Chapter 11
General Issues in Psychotherapy

Does Psychotherapy Work?
Whom, When, and How Should Researchers Ask?

Box 11.1. Considering Culture: Culture-Specific Expectations
About Psychotherapy

Efficacy Versus Effectiveness of Psychotherapy
Results of Efficacy Studies
Results of Effectiveness Studies
Alternate Ways to Measure Psychotherapy Outcome

Which Type of Psychotherapy Is Best?
The "Dodo Bird Verdict" and Common Factors
Therapeutic Relationship/Alliance
Other Common Factors

Box 11.2. Metaphorically Speaking: If You Use Toothpaste, Then You Understand
Common Factors in Psychotherapy

Reconsidering the Dodo Bird Verdict—Specific Treatments for Specific Disorders

Box 11.3. Considering Culture: Are Evidence-Based Treatments Appropriate for
Diverse Clients?

What Types of Psychotherapy Do Clinical Psychologists Practice?
The Past and Present
The Future
Eclectic and Integrative Approaches

(Continued)
With this chapter, we begin our exploration of psychotherapy, the most common professional activity of clinical psychologists (Norcross & Karpiak, 2012). Upcoming chapters offer details on specific approaches to psychotherapy, including psychoanalytic/psychodynamic, humanistic, behavioral, and cognitive techniques. But in this chapter, we consider some important “across-the-board” psychotherapy issues, including how well it works and how it has been practiced by clinical psychologists.

DOES PSYCHOTHERAPY WORK?

Questions about the outcome of psychotherapy have been prominent throughout the history of clinical psychology, and studies investigating these questions have taken many forms. Through the mid-1900s, most of the evidence offered in support of psychotherapy came in the form of anecdotes, testimonials, and case studies—essentially, subjective descriptions of individual clients’ progress, usually written by the therapists themselves. Controlled, empirical studies of therapy outcome didn’t appear regularly until the 1950s (Weissmark & Giacomo, 1998). Hans Eysenck (1952) published a historic study during this early period. Its claims were noteworthy and controversial: After reviewing some of the early empirical studies on psychotherapy outcome, Eysenck concluded that most clients got better without therapy and that in general, psychotherapy was of little benefit. His scientific methods have since been criticized and his claims overturned, but Eysenck’s allegation that therapy doesn’t work inspired thousands of subsequent empirical studies on therapy outcome (Routh, 2011; Wampold, 2010b).

Many of those empirical studies on therapy outcome were conducted in the 1960s and 1970s. By the late 1970s and 1980s, meta-analyses began to appear. A meta-analysis statistically combines the results of many separate studies—in some cases, hundreds—to create numerical representations of the effects of psychotherapy.
as tested across massive numbers of settings, therapists, and clients. As we see in this chapter, these meta-analyses have yielded consistently supportive results about how well psychotherapy works. But before exploring those results, let’s consider just some of the methodological issues involved in a simple investigation of psychotherapy outcome.

**Whom, When, and How Should Researchers Ask?**

Designing and running an empirical study to measure the outcome of psychotherapy can be a complex task for researchers. One of the fundamental questions they must answer involves the fact that different people involved in the therapy may have different vantage points on the results of the therapy. Whose opinion should researchers seek?

*Hans Strupp*, a legendary and pioneering psychotherapy researcher, identified three parties who have a stake in how well therapy works and who may have different opinions about what constitutes a successful therapy outcome. He and his colleagues have labeled their theory the *tripartite model* (with *tripartite* literally meaning “three parties”) (Strupp, 1996; Strupp & Hadley, 1977; Strupp, Hadley, & Gomes-Schwartz, 1977). One party, of course, is the client. After all, clients are the ones whose lives are affected by therapy, and improving their lives in some meaningful way is presumably the focus of the therapy. Clients’ opinions about therapy outcome are extremely valuable, but they can also be extremely biased. Some clients may be overly eager to see positive results, especially after investing significant time and money, and therefore overestimate therapy’s benefits. Other clients’ opinions about psychotherapy may be negatively influenced by the very factors that brought them to therapy in the first place—for example, a depressed client who tends to interpret events in an unrealistically negative way may apply that kind of distorted thinking to his or her therapy. So a researcher may choose to turn to the therapist—the second party—as another source of feedback. The therapist typically has more experience in mental health issues than the client and may therefore have more reasonable expectations. However, therapists’ views can be biased as well. Therapists witness only a fraction of clients’ lives, and they may feel that negative evaluations reflect poorly on their own therapeutic skills. The third party identified by Strupp and his colleagues, society, can take the form of any outsider to the therapy process who has an interest in how therapy progresses. This can include the general public, the legal system, clients’ family and friends, clients’ employers, and, especially today, managed-care companies who pay the psychotherapy bill. These third parties tend to bring a perspective that emphasizes the client’s ability to perform expected duties in a stable, predictable, unproblematic way. Certainly, the question of who to ask is crucial to the process of measuring therapy outcome. Thankfully, researchers need not choose a single perspective exclusively; they can and often do solicit multiple opinions.
Regardless of whom the researchers ask about therapy outcome, when should they ask? Perhaps the obvious answer is immediately after therapy ends. At that point, it would be reasonable to expect some improvement from the client’s initial level of functioning. But how long should those benefits last? Is it reasonable to expect that therapy’s benefits would continue to be evident 1 month, 6 months, 2 years, or 5 years down the road? And what about benefits before therapy ends? Should there be some evidence of improvement at various points in therapy or perhaps even at each session? Again, shrewd researchers may choose multiple answers to the question of when, either within or across psychotherapy studies. But it is evident that the time at which the researchers answer this question may influence the results they see (Lambert, 2011).

Finally, researchers have many options regarding how they measure the outcome of psychotherapy. If they choose to solicit opinions of an interested party, they can use questionnaires or interviews. Of course, the content and structure of these questionnaires or interviews will have an impact on the data they yield. Researchers may elect to use a more behavioral measure of therapy outcome instead. As an example, consider a researcher who seeks to determine the outcome of psychotherapy for a boy treated for attention-deficit/hyperactivity disorder. Rather than asking the boy, his therapist, his parents, or his teachers, a researcher could directly observe the boy at school or at home to determine if his behavior has changed since therapy began. As with the questions of who and when, the researcher’s decision regarding how psychotherapy outcome is measured can shape the results of the investigation.

Box 11.1  Considering Culture

**Culture-Specific Expectations About Psychotherapy**

Our discussion about psychotherapy outcome, especially from the client’s perspective, must take into consideration the fact that clients from diverse cultures often hold widely varying expectations about the psychotherapy process. A culturally competent therapist will be able to attain a more successful psychotherapy outcome by appreciating the presumptions related to each client’s cultural background.

As it is traditionally practiced in North America and the Western world, psychotherapy involves verbally discussing one’s problems, focusing attention on them, and gaining greater understanding or control over them. These basic processes clash with cultural values common to some non-Western cultures whose members often prefer to “conceal” rather than “reveal” (Fontes, 2008; Toukmanian & Brouwers, 1998). Individuals from Eastern cultures often prefer to avoid, rather than confront, negative thoughts. Thus, the communication styles of clients with psychotherapists—in simplest terms, the extent to which they are comfortable self-disclosing
about problematic behaviors, thoughts, and feelings—may depend significantly on their cultural values.

A client’s willingness to self-disclose to a psychotherapist may also depend on the individualistic versus collectivistic nature of a client’s culture. Western cultures tend to foster an individualistic way of life, emphasizing self-reliance and self-determination. In contrast, Eastern cultures tend to encourage collectivism, whereby the needs of the family/group and the relationships that bind the family/group take priority over individual goals. Thus, whereas a client of European descent may feel slightly uncomfortable discussing a personal problem or shortcoming, a client of Asian descent may feel a much stronger sense of shame about a similar problem or shortcoming because of his or her perception that the problem reflects on family members as well (Sue & Sue, 2008; Toukmanian & Brouwers, 1998).

Training psychotherapists to be culturally competent is the foundation on which they can build an appreciation of clients’ expectations about psychotherapy. Like many others, Toukmanian and Brouwers (1998) recommend that training in psychotherapy emphasize the personal development of the therapist’s attitude toward diverse cultures.

This training should encompass four levels: self-understanding (of one’s own cultural values), listening to clients’ cultural values, accepting clients’ cultural values, and understanding clients’ cultural values.

If you were the client, how important would it be for your psychotherapist to appreciate your expectations about psychotherapy that relate to your cultural background? Specifically, which values would be most important to recognize?

EFFICACY VERSUS EFFECTIVENESS OF PSYCHOTHERAPY

Empirical studies of psychotherapy outcome generally fall into two categories. The extent to which psychotherapy works “in the lab” refers to its efficacy. Most recent studies of psychotherapy outcome are efficacy studies. They maximize internal validity—that is, the ability to draw conclusions about the cause-effect relationship between therapy and outcome—by controlling as many aspects of therapy as
possible. Efficacy studies typically feature well-defined groups of patients, usually meeting diagnostic criteria for a chosen disorder but no others; manualized treatment guidelines to minimize variability between therapists; and random assignment to control and treatment groups (Nathan & Gorman, 2002; Spokas, Rodebaugh, & Heimburg, 2008; Truax & Thomas, 2003).

In contrast, the extent to which psychotherapy works “in the real world” refers to its effectiveness. Effectiveness studies tend to include a wider range of clients, including those with complex diagnostic profiles; allow for greater variability between therapists’ methods; and may or may not include a control group for comparison to a treatment group. Effectiveness studies lack the internal validity of efficacy studies, because the researchers control and manipulate fewer variables. However, effectiveness studies typically have greater external validity than efficacy studies because their methods better match therapy that actually takes place in clinics, private practices, hospitals, and other realistic settings (Nathan & Gorman, 2002; Spokas et al., 2008; Truax & Thomas, 2003).

Results of Efficacy Studies

Thousands of efficacy studies of psychotherapy have accumulated in recent decades; in fact, reviews and meta-analyses that serve as summaries of individual studies now number in the hundreds as well. Again and again, these research efforts yield the same affirmative conclusion: Psychotherapy works (Lambert, 2011; Wampold, 2010a). For example, a primary finding of a landmark meta-analysis of 475 psychotherapy efficacy studies (Smith, Glass, & Miller, 1980) was that the average effect size for psychotherapy was .85, indicating that “the average person who receives therapy is better off at the end of it than 80 percent of the persons who do not” (p. 87). More recent reviews and meta-analyses of therapy efficacy studies (e.g., Lambert & Simon, 2008; Shapiro & Shapiro, 1982), including some very large-scale mega-reviews of meta-analyses (e.g., Lipsey & Wilson, 1993; Luborsky et al., 2002) have confirmed these findings. Summarizing their recent comprehensive review of psychotherapy efficacy data, Lambert and Ogles (2004) stated, “The pervasive theme of this large body of psychotherapy research must remain the same—psychotherapy is beneficial. This consistent finding across thousands of studies and hundreds of meta-analyses is seemingly undeniable” (p. 148).

Not only does psychotherapy work, its benefits appear to endure over long periods of time, exceed placebo effects, and represent clinically (not just statistically) significant change in clients’ well-being (e.g., Lambert & Ogles, 2004; Smith et al., 1980). It should be noted that psychotherapy is not a panacea—a small minority of therapy clients do appear to worsen during the therapy process (Striano, 1988; Strupp et al., 1977). On a similar note, some clients drop out of therapy prematurely, and others experience only short-lived benefits (Lebow, 2006). However, these negative effects clearly appear to be the exception rather than the rule.
In spite of the overwhelming evidence offered by efficacy studies, their results are not always heeded by those who practice therapy in the real world (Boswell et al., 2011; Safran, Abreu, Ogilvie, & DeMaria, 2011). There is, for lack of a better term, a gap between those who conduct efficacy research on psychotherapy and those who practice it. Depending on which side you ask, the gap is caused either by researchers who conduct studies that are artificial, contrived, and irrelevant to how clinicians really practice in their clinics, hospitals, and offices, or by practitioners who refuse to open their eyes to scientific data regarding the outcome of various therapies and who resist changing their practices accordingly. Regardless of the reason, this gap is problematic for the field of clinical psychology. Fortunately, efforts to recognize and bridge it have increased in recent years (e.g., Dattilio, Edwards, & Fishman, 2010; Littell, 2010).

**Results of Effectiveness Studies**

Effectiveness studies have not been conducted as frequently as efficacy studies, but those that have been conducted have generated similarly positive results. So, whereas efficacy studies indicate that psychotherapy works when tested in controlled settings, effectiveness studies indicate that psychotherapy works as it is commonly applied in realistic settings.

As an example of an effectiveness study, consider the investigation conducted by *Consumer Reports* magazine in 1995 ("Mental Health," 1995; Seligman, 1995). The popular magazine—the same one that surveys its subscribers about their experiences with cars, DVD players, and laundry detergent—surveyed its many subscribers about their experiences with psychotherapy. The primary finding was that for the vast majority of respondents, psychotherapy had very positive, lasting effects. As stated by Seligman (1995),

There were a number of clear-cut results, among them:

- Treatment by a mental health professional usually worked. Most respondents got a lot better.
- Averaged over all mental health professionals, of the 426 people who were feeling *very poor* when they began therapy, 87% were feeling *very good, good, or at least so-so* by the time of the survey. Of the 786 people who were feeling *fairly poor* at the outset, 92% were feeling *very good, good, or at least so-so* by the time of the survey. These findings converge with meta-analyses of efficacy (Lipsey & Wilson, 1993; Shapiro & Shapiro, 1982; Smith et al., 1980).

Like any effectiveness study, the *Consumer Reports* study is constrained by some troubling methodological questions (Seligman, 1995). For example, was there a sampling bias such that those whose therapy experience was successful were most...
likely to respond? Of the many clients who improved, how many would have improved without psychotherapy (i.e., in a control group)? How reliable and valid are clients’ own self-reports about psychotherapy outcome, especially after months or years have elapsed? Nonetheless, effectiveness studies such as this one complement efficacy studies, and together they strongly support the benefits of psychotherapy.

Alternate Ways to Measure Psychotherapy Outcome

Efficacy and effectiveness studies have been two primary ways of assessing how well therapy has worked, but there are others, both direct and indirect. For example, in recent years, researchers have paid increased attention to the neurobiological effects of psychotherapy. Although this field of study is in the early stages, the initial conclusion is unmistakable: psychotherapy changes the brain (Arden & Linford, 2009; Viamontes & Beitman, 2009). Studies using functional magnetic resonance imaging (fMRI) and positron emission tomography (PET) neuroimaging technologies have repeatedly found that successful therapy for particular disorders produces reliable changes in brain activity and structure. Among other findings, behavioral therapy for obsessive-compulsive disorder has been found to decrease metabolism in the caudate nucleus, behavior activation affects the dorsal striatum of depressed clients, and both cognitive behavioral therapy and interpersonal psychotherapy have been found to decrease activity in dorsal frontal regions and increase activity in ventral frontal and subcortical regions (Dichter et al., 2009; Roffman, Marci, Glick, Dougherty, & Rauch, 2005). (All these therapies are described in more detail in later chapters.) Although medication studies have focused on neurological changes in the brain, such studies are relatively new for psychotherapy studies. As they accumulate, they will provide even further evidence of the effects of psychotherapy.

In an indirect way, medical cost offset is another intriguing way to assess the outcome of psychotherapy. The logic goes like this: Many people with mental or emotional problems will either seek medical (rather than psychological) assistance or will put off treatment for so long that the problem worsens the individual’s physical state, necessitating medical treatment. If they seek psychotherapy, will they reduce their medical costs? According to the available data, the answer appears to be a resounding yes (Lambert & Ogles, 2004). A review of more than 90 studies on this issue found that, on average, clients receiving therapy spent fewer days in the hospital and saw their medical costs reduced by 15.7%, while comparable clients in control groups spent more days in the hospital and saw their medical costs increased by 12.3% (Chiles, Lambert, & Hatch, 1999). Additionally, psychotherapy has been found to reduce the need for emergency room visits (Carr, 2008). Whether the medical bills are being paid by a health insurance company or by the clients themselves, the finding that psychotherapy is a good investment in both mental and physical health again points to its positive effects.
WHICH TYPE OF PSYCHOTHERAPY IS BEST?

Soon after the finding that psychotherapy works started to become an established fact, infighting began among the various orientations and approaches about which had the strongest empirical support (Lambert, 2011). Each claimed superiority over the others, and as the language below implies, the competition was quite fierce.

Although there were many combatants—Freudians versus cognitivists versus humanists—the principals in this war were behaviorists and nonbehaviorists. These groups have called each other names and traded high sounding insults. But the issue was not over psychotherapy versus no psychotherapy, but brand A psychotherapy versus brand B psychotherapy. . . . Different forms of therapy were viewed as adversaries, competitors, or contestants, and the arena of conflict was the controlled experiment. (Smith et al., 1980, pp. 2–3)

The “Dodo Bird Verdict” and Common Factors

Indeed, many empirical outcome studies throughout the latter half of the 1900s have pitted one form of therapy against another. The collective results of these studies have, again and again, yielded a result that surprised many in the field: a virtual tie. In other words, in the hundreds of empirical studies designed to compare the efficacy of one form of therapy with the efficacy of another, the typical result is that the competing therapies are found to work about equally well (Lambert, 2011; Lambert & Ogles, 2004; Norcross & Newman, 1992; Smith et al., 1980; Wampold, 2001, 2010a, 2010b; Weissmark & Giacomo, 1998). In one of the earliest review articles to reach this conclusion, the authors borrowed a line from the dodo bird in *Alice in Wonderland* who, after judging a race between many competitors, stated that “everybody has won and all must have prizes” (Luborsky, Singer, & Luborsky, 1975, p. 995).

How could the “dodo bird verdict” apply to psychotherapy outcome? The various forms of psychotherapy—psychoanalysis, humanism, cognitive, behavioral, and others—are indeed quite discrepant from one another, so how could they consistently produce such similar results? Most researchers explain this finding by pointing to common factors across all forms of psychotherapy (e.g., Stricker, 2010; Wampold, 2001). That is, although proponents of each school of therapy tout the unique and distinctive aspects of their own approaches, they all share some fundamental components as well. Actually, the notion that different therapies benefit from the same underlying mechanisms was suggested as early as the 1930s (Rosenzweig, 1936) and has been reiterated numerous times since (e.g., Frank, 1961; Torrey, 1986). The difference in the most recent versions of this argument is that they are supported by extensive empirical data on psychotherapy outcome.
It is important to recognize that these common factors are not merely present; they are therapeutic (Lambert & Ogles, 2004; Wampold, 2010a, 2010b). They function as “active ingredients” in all forms of psychotherapy, which helps explain the comparable results of the various approaches: “All of the specific types of therapy achieve virtually equal—or insignificantly different—benefits because of a common core of curative processes” (Wampold, 2001, p. ix). So what are the common factors that make up this common core of curative processes?

Therapeutic Relationship/Alliance

Of the many common factors for psychotherapy outcome that have been proposed, the leading candidate is a strong relationship between therapist and client (Beitman & Manring, 2009; Crits-Christoph, Gibbons, Hamilton, Ring-Kurtz, & Gallop, 2011; Horvath, Del Re, Fluckiger, & Symonds, 2011; Lebow, 2006; Norcross & Lambert, 2011a, 2011b). This relationship goes by many names: therapeutic relationship, therapeutic alliance, working alliance. In fact, the word alliance is perhaps the most illustrative of the nature of this relationship—a coalition, a partnership between two allies working in a trusting relationship toward a mutual goal. Research unequivocally indicates that whether the clients are adults, children, or families, and whether the therapy format is individual or group strongly contribute to psychotherapy outcome (Norcross & Wampold, 2011a, 2011b).

In fact, numerous studies have concluded that the therapeutic relationship is perhaps the most crucial single aspect of therapy. Specifically, researchers have argued that the quality of the therapeutic relationship is the best predictor of therapy outcome and that it accounts for more variability in therapy outcome than do the techniques specific to any given therapy approach (e.g., Beitman & Manring, 2009; Wampold, 2001, 2010b). The strength of the therapeutic relationship is especially important from the client’s point of view; after all, the client’s perception of this relationship is what facilitates positive change. It is also interesting to note that the quality of the therapeutic relationship is vital to therapy regardless of how much emphasis the therapist places on it. Some therapists (e.g., behaviorists) tend to deemphasize therapy relationships, others tend to pay it moderate attention (e.g., cognitive therapists), and others tend to focus heavily on it (e.g., humanists and psychoanalysts). But through the eyes of the client, the therapeutic relationship remains a consistently vital component of psychotherapy (Norcross & Lambert, 2011a, 2011b).

Having established the centrality of the therapeutic alliance, researchers have begun to investigate how, exactly, it contributes to successful psychotherapy. Kazdin (2007) brings up an interesting point: The connection between a good therapeutic alliance and client improvement is not necessarily a one-way street. In other words, in addition to the likelihood that a good alliance facilitates client improvement, it is also possible that as clients improve, they experience an enhanced relationship with
CHAPTER 11  General Issues in Psychotherapy  265

their therapists. (Just imagine how you would rate the alliance with a physician if he or she cured you of a serious disease.) Of course, a reciprocal relationship between the two—an upward spiral of sorts—is also a possibility (Webb et al., 2011). This issue highlights what you may have learned in a statistics course: A correlation between two variables does not necessarily indicate a definitive cause-and-effect relationship.

Researchers have also begun to break down the therapeutic relationship—that is, to look more closely at its specific components to determine exactly what makes a therapeutic relationship beneficial (Horvath et al., 2011; Orlinsky, 2010). Numerous elements have been identified—most emphatically, the therapist’s ability to provide empathy and acceptance to the client (Lambert, 2011; Norcross, 2010). (These elements overlap significantly with cornerstones of humanistic therapy, which we will discuss in detail in a later chapter.) Empirical study of the therapeutic relationship remains in the early stages, but as it continues, it promises to guide therapists toward establishing healing interpersonal relationships with their clients, regardless of the clients’ presenting problems or the particular techniques chosen by the therapists (Norcross & Wampold, 2011a, 2011b).

So, in addition to empirical data supporting particular techniques that work, clinical psychologists also have data supporting particular kinds of therapeutic relationships that work. Rather than siding with either the techniques or the relationships, clinical psychologists can embrace both. In other words, these two components of therapy can complement each other to create the most beneficial experience for clients. As Castonguay and Beutler (2006) put it,

One of the most salient controversies in the field of psychotherapy is whether client change is primarily due to the therapist’s techniques or the quality of the therapeutic relationship. . . . This controversy reflects, more or less implicitly, an “either/or” assumption that is conceptually flawed and empirically untenable. The complexity of the process of change requires, at least in our view, a consideration of both technical and interpersonal factors. (p. 353)

Other Common Factors

The therapeutic relationship is not the only common factor that psychotherapy researchers have proposed. Hope (or positive expectations) has also received support as a common factor (Constantino, Glass, Arnkoff, Ametrano, & Smith, 2011; Prochaska & Norcross, 2010). Simply stated, therapists of all kinds provide hope or an optimism that things will begin to improve. Although the mechanism by which this improvement will take place may differ, the improvement may actually begin before any techniques, per se, have been applied. Anyone who has walked despairingly into a physician’s office, or even a car repair shop, and received a confidently
delivered message that the problem can be fixed understands the curative power of hope.

Attention may also be a common factor across psychotherapies. Also known as the Hawthorne effect (a name derived from classic organizational psychology studies in which factory workers’ performance improved as a result of being observed), the attention the therapist and client direct toward the client’s issues may represent a novel approach to the problem. That is, clients may have previously attempted to ignore problems that are ultimately addressed in therapy. Simply by openly acknowledging a problem and focusing on it with the therapist, a client may begin to experience improvement, even before formal intervention begins. In addition to the therapeutic relationship, hope, and attention, other common factors that researchers have proposed include reinforcement of novel behaviors, desensitization to threatening stimuli, confronting a problem, and skill training (Prochaska & Norcross, 2010).

Is it possible that the common factors underlying all forms of psychotherapy occur in a predictable sequence? Lambert and Ogles (2004) put forth a three-stage sequential model of common factors, beginning with the “support factors” stage—common factors such as a strong therapist-client relationship, therapist warmth and acceptance, and trust. They label the second stage “learning factors,” including such aspects as changing expectations about oneself, changes in thought patterns, corrective emotional experiences, and new insights. The third and final stage consists of “action factors,” such as taking risks, facing fears, practicing and mastering new behaviors, and working through problems. In brief, this sequential model suggests that psychotherapists of all kinds help clients by moving them through three common steps: connecting with them and understanding their problems; facilitating change in their beliefs and attitudes about their problems; and, finally, encouraging new and more productive behaviors.

It is interesting to compare this three-step sequence with the more informal process of helping a friend who comes to you with a personal problem. Typically, we begin by communicating understanding and compassion, then move on to help them see their problems in a new light, and ultimately help them develop a strategy and take new action to address it. If we skip any of these steps or do them “out of order,” the helping process may be hindered. By the same token, some friends (or clients) may need more time at certain stages and less time at others—perhaps more support and less action or vice versa. And cultural factors can play an important role in the value of each stage to the person seeking help, as members of some groups may tend to favor support, learning, or action.
If You Use Toothpaste, Then You Understand

Common Factors in Psychotherapy

Toothpaste companies spend a lot of time and money convincing us that, because of some "special" feature, their product is the best. Crest, Colgate, Aim, Gleem, Aquafresh—all make claims that they have something unique that sets their toothpaste apart. You've probably tried a few yourself: toothpastes with baking soda, with mouthwash, with sparkles, in a stand-up tube, in winter-fresh gel, and so on.

Ever read the list of ingredients on one of those tubes of toothpaste? Beneath the full list of ingredients, you'll see a separate, important category: "Active Ingredient." And that category has only one item listed: fluoride. That's true across all the brands, all the varieties. In other words, although the manufacturers and advertisers try to sell us on the unique features—extra ingredients, special flavors—what makes one toothpaste work is the same thing that makes its competitors work: fluoride. (That's why our dentists rarely mention a specific brand when they remind us to brush—as long as it has fluoride, any brand will prevent cavities about as well as the others.)

Decades of outcome studies have suggested that the same type of phenomenon has taken place in the psychotherapy field. Each "brand" of psychotherapy has promoted its unique features, those aspects that distinguish it and supposedly make it better than the other brands. But those claims are contradicted by the consistent result of many controlled, empirical psychotherapy outcome studies: Different forms of psychotherapy work about equally. Consequently, it makes sense to speculate about the underlying common ingredient—the "fluoride" of psychotherapy.

So what is the “fluoride” of psychotherapy? At this point, the therapeutic relationship/alliance has emerged as the leading candidate. That is, a strong relationship between therapist and client has proven beneficial, regardless of whether the therapist in that relationship uses psychoanalytic, humanistic, cognitive, or behavioral techniques. Other common factors have garnered significant attention and support from psychotherapy researchers as well, including hope/optimism, attention, and insight (Prochaska & Norcross, 2010; Wampold, Imel, Bhati, & Johnson-Jennings, 2007). Perhaps various forms of psychotherapy share not a single ingredient (like toothpastes share fluoride) but a "common core" of ingredients, in which some of the factors described here combine to help a client (Wampold, 2001, p. ix).

(Continued)
Reconsidering the Dodo Bird Verdict—Specific Treatments for Specific Disorders

The dodo bird verdict has not gone unchallenged. Although it is a widely accepted finding in the field that the various forms of psychotherapy are, in general, equally effective, some researchers have made the case that certain psychotherapies are, in fact, superior to others in the treatment of specific problems (e.g., Antony & Barlow, 2010; Carr, 2008; Chambless & Ollendick, 2001).

Dianne Chambless, a prolific and highly respected psychotherapy researcher, has argued strongly against the idea that all psychotherapy approaches are equally efficacious (e.g., Chambless & Ollendick, 2001; Siev & Chambless, 2007). For instance, in her 2002 article (fittingly titled “Beware the Dodo Bird: Dangers of Overgeneralization”), Chambless points out that although empirical studies have compared many therapies with one another, there are many specific comparisons—certain therapies for certain disorders—that studies have not yet examined. Thus, it would be premature to conclude that all therapies are equal for the treatment of all disorders, even if equal efficacy has been the typical finding in studies so far. Additionally, as described in Chapter 3, Chambless is a champion of the movement toward manualized, evidence-based treatments and has led the task forces that established criteria for efficacious treatments for specific disorders and determined which therapies made that list (Chambless et al., 1996, 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995).

The contention made by Chambless and others that the dodo bird verdict is inaccurate—and that, therefore, common factors should take a back seat to specific ingredients in each therapy technique—has itself been countered by other leading psychotherapy researchers (e.g., Norcross, 2002). For example, in their 2002 article (aptly titled “Let’s Face Facts: Common Factors Are More Potent Than Specific Therapy Ingredients”), Stanley Messer and Bruce Wampold (2002) review the literature on therapy efficacy and conclude that “the preponderance of evidence points to the widespread operation of common factors such as therapist-client alliance . . . in determining treatment outcome” (p. 21). They further argue that the prescriptive
CHAPTER 11  General Issues in Psychotherapy

approach to therapy—in which specific therapy techniques are viewed as the treatment of choice for specific disorders (e.g., Antony & Barlow, 2010)—should be replaced by an approach that more broadly emphasizes common factors, especially the therapeutic relationship.

Others are quick to add that the debate over what's best for the client should not overlook what the client wants (Swift & Callahan, 2009; Swift, Callahan, & Vollmer, 2011). In other words, client preferences are important to consider for retention (keeping the client from dropping out of therapy), enhancement of the therapy relationship, and, ultimately, outcome. As an example, consider the client’s preferred coping style (Beutler, Harwood, Kimpara, Verdirame, & Blau, 2011). Some clients may have an externalizing coping style, so they prefer to deal with problems by presuming that their origins are outside of themselves; as such, they may respond better to a therapy that emphasizes symptoms but deemphasizes their root causes. Other clients may have a more internalizing coping style—presuming that their problems originate from within themselves—and would therefore respond better to a therapy that emphasizes insight into root causes rather than just symptom reduction. Appreciating this client preference could be the key to therapy’s success; ignoring it could be the cause of its failure.

A form of psychotherapy becomes an evidence-based treatment when empirical studies demonstrate that it produces successful results with clients. But what if the clients from the study differ in important ways from clients who might receive the treatment in the real world? Can we expect similarly positive results with all clients?

Empirical studies of psychotherapy have done a poor job of including diverse populations in their clinical trials, according to some recent criticisms. Specifically, a series of entries to an important book titled Evidence-Based Practices in Mental Health: Debate and Dialogue on the Fundamental Questions (Norcross, Beutler, & Levant, 2006) argue strongly that studies examining the efficacy of manualized therapies have commonly neglected issues of

- ethnicity (Sue & Zane, 2006),
- gender (Levant & Silverstein, 2006),
- disability (Olkin & Taliaferro, 2006), and
- lesbian, gay, bisexual, or transgender (LGBT) clients (Brown, 2006).

Regarding ethnicity, Sue and Zane (2006) report that despite the massive number of clinical studies evaluating the efficacy of specific therapies since 1986 (encompassing about 10,000

(Continued)
clients), the number of these studies that measured the efficacy of the treatment according to ethnicity or race is zero. Further, in about half these studies, ethnicity information was not reported at all, and in most of the rest, very few minority clients were included. Regarding people with disabilities, Olkin and Taliaferro (2006) report that they “have been unable to locate any published materials on [evidence-based practices] and people with disabilities,” which “fuels our concern that [evidence-based practice] will develop without due consideration of this minority group” (pp. 353–354). Brown (2006) and Levant and Silverstein (2006) offer comparable summaries regarding inattention to LGBT and gender issues, respectively.

Not only are clients from these diverse groups often omitted from clinical trials, but the authors of some clinical studies (and the therapy manuals they test) do not suggest specific adaptations to their treatment to better suit any such clients. Fortunately, very recent research has focused on exactly these kinds of adaptations. That is, there is a current movement among psychotherapy outcome researchers to describe how evidence-based therapies could be adapted to specific cultural populations, and to empirically test these adaptations (Castro, Barrera, & Steiker, 2010; Morales & Norcross, 2010; Smith, Rodríguez, & Bernal, 2011). For example, BigFoot and Schmidt (2010) successfully tested an adaptation of cognitive-behavioral therapy for American Indian and Alaska Native children with posttraumatic symptoms, and Aguilera, Garza, and Muñoz (2010) successfully tested an adaptation of cognitive-behavioral therapy for Spanish-speaking clients with depression.

For a moment, imagine that you are a psychotherapy client. Your clinical psychologist informs you that a particular form of therapy has been shown in a series of studies to successfully treat the disorder with which you have been diagnosed. How important is it to you that the clients on whom the therapy was successfully tested may differ from you in important ways? If most of the clients in the successful clinical trials differed from you in terms of ethnicity, gender, disability status, or sexuality, would you feel confident that the therapy would work equally well for you? If you were the clinical psychologist, how comfortable would you be following a manual empirically supported by research conducted on clients who differ from the client in your office?
The debate over the dodo bird verdict—whether the benefits of psychotherapy are due primarily to ingredients shared across therapies or specific to certain therapies—carries on. In fact, *The Great Psychotherapy Debate*, an important book by Bruce Wampold (2001), suggests that the quarrel is far from over. In the middle ground of this dispute, numerous researchers and clinicians have tried to form a compromise that recognizes the importance of both the specific treatment and more general, common effects (e.g., Norcross, 2005). In fact, some have pointed out that change in therapy can be attributable to many factors, including common factors, specific factors, and numerous others. For example, some call attention to the fact that in addition to the specific and common factors cited above, there are client characteristics, therapist characteristics, and problem characteristics (how severe, how chronic, etc.) that can affect the outcome of therapy (Beitman & Manring, 2009; Rosenfeld, 2009). Not to mention, extra-therapeutic forces—that is, life events the client experiences while in therapy—can also have a powerful impact on the client’s well-being at the end of therapy (Norcross, 2005; Rosenfeld, 2009; Wampold, 2001). Perhaps a wise resolution of this debate is to consider the full range of potential influences on therapy outcome, as suggested by Paul (2007):

> The treatment method, the therapist, the relationship, the client, and principles of change are vital contributors, and all must be studied. Comprehensive evidence-based practices will consider all of these determinants and their optimal combinations. “Common and specific effects” and “art and science” appear properly complementary, not as “either/or” dichotomies. (p. 141)

**WHAT TYPES OF PSYCHOTHERAPY DO CLINICAL PSYCHOLOGISTS PRACTICE?**

**The Past and Present**

Seven times since 1960, researchers have surveyed the Division of Clinical Psychology (Division 12) of the American Psychological Association to assess, among other things, the type or orientation of psychotherapy that its members practice. The most recent of these surveys incorporates responses from 549 clinical psychologists and includes a comparative review of the six previous surveys as well (Norcross & Karpiak, 2012). These results are summarized in Table 11.1.
Several observations and trends related to Table 11.1 are noteworthy:

- Eclectic/integrative therapy has been the most commonly endorsed orientation in every survey summarized in the table until 2010, when it fell to second place. That is, over the past half century, more psychologists have described themselves as “mutts” who blend multiple approaches or use an assortment of therapies than as “purebreds” who practice one type exclusively. Additional research (e.g., Cook, Biyanova, Elhai, Schnurr, & Coyne, 2010) has confirmed that combined orientations remain extremely common, not only among clinical psychologists but among psychotherapists more broadly. Therapists combine orientations in a wide variety of ways, but surveys suggest that the combination of cognitive and behavioral approaches (each of which is described in detail in a later chapter) is the most common (Hickman, Arnkoff, Glass, & Schottenbauer, 2009).

- Even among those therapists who endorse a singular orientation rather than calling themselves eclectic, the actual techniques they use often fall outside the boundaries of their singular orientation. For example, a therapist who calls herself behavioral may in fact use cognitive techniques from time to time, or another therapist who calls himself humanistic may in fact use psychodynamic techniques occasionally (Thoma & Cecero, 2009).

- The endorsement of psychodynamic/psychoanalytic therapy has declined significantly since 1960, when it far exceeded any other single approach and

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eclectic/Integrative</td>
<td>36</td>
<td>55</td>
<td>31</td>
<td>29</td>
<td>27</td>
<td>29</td>
<td>22</td>
</tr>
<tr>
<td>Cognitive</td>
<td>—</td>
<td>2</td>
<td>6</td>
<td>13</td>
<td>24</td>
<td>28</td>
<td>31</td>
</tr>
<tr>
<td>Psychodynamic/Psychoanalytic</td>
<td>35</td>
<td>16</td>
<td>30</td>
<td>21</td>
<td>18</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Behavioral</td>
<td>8</td>
<td>10</td>
<td>14</td>
<td>16</td>
<td>13</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Humanistic/Rogerian/Existential/Gestalt</td>
<td>6</td>
<td>7</td>
<td>7</td>
<td>12</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

rivaled the eclectic/integrative approach in terms of popularity. In 2010, only 18% of clinical psychologists endorsed it as their primary orientation—about half the percentage reported in 1960. Nonetheless, psychodynamic/psychoanalytic therapy remains the second most commonly endorsed orientation among the single-school approaches.

- Cognitive therapy has witnessed a remarkable rise in popularity, especially since the 1980s. Prior to the 1980s, the unpopularity of the cognitive approach suggested it was hardly worth including on these surveys, but by 2010, it had become by far the most commonly endorsed single-school approach and had also overtaken the eclectic/integrative approach.

The same survey (Norcross & Karpiak, 2012) offers a description of the formats, or modalities, most commonly used by clinical psychologists. Table 11.2 presents highlights of these results for clinical psychologists responding to the most recent edition of the survey.

As the table indicates, psychotherapy with individual clients dominates the professional activities of contemporary clinical psychologists (see also Cook et al., 2010). Almost all (98%) conduct some individual therapy. However, the other formats of therapy—couples/marital therapy, family therapy, and group therapy—are also practiced by sizable numbers of clinical psychologists.

Regardless of the type of therapy, it has become increasingly evident that clients enter therapy at various points regarding willingness to change. Simply put, some clients are quite ready to change when they enter therapy, while others are not. Psychotherapy researchers (e.g., Norcross, Krebs, & Prochaska, 2011) have developed and provided empirical support for a stages of change model to describe the various

<table>
<thead>
<tr>
<th>Psychotherapy Format</th>
<th>Percentage of Clinical Psychologists Who Practice It</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>98</td>
</tr>
<tr>
<td>Couples/Marital</td>
<td>48</td>
</tr>
<tr>
<td>Family</td>
<td>34</td>
</tr>
<tr>
<td>Group</td>
<td>20</td>
</tr>
</tbody>
</table>

**TABLE 11.2 Involvement of Clinical Psychologists in Various Psychotherapy Formats**

points where clients may fall in terms of readiness. Specifically, clients may enter therapy at one of these five stages:

- **Precontemplation stage**—no intention to change at all. These clients are largely unaware of their problems, and they may have been pressured to enter therapy by family or friends who are more aware than they are themselves.

- **Contemplation stage**—aware that a problem exists, considering doing something to address it, but not ready to commit to any real effort in that direction. These clients are often ambivalent and are not yet willing to give up the benefits of the behavior they recognize as somewhat problematic.

- **Preparation stage**—intending to take action within a short time (e.g., weeks, a month). These clients may be taking small steps but have not made significant or drastic change.

- **Action stage**—actively changing behavior and making notable efforts to overcome their problems. More than any other stage, this stage requires sustained effort and commitment to the therapeutic goals.

- **Maintenance stage**—preventing relapse and retaining the gains made during the action stage. This stage lasts indefinitely.

It is important for therapists to assess the stage of change clients are in when they seek therapy. It would be a mistake to assume that most are at the action stage; indeed, data suggests that the vast majority are at an earlier stage at the outset of therapy. Thus, initial goals should emphasize increasing clients’ readiness to change rather than forcing them to change prematurely (Norcross, Krebs, & Prochaska, 2011; Prochaska & Norcross, 2010).

**The Future**

The practice of psychotherapy among clinical psychologists has certainly changed in the past half century. How might it change in the near future? Sixty-two psychotherapy experts, including many editors of leading journals in the field, were surveyed about the trends they foresee for the near future (Norcross, Hedges, & Prochaska, 2002). The results included several provocative predictions, including a rise in the use of

- cognitive and behavioral approaches to therapy,
- culturally sensitive therapy,
- eclectic/integrative approaches to therapy, and
- empirically supported or evidence-based forms of therapy.
The survey also suggested that classic psychoanalysis will continue to decline in use soon. Of course, only time will tell if these predictions are accurate.

**Eclectic and Integrative Approaches**

Eclectic and integrative approaches to psychotherapy hold a unique position among clinical psychologists, as we have seen. Whereas the various single-school forms of therapy have risen and fallen in popularity over the years, eclectic/integrative therapy has remained at or near the top of the list in terms of popularity (Norcross & Karpiak, 2012).

Although the terms are often linked and both involve multiple therapy approaches, an eclectic approach to therapy actually differs in important ways from an integrative approach. Eclectic therapy (also known as technical eclecticism) involves selecting the best treatment for a given client based on empirical data from studies of the treatment of similar clients (Gold, 1996; Norcross & Newman, 1992; Stricker, 2010). In other words, a truly eclectic therapist turns to the empirical literature as soon as the diagnosis is made and practices whatever technique the literature prescribes for that diagnosis. So if the empirical literature dictates it, an eclectic therapist might practice cognitive therapy with a 9:00 a.m. client with generalized anxiety disorder, behavioral therapy with a 10:00 a.m. client with a phobia, and so on.

An integrative approach to therapy, on the other hand, involves blending techniques in order to create an entirely new, hybrid form of therapy (Beitman & Manring, 2009; Norcross, 2005). An integrative therapist may combine elements of psychoanalytic, cognitive, behavioral, humanistic, or other therapies into a personal therapy style applied to a wide range of clients.

In 1977, Paul Wachtel was one of the first to successfully integrate complementary (some might have said incompatible) approaches, namely psychoanalysis and behavior therapy. Soon after, especially in the 1980s, integrative therapy grew into a full-fledged movement. One of the champions of this movement has been John Norcross, who explained that the psychotherapy integration movement grew out of “a dissatisfaction with single-school approaches and a concomitant desire to look across and beyond school boundaries to see what can be learned from other ways of thinking about psychotherapy and behavior change” (Norcross & Newman, 1992, p. 4). Norcross and Newman identify a number of factors that have fostered the popularity of integrative forms of psychotherapy, especially since the 1980s. Among the most important of these factors are two that we identify in this chapter: the lack of differential effectiveness among therapies and the recognition that common factors contribute significantly to therapy outcome.
If You Know the Difference Between a Fruit Salad and a Smoothie, You Understand the Difference Between Eclectic and Integrative Psychotherapists

A fruit salad includes a variety of ingredients, but each bite brings only one flavor. The fork may stab a strawberry first, a blueberry next, and a pineapple chunk third. Each piece is pure, discrete, and easily distinguished from the others. But in a smoothie made of these ingredients, every sip includes the same combination of ingredients, and the taste of every sip reflects that unique blend. Mixed together, the ingredients create a distinct concoction with a taste wholly its own.

An eclectic approach to psychotherapy is a lot like a fruit salad. Eclectic therapists use a pure, discrete approach to therapy with each client, and they choose that approach according to empirical support. They allow empirical studies of psychotherapy efficacy to direct them toward the therapy most likely to succeed for a particular diagnosis. As described in Chapter 3, recent publications have supplied therapists with lists of the most empirically supported treatments for particular disorders (e.g., Chambless et al., 1998). An eclectic therapist would refer to such a list for each client separately.

Because such lists prescribe very different forms of therapy for various disorders, eclectic therapists must be versatile enough to practice many techniques competently. Eclectic therapists have no loyalty to any particular approach to therapy; their loyalty is to the empirical data.

Integrative therapy, in contrast, is more like a smoothie—a custom blend of ingredients that forms an original creation. This “hybrid” approach to therapy is often used across clients and across diagnoses. Thus, integrative therapists are less concerned with employing evidence-based, manualized techniques in their pure form; instead, they are concerned with synthesizing the best features of various theories of psychotherapy. Whereas an eclectic therapist’s approach might contrast greatly from one client to the next (depending on empirical data for treatments of various disorders), an integrative therapist’s approach might remain a bit more constant, just as in a smoothie—the flavor combination doesn’t vary much from sip to sip.

As a clinical psychologist, which of these approaches to therapy—eclectic or integrative—would you prefer? If you were the client, which approach might you prefer that your clinical psychologist take? What are the pros and cons of each approach?
DENISE: A FICTIONAL CLIENT TO CONSIDER FROM MULTIPLE PERSPECTIVES

The next four chapters of this book each feature a specific approach to psychotherapy: psychoanalytic, humanistic, behavioral, and cognitive. To illustrate each fully, we consider a therapy summary of a fictional client named Denise. (As this chapter indicates, if Denise were a real client seen by a real clinical psychologist, she would most likely receive eclectic or integrative treatment, but therapy summaries of the single-school approaches will nonetheless exemplify the elements of the various approaches.) As therapy summaries, these reports appear in the past tense, as if Denise has completed a full course of the featured treatment and the therapist has written a synopsis of the treatment that might be useful if Denise returns later or resumes therapy with another therapist.

As with any client, Denise’s cultural background is an important aspect of her therapy. In creating this fictional client, many of her demographic characteristics were selected because they match descriptions of individuals most likely to seek psychotherapy (Vessey & Howard, 1993). Of course, culturally competent clinical psychologists may make adjustments to therapy for clients with similar presenting problems but different cultural characteristics.

A full description of Denise is presented in Box 11.5.

Box 11.5 Denise: A Fictional Client to Consider From Multiple Perspectives

Denise is a 30-year-old, single, heterosexual, Caucasian woman who has lived her entire life in a large Midwestern city. She has no history of significant illness or injury and is in generally good health. Denise grew up as the fifth of six children in a middle-class family in which both parents worked full-time. She attended 2 years of college immediately after high school but transferred to culinary school where she graduated near the top of her class. She currently lives alone and maintains an upper-middle-class lifestyle.

Denise has worked as the only chef in a small upscale restaurant for about 5 years. Denise has enjoyed her job very much. One of her favorite aspects of her job had always been coming out of the kitchen to ask customers how they were enjoying their meals, especially because

(Continued)
the feedback she received from them was almost exclusively positive. The owner of the restaurant had allowed Denise to do this because he believed it added a personal touch to the dining experience. Another of her favorite aspects of the job had been the creative freedom she enjoyed in the kitchen. The owner had allowed her to create her own unique entrées and change them as frequently as she liked.

Recently, though, Denise’s feelings toward her job have changed drastically. A new owner took over the restaurant, and the new owner firmly stated to Denise that her job was to stay in the kitchen preparing food and not talk with customers at all. The new owner has also provided Denise with a strict, predetermined, permanent menu that the owner alone created and that Denise must now follow. She finds this revised job description inconsistent with her own personal style, and she sorely misses both the praise she had become accustomed to receiving from customers and the opportunities to create her own dishes.

Since this change was implemented, Denise has been experiencing mild to moderate depressive symptoms, including sadness, loss of interest in daily activities, low energy, difficulty sleeping, and difficulty concentrating. She has had difficulty getting to work on time and preparing dishes in a timely and conscientious manner, and her exercise routine, which had been very regular, is now sporadic. Sometimes Denise suspects that the new owner may have implemented this new policy specifically to hurt her. She states that she wants to return to the way she felt before this happened, and she is concerned that if she cannot overcome this problem, her performance at work will suffer to the extent that she will lose her job.

CHAPTER SUMMARY

Psychotherapy is the most common professional activity of clinical psychologists. Following some published doubts about its efficacy in the 1950s, researchers in the subsequent decades amassed enormous amounts of empirical outcome data, much of which has been combined in meta-analyses, supporting the conclusion that for the vast majority of clients, psychotherapy works. Recent data suggests that it also reduces medical costs and produces neurological changes in the brain. Outcome studies that have compared the efficacy of various approaches to therapy with one another have consistently resulted in a virtual tie, a finding that has been nicknamed the “dodo bird verdict.” The presence of common factors across all forms of therapy, including a strong therapeutic relationship, hope, and attention, may underlie their equal efficacy. More recent and targeted outcome studies focusing on particular manualized therapies for particular disorders have given rise to further debate about the relative contributions of
the common factors versus specific therapy techniques. All empirical psychotherapy outcome studies must address numerous methodological issues, including who, when, and how to ask about the outcome of therapy. Additionally, efficacy studies, which assess how well a therapy works “in the lab,” should be understood in conjunction with effectiveness studies, which assess how well a therapy works “in the real world.” Surveys indicate that since 1960, the eclectic/integrative therapy orientation has generally been most commonly endorsed by clinical psychologists, and among single-school approaches, the psychodynamic/psychoanalytic orientation has been on the decline, whereas the cognitive orientation has been on the rise.

**KEY TERMS AND NAMES**

**attention** Hans Eysenck
Bruce Wampold Hans Strupp
common factors hope
dodo bird verdict integrative
eclectic John Norcross
effectiveness meta-analysis
efficacy prescriptive approach
psychotherapy

**CRITICAL THINKING QUESTIONS**

1. According to the tripartite model, parties other than the client and the therapist can have a meaningful perspective on the outcome of a client’s psychotherapy. Specifically, which third parties might have the most valid perspective? Clients’ partners, friends, kids, supervisors, coworkers, managed-care companies, or someone else?

2. What conclusions do you draw from the results of large-scale effectiveness studies such as the 1995 *Consumer Reports* study?

3. When graduate programs train their students in psychotherapy, to what extent should they emphasize common factors (e.g., forming and maintaining strong therapeutic relationships) as opposed to specific therapy techniques?
4. Consider the three-step sequential model of common factors. In your opinion, would men and women tend to move through the sequence identically? What steps might each group tend to emphasize or deemphasize?

5. What are the implications of the finding that the eclectic/integrative orientation has been the most commonly endorsed orientation among clinical psychologists in surveys since 1960?

STUDENT STUDY SITE RESOURCES

Visit the study site at www.sagepub.com/pomerantz3e for these additional learning tools:

- Self-quizzes
- E-flashcards
- Culture Expert Interviews
- Full-text SAGE journal articles
- Additional web resources
- Mock Assessment Data

The author provides additional background and reinforcement of the topics covered in this chapter.