



NO MORE BELLS AND WHISTLES

*Effective
therapy
doesn't have
much to do
with either
theory or
technique*

IN ONE ANCIENT ZEN STORY, THE MASTER OF FOUR APPRENTICE monks who are seeking enlightenment counsels them to observe strict silence. Upon hearing this, the first young monk responds impetuously, "Then I shall not say a word." The second monk then chastises the first, saying, "Ha, you have already spoken." "Both of you are stupid," the third monk remarks and then asks, "Why did you talk?" In a proud voice, the fourth monk concludes, "I am the only one who has not said anything!"

These four apprentice monks competing to show their unique grasp of the truth are not unlike the proponents of various treatment models in the field of therapy. All are eager to demonstrate their special insight into the mysteries of the treatment process and the superiority of their chosen method. Yet while the number of therapy models has proliferated, mushrooming from 60 to more than 400 since the mid-1960s, 30 years of clinical outcome research have not found any one theory, model, method

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or package of techniques to be reliably better than any other. In fact, virtually all of the available data indicate that the different therapy models, from psychodynamic and client-centered approaches to marriage and family therapies, work equally well (1) This startling truth applies even to comparisons between talk therapies and the much-ballyhooed advances in biological psychiatry. Recent publicity aside, data comparing a variety of psychotropic medications with numerous psychological interventions indicate that they all achieve roughly equivalent results. Furthermore, findings that once appeared to show the superiority of cognitive and behavioral therapies turned out to be artifacts of the measures being used and the confirmatory bias of the investigators.

Given the clear demonstrations from research that there is little appreciable difference in outcome among the various therapy models, it is puzzling that they remain the centerpiece of so many graduate education programs, continuing education seminars and professional publications. How can something that makes so little difference continue to dominate professional discussion? The answer is simple: treatment models really do make a difference, just not to the client.

Consider the current popularity of brief therapy. Proponents of these approaches have gone to great lengths to point out the difference between brief and more traditional forms of treatment. The differences are so numerous that Steve deShazer, the developer of one brief treatment approach, devoted no less than five chapters to detailing them in his book, *Putting Difference to Work*. The proponents of brief therapy promise that these differences translate into more efficient and more effective forms of clinical practice. For example, in *Shifting Contexts: The Generation of Effective Therapy*, Bill O'Hanlon and James Wilk claim their brief therapy approach will enable clinicians to "achieve dramatic therapeutic successes more rapidly, more enduringly, more effortlessly, more pleasurable, and more reliably than any psychotherapeutic approach [and] most in a single session."

The only problem is that there is not a single shred of evidence to support such claims. In fact, there is not any evidence that brief therapy is actually briefer than existing therapeutic approaches. (2) Rather, the research clearly indicates that most therapy is of relatively short duration and always has been *regardless of the treatment model employed*. The average

client of any therapy, for example only attends five or six sessions! Similarly, there is no evidence that brief therapy results in more single-session cures. Once again, the research indicates that a single session is the modal number of sessions for all clients in therapy *regardless of the treatment model employed*. Finally, there is absolutely no evidence that brief therapy results in more effortless, reliable or even enduring change than "longer term" treatment. Indeed, available data suggest that brief therapy achieves roughly the same results as the traditional approaches they are supposed to replace. In short, whatever differences the experts may believe exist between brief and traditional therapy, there simply isn't a difference in terms of outcome.

Why then do the developers of treatment models spend so much time and effort highlighting the differences between their respective approaches when no empirical support exists for such differences? One possibility is that advocates for the various models are trying to influence and impress their primary consumers—not clients, but *other therapists*. After all, therapists are the ones most likely to be interested in one theory or another, to use the various models to conceptualize and organize their clinical work and to buy professional books and attend training workshops. From a marketing point of view, proponents of brief therapy should be considered especially skilled salespeople since they have successfully convinced large numbers of clinicians to buy a model that produces essentially the same results as other models presently in use. How could such a large segment of practicing clinicians be sold such a bill of goods?

To succeed in the "therapy model marketplace," the proponents of a particular brand of treatment must somehow manage to make their model stand out from the competition. Clearly, the more exclusive the product and the more distinguishable from rival brands, the better. One way to distinguish one treatment model from another in the absence of validating data is to develop a special way of talking about the techniques and theory that are exclusive to that model; having a special language imbues it with an aura of difference that seems to justify its claims of uniqueness. In fact, most psychotherapy models seem different because they *sound* different. As in the advertising business, making distinctions with words is tremendously important in the psychotherapy marketplace precisely because words are prac-

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tically all that separates one model from another

However, as Abraham Lincoln was fond of saying, agreeing to call a dog's tail a foot does not mean that the dog really has five feet. At a time when therapists are more than ever before being held accountable for the service they provide to clients, equating differences in language with differences in effect may ultimately prove very costly to the practice of therapy. In order to survive in the new millennium, psychotherapy as

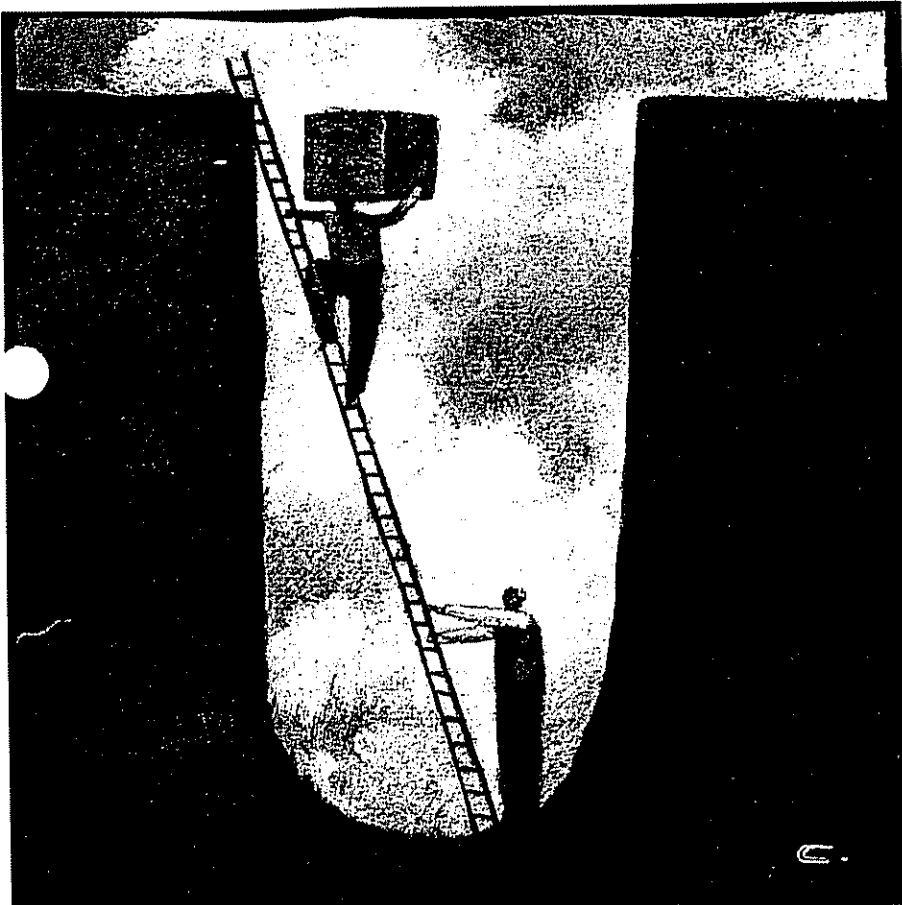
created the slogan, "I can't believe I ate the whole thing." The announcement came as a shock since the series of clever commercials had so quickly become part of the national vernacular and garnered much critical acclaim within the industry. Advertising companies all over the world had rushed to produce look-alike commercials. The makers of Alka Seltzer, however, had one fundamental problem with the commercials—they didn't sell more Alka Seltzer. Likewise, the time has come for therapists to "fire" treatment

better off than 80 percent of people in a control group with a similar difficulty who received no treatment. Therapists, the research makes clear, are not tricksters, snake-oil peddlers or ineffectual do-gooders.

Neither does challenging the central role that models play in the field mean that "anything goes" in treatment or that no guidelines exist for helping therapists navigate the ambiguities of therapeutic work. In fact, we already have 30 years of research evidence that makes it clear that the *similarities* rather than the *differences* between models account for most of the change that clients experience across therapies. What emerges from examining these similarities is a group of common factors that cut across models and contrast sharply with the current emphasis on differences in theory and technique characterizing most professional discussion.

The whole idea of a set of common therapeutic factors is not new. Indeed, in 1961, in his groundbreaking book, *Persuasion and Healing*, Jerome Frank posited that a core group of factors was responsible for the relatively uniform outcomes of different treatment models. Later on, Stupp and Hadley added research support to Frank's observations in a classic study titled "Specific and nonspecific factors in psychotherapy," which appeared in *Archives of General Psychiatry*.

