# 1

# What Is Responsible for Therapeutic Change?

## *Two Paradigms*



*What is responsible for therapeutic change?* Science offers many examples of misguided assumptions about causality. Until the early 1980s, the majority of physicians as well as lay people believed peptic ulcers were caused by worry, stress, and personality variables (or by excessive coffee drinking or spicy foods). Today we know that about 90% of peptic ulcers are primarily caused by the *H. pylori* bacteria, which typically can be treated successfully through a 1- to 2-week regimen of antibiotics.

When I (D. H. S.) was growing up, most people thought "good foods" were those rich in vitamins. I was encouraged to eat a lot of spinach since it was high in vitamins A and C. I was discouraged from eating blueberries since they had few vitamins and therefore did not contain the essential ingredients that caused good health. Now we know that phytochemicals make a much greater contribution to wellness and that some foods like blueberries, with relatively few vitamins, are loaded with phytochemicals that powerfully promote health. In this instance, while vitamins contribute to good health, they turned out to be not as central as science had previously assumed.

This book challenges the commonly held assumption that what causes change in psychotherapy is primarily the unique ingredients in therapy models and techniques. While, like vitamins, these ingredients are typically beneficial and we hold them in high regard, we nonetheless challenge their centrality in the process of change. We

also think that the question "What is responsible for therapeutic change?" should be incredibly important to the psychotherapeutic practitioner, as well as to the theoretician and the researcher. For the answer surely guides what we do in the consulting room, determines how we view or explain what we do, and should be the focus of what we investigate.

Our answer to this question differs from how we (the three authors of this book) were trained and goes against the grain of most of the most powerful forces in the psychotherapy establishment. This book sets forth an emerging paradigm (common-factors-driven change) of why therapy works, with a special emphasis on how this paradigm plays out in couple and family therapy. In brief, this paradigm suggests that psychotherapy works predominantly not because of the unique contributions of any particular model of therapy or unique set of interventions (what we call the model-driven change paradigm) but rather because of a set of common factors or mechanisms of change that cuts across all effective therapies. We further believe that this emerging view has powerful implications for therapists, supervisors, and trainers, and that mastering this approach will improve your results.

As is discussed in more detail in the next chapter, while we call it "emerging," this paradigm is not technically "new." Its roots go back over 70 years, and there has been a vocal minority of scholars and clinicians within psychotherapy that has long advocated for it (Karasu, 1986; Lambert, 1992; Lambert & Ogles, 2004; Luborsky, Singer, & Luborsky, 1975). There has also been a small group of relationship therapists (Hubble, Duncan, & Miller, 1999) upon whose ideas we have built the particulars of our approach. But the paradigm remains "emerging" in the sense that it remains a countercultural minority position that is not consciously at the center of the practice of most psychotherapists or important to the major funding agencies like the National Institutes of Health (NIH) or the psychotherapy research establishment. These groups largely remain committed to the model-driven paradigm.

The three authors of this book are all practicing therapists (with a special emphasis in couple and family therapy). Although we also teach and do research at universities, we see individuals, couples, and families on a daily basis and have the hearts of clinicians. Because we work in the trenches, we will endeavor to speak to practitioners as the primary audience for this book. We also, however, share a lifelong passion for thinking about why change occurs, and we believe that

theory-driven (as opposed to "seat-of-the-pants") therapy is likely to be more coherent and effective. Hence, we try to engage you, the reader, in the theoretical rationale for our approach under the assumption that there is "nothing as practical as a good theory." Finally, we are also applied researchers who value evidence. We came to believe in this emerging paradigm because we thought the evidence for it is more compelling than for the earlier paradigm. Wherever possible, then, we do not expect you simply to take our word for these ideas but instead offer data that we think support the emerging paradigm. In sum, this book is written for practitioners and students who are open to being theoretically and research-informed.

## Two Paradigms of Therapeutic Change

If you ask most psychotherapists why change occurs, they would explain the process primarily in terms of their preferred model of change. A structural family therapist, for example, might say that change occurs when the therapist facilitates families' changing their organizational pattern—like from rigid or diffuse boundaries to clear boundaries. A narrative therapist might say that change occurs when therapists encourage clients to reauthor their lives from disempowering, subjugated life stories to self-narratives that are empowering and self-efficacious. Common factors that cut across all successful therapies might be mentioned and might even be valued (considered necessary), but they would not likely be considered the major reasons that change occurs. Instead, the emphasis would be on the unique contribution of the model.

If you had asked all three of us the same question 10–15 years ago, we probably would have probably answered it in terms of the earlier paradigm. For me (D. H. S.), it would have never occurred to me to think otherwise. Remember that a paradigm is a large interpretive framework that shapes how we see things, and until and unless we undergo a paradigm shift, it is almost impossible for us to view things differently. When I came into the couple and family therapy field in the 1970s, it was the "golden age" of the great model developers, and I remember being mesmerized at workshops by such luminaries as Salvador Minuchin, Carl Whitaker, Virginia Satir, Jay Haley, and James Framo. What these people seemed to be doing with clients was so remarkable that I never questioned that what was responsible for therapeutic change was anything other than the specific contribu-

tions of each model. For me, the only real question was which models were "true" and which model or models should guide my work.

Couple and family therapy, of course, is not unique in its fascination with models. At least 400 different models of psychotherapy have been documented as model developers have continued the unending quest to answer the question that opened this chapter. Indeed, this proliferation of models led Sol Garfield (1987) to quip, "I am inclined to predict that sometime in the next century there will be one form of psychotherapy for every adult in the Western world" (p. 98). One potential benefit, then, of adopting the new paradigm is that it may no longer be necessary to continue inventing new models (Sprenkle & Blow, 2004a)!

Some of the major factors that distinguish the two paradigms—old and new—are depicted in Figure 1.1. In the explanations that follow the figure, we make clear that the two paradigms are not polar opposites but rather represent matters of emphasis that probably exist along a continuum. We also believe that there is some merit to the model-driven change paradigm. We will elaborate on these ideas in Chapter 5 when we talk about our "moderate" approach to common factors.

More details of the two paradigms will be supplied in later chapters. In keeping with our thesis that the two paradigms are not

| **Model-driven change** | **Common-factors-driven change** |
|---|---|
| Primary Explanation for Change | |
| Emphasizes the unique elements and mechanisms of change within each model. | Emphasizes the common mechanisms of change that cut across all effective psychotherapies; models are the vehicles through which common factors operate. |
| Guiding Metaphor | |
| *Medical*: considers treatment as analogous to medical procedures and drugs. | *Contextual*: believes such qualities as credibility, alliance, and allegiance "surrounding" the treatment are more important than the unique aspects of treatment. |
| Therapists' Role in Change | |
| Emphasizes the treatment that is dispensed rather than who offers it. | Asserts that the qualities and capabilities of the person offering the treatment are more important than the treatment itself. |

(*continued*)

| Clients' Role in Change | |
|---|---|
| More therapist-centric: although therapy can be collaborative, places greater emphasis on the value of the therapist's performing the treatment in a *specified manner*; and invests a stronger conviction in clients using the treatment in the ways the therapist intends and recommends. | More client-centric: places less importance on performing the treatment in a specific way and more on improvising to match the clients' needs and world views; and invests a stronger conviction in clients using whatever is offered in therapy for their own purposes in often unique and idiosyncratic ways. |
| **Place in the Culture** | |
| Most funded research (e.g., NIH research) emphasizes this paradigm; represents the majority voice; and advocates lists of "approved" treatments. | Funding sources deemphasize this paradigm; represents the minority voice; and opposes lists of "approved" treatments. |

**FIGURE 1.1.** Two paradigms of therapeutic change.

opposite entities, we underscore the observation that models *do* play an important role in common-factors-driven change. However, proponents of our favored paradigm see models less as unique sources of change than the vehicles through which common factors operate. Therapists need models to give their work coherence and direction, but this paradigm values them more for their capacity to activate common mechanisms of change found in all successful psychotherapies.

The older model uses a medical lens through which to view psychotherapy—hardly surprising, given that the earliest psychotherapists were physicians. It follows that many psychotherapy researchers believe that therapies "are analogous to medications that need to be assessed in tightly controlled research that establishes specific variants of therapy as safe and effective for the treatment of particular disorders; essentially drug research without the drugs" (Lebow, 2006b, p. 31). In his well-documented challenge to the medical model, Wampold (2001) makes a strong empirical case for the greater impact of certain "contextual" qualities that surround treatment—like "allegiance" (the commitment of the therapist to the model) and "alliance" (the quality of the client–therapist relationship and the extent to which clients believe therapists are on the "same page"); and he documents empirically that a number of other variables *not* specific to the treatment contribute more to the outcome variance in psychotherapy than the "specific" treatment factors do.

Of course, we think that the medical model has done wonders for medicine. We also believe it has been very beneficial for psychotherapy to the extent that it has encouraged the use of randomized clinical trials in psychotherapy research to demonstrate that psychotherapy "works." Because of these trials we can say to external audiences, like third-party payers, with considerable confidence that psychotherapy (both individual and relational) is very effective (Wampold, 2001; Shadish & Baldwin, 2002). We will never understate the importance of this hard-fought knowledge gained through clinical trials research.

However, it is one thing to say that we know that psychotherapy is effective but quite another to say that we know *why* psychotherapy is effective. While appreciating the contributions of the medical model, we argue against the medical model assumptions that the various "treatments" explain the "why" and that comparative treatments should be the primary focus of research attention in the same way that competing drugs are the focus in drug investigations.

Another major difference between the two paradigms is the role of the therapist. It follows, in the older paradigm, that if psychotherapies are like medications, then the treatment being "dispensed" is much more important than who administers it. As Lebow (2006) has put it:

> Psychotherapy researchers typically focus exclusively on different clinical interventions while ignoring the psychotherapists who make use of them. It's as if treatment methods were like pills, in no way affected by the person administering them. Too often researchers regard the skills, personality, and experiences of the therapist as side issues, features to control or to ensure that different treatment groups receive comparable interventions. (pp. 131–132)

In the emerging paradigm, the role of the therapist is essential to activating the model or treatment, and without the therapist's expertise the model is little more than words on a piece of paper. New-paradigm advocates suggest that the role of the therapist is underemphasized in traditional psychotherapy research, given its emphasis on pitting treatments against one another. This focus also flies in the face of common sense since it is obvious that therapists differ in their effectiveness. As Wampold (2001) has noted, just as some lawyers achieve better outcomes than others, some artists produce more memorable sculptures, and some teachers engender greater student achievement, it only makes sense that some therapists will achieve better results. In spite of these truisms, the older paradigm gives relatively little atten-

tion to therapist variables as contributors to outcome. We present the empirical case for differences in therapist effectiveness in Chapter 4.

Because of its emphasis on the unique treatment being offered, the older paradigm often ends up being more therapist-centric. Granted, it would be inaccurate to say that all model-driven therapists see therapy as something they "do" as an "expert" to a relatively passive client. Many model-driven therapists, especially those with a social constructionist bent, work in ways that are very collaborative. Nonetheless, we believe there is often a tendency—*if* a therapist believes that change is due to a very specific set of operations found within a treatment model—to focus more on "dispensing" or "performing" those specific operations. And this "true believer" therapist will more likely believe that how faithfully he or she performs those specific operations will determine whether change occurs. When change does occur, we believe this therapist is also more likely to believe the client will think the change is due to these unique operations. In other words, this therapist will believe that the clients use the therapy in the way that the therapist thinks he or she uses it. For example, the structural family therapist will believe that the family in treatment was successful because its members used the therapy to develop more clear boundaries. Similarly, the narrative therapist will believe that therapy was successful because his or her clients learned to create new and more empowering stories about themselves.

In the newly emerging paradigm, there is more of a tendency to see clients as actively utilizing *whatever is offered for their own purposes*. While the family in treatment may have used the therapy to develop more clear boundaries, or to develop more empowering narratives, alternately family members may believe they have changed because they used the therapy to learn how to manage their differences or to gain insight about how to perform better at work (or any one of myriad other explanations that were not central to the therapist's belief as to why the treatment succeeded). Of course, both the therapist's and the clients' perspectives may be "valid," but the new paradigm privileges the clients' interpretation. Therapists who take the time to ask their clients why they think therapy succeeded are often shocked to discover that clients often say it had little to do with the therapists' cherished explanations (Helmeke & Sprenkle, 2000). Our central point here is that clients using whatever is offered for their own purposes largely explains or accounts for the robust finding (Shadish & Baldwin, 2002; Wampold, 2001) that there are typically only modest differences in the results achieved by very disparate therapies that

independently have been shown to be effective. For example, in the largest and arguably the best psychotherapy outcome study ever completed, cognitive-behavioral therapy for depression achieved no better results than interpersonal therapy, a psychodynamic treatment (Elkin et al., 1989). Shadish and Baldwin (2002) have demonstrated that the results of 20 meta-analyses show no differences or only modest ones between the various seemingly disparate relational therapies. That is, clients use whatever is offered, in their own idiosyncratic ways, to achieve their goals.

I (D. H. S.), for example, have even had numerous experiences with clients totally misinterpreting me and later thanking me for something I never intended to say or do. For example, a recently divorced woman told me her life changed dramatically for the better when she became single; and she thanked me for "telling" her to leave her husband. I believe I bent over backwards to help her look at all sides of her ambivalence during divorce decision-making therapy and never "told" her what to do. If anything, I thought I encouraged hope for the relationship throughout couple and individual sessions with this client. She used—as clients often do—whatever the therapist offered for her own purposes in getting better.

Finally, engaging and motivating clients is at the heart of the new paradigm since the client's involvement is more important than the therapist's specific activity. In fairness, though, some old paradigm models give considerable attention (along a continuum from considerable to very little) to engaging and motivating clients, and so, once again, we don't want to portray the two paradigms as "either–or."

Finally, the old paradigm is much more entrenched in the dominant culture. Lebow (2006) points out that the medical model-type research "makes up the preponderance of research on mental health treatment funded over the last 20 years by the National Institutes of Health" (p. 31). It is much more closely aligned with the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) power structure in that it assumes certain mental health "diagnoses" are best treated by manualized models demonstrated to be "effective" in randomized clinical trials. In fairness, however, the NIH does fund process research, and so it is not the case that its entire emphasis is on comparative treatment research. So, to repeat, the contrasts between the two paradigms should not be overdrawn. Proponents of the model-driven paradigm push for approved "lists" of efficacious treatments, and there is a growing trend in the mental health provider establishment to reimburse only for treatments put on these lists.

Although the new paradigm has a strong research base (Shadish & Baldwin, 2002; Wampold, 2001), most common factors research is not funded by major sources like NIH, since this type of research focuses not on unique treatments but, rather, shared sources of variance in therapeutic outcomes. While proponents see some value in the DSM as a way of reliably identifying patterns of symptoms, they reject the notion that a diagnosis alone is a meaningful basis for treatment planning since, for example, the etiology of "major depression" is too varied to prescribe limited treatment options. Furthermore, they believe the notion of "lists" of approved treatments is misguided since they reject, among other things, the notion that what makes treatments effective are their unique elements. They believe that this movement too readily embraces the most commonly researched models (typically cognitive behavior and its variations) when other approaches (often better suited to particular therapists) are likely to be just as effective. Given the varied and changing needs of clients, proponents of common factors also want to make a larger place for therapist *improvisation*. The proponents of the new paradigm are considered at least somewhat "countercultural" and at times are even labeled gadflies, iconoclasts, or rebels.

In summary, advocates of the two paradigms typically use the same ingredients, but they view them very differently. Just as the Ptolemaic and Copernican paradigms both included the earth, the sun, and the planets but saw their interrelationships differently, similarly advocates of both the old and the emerging paradigms of change use the same phenomena—models, therapists, clients, and the process of change—but see their interrelations differently. It is our contention (invoking Gregory Bateson's famous phrase) that it is a "difference that will make a difference" in your clinical work. For example, if your competence as a therapist—independent of the model you adopt—is more important than the model itself, you are likely to search for common ingredients in therapist expertise and push for researchers to learn more about these variables.



## The Broad and Narrow Conceptualizations of Common Factors

Although our definition of "common factors" focuses on those variables that contribute to change that are not the province of any particular theoretical approach or model, we acknowledge that com-

mon factors can be narrowly and broadly defined. The narrow view (Lambert, 1992) conceptualizes them in terms of common aspects of interventions found in disparate models under different names (for example, creating changes in meaning may be labeled "insight," "reframing," or "externalizing the problem"). The broad conceptualization (Hubble et al., 1999) sees common factors as including other dimensions of the treatment setting—like client, therapist, relationship, and expectancy variables. From this perspective, for example, one can see "therapist variables" (characteristics of the therapist that contribute to the outcome) as a common factor since it is quite clear that therapist competence (independent of whatever model he or she employs) is an important contributor to outcome. Generally speaking, the broader approach is favored throughout this book. But whether broadly or narrowly defined, common factors can be contrasted with *specific* factors—those variables that contribute to outcome that are unique to a particular approach or model.

## Resistance to Common Factors among Relational Therapists

We believe that there appears to be more resistance to the common-factors paradigm among relational therapists than among individual therapists. This heightened resistance may be attributable to the fact that the application of common factors to couple and family therapy did not appear in the literature to any great extent prior to the 1990s. Nonetheless, we also believe that the history of relationship therapy has tended to emphasize differences—first, in order to differentiate it from mainstream psychotherapy and, second, from other relational approaches. Couple and family therapy model developers have typically been highly charismatic individuals with exceptional capacities to "sell" their models and gain adherents. This emphasis on distinctiveness was made easier because the field has not been particularly influenced by research but has grown more on the basis of intuitive or emotional appeal (Nichols & Schwartz, 2001). In addition, the field has historically focused on difficult cases, and this tendency may have contributed to the belief that unique models and methods are necessary for successful outcomes. Moreover, the field has always welcomed innovation and may therefore attract people with an above-average need to believe what they are doing is uniquely relevant. For whatever reasons, relationship therapists seem to be very emotionally invested in their models, and there may be simply too much cognitive disso-

nance for them to admit that their pet theories may not be demonstrably superior after all. Finally, since couple and family therapies are frequently promoted by charismatic figures on the workshop circuit, such an undramatic approach as common factors may seem dull by comparison. As Frank (1976) expressed it, "Little glory derives from showing that the particular method one has mastered with such effort may be indistinguishable from other methods in its effects" (p. 47). Of course, not all model developers are charismatic, and some value evidence more than dogma; but we maintain that the field has had more than its share of religion masquerading as science.

## The Plan for This Book

### Foundations of Common Factors in Couple and Family Therapy

The first five chapters are foundational and more general. Chapter 2 traces the history of common factors. While the contemporary history stretches back to 1936, you may be fascinated to learn—or be reminded—that as early as the late 1700s healers were making causal claims for specific methods that undoubtedly worked through common factors. Indeed, the history of psychotherapy in general and relationship therapy in particular is a history of growing awareness and appreciation (albeit only relatively recently for relationship therapies) of commonalities among change models.

Although much more has been written about common factors in the individual therapy literature, Chapter 3 focuses on four common factors that are unique to couple and family therapy: (1) conceptualizing difficulties in relational terms, (2) disrupting dysfunctional relational patterns disruption, (3) expanding the direct treatment system, and (4) expanding the therapeutic alliance. While few in number, these common factors are extremely important and rooted in the ways in which relationship therapy is itself distinctive.

Chapter 4 paints a "big picture" view of the major common factors (both "broad" and "narrow") that we believe drive change. Six categories of common factors are offered, along with an overview of the research evidence supporting them. This chapter sets the stage for Chapters 6–9, which present most of these categories in greater detail.

Chapter 5 focuses on our "moderate" view of common factors and how it differs from more radical versions that, among other things, suggest that models are irrelevant, impotent, or both. We articulate

in greater depth our "both–and" position that values models but emphasizes that their major role is to activate common factors. Other common misconceptions (e.g., common factors are mostly about the therapeutic relationship) are also dispelled.

## Specific Applications of Common Factors in Relational Therapy

Chapters 6–9 are the most practical sections of the book, offering many clinical examples. Chapter 6 looks at key "client" and "therapist" common factors and, specifically, how therapists can engage clients and match their level of motivation. The chapter applies Prochaska's (1999) transtheoretical stages of change and also Miller and Rollnick's (2002) motivational interviewing—two models traditionally used with individuals—as common factors lenses that can also inform relational therapy.

Chapter 7 hones in on the important therapeutic alliance—what it consists of and how it is formed, torn, and repaired—and the unique aspects of the alliance in couple and family therapy. Although most therapists think that they are skillful at building alliances, doing so successfully is a complex task requiring considerable skill, given both the unique alliance needs of specific clients and the pitfalls and intricacies of the multiple alliances in relational therapy.

Chapter 8 focuses on the unique relational common factor of interrupting dysfunctional relational patterns/cycles. What makes this chapter fascinating is that interventions from three seemingly disparate models (object relations, emotionally focused, and solution-focused) are shown to operate in similar ways as they interrupt the dysfunctional cycles of the same client couple. When one "stands meta" to (i.e., as though outside) these specific "different" interventions, it is clear that they utilize common principles of change.

Chapter 9 concludes this section by presenting a common factors meta-model of change for couple therapy. This "model of models" offers a guide to the change process irrespective of which relational model is being used. It integrates broad and narrow common factors into a coherent principle-based explanation of therapeutic change.

## Conclusions, Implications, and Recommendations

Chapters 10–12 focus on conclusions, implications, and recommendations based on the common-factors-driven paradigm of change.

Although we are common factors proponents, we are also "evidence people" and thought we should also include a chapter (10) on "The Case against Common Factors." Here we review the challenges to common factors and our responses to them. Chapter 11 discusses the implications of the common factors movement in relationship therapy for training and supervision. Our approach does not require educators to dramatically overhaul the content they teach, but it does have implications for both how models are viewed and how skills are taught in relation to one another. We also stress the need to learn multiple or flexible models because of the need to adapt to different types of clients. Finally, Chapter 12 offers specific recommendations to clinicians, supervisors, and researchers based on the ideas explored and explicated in this volume. We also use this opportunity to speak to the field of couple and family therapy.

Taken together, the chapters that follow add flesh to the bones of the contrast between the model-driven and the common-factors-driven paradigms of change set forth in Chapter 1. Hopefully, they will lead you, the reader, to think differently about, as well as weigh the implications of, our opening question, "What is responsible for therapeutic change?"