clinicians are enjoying respect and prosperity. For the most part, it seems, therapists have the freedom to practice how they want and when and where they choose. This is an illusion, however; the mood among many therapists, far from upbeat, is best captured in one word: despair.

Psychotherapy as a Viable Profession

In the 1990s, reports emerged about the declining incomes of psychologists. A survey conducted under the auspices of *The National Psychologist* (Saeman, 1998), for instance, determined that the average income in this group had plunged notably in the preceding 30-month period. In that polling, the majority of respondents also viewed their future job prospects as negative and would not recommend that their son or daughter try psychology as a career. Leon Vandecreek (2005), then president of Division 29 of the APA (Psychotherapy), later wrote that during the past 15 years, practitioners had seen their income levels turn down and the opportunities for employment in traditional practice shrink. In the same year, Norcross (2005) documented decreased incomes for private practitioners. For those acknowledging a decline, "the mean

and median reduction in net income was 15%" (Norcross, 2005, p. 665). National surveys yielded similar results (Minami & Wampold, 2008).

Managed care and the tight-fisted financial policies of third-party payers are often cited as the usual suspects behind psychotherapists' financial woes. Doubtless, their impact is a reality, keenly felt throughout the health care industry. Nonetheless, as much as those nefarious "bean counters" might provide an easy enemy to rally against, the answer does not conveniently end there. Changes in demographics and the sheer size of the therapist workforce are contributory. Regarding the latter, as much as the profession has grown, the profession may have grown too much (see chap. 10, this volume). In short, there are more clinicians than are needed. Combined with flat utilization rates, the supply of therapists far exceeds demand, creating unrelenting downward pressures on reimbursement. The Therapy in America Survey (Harris Poll, 2004) also revealed that among those who needed treatment but chose not to pursue it, doubt about its efficacy was cited as the deciding factor after cost. If that were not enough, the APA's 2004 Survey (Penn, Schoen, & Berland Associates, 2004; a comprehensive, nationally representative telephone study) found that 78% polled identified lack of confidence in the outcome as the major reason for not seeking treatment—nearly 8 out of 10—and this figure was up 1% from the 2000 APA Survey. In comparison, only 20% identified stigma.

These data may explain why Americans are choosing to spend billions on alternative health care remedies rather than psychotherapy (Duncan, Miller, & Sparks, 2004). The data may also account for why nearly half of those who begin psychotherapy quit (Wierzbicki & Pekarik, 1993). Like it or not, this is the perception of a large segment of consumers: Psychotherapy is unable to fulfill the need for change.

These adverse findings are coinciding with other events in the mental health marketplace, which are all potentially unfriendly to the practice of psychotherapy. For one, here and abroad, and more than at any previous time in the history of the field, policymakers and payers are insisting that to be paid, therapists and the systems of care in which they operate must "deliver the goods." As Hubble, Duncan, and Miller (1999b) predicted more than a decade ago, accountability is the watchword of the day, and real returns on investment are the guiding metric. The chickens have since come home to roost. This goes beyond the mere cost-cutting and containment methods of managed care. Those who underwrite mental health services want proof. They are not willing to listen to the expert claims of the mental health guilds and their officers, especially whiny complaints that practitioners are being treated unfairly or insufficiently reimbursed for their fine work. The assertion that overall psychotherapy has proven its effectiveness year after year, study after study, is also not enough. In all, it is as though the Missouri state motto has become the mantra of the industry: "Show me."

Underutilization

Clearly, psychotherapy is an effective treatment for psychological distress. But are clients receiving the mental health services they need? Nationally, about 20% of the population obtains some service for emotional or substance abuse problems (Minami & Wampold, 2008). However, many presenting with what would be classified as a mental disorder (e.g., a *Diagnostic and Statistical Manual of Mental Disorders* diagnosis) do not receive any mental health treatment, and those who do are often treated in the medical system (i.e., with psychotropic medication, chiefly by primary care physicians). It is estimated that of those with psychological or behavioral problems, less than 16% are seen by clinicians who would offer psychotherapy (Minami & Wampold, 2008).

On the basis of national survey, Wang et al. (2005) noted that "most people with mental disorders in the United States remain either untreated or poorly treated" (p. 629). Wang et al. also reported that the problem is worse for clients most in need: "Unmet need for treatment is greatest in traditionally underserved groups, including elderly persons, racial–ethnic minorities, those with low incomes, those without insurance, and residents of rural areas" (p. 629). These findings give little cause to be sanguine.

Therapist Competency

As will be discussed later in this chapter and in several subsequent chapters, much of the variability in outcomes in therapy is due to the therapist (Kim, Wampold, & Bolt, 2006; Okiishi, Lambert, Nielsen, & Ogles, 2003; Wampold & Brown, 2005). This is a result found in day-to-day practice and in clinical trials in which therapists are first selected for their skill and then later receive training with ongoing supervision. Although it is not surprising that therapists should vary considerably in their abilities, the disturbing news is that the poorest performing therapists consistently deliver a quality of service that would be classified as second rate. Indeed, Okiishi et al. (2003) noted that "therapists whose clients showed the slowest rate of improvement actually showed an average increase in symptoms among their clients" (p. 361). Wampold and Brown (2005) found that approximately one fifth of clients receiving care from the lowest quartile of therapists achieve a reliable change in their level of functioning. This may also explain why many clients who begin therapy drop out before experiencing significant benefit. In this volume, much attention is given to the proposition that to improve outcomes, effort should be directed to the person of the therapist.

In conclusion, it is safe to say that the tide is slowly beginning to turn but the ship remains at risk of going under. Will the profession reach safe harbor before sinking? Fortunately, science and a little common sense are showing the

way. The profession has the means to (a) instill trust in the public that therapy works, (b) improve results, and (c) be accountable. To these issues we now turn.

WHAT WORKS IN THERAPY REDUX

Proving that psychotherapy is deserving of the public's confidence will not come from more attempts to design the "right" treatment. No "right" treatment exists anyway. The data are unequivocal: All treatment approaches have won, and all deserve prizes. It is time to bury once and for all the doctrine of specificity—the idea that specific treatments have differential effects for specific disorders. As Wampold (2001) reported, "Research designs that are able to isolate and establish the relationship between specific ingredients and outcomes . . . have failed to find a scintilla of evidence that any specific ingredient is necessary for therapeutic change" (p. 204; see also Ahn & Wampold, 2001; Wampold & Bhati, 2004; Wampold, 2007). For this reason, the public must learn how psychotherapy really works. Here again, the evidence is indisputable: Change as a result of psychotherapy derives from key ingredients or elements that transcend all approaches. Sharing such findings will foster the public's trust. Even more, such sharing is a professional duty owed to the consumers of psychological services.

Lambert (1986, 1992), following an extensive review of outcome research spanning decades, identified four therapeutic factors. He ranked their importance on the basis of their estimated percentage-wise contribution to outcome. The four factors were extratherapeutic variables (40%); common factors (30%); hope, expectancy, and placebo (15%); and model or technique (15%). Conceding that the percentages were not derived from a strict statistical analysis, he suggested that they embody what studies indicated at the time about treatment outcome. The first edition of this volume used Lambert's proposal as a framework for the common factors but with modification. His *common factors* were amended to *relationship factors*, a change that reflected how he actually described these variables in his works (i.e., "empathy, warmth, acceptance, encouragement of risk taking, etc." [1992, p. 97]).

As previewed earlier in this chapter (in the section Common Factors Come of Age), research findings published since the first edition of *The Heart and Soul of Change* necessitate major revisions in the conceptualization of the factors responsible for change. Specifically, data accrued from meta-analytic studies call for another look at how these elements interact and contribute to success. A reassessment of what factors to include is also required. Of singular import, Wampold's (2001) investigation of psychotherapy outcome, which serves as the foundation for the current volume, extended the understanding of the common factors—broadening an appreciation of the potency of client,

therapist, and alliance factors—while elucidating the limited impact of model differences. His analysis revealed that the differences among models accounted for only 1% of the variance of outcome, dramatically reducing Lambert's (1986, 1992) estimate of the contribution of specific effects.

There is more. The simple pie chart used to depict the relationship among the factors (Asay & Lambert, 1999; Hubble et al., 1999c) allocated to each an invariant or fixed percentage, implying that the factors were independent and the percentages additive. This apportionment of percentages also suggested that the factors were, or could be, rendered as discrete elements and thus individually operationalized. It is not surprising that over time the empirically unsubstantiated logic of specificity came to be applied to the common factors. It was as though they could be distilled into a treatment model, used to create techniques, and then administered to the client. From this point of view, if one wants a good outcome add a little more therapist–client alliance (a potent therapeutic factor), and this is how to do it: Be a good listener, reflect, nod, smile, and maintain eye contact; offer a tissue; validate; and serve coffee, tea, or bottled water. Similarly, as an antidote to despair, add client and extratherapeutic factors. Mix in two parts client strengths and a pinch of social support, all the while being sensitive to the client's stage of change.

In reality, the common factors are not invariant, proportionally fixed, or neatly additive. Far from it, they are interdependent, fluid, and dynamic. Unlike a manufacturing operation, with linear inputs and predictable outputs, therapy is a reciprocal process, in which the inputs are changed in and by the participants' interaction. In short, the role and degree of the influence of any one factor are dependent on the context: who is involved; what takes place between therapist and client; when and where the therapeutic interaction occurs; and ultimately, from whose point of view these matters are considered. Much like raw materials in nature, the common factors exist in an unprocessed or minimally processed state and must be used or acted on to create a product or structure. The eventual form a treatment assumes is thus entirely dependent on the materials available; the skills of the artisan; and most important, the desires and preferences of the end user.

To illustrate, any treatment involves specific components (e.g., reality testing in CBT), but the manner in which they unfold or are manifested depends on the interaction between therapist and client. In this respect, the therapist and client produce the treatment collaboratively. A CBT provided by an empathic and skilled therapist to a motivated client, with sufficient social support and cultural sensitivity, is considerably different from a CBT provided in a context in which those factors do not exist.

The first edition of *The Heart and Soul of Change* anticipated the transition from discrete common factors to interdependent factors that are mobilized by the delivery of a treatment. Hubble et al. (1999a) asserted that

> in contrast with the tradition of separating models and techniques from the common factors . . . theoretical models and their related techniques are included here as part of the family of common factors . . . models and techniques help provide therapists with replicable and structured ways for developing and practicing the values, attitudes, and behaviors consistent with the core ingredients of effective therapy. This nontraditional role for models and techniques suggests that their principal contribution to therapy comes about by enhancing the potency of the other common factors. . . . A way to view techniques is to see them as something akin to a magnifying glass. *They bring together, focus, and concentrate the forces of change, narrow them to a point in place and time, and cause them to ignite into action* [italics added]. (pp. 421–422)

The Common Factors in Context

What the latest science has to say about the common factors comes next. In particular, we briefly discuss four elements: client and extratherapeutic factors, models and techniques, therapists, and therapeutic relationship or alliance. Although presented sequentially, bear in mind that they cause and are caused by each other, exerting their benefits through their joint and inseparable emergence over the course of therapy. It may well be that the specific ingredients of particular therapies are related to outcomes and yet, that contribution is negligible (i.e., less than 1% of the variability; Wampold et al., 1997) compared with the potency of the common factors working together.

Client and Extratherapeutic Factors

These factors encompass all that affects improvement independent of treatment. As any therapist knows, clients come to therapy with varying degrees of motivation and with varying degrees of internal and external resources. Once clients are in therapy, events beyond the control of the therapist and the client occur, and these events influence the outcome of therapy. Research has demonstrated the importance of clients' readiness for change, strengths, resources, level of functioning before treatment, existing social support network, socioeconomic status, personal motivations, and life events.

As discussed in chapter 3 of this volume, in many ways clients are the most neglected therapeutic factor in studies of psychotherapy. Descriptions of consumers are frequently circumscribed, limited to portrayals as the poster children of dysfunction. It is more realistic to describe clients as people who are having trouble in life, have made valiant attempts to change, and use therapy constructively (Bohart & Tallman, 1999; Duncan et al., 2004; Hubble & Miller, 2004; Linley & Joseph, 2004; Seligman, 2002). The latest data challenge the field to leave behind the belief that therapy is reducible to a set of

diagnostic or classification schemes and formulaic practices. To quote Lambert, Garfield, and Bergin (2004), "Clients are not inert objects or diagnostic categories on whom techniques are administered. They are not dependent variables on which independent variables operate . . . people are agentive beings who are effective forces in the complex of causal events" (p. 814).

As basic as it is to adjust therapy to the client—a complete commitment to "starting where the client is at"—it is critically important. In practical terms, without preconceptions, this means organizing clinical services to clients: who they are, what they want, and what constitutes and influences the circumstances of their lives. It also means that assessments of the quality and the outcome must come from the client, the ultimate beneficiary of the service. The field can no longer assume that therapists know what is best independent of consumers. As later chapters show, regardless of the theoretical orientation, therapies that include the client's ongoing evaluation of progress, as well as feedback to the participants with that information, achieve significantly superior results.

Models and Techniques

Over the past decade, while the profession as a whole has confined its search for what works to a handful of specific treatments for a circumscribed set of disorders, the editors' understanding of the role of models and techniques has evolved in a major way. Since the first formulation of the common factors, any discussion of models was considered separately from the contribution of placebo, hope, and expectancy (see Asay & Lambert, 1999; Hubble et al., 1999b; Lambert, 1986; Miller, Duncan, & Hubble, 1997). The latest evidence indicates that this division is no longer warranted. Models achieve their effects in large part, if not completely, through the activation and operation of placebo, hope, and expectancy. In fact, when a placebo or technically inert condition is offered in a manner that fosters positive expectations for improvement, it reliably produces effects almost as large as a bona fide treatment (Wampold, 2007). Studies further show that when researchers and practitioner's allegiance to a method is added, the variability attributable to differences in models is almost, if not entirely, explained (see, e.g., Miller, Wampold, & Varhely, 2008).

At the core, model or technique factors induce positive expectations and assist the client's participation in healthy and helpful actions. Common to all treatments, they offer the client an appropriate explanation for his or her difficulties and set forth strategies for problem resolution (Frank & Frank, 1991; Wampold, 2007). Because comparisons of therapy techniques have found little differential efficacy, they may all be understood as healing rituals—technically inert, but nonetheless powerful, organized methods for enhancing expectations of change—the so-called and perhaps poorly named *placebo*

factors. That they are not specifically curative should not be construed to imply anything goes in a therapy. Packaging is important. In fact, studies conducted have indicated that a good predictor of a negative outcome is a lack of structure and focus in treatment (e.g., Lambert & Bergin, 1994; Mohl, 1995; Sachs, 1983).

Owing to these findings, we conclude that what happens (whether a clinician is confronting negative cognitive schema, addressing family boundaries, or interpreting transference) is less important than the degree to which any particular activity is consistent with the therapist's beliefs and values (allegiances) while concurrently fostering the client's hope (expectations). Allegiance and expectancy are two sides of the same coin: the faith of both the therapist and the client in the restorative power and credibility of the therapy's rationale and related rituals. Though rarely viewed in this way, models and techniques work best when they engage and inspire the participants.

The Therapeutic Relationship/Alliance

Of those factors directly related to treatment outcome, one of the largest contributors to outcome is the therapeutic relationship, which encompasses a wide range of variables found among therapies, no matter the therapist's theoretical persuasion. Therapist-provided variables, especially the core conditions popularized by Rogers (1957), have not only been empirically supported but are also remarkably consistent in client reports of successful therapy (Norcross & Lambert, 2005).

Evidence regarding the power of the alliance is reflected in more than 1,000 findings (Orlinsky, Rønnestad, & Willutzki, 2004). Researchers repeatedly have found that a *positive alliance*—that is, a partnership between the client and therapist to achieve the client's goals (Bordin, 1979)—is one of the best predictors of outcome (see chap. 4, this volume; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Depending on which study is cited, the amount of change attributable to the alliance is five to seven times greater than that of specific models or techniques (Horvath & Symonds, 1991; Martin et al., 2000; Wampold, 2001).

Consider several other interrelated findings. First, studies indicate that clients' evaluations of the alliance are better predictors of outcome than therapists' (Bachelor & Horvath, 1999). Second, little or no correlation exists between the length of treatment and the strength of the alliance. Third, the alliance is predictive of outcome across different types of therapy and is even predictive of outcome in psychopharmacotherapy. And finally, alliance formation at the initiation of therapy is predictive of outcome and not merely an artifact of improvement (Baldwin, Wampold, & Imel, 2007; Horvath & Symonds, 1991).

The alliance, however, is not independent of other factors. Clients come to therapy with an attachment history and varying capacities to form a relationship with the therapist. However, it is the therapist's ability to forge a collaborative relationship with the client that is predictive of outcome (Baldwin et al., 2007). Because the alliance involves agreement about the tasks and goals of therapy, it is not really possible to form an adequate alliance without a treatment; that is, the alliance comes about within the context of the treatment. The therapist needs to present a cogent rationale to the client, offer an adequate explanation for the presenting problems, and implement a set of procedures consistent with the rationale and explanation to develop properly a working alliance.

Taken together, these data, yet again, point to the importance of starting where the client is. Therapists cannot presume that given enough time a good alliance will develop. Instead, they must ensure that from the first moments of the therapeutic encounter, the client is experiencing the relationship as meaningful and positive. The simplest course of action is to solicit the client's perspective regarding the relationship (see chaps. 4 and 8).

Therapist Factors

In this volume, a new addition to the list of curative factors is the person of the therapist. That the therapist was previously overlooked turns out to be a particularly egregious omission. Available evidence documents that the therapist is the most robust predictor of outcome of any factor ever studied. As Wampold (2005) summarized, "The variance of outcomes due to therapists (8%–9%) is larger than the variability among treatments (0%–1%), the alliance (5%), and the superiority of an empirically supported treatment to a placebo treatment (0%–4%)" (p. 204).

Research confirms what everybody knows but at the same time is unwilling to acknowledge or explore: Some therapists are more effective than others. Clients of the most effective therapists, for instance, experience 50% less dropout and 50% more improvement than those seen by average clinicians. Many variables widely and enthusiastically believed to be determinative (e.g., age, gender, years of experience, professional discipline, degree, training, licensure, theoretical orientation, amount of supervision, personal therapy, specific or general competence, use of evidence-based methods) do not account for the variability among practitioners (Beutler et al., 2004; Miller, Hubble, & Duncan, 2007). Unfortunately, the characteristics or actions of the most effective therapists are not really known (Beutler et al., 2004), but the evidence suggests that better therapists use the common factors to achieve better outcomes. Take, for example, the alliance. Baldwin et al. (2007) found that variability among therapists in terms of outcome was explained by the therapists'

contributions to the alliance; that is, better therapists formed better alliances with a range of clients. This finding suggests that helping therapists in building relationships may represent an arena for influencing outcome due to the therapist. Several chapters in this volume (8, 9, 10, 11, 12, and 14) address how systematic client feedback can improve individual therapist performance.

MOVING FROM WHAT WORKS TO DELIVERING WHAT WORKS

Understanding and disseminating the science of the common, therapeutic factors—how therapy really works—can go a long way toward restoring public confidence. It does not, however, address the issue of accountability. Meeting that challenge requires a major shift in the traditional way psychotherapy has been conducted and researched. It is no longer a matter of which therapeutic approach is best. Rather, it is about showing that a treatment, conducted by a given therapist with particular client at specific time and place, yielded positive results. A little reflection reveals that what payers and consumers want is the "right" outcome. They could not care less how it comes about, they simply want it. In this case, "right" means that a treatment worked and that the money paid was well spent.

Building a practice around the right outcome is not difficult. It is part of the culture; people are accustomed to it and expect it. It is the way businesses are successful. They begin with the customers and concentrate on their needs. Then, they concern themselves with the delivery of what the customer wants (Levitt, 1975; Miller, Duncan, & Hubble, 2004). Those who succeed in a competitive market stay results driven and people focused; work with their customers to create enduring partnerships; and, when required, are ready to act as champions for their customers.

Within the profession, researchers are already making the shift. They are setting aside evidence-based practice, in which the emphasis is placed on the treatment itself, in favor of *practice-based evidence* (Anker, Duncan, & Sparks, 2009; Barkham et al., 2001; Duncan et al., 2004; Miller et al., 2005). In practical terms, this means not only gathering data on how treatment is working for a particular client and therapist pairing but also then providing feedback to the therapist about the client's improvement (Howard, Moras, Brill, Matinovich, & Lutz, 1996). The results are impressive (Anker et al., 2009; Lambert, 2005; Miller, Duncan, Brown, Sorrell, & Chalk, 2006). The combination of measuring progress (i.e., *monitoring*) and providing feedback consistently yields clinically significant change, with treatment effects outstripping whatever has been seen in the so-called empirically supported psychotherapy literature. Rates of deterioration are cut in half, as is dropout. Include feedback about the client's formal assessment of the relationship, and the client is less

likely to deteriorate, more likely to stay longer, and twice as likely to achieve a clinically significant change (see chaps. 8, 10, 11, 12, and 13, this volume).

Feedback also allows psychotherapy to be individualized taking into account treatment response and client preference. Client-based feedback, therefore, remedies any rigid interpretation of the common factors, enabling a reliable and valid method of tailoring services to the individual. It allows the therapeutic factors to be delivered to one client at a time.

Monitoring combined with feedback is a simple method, divorced of theoretical baggage, for providing accountability. The results are apparent to all who have an interest in the outcome: therapists, consumers, administrators, and payers. Accepting the premise that therapeutic factors constitute the engine of change, then monitoring and feedback offers the means to deliver them. Many are anxious about the future and deservedly so. At the same time, the profession has the opportunity to establish itself in its own right. Psychotherapy works. It works. Therapists now have the ability to show it and the means to banish the despair in the workforce. The challenge is to put it into practice.

In the end, monitoring outcomes may provide a common ground for those who advocate empirically supported treatments and those who espouse the importance of the common factors. Improvement in the results attained by clients in actual practice is and should be the shared goal. Leaving behind the polemic of what is specific or common, this edition of *The Heart and Soul of Change* focuses on methods for promoting excellent outcomes across all systems of care. In short, we want the best for those who seek help from psychotherapists.

ORGANIZATION

The Heart and Soul of Change, Second Edition: Delivering What Works in Therapy is intended, as was the first edition, as a crossover work for researchers, teachers, students, and practitioners. Each chapter provides thorough coverage of the research on the topic under review. Plus, the chapters specify the day-to-day implications of the latest research findings. As before, all chapters end with questions from the editors and the contributors' responses. These questions, requesting further reflection, provide the authors an opportunity to candidly discuss the implications raised in their work. The organization of the book follows, with synopses of each chapter.

The book is divided into four parts. Part I, What Works and What Does Not, consists of six chapters. In chapter 2, Wampold reviews the evidence regarding the efficacy of psychotherapy, contrasting the medical model with a common factors paradigm and setting the stage for the rest of the book. In

chapter 3, Bohart and Tallman argue that despite their powerful contribution to treatment outcome, clients are without doubt the most neglected therapeutic factor in studies of psychotherapy. Norcross follows in chapter 4 with a discussion of the importance of the therapeutic relationship and the research that supports this factor. Rounding out the common factors covered in this section, Anderson, Lunnen, and Ogles, in chapter 5, thoughtfully address the role of models and techniques, arguing convincingly that the power of treatments resides largely in the provision of a credible myth and a healing ritual.

The next two chapters in Part I challenge popular claims about psychotherapy and psychopharmacology. In chapter 6, Littell provides a practical template and examples for scrutinizing the claims regarding the superior efficacy of empirically supported treatments. Sparks, Duncan, Cohen, and Antonuccio, in chapter 7, demonstrate that drug effectiveness is overstated and variables other than the psychoactive properties of medications account for a significant portion of the outcomes. Like Littell, the authors provide a method for evaluating the claims of psychopharmacotherapy.

Part II, Delivering What Works, covers the newest common factor: the therapist. It also describes how the field can shift toward practice-based evidence. In the first of three chapters in this section, Lambert (chap. 8) answers the question he and his colleagues posed in an influential previous article (Lambert et al., 2003): Is it time for psychotherapists to routinely track outcome? He reviews the evidence about client feedback, making a strong case for an affirmative reply. Lambert also surveys available systems of outcome management. Building on a review of therapist variability and current trends in managed care, Brown and Minami (chap. 9) assert that achieved outcome is emerging as the ultimate arbiter of reimbursement. They make the provocative argument that therapist variability points to a need to validate psychotherapists, not psychotherapies. Bohanske and Franczak (chap. 10) uniquely combine the consumer and recovery movements to present an innovative application of the common factors in public behavioral health. They demonstrate through the experiences of two large community behavioral health organizations that transformation of public behavioral health can occur when a consumer-directed, outcome-informed infrastructure is in place.

Part III, Special Populations, reviews the common factors and their application with diverse groups and differing modalities of service. Kelley, Bickman, and Norwood (chap. 11) cover child and adolescent therapies; Sparks and Duncan (chap. 12) address marriage and family therapies; and Mee-Lee, McLellan, and Miller (chap. 13) discuss addiction services.

Finally, Part IV, Conclusions, contains the last chapter: In it we distill the implications from all the contributors. The final chapter also comments on the exciting findings emerging from practice-based evidence and explores the new frontier of therapist variability. Identifying the best from the rest and

studying how they do therapy provides insight into what makes for excellence as a therapist. Finally, we speculate on what the future might hold, and although caution is warranted, hope is in the forecast.

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