The greatest support for the common factors, however, comes from studies that originally set out to demonstrate the unique effects of one particular approach or another and instead found that all models work equally well. The body of this work indirectly but unequivocally demonstrates the importance of a set of core factors common to all methods that really account for therapy's positive outcome, regardless of what the model's theoreticians believe. Unfortunately, these factors do not, in themselves, have the ideological allure that initially draws many practitioners to a given model. They simply do not *sound* unique, special or intriguingly arcane. They have no charisma! Moreover, they lack the promise of complexity and seeming explanatory power that clinicians have come to expect of psychotherapy theories. Finally, they are not touted by persuasive advocates. As H.I. Mencken once observed, the problem with truth is that "it is mainly uncomfortable, and often dull. The human mind seeks something more amusing, and often caressing." Yet, despite these disadvantages, these factors do offer



a *whole* must be able to document that the methods employed by clinicians actually deliver what they promise. More and more, third-party payers want to know about the effectiveness of the services that professionals provide. They are increasingly insisting that, to be reimbursed, therapists must be able to deliver the goods

IN THE LATE 1970s, THE MAKERS OF Alka Seltzer surprised everybody by firing the advertising company that

models and their ideological proponents for that same, simple reason—they do not work. They neither explain nor contribute to effective therapy

Rejecting the hegemony of treatment models does not mean that therapy in general should be dismissed as ineffective. On the contrary, considerable evidence now exists demonstrating the superiority of therapy to both placebo and no-treatment control groups. Among other things, this research indicates that the average client receiving treatment is

something no current model can provide—clear, empirically validated guidelines for clinical practice in this era of accountability.

FOUR COMMON FACTORS, EACH central to all forms of therapy despite theoretical orientation, mode (i.e., individual, group, marriage, family, etc.), or dosage (frequency and number of sessions), underlie the effectiveness of therapy: (5)

Therapeutic technique. In any given session, one may see a therapist asking questions, listening and reflecting, dispensing reassurance, confronting, providing information, offering explanations (reframes, interpretations), making suggestions, self-disclosing or assigning tasks to be done both within and outside the therapy session. The content of the talk or questions is different depending on the therapist's orientation and technique. Whatever model is employed, however, most therapeutic procedures prepare clients to take some action to help themselves. Across all models, therapists expect their clients to do something different—develop new understandings, feel emotions, face fears, take risks or alter old patterns of behavior.

In his widely cited review of psychotherapy outcome research, Brigham Young University researcher Michael Lambert estimates that the therapist's model and technique contribute only 15 percent to the impact of psychotherapy. (3) While this may be troubling to some schools of therapy that pride themselves on their unique conceptualization of therapeutic process or innovations in intervention methods (e.g., family sculpting, genograms, miracle questions, etc.), the data are clear: clients are largely unimpressed with their therapist's technique. As Lambert puts it: "Patients don't appreciate techniques and they don't regard them as necessary. They hardly ever mention a specific technical intervention the therapist made. I'd encourage therapists to realize that their phenomenological world regarding the experience of therapy is quite different from that of their patients. The nontechnical aspects are the ones patients mention. Also, when objective judges listen to tapes of therapy, the nontechnical aspects are the things that correlate with outcome more than any technical intervention."

Expectancy and placebo. As a factor in outcome, technique matters no more than the "placebo effect"—the increased hope and positive expectation for change that clients experience simply from

making their way into treatment. As one might expect, the creation of such hope is greatly influenced by the therapist's attitude toward the client during the opening moments of therapy. Pessimistic attitudes conveyed to the client by an emphasis on psychopathology or the difficult, long-term nature of change are likely to minimize the effect of these factors. In contrast, an emphasis on possibilities and a belief that therapy can work will likely counteract demoralization, mobilize hope and advance improvement.

consumer's participation in therapy is the single most important determinant of outcome. What is more, several studies have found that clients' ratings of that bond or alliance, rather than the therapists' perceptions, are more highly correlated with outcome.

A positive bond or alliance results, at least in part, when the therapist is empathic, genuine and respectful—when he or she exhibits the relationship factors that humanistic psychotherapist Carl Rogers considered the "core conditions"



Therapeutic relationship. Lambert estimates that the therapeutic relationship contributes a hefty 30 percent to outcome in psychotherapy, making it a far more critical factor than either therapeutic technique or expectancy. Clients who are motivated, engaged and connected with the therapist in a common endeavor will benefit the most from therapy. Their participation is, of course, largely a result of the bond or alliance that clients form with the helping professional; studies show that the

of effective psychotherapy. In this regard, the latest thinking and research indicate that strong alliances are formed when clients perceive the therapist as warm, trustworthy, nonjudgmental and empathic. Therapists' own evaluations of their success in creating this kind of therapeutic environment for the client are not enough. The core conditions must actually be perceived by the client, and each client will experience the core conditions differently. The most helpful alliance will develop when the therapist establishes a

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therapeutic environment that matches the client's definition of empathy, genuineness and respect.

Client factors. In the clinical literature, clients have long been stereotyped as the message-bearers of family dysfunction, the manufacturers of resistance and, in the strategic tradition, the targets for the presumably all-important technical intervention. Rarely, however, have clients been identified as the chief agents of change. Nevertheless, the client is actually the single most potent factor, contributing an impressive 40 percent to outcome. The quality of a client's participation in treatment, his or her perceptions of the therapist and what the therapist is doing, determine whether *any* treatment will work. In fact, the total matrix of who they are—their strengths and resources, the duration of their complaints, their social supports, the environments in which they live, even fortuitous events that weave in and out of their lives—matters more heavily than anything therapists might do.

The importance of client factors was clearly demonstrated in a meta-analytic study statistically compiling results from many other studies reporting that in the treatment of anxiety and depression—the two most common mental health complaints—self-help approaches worked about as well as treatments conducted by therapists. While perhaps humbling, this research makes clear that the most influential contributor to change is the client—not the therapy, not the technique, not the therapist, but *the client*. The sheer impact of their contribution when compared to other factors serves as a powerful reminder that whatever the theory, model or nature of the therapeutic relationship, however famous the therapist or dazzling the procedure, no change is likely to occur without the client's involvement.

TO GENERATIONS OF THERAPISTS reared on the proposition that ingenious and intellectually stimulating treatment models and their associated techniques make the real difference in therapy, the four common factors that really count may seem pallid and anticlimactic. Therapists have been taught that producing change is a complicated, technical and often dramatic business. Faced with the ardors of day-to-day clinical work, many therapists may feel that the four factors are simply too inert, offering little help in addressing the

complex problems modern clients bring to the consulting room.

The fact of the matter, however, is that while therapists' theories of problems and their experience of the therapeutic process may be complex, the factors that contribute to successful therapy are not. The data indicate that successful psychotherapy would be more correctly construed as a rather simple, straightforward business, distinguishable from other helpful experiences in life only by the explicit, socially sanctioned contract to be helpful that exists between a therapist and client. To be sure, the practice of psychotherapy is not always an easy one. Easy and *simple* are, however, two very different matters.

Clinical work may frequently be trying, but that does not mean that the factors contributing to successful psychotherapy are necessarily complicated. As evidence of this, consider a growing body of literature demonstrating that minimally trained and paraprofessional psychotherapists achieve largely the same results as highly trained, highly paid professionals. (6) While this may be alarming to some mental health providers, it says something profoundly optimistic about the possibilities for human change.

To establish a more empirically based practice, therapists can begin by simply examining their own practice. No guru, no complex theory of human behavior and no advanced psychotherapy workshop is needed. Like Dorothy in *The Wizard of Oz*, therapists have always had the means to get back to Kansas.

Start by setting aside your chosen theory and look for the proven factors that are currently operating in your own clinical work. How do you, for example, draw on the strengths, resources and worldview of your clients to help them achieve their goals? To what extent do you take into account and use the client's environment and existing support network? Do you expand on the spontaneous changes that clients experience outside of therapy?

In our own work, one of the ways we make use of client factors is simply by listening for and validating any and all evidence of their strengths and resourcefulness. Questions may also be used to highlight areas of competence, past successes or unrecognized resources. When clients make their first contact with us for therapy, we try to actively incorporate into the treatment process their natural tendency to experience improvement between the time they first

make contact and their first session of therapy. For example, during that initial phone call, we might ask clients to be on the lookout for any improvement that occurs before the first meeting. In many cases, at the first session, they report improvement directly related to their reasons for seeking therapy, which can be incorporated into the treatment process. Asking about such change is not, however, an invariant technical procedure to be applied unthinkingly to everybody, nor is there anything magical about it. Most clients contact a treatment professional when they are feeling the greatest distress or discouragement; they have no place to go but up. As a result, simply making the first call to a therapist propels them in the direction of improvement.

Our awareness of the importance of client factors has led us to pay considerably more attention to any fortuitous events in the lives of clients that result in change or improvement and to actively make use of such events in treatment. In the process, we have been humbled by the recognition that some of our most successful cases resulted more from events outside than inside therapy. For example, one man came to therapy complaining of depression that he believed resulted from long-standing marital problems. Since an argument nearly two years earlier, the man and his wife had slept in separate bedrooms and spoken to each other only when they needed to take care of business. Although we worked with the man individually for several sessions, he continued to be depressed and his marital problems remain unchanged. Attempts to draw his wife into counseling were not successful and, increasingly, it looked as if we might not be helpful to the man, until relatives showed up unexpectedly one evening at the couple's home.

Not having seen each other for some time, the two couples talked, laughed and allowed the evening to slip by unnoticed. When they finally realized the time, it was too late for the visitors to drive home or find a hotel room, so they stayed the night. Since there were only two bedrooms in the house, our client and his wife were forced to sleep together in the same room, which set a chain of events in motion. For the first time in two years, the two spoke to each other about matters other than business. Before the night was over, they had even made love. The talk continued into the next day and they slept together again

that night. Much to our surprise, the couple showed up together for the man's next appointment. They told us what had happened and how their relationship had been improving since that evening. We spent most of the session talking about the improvements. Time was also spent making sure that the changes dovetailed with what each of the partners wanted, and discussing their ideas for maintaining momentum. By the conclusion of therapy, the relationship had improved considerably and the

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man's depression had resolved. Therapy was clearly helpful to this couple, but not because it was comprised of some technically marvelous intervention. Basically, we did little more than encourage, or at least keep from interfering with, their own efforts to improve their lives.

In addition to being aware of client factors, therapists can examine how they use relationship factors in their clinical work. Given that the quality of the therapeutic relationship is the second largest contributor to psychotherapy

outcome, consider how you establish a strong working alliance. What do you do, for example, to engage the client in treatment; and how do you engage those clients who seem uninterested or unmotivated? What special ways have you found for encouraging the client on the fringe of engagement to assume a more active role in treatment? Are the goals and the tasks for therapy defined largely by the model of therapy you practice or do they result from a collaborative effort between you and your client? Most important, what do you do to provide the core conditions of empathy, genuineness and respect, and how do you tailor them to the individual client? For example, in contrast to what most therapists learned in graduate school, the research indicates that the majority of clients do *not* experience empathy from the therapist as a nurturing, warm-and-fuzzy focus on their feelings, but rather as discerning and thoughtful appreciation of their situation. Therapists who want to maximize the core effective factors of therapy, therefore, will make a concerted effort to speak in the language and worldview of their clients rather than in the terminology of their own treatment model.

In our practice, we spend little time developing a diagnosis or a theory about the possible etiology of the presenting complaint and even less on what therapeutic approach or techniques will be most useful. The process of treatment is comprised of careful listening combined with questions aimed at defining and refining the client's goals for treatment. As may be obvious, the immediate emphasis on the client's goals and consequent de-emphasis of the client's history and psychopathology also make use of placebo and expectancy factors. From the outset, feelings of hope and expectancy are stimulated.

During therapy, we also devote considerable attention to working collaboratively with the client to develop the strategies, tasks and/or homework assignments that will help them reach their desired outcome. In doing so, we have gained new respect for the resourcefulness of our clients and confirmed our belief that many, if not most, of the clever therapeutic procedures attributed to master therapists may actually have come from their clients themselves. For example, 10-year-old Hannah was brought to treatment by her parents because of recurrent nightmares and an inability to sleep in her own room. Hannah and her family had already seen two other therapists. The first, we learned, had thought-

fully and carefully listened to and explored Hannah's feelings about the nightmares Hannah liked the therapist, but the nightmares didn't go away, so the family went to a second therapist, who had been recommended by a friend. They stopped treatment, however, when they were told that they needed marital therapy because Hannah's problems were a symptom of the conflicts in their marriage.

From the beginning of the first session with the family, there was agreement about the goals for therapy. Everyone wanted the nightmares to stop and for Hannah to be able to sleep in her own room. We asked Hannah herself what she thought might help solve her dual problems. She had a number of ideas, including using extra pillows and her favorite stuffