Common Factors in Psychotherapy Outcome: Meta-Analytic Findings and Their Implications for Practice and Research

James W. Drisko

Abstract

It is often reported in meta-analytic studies of adult psychotherapy that psychotherapy produces positive change but that there are few significant differences between different types of psychotherapy. Because meta-analyses indicate more similarities than differences among therapies, the "active ingredients" of therapy appear to include important factors in addition to specific therapeutic techniques. Research on common factors across therapies has existed for more than 60 years but is rarely mentioned in the social work literature. Common factors include the client and the client's context, the therapeutic relationship, and expectancy. These studies support the worth of the efforts of social work practitioners, suggest avenues for future research, and have implications for policy and education. The author of this article describes relevant meta-analytic studies of adult psychotherapy, examines the common factors perspective on psychotherapy efficacy, and sets forth implications for social work.

Recently the National Association of Social Workers (NASW)(O'Neill, 1999), citing federal statistics, reported that social workers provide more mental health services than do professionals from all other disciplines combined. A large percentage of these social work services consists of psychotherapy. Despite the widespread use of psychotherapy, consumers, researchers, and payers nonetheless question that it produces change. Indeed, in this era of managed care and diminishing financial support for mental health services, the issue of which therapies yield tangible results in treating specific clients with specific disorders is hotly contested. How this question is framed and tested may be viewed as fully adequate or as unduly narrow and limited, depending on one's stake and perspective on the issue.

Psychotherapy researchers seek to "examine empirically both the process of the therapeutic encounter and the changes that result from participation in this process" (Lambert & Hill, 1994, p. 72). Such research may be quantitative or qualitative and may range from studies of single cases to hundreds of cases across multiple locations. Outcome researchers, who examine the results of psychotherapy, address immediate to long-term changes in the client and sometimes in the larger client system. Approaches to outcome research have diverged in recent years, with carefully controlled experimental efficacy studies offset by less well-controlled studies of the effectiveness of psychotherapy as practiced in "real world" settings with a wider mix of clients and broader qualitative methods (Maione & Chenail, 1999).

Families in Society: The Journal of Contemporary Social Services | **www.familiesinsociety.org**

Much of the research directed to the question of the outcome of psychotherapy, whether focusing on efficacy or effectiveness, has taken the form of comparative studies. In these experimental designs, the results of one or more psychotherapies are compared with each other and with an untreated control group. Indeed, compilations of treatments that work (Lambert & Bergin, 1994; Roth & Fonagy, 1996; Thyer & Wodarski, 1998) draw heavily on such comparative studies. There are differences among researchers and practitioners regarding the merits of efficacy versus effectiveness studies. Despite these differences in purpose, comparative studies can be very useful in examining the results of psychotherapy (Kazdin, 1994). When done well, such studies limit threats to the reliability and internal validity of comparisons among therapies. On the other hand, comparative studies examine relatively few treatments (one to four), often on relatively small numbers of clients delivered in very few settings by very few providers. In real world effectiveness studies, complications such as comorbid medical and mental health conditions are frequent (Guthrie, 2000). Because comparative studies are usually based on random samples from no more than two or three geographic areas, their external validity—the ability to generalize from the results of a given test—may be limited. Replication of any given result in other settings is required to empirically establish any claims to generalizability.

Further, questions arise regarding the nature of the psychotherapies applied in comparative studies. To practitioners, psychotherapy is a highly individualized process, tailored to the unique needs and style of the client (Drisko, 2001). For comparative research purposes the nature of the interventions applied must be clearly defined and replicable. To this end "manualized" approaches to psychotherapy have been developed to ensure treatment fidelity (Guthrie, 2000; Mitchell, Reithoffer, & Blythe, 2000) in comparative research. However, manualized treatments have been employed in few psychotherapy studies. (Manualized treatments specify required interventions that characterize each key treatment component. These interventions must often be implemented in order. Further, certain interventions may be excluded.)

Some authors have noted that manualized treatments may enhance the internal validity of psychotherapy research—the ability to demonstrate the treatment caused the change. Others have noted that manualized treatments undermine the external validity of study findings, as little real world therapy employs manualized treatments (Guthrie, 2000).

Given their complexity and numbers, the yield of comparative studies is very difficult to assess. Some consistencies emerge, but many contradictions are evident as well. There are also many gaps and omissions; not all therapies have been widely studied. The level of detail offered in published reports regarding client characteristics, assessments and measures of specific client problems, descriptions of therapist characteristics, and descriptions of treatments vary widely (Reid, 1997; Wampold, 2001). It is often unclear whether the selected focal problems are equally fair and appropriate measures of result for all therapeutic approaches under study (Guthrie, 2000). It is also often unclear whether the time frames used to compare across therapies are equally appropriate to the course of change projected for each approach (Orlinsky, Grawe, & Parks 1994). A 10-week course of operant conditioning is expected to yield a more linear course of progress than is a similar course of solution-focused therapy or family therapy, in which an ongoing course of change is begun but not concluded at termination. Although many researchers support the position that psychotherapy is effective as well-established, others note that conclusions about the yield of psychotherapy are difficult to draw from the varied comparative research literature.

Meta-Analysis: A Technique to Aggregate and Compare Results of Numerous Individual Studies

About 25 years ago another empirical approach called meta-analysis was introduced by Glass (1976). Meta-analysis is an empirical approach to summarizing the results of multiple studies. Glass advanced the view that the results of a given study should be understood in the context of the distribution of findings on the focal problem. To this end, meta-analysis begins with a systematic and comprehensive review of the literature on a given topic to identify studies of sufficient quality to be considered for inclusion in the meta-analysis. For example, a researcher might compare a set of studies on the effectiveness of several different psychotherapies for anxiety disorders with each other. Second, in a meta-analysis a procedure for selecting studies that meet specified target criteria is defined. The researcher then codes the features of the studies to provide a check on the selection criteria, which later serves as a form of audit trail. These features might include the measures of the problems addressed by the therapy, the characteristics of the sample studied, and the quality and/or consistency of the application of the therapy. Great care is needed in both these conceptual steps to avoid unfair "apples versus oranges" comparisons. Third, the researcher transforms the numerical results of selected studies to a common metric for comparison. Effect size, a standardized measure of improvement, is widely used to compare differences. This transformation allows for fair statistical comparison across different measures with differing numerical scores. Finally, the researcher compares the effect sizes statistically (Glass, McGaw, & Smith, 1981; Hunter & Schmidt, 1990, Lipsey & Wilson, 2001; Wampold, 2001).

When meta-analysis is done well, the researcher provides ample detail on criteria for including or excluding studies from a given meta-analysis and describes efforts to reduce bias in study selection and methods of analysis. A key benefit of detailing selection criteria is that later scholars may

fully review the process for potential bias (Glass, McGaw, & Smith, 1981). Thus, the informal intrusion of researcher bias in comparative studies or narrative reviews is replaced with a more complete and public record. Bias, however, is still possible.

In studies of adult psychotherapy, some meta-analyses draw on carefully controlled and tightly supervised experimental efficacy studies. More often meta-analyses draw on effectiveness studies of psychotherapy, as professionals actually practice it in everyday settings. Still other meta-analyses include both forms of comparative research. Thus meta-analyses may be useful to show whether psychotherapy works, and if it does, which approaches yield the greatest improvement. However, both forms of study de-emphasize environmental factors such as agency setting and the adequacy of client support systems.

Thus meta-analyses may be useful to show whether psychotherapy works, and if it does, which approaches yield the greatest improvement. However, both forms of study de-emphasize environmental factors such as agency setting and the adequacy of client support systems.

Meta-analyses are widely used in situations in which large numbers of studies show no conspicuous and conclusive result. They have been employed to compare educational approaches (Bangert-Drowns & Rudner, 1991), to examine the effectiveness of different cancer treatments (Avery, 1998), to differentiate the placebo from active drug effects (Kirsch & Sapirstein, 1998), and to compare psychopharmacological treatments (Connor, 1999). They have also been widely used to examine the effectiveness of psychotherapy (Lambert & Bergin, 1994). Researchers can use meta-analysis to examine the absolute efficacy of psychotherapy. *Absolute efficacy* refers to the difference in outcome for people receiving psychotherapy compared with those who have not received psychotherapy. Researchers can also use meta-analyses to examine the relative efficacy of psychotherapies. *Relative efficacy* refers to differences in outcome between different types of psychotherapy.

Since the first application of meta-analysis to psychotherapy by Smith and Glass in 1977, few enduring differences across types of psychotherapy have been demonstrated. In fact, as the methodology of meta-analysis has matured, the conclusion that there are no significant differences across therapies or very minimal differences across therapies has been a common result (Ahn & Wampold, 2001; Elliot, 1996; Grawe, Caspar, & Ambuhl, 1990; Robinson, Berman, & Neimeyer, 1990; Sloan, Staples, Cristol, Yorkston, & Whipple, 1975; Smith, Glass, & Miller, 1977; Smith & Glass, et al., 1980; Wampold, 2001; Wampold, Mondin, Moody, Stich, Benson, & Ahn, 1997). These results are telling because the methods of meta-analysis also have improved. In recent meta-analytic studies of psychotherapy, regression approaches have been used to control for differential reactivity in outcome measures; greater standardization of selection criteria for inclusion is evident, and the statistical methods used in meta-analysis have improved (e.g., better statistics for effect size, better understanding of the distribution of results; Lipsey & Wilson, 2001; Wampold, 2001).

It is important to note, however, that the results of some meta-analyses do indicate differences between types of psychotherapy. For example, Shapiro and Shapiro (1982) found cognitive therapy superior to systematic desensitization and minimal intervention. However, during their later review of these specific differences, Berman, Miller, and Masserman (1985) found only a minimal difference. Examining child work exclusively, Weisz and colleagues (1995) found behavioral and cognitive–behavioral interventions to be more effective for certain disorders than are other therapies. In the core concerns of depression and anxiety, Dobson (1989) and Durham and Allan (1993) found cognitive interventions to be more effective than behavioral and other interventions. Reid (1997) reviewed numerous recent meta-analyses on a much broader range of problems and programs than are found in psychotherapy reviews. Reid reported that, across a wide range of concerns of interest to social workers with relatively large sample sizes, behavioral and cognitive interventions were often more effective than alternatives. Reid (1997, pp. 11–14) also noted that many challenges to meta-analysis exist: selection and measurement biases due to the "therapeutic allegiance" of the researcher are possible, or even likely; behavioral measures are often more reactive than are nonbehavioral measures; and the use of "therapy analogs" rather than actual therapies may undermine the "clinical realism" of some included studies. However, Reid purposefully addressed studies of problems (juvenile delinquency, mental retardation, smoking) that differ from those generally examined in meta-analyses of adult psychotherapy, more narrowly defined.

In contrast, in additional, more recent meta-analyses no significant differences across adult psychotherapies were

The most general conclusion is that common factors shared by all psychotherapies are the most important "active ingredients" of psychotherapy. These common factors appear to be more important to client improvement than are differences in specific psychotherapy techniques.

found (Ahn & Wampold, 2001; Stevens, Hynan, & Allen, 2000; Wampold et al., 1997). Wampold (2001) noted that close review of meta-analyses often reveals no significant difference across psychotherapies examined. He also noted that some reports of differences between psychotherapies are expectable by chance alone, given statistical decision-making criteria. In addition, Luborsky et al. (2002) did not find differences in effect sizes by using a method intended to control for researcher allegiance to particular therapeutic models. There is an extensive and often-reviewed, even deconstructed, set of meta-analytic studies in which very few enduring differences in the outcomes of different psychotherapies are reported.

Core Meta-Analytic Findings on Adult Psychotherapy

Two findings stand out from meta-analytic studies of psychotherapy. First, people who receive psychotherapy do better than similar untreated controls. The overall effect size of meta-analyses ranges from .75 to .85 (Wampold, 2001). This is a large effect size compared with most social science results and many medical procedures. (These labels are not standardized, but Cohen, 1977, called an effect size of .20 "small," an effect size of .50 "moderate," and an effect size of .80 and above "large.") This effect size means that the average client completing psychotherapy is better off than 79% of untreated controls (Rosenthal, 1984). Put another way, 31% of controls improve without therapy, whereas 69% of the treated clients improve in the same time span (Wampold, 2001). Psychotherapy works! Meta-analytic results have indicated that people who receive therapy, in aggregate, do much better than those who do not. Second, meta-analysis has revealed that there are very minimal differences across types of psychotherapy. That is, meta-analytic results have indicated that there is little to no difference in the yield of diverse adult psychotherapies for anxiety and depression.

If there is little to no difference in the yield of various types of psychotherapy, it appears that therapeutic theories and techniques are not the key determinants of therapeutic change. The conclusion that psychotherapies are efficacious but that no single approach is generally better than are others raises many important questions. It is noteworthy that even authors who question the equivalent yield from different psychotherapies nonetheless acknowledge the importance of common factors. Nathan and Gorman (2002, p. 643), in their *Guide to Treatments That Work*, noted "it is indisputable that variables common to psychological treatments also carry a substantial amount of the outcome variance." If differences in treatments do not account for much or most of variation in outcomes, what does?

The Common Factors in All Psychotherapies

The most general conclusion is that common factors shared by all psychotherapies are the most important "active ingredients" of psychotherapy. These common factors appear to be more important to client improvement than are differences in specific psychotherapy techniques. This view is not new: Rosenzweig (1936) suggested that the outcome of different psychotherapies is likely to be roughly equivalent. His suggestion is widely and humorously known as the "Dodo bird verdict," based on the subtitle from Lewis Carroll's *Alice in Wonderland*. Several psychotherapy researchers have looked for differences attributable to client and therapist characteristics that impact psychotherapy outcome. Although few obvious differences have been identified consistently by researchers, it is appears clear that the interaction of client and therapist is complex and important. This led Frank (1971) to explore the commonalities of psychotherapy and other healing processes and rituals across cultures. He concluded that several formal aspects of psychotherapy might be vital to its efficacy, parallel to healing practices in other cultures (Frank, 1971; Frank & Frank, 1991). Meta-analyses and reviews of psychotherapy have suggested that common factors are more important to positive outcome than are specific techniques (Ahn & Wampold, 2001; Hubble, Duncan, & Miller, 1999; Lambert & Bergin, 1994; Luborsky et al, 2002; Wampold, 2001).

To date there are only estimates of the common factors at work in all forms of psychotherapy. Lambert's (1992)

review of the psychotherapy outcome literature led him to estimate the percentages of variance attributable to four key components of psychotherapy. Lambert's work is widely discussed in the common factors literature, in discussions of psychotherapy process, and in discussions of psychotherapy integration (merging the best features of different therapies). Lambert identified four key factors: extratherapeutic factors, the therapeutic relationship, technical factors (specific therapeutic techniques), and expectancy or placebo effects. He estimated that 40% of the variance in outcome is due to extratherapeutic factors, 30% is due to the therapeutic relationship, 15% is due to technical factors, and 15% is due to expectancy. I address each factor in order.

Extratherapeutic Factors

The policy and agency context. Not a social worker, Lambert (1992) concentrated on the inner world of the client and did not address the impact of policy and agency factors on the client. For a client to enter and remain in therapy, several factors must be present. The potential client must know services are available and that they are likely to help. Services must also be accessible—within reasonable geographic proximity, accessible to transportation, and without significant barriers for people with disabilities. Services also must culturally sensitive to the potential client. Furthermore, services should be relatively user-friendly, even inviting, to people under stress and doubtful of being treated with respect and care. Contacts prior to meeting the therapist also may aid or hinder the therapeutic work. Costs should be reasonable, and there should be no undue obstacles in referral procedures and management paperwork. Reimbursement to service agencies must offset the cost of doing business and be sufficient to create supportive working conditions (pay, diversity, supervision, and site) for all staff.

The client's context. It is no surprise to social workers that the client's context can play an important role in sustaining involvement in psychotherapy or in undermining this effort. Family support and the support of significant others can aid change (Lambert, 1992). On the other hand, the lack of family and significant social support—or their absence or hostility—can hinder therapeutic change. Similarly, peer and workplace supports can serve as aids, hindrances, or neutral influences to therapy. For many people, spiritual supports and support groups sharing common concerns (such as the therapeutic problem or other issues) can also influence therapy participation and outcome. On a larger scale, neighborhood resources or challenges may ease involvement in therapy or increase the effort required to enter and remain in therapy. It is also clear that the meaning of engaging in psychotherapy, and its very appropriateness as a source of improvement, differs across cultures (Sue, Zane, & Young, 1994). Thus, the wisdom of seeking therapy and support for the undertaking over time may not be simple or steady for many potential clients.

The client as a common factor. Lambert (1992) stated that therapy appears to facilitate the naturally occurring, healing aspects of client's lives. These include the client's intelligence, motivation to change, capacity to trust, and resilience. According to the wider psychotherapy literature, there are several key client factors that impact the yield of psychotherapy. These include the number of problems and symptoms a client identifies, the severity of these problems, the client's ability to identify a focal problem and the severity of this problem, level of motivation, capacity to relate, capacity to tolerate and manage affect (both changes in types and in intensity), comorbid physical conditions and, from some perspectives, ego strength and psychological mindedness (Lambert & Asay, 1984). This list parallels the view of many therapists that client resources are vital assets to the therapeutic process. The list also suggests that pretherapeutic, preparatory efforts to enhance certain of the client's capacities may be helpful or pivotal to the success of a later, formal psychotherapy.

Prochaska (1999) and others suggested readiness to change is important and has a rough stage format. Some clients may be unready for treatment and unable or unwilling to engage fully in it ("window shoppers"). Others may be ready but may need further support and preparation to make use of it. Still others may easily and eagerly use psychotherapy. Prochaska also suggested treatment readiness may not be a stable trait but may be a variable or cyclic phenomenon. Differential responses to treatment may indicate, at least in part, unassessed differences in treatment readiness or participation.

Notably, the therapist's personal importance also is reduced if extratherapeutic factors play such an important role in the outcome of therapy. Tallman and Bohart (1999, p. 91) viewed therapists as resource providers and support systems to clients rather than the as technicians who fix "malfunctioning machinery." Thus, the therapist is no heroic healer but a facilitator and catalyst with a smaller degree of influence over the outcome of therapy. Such a view offers a parsimonious explanation for the Dodo bird result: that technique matters much less than does ability to provide resources and appropriate support. It may be that similar results are obtained across therapies because the client's ability to make use of (or inability to make use of) what therapy and therapists offer surpasses the impact of technique or theoretical approach (Tallman & Bohart, 1999, p. 95).

Garfield (1994) and Luborsky and Diguer (1995) both noted that making generalizations from the empirical literature on client variables remains difficult given the wide range of client types and problems researched to date. Garfield (1994) noted that making predictions about outcome solely on the basis of client characteristics is rarely successful. However, the research Garfield reviewed has emphasized the demographic and psychological characteristics of clients almost exclusively. More encompassing studies of the client and the client's context may be more illuminating but will be extremely challenging.

The Therapeutic Relationship

The dimensions of the therapeutic relationship constitute what therapists generally label as the *common factor* in the psychotherapy (Frank & Frank, 1991; Rosenzweig, 1936). Differing somewhat from Lambert (1992), Orlinsky, Grawe, and Parks (1994) stated the relationship is the largest curative factor in psychotherapy. Generally, the psychotherapy literature since the 1950s has emphasized that the caring, warmth, empathy, and acceptance demonstrated by the therapist are vital to therapeutic result. Lambert (1992) noted that relationship factors—as perceived by a given client—are central to a positive and productive therapeutic relationship. In addition, Lambert (1992) and Lambert and Hill (1994) both noted that mutual affirmation (which may include accurate and sufficient affective attunement), active encouragement to support affective, cognitive, and behavioral changes, including the taking of risks by the client and clear acknowledgment of change and new mastery, are elements of the therapeutic relationship. The importance of the ability to recover from missteps or failures of attunement also is noted in the practice literature. Notably, the difficult to define concept of empathy is only implicit in this list of key elements in a therapeutic relationship.

Comparative psychotherapy researchers rarely examine the quality and vicissitudes of the therapeutic relationship. Instead, such researchers seek to control for variation across therapists to prove the internal validity of the research. In some recent studies, manualized treatments were used to control for differences in therapeutic relationship and therapist skill. Some argue, however, that this practice may systematically undermine full development and therapeutic use of the relationship. Indeed, manualized psychotherapies appear to assume there is no meaningful interaction between the therapeutic relationship and the techniques of therapy.

An extensive review of the linkage between psychotherapy process and outcome by Orlinsky et al. (1994) supports the importance of the therapeutic relationship and emphasizes certain aspects of it. They found that simply having a therapeutic contract has no consistent relation to outcome, but many elements of the implementation of a contract are pivotal. The literature reveals that preparation of the client, clarification of expectations, consensus on goals, patient activity, and the therapist's adherence to a treatment model all are important to positive outcome. Client suitability for treatment, as assessed by the client's cognitive and behavioral processes observable in the client's problem presentation, is also linked to positive outcomes. Nathan and Gorman (2002) summarized that research on psychotherapy process and outcome is very difficult and currently shows few consistent results. Yet the importance of common factors suggests further conceptualization, and research in this area would be worthwhile.

Therapeutic Technique (or Specific Factors)

Model- or technique-specific factors are those based on procedures or beliefs that are unique to a particular treatment. These specific factors differentiate therapies. Examples of these factors include systematic desensitization, biofeedback, the miracle question in solution-focused therapy, genograms in Bowenian family therapy, and transference interpretations in psychodynamic therapies (Lambert, 1992).

Beutler, Machado, and Neufeldt (1994) found that use of therapy manuals to standardize technique led to more positive outcomes than did nonmanualized therapy (see also Robinson et al., 1990). However, Beutler et al. (1994) also noted that variability in such findings suggests "not all manualized interventions are equally effective under all conditions" (p. 259). Another finding was that therapist directiveness generally led to poor outcomes, though some types of clients may benefit from it. Orlinsky, Grawe, and Parks (1994) found few studies on the use of self-disclosure, interpretation, or general skillfulness.

Others view technique specific factors more broadly (Hubble et al., 1999) as therapeutic or healing rituals. Not only specific techniques but also the full conceptual rationale for the existence of the problem, the ways it may change, and related strategies for making changes may be considered as specific techniques (so long as they are distinguishable from other approaches). That is, different approaches to therapy emphasize different content and therefore expect clients to do different things that other models do not. Behavioral therapists focus on behavior, psychodynamic therapists focus on affect and self-understanding, and strengths therapists focus on strengths. Notably such a broad position poses problems for psychotherapy theorists and researchers who must fully distinguish these "worldview" differences from potential common factors such as the therapeutic relationship.

Expectancy and Placebo Effects

Frank and Frank (1991) viewed therapeutic change as occurring in a ritualized format not unlike that provided by native healers. In such ritualized formats, hope and expectancy are encouraged by the act of working within a recognized and client- and therapist-accepted approach to successful change. This proportion of change is not due to specific procedures or easily identifiable actions but is due to expectancy and hope. Included in expectancy are placebo effects due to clients' (and therapists') knowledge that they are being treated with a treatment that has an ameliorating, restorative, healing, or curing power.

It may also be that clients differ in their expectancy responses. A complex interaction of client characteristics and ability to respond to a healing process may exist, including both organic and psychological dimensions. Smith, Glass, and Miller (1980) found a small positive difference in effect size based on similar cultural attitudes between client and therapist. However, Beutler et al. (1994) found little research on the impact of more general value and attitude similarity between therapist and client. They noted that hope and client expectancies have been studied very little.

... although efforts to define best practices are valuable in today's managed care environment—and should be continued with vigor—attention to therapeutic action and therapeutic process is also necessary. Research on how and why therapy works would provide a more complete and valid foundation for developing effective interventions.

In an era of therapeutic eclecticism, professionals should attend to the common factors that surround, and likely shape, therapeutic efficacy and effectiveness alike. Considerable numbers of researchers suggest common factors are important influences on psychotherapeutic change. Still, there are those who disagree. Strupp (1986) believed the distinction between common and specific factors is a nonissue and that it retards progress in psychotherapy research. Strupp believed common factor effects are built in to the outcomes of the specific techniques. In response, it is notable that Castonguay, Goldfried, Wiser, Raue, and Hayes (1996), using a component research design, demonstrated that relationship was indeed pivotal to the effectiveness of at least one form of cognitive–behavioral treatment that did not recognize its importance. Wampold (2001) also offered many examples of the importance of considering common factors in understanding psychotherapy processes and outcomes. Further professional discussion, conceptualization, and research on common factors is warranted.

Summary

The social work literature includes very few mentions or examinations of meta-analyses of adult psychotherapy. Further, in the social work research literature, common factors as an influence on psychotherapy outcome are rarely addressed. The results of many meta-analyses indicate that there is little difference in the yield of different types of psychotherapy. This result suggests factors other than theory and technique are the core sources of therapeutic change. Reid's (1997) review of meta-analyses suggests that technique has more relative importance in the outcome of some social work interventions than it appears to have in adult psychotherapy. Indeed, cognitive and behavioral interventions may well be important to therapeutic change involving influence on other people in the client's social context (parents, teachers, coworkers, etc.), and they may be more important in preparation for psychotherapy than they are in psychotherapy proper. Conceptualizing and examining the differences between psychotherapy and wider psychosocial interventions is important to clarifying what leads to, or undermines, change in each type of endeavor.

There is clearly room for additional research in the area of psychotherapy process and outcome research. As major providers of mental health services, social workers should explore and discuss research on psychotherapy, including meta-analyses, more frequently. Empirical findings provide support for social work's emphasis on the importance of relationship to therapeutic endeavors of all kinds. Empirical findings also provide support for efforts to enhance the family and social support systems of primary clients and to encourage hope that change is possible.

Implications for Social Work Research and Practice

First, social workers should be better informed regarding the yield of psychotherapy based on empirical meta-analytic findings. There is considerable empirical evidence that adult psychotherapy for anxiety and depression generally works very well. Because the NASW reports that social workers provide more mental health services than all other professions combined in the past few years, social workers should give voice to the general value of therapy. Greater positive publicity might also impact the organizational structures in which psychotherapy is practiced and researched (Holosko & Leslie, 1998). This content should be included in educational content as a part of empirical evidence on practice.

Second, although efforts to define best practices are valuable in today's managed care environment—and should be continued with vigor—attention to therapeutic action and therapeutic process is also necessary. Research on how and why therapy works would provide a more complete and valid foundation for developing effective interventions. Omer and Dar (1992) noted that both the practice of psychotherapy and psychotherapy research have become more pragmatic and less theoretically informed in recent years. It is important to know why therapy works in addition to demonstrating that it does work. The issue is of academic interest but is also important to the credibility and scientific

The modifications and extension of psychotherapy into psychosocial therapies has not been well conceptualized or empirically examined. A broader vision of how psychotherapy works may prove supportive of social work's worldview and of historic emphasis on persons-in-situations. Such conceptualization and research would likely affirm social work's emphasis on relationship as central to practice.

foundations of practice. Practitioners are likely to be very interested in how and why therapy works. Notably, Kazdin (2001) argued for greater attention to answering questions regarding how and why psychotherapy works while simultaneously calling for continued attention to identifying treatments that work. Both types of research efforts are necessary and deserve support.

Third, Lambert's (1992) estimate of the importance of common factors in psychotherapy is consistent with social work's longstanding worldview. The importance of contextual factors and the therapeutic relationship are central to social work's values (NASW, 1996). Social work's value on relationship fits with the need to emphasize common factors in psychotherapy as well. Social workers also seek to include attention to context—policy, community, and agency—that is consistent with the importance of these extratherapeutic factors. However, social workers may not do very well at articulating or enacting a unique social work approach to client assessment (Meyer, 1992). So far, social work's own empirically supported list of therapy draws very heavily on psychology (e.g., Thyer & Wodarski, 1998). The modifications and extension of psychotherapy into psychosocial therapies has not been well conceptualized or empirically examined. A broader vision of how psychotherapy works may prove supportive of social work's worldview and of historic emphasis on persons-in-situations. Such conceptualization and research would likely affirm social work's emphasis on relationship as central to practice.

Social workers should also note that the measures of outcome used in most research are solely client-centered and symptom-focused. The worldview of outcome research is generally oriented by the medical model and does not attend to broader psychosocial influences on client circumstances or change processes. This is an area social work scholars and researchers should address and improve.

Fourth, attention to how therapy works is of great interest to social work practitioners (and practitioners in other disciplines). Psychotherapy researchers generally appear to address the interests of audiences of peer academics and researchers as well as those of policy makers and funding sources. It has had little direct impact on the activities of practitioners across disciplines (Drisko, 2000; Nathan & Gorman, 2002). Attention to therapeutic action and process could draw the interest of practitioners, influence their actions, and perhaps better engage them as collaborators in practice research. Increasing interest and participation in practice research among practitioners may help bridge a historic dichotomy.

Fifth, the empirical findings of meta-analysis are also important in orienting social work education. Both common factors and specific techniques are important to optimal effectiveness in education and psychotherapy practice. Attention to contextual factors, client factors—including client readiness for change—and therapist variables, such as warmth and caring, deserve consistent attention along with theory and technique. As noted, Castonguay et al. (1993) found that even cognitive–behavioral therapy for depressed clients was effective only when the therapeutic relationship was strong and the client was emotionally involved in the work. Lacking these factors, the technique was not effective. Synder and Wills (1989) found that two forms of marital therapy, as actually delivered to clients, included extensive overlap in terms of common factor content. The common factors literature affirms social work's historical perspective on persons-in-environments as well as the professional value on the importance of relationship.

Recent changes to the Council on Social Work Education's accreditation standards emphasize empirically based knowledge and evidence-based interventions. Meta-analytic studies are empirically based and provide evidence to support interventions based on relationship and other psychosocial factors, not technique alone.

Sixth, research on psychotherapy should include attention to component models of therapy research (Kazdin, 1994; Stevens et al., 2000; Wampold, 2001). In such models, specific elements of a single model of psychotherapy are

systematically included or excluded during research, allowing clarification of the active components of therapeutic influence. Such researchers must explicitly include contextual, client, and relationship factors as important to outcome, rather than viewing them only as uninvited guests. Faculty also should pay greater attention to the methods and purposes of meta-analytic studies in advanced-level graduate programs.

Finally, the common factors versus specific techniques literature is informative about the science of psychotherapy research. Wampold (2001) pointed out that most researchers accept empirical evidence if it supports a favored view and discount if it does not. He also cited several examples of such potential bias in the juried psychotherapy literature. In the current economic and academic marketplace, competition among different therapies is emphasized, and efforts at identifying common factors across therapies are not actively supported. In addition, empirically supported efforts to create integrative models of psychotherapy are not emphasized and widely supported. Thomas Kuhn, the philosopher of science, would appreciate this example of how self-sealing and self-serving our worldviews can be. Certain questions appear to be a more welcome fit with our current science and economic interests. Other questions, which fit well with a combined inductive–deductive model of science, appear to be neglected or devalued. Psychosocial studies of psychotherapy and its larger systemic effects are few.

Social workers are rarely taught, and rarely apply, meta-analytic methods. Despite substantial empirical support, common factors are not widely discussed in social work, nor are they discussed widely in the psychotherapy research literature. They should be for the many reasons detailed above. A complete understanding of psychotherapy requires not only demonstrations of its high controlled efficacy and its real world effectiveness, but it also requires a theoretical model of how and why it works (Kazdin, 2001). Such a full understanding is currently lacking. Further efforts to understand the common factors present in most forms of therapy would be conceptually and practically beneficial to social workers and others who provide, supervise, administer, and teach about psychotherapy. Research on common factors may have some useful impact on policy makers and funders of psychotherapy services. Research on common factors would also be beneficial to the clients social workers serve.

References

Ahn, H., & Wampold, B. (2001). Where, oh where, are the specific ingredients? A meta-analysis of component studies in counseling and psychotherapy. *Journal of Consulting and Clinical Psychology, 48,* 251–257.

Avery, G. (1998). Lung cancer. *Health Evidence Bulletins, Wales.* Retrieved November 14, 2001, from http://hebw.uwcm.ac.uk/cancers/Chapter1.html

Bangert-Drowns, R., & Rudner, L. (1991). Meta-analysis in educational research. *ERIC Digest.* Retrieved October, 16, 2001, from http://www.ed. gov/databases/ERIC_Digests/ed339748.html

Berman, J., Miller, C., & Massman, P. (1985). Cognitive therapy versus systematic desensitization: Is one treatment superior? *Psychological Bulletin, 97,* 451–461.

Beutler, L., Machado, P., & Neufeldt, S. (1994). Therapist variables. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 229–269). New York: Wiley.

Castonguay, L., Goldfried, M., Wiser, S., Raue, P., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology, 64,* 497–504.

Cohen, J. (1977). *Statistical power analysis for the behavioral sciences* (rev. ed.). New York: Academic Press.

Connor, D. (1999). A meta-analysis of clonidine for symptoms of attention deficit hyperactivity disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 38,* 1551–1559.

Dobson, K. (1989). A meta-analysis of the efficacy of cognitive therapy for depression. *Journal of Clinical and Consulting Psychology, 57*(3), 414–419.

Drisko, J. (2000). Conceptualizing clinical practice evaluation: Historical trends and current issues. *Smith College Studies in Social Work, 70,* 185–205.

Drisko, J. (2001). How do clinical social workers evaluate practice? *Smith College Studies in Social Work, 71,* 419–439.

Durham, R., & Allan, T. (1993). Psychological treatment of generalised anxiety disorder: A review of the clinical significance of results in outcome studies since 1980. *British Journal of Psychiatry, 163,* 19–26.

Elliot, R. (1996). Are client centered/experiential therapies effective? A meta-analysis of outcome research. In U. Esser, H. Pbast, & G. Speierer (Eds.), *The power of the person-centered approach: New challenges-perspectives-answers* (pp. 125–138). Koln, Germany: GwG Verlag.

Frank, J.D., (1971). Therapeutic factors in psychotherapy. *American Journal of Psychotherapy, 25*(3), 350–361.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore: Johns Hopkins University Press.

Garfield, S. (1994). Research on client variables in psychotherapy. In A. Bergin & S. Garfield, (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 190–228). New York: Wiley.

Garfield, S., & Bergin, A. (1994). Introduction and historical overview. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 1–18). New York: Wiley.

Glass, G. (1976). Primary, secondary and meta-analysis of research. *Educational Researcher, 5,* 3–8.

Glass, G., McGaw, B., & Smith, M. L. (1981) *Meta-analysis in social research.* Beverly Hills, CA: Sage.

Grawe, K., Caspar, F., & Ambuhl, H. (1990). The Bernese comparative psychotherapy study. *Zeitschrift for Klinische Pscyhologie, 19,* 287–376.

Guthrie, E. (2000). Psychotherapy for patients with complex disorders and chronic symptoms: The need for a new research paradigm. *British Journal of Psychiatry, 177,* 131–137.

Holosko, M., & Leslie, D. (1998). Obstacles to conducting empirically based practice. In B. Thyer & J. Wodarski (Eds.), *Handbook of empirical social work practice* (Vol. 2., pp. 433–451). New York: Wiley.

Hubble, M., Duncan, B., & Miller, S. (1999). Introduction. In M. Hubble, B. Duncan, & S. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 1–19). Washington, DC: American Psychological Association.

Hunter, J., & Schmidt, F. (1990). *Methods of meta-analysis: Correcting error bias in research findings.* Newbury Park, CA: Sage.

Kazdin, A. (1994). Methodology, design and evaluation in psychotherapy research. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 19–71). New York: Wiley.

Kazdin, A. (2001). Progression of therapy research and clinical application of treatment require better understanding of the change process. *Clinical Psychology: Science and Practice, 8,* 143–151.

Kirsch, I., & Sapirstein, G. (1998). Listening to Prozac but hearing placebo: A meta-analysis of antidepressant medication. *Prevention & Treatment, 1,* Article 0002a. Retrieved March 24, 2002, from http://journals.apa.org/prevention/volume1/pre0010002a.html

Lambert, M. (1992). Implications of outcome research for psychotherapy integration. In J. Norcross & J. Goldstein (Eds.), *Handbook of psychotherapy integration* (pp. 94–129). New York: Basic Books.

Lambert, M., & Asay, T. (1984). Patient characteristics and their relationship to psychotherapy outcome. In M. Herson, L. Michelson, & A. Bellack (Eds.), *Issues in psychotherapy research* (pp. 313–359). New York: Plenum.

Lambert, M., & Bergin, S. (1994). The effectiveness of psychotherapy. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 143–189). New York: Wiley.

Lambert, M., & Hill, C. (1994). Assessing psychotherapy outcomes and processes. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 72–113). New York: Wiley.

Lipsey, M., & Wilson, D. (2001). *Practical meta-analysis.* Thousand Oaks, CA: Sage.

Luborsky, L., & Diguer, L. (1995). A novel CCRT reliability study: Reply to Zander et al. *Psychotherapy Research, 5,* 237–241.

Luborsky, L., Rosenthal, R., Diguer, L., Andrusyna, T. P., Berman, J., Levitt, J., et al. (2002). The dodo bird verdict is alive and well—mostly. *Clinical Psychology: Science and Practice, 9,* 2–12.

Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that "everyone has one and all must have prizes"? *Archives of General Psychology, 42,* 602–611.

Maione, P., & Chenail, R. (1999). Qualitative inquiry in psychotherapy: Research on the common factors. In M. Hubble, B. Duncan, & S. Miller (Eds.), *The heart and soul of change: The role of common factors in psychotherapy* (pp. 57–88). Washington, DC: American Psychological Association.

Meyer, C. (1992). Social work assessment: Is there an empirical case? *Research on Social Work Practice, 2,* 297–305.

Mitchell, J., Reithoffer, A., & Blythe, B. (2000). *Outcome studies in social work research: The state of the art.* Paper presented at the 4th Annual Conference of the Society for Social Work and Research, January 2000, Charleston, SC.

Nathan, P., & Gorman, J. (2002). Efficacy, effectiveness and the clinical utility of psychotherapy research. In P. Nathan & J. Gorman (Eds.), *A guide to treatments that work* (pp. 643–654). New York: Oxford University Press.

National Association of Social Workers [NASW]. (1996). *Code of Ethics.* Washington, DC: Author.

Omer, H., & Dar, R. (1992). Changing trends in three decades of psychotherapy research: The flight from theory to pragmatics. *Journal of Consulting and Clinical Psychology, 60,* 88–93.

O'Neill, J. (1999, June). Profession dominates in mental health. *NASW News, 44*(6), p. 1.

Orlinsky, D., Grawe, K., & Parks, B. (1994). Process and outcome in psychotherapy—Noch Einmal. In A. Bergin & S. Garfield. (Eds.), *Handbook of psychotherapy and behavior change: An empirical analysis* (4th ed., pp. 152–209). New York: Wiley.

Prochaska, J. (1999). How do people change and how can we change to help more people? In M. Hubble, B. Duncan, & S. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 227–255). Washington, DC: American Psychological Association.

Reid, W. (1997). Evaluating the dodo's verdict: Do all interventions have equivalent outcomes? *Social Work Research, 21*(7), 5–15.

Robinson, L., Berman, J., & Neimeyer, R. (1990). Psychotherapy for the treatment of depression: A comprehensive review of controlled outcome research. *Psychological Bulletin, 108,* 30–49.

Rosenthal, R. (1984). *Meta-analytic procedures for social research.* Beverly Hills, CA: Sage.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy: "At last the Dodo said, 'Everybody has won and all must have prizes.'" *American Journal of Orthopsychiatry, 6,* 412–415.

Roth, A., & Fonagy, P. (1996). *What works for whom? A critical review of psychotherapy research.* New York: Guilford Press.

Shapiro, D. A., & Shapiro, D. (1982). Meta-analysis of comparative therapy outcome studies: A replication and refinement. *Psychological Bulletin, 92,* 581–604.

Sloan, R., Staples, F., Cristol, A., Yorkston, N., & Whipple, K. (1975). *Psychotherapy versus behavior change.* Cambridge, MA: Harvard University Press.

Smith, M., & Glass, G. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist, 32,* 752–760.

Smith, M., Glass, G., & Miller, T. (1980). *The benefits of psychotherapy.* Baltimore: Johns Hopkins University Press.

Snyder, D., & Wills, R. (1989). Behavioral versus insight-oriented marital therapy: effects on individual and interspousal functioning. *Journal of Consulting and Clinical Psychology, 57*(1), 39–46.

Stevens, S., Hynan, M., & Allen, M. (2000). A meta-analysis of common factor and specific treatment effects across the outcome domains of the phase model of psychotherapy. *Clinical Psychology: Science and Practice, 7,* 273–290.

Strupp, H. (1986). The nonspecific hypothesis of therapeutic effectiveness: A current assessment. *American Journal of Orthopsychiatry, 56,* 513–520.

Sue, S., Zane, N., & Young, K. (1994). Research on psychotherapy with culturally diverse populations. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change: An empirical analysis* (4th ed., pp. 783–820). New York: Wiley.

Tallman, K., & Bohart, A. (1999). The client as a common factor: Clients as self- healers. In M. Hubble, B. Duncan, & S. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 91–131). Washington, DC: American Psychological Association.

Thyer, B., & Wodarski, J. (Eds.). (1998). *Handbook of empirical social work practice* (Vol. 2). New York: Wiley.

Wampold, B. (2001). *The great psychotherapy debate: Models, methods and findings.* Mahwah, NJ: Erlbaum.

Wampold, B., Mondin, G., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "all must have prizes." *Psychological Bulletin, 122,* 203–215.

Weisz, J., Weiss, B., Han, S., Granger, D., & Morton, T. (1955). Effects of psychotherapy with children and adolescents revisited: A meta-analysis of treatment outcome studies. *Psychological Bulletin, 117,* 450–468.

James W. Drisko, PhD, is professor, Smith College School for Social Work, Lilly Hall, Northampton, MA 01063. E-mail: jdrisko@smith.edu. Professor Drisko has 20 years of clinical practice experience in addition to his academic positions.

Manuscript received: February 3, 2003
Revised: December 2, 2003
Accepted: December 4, 2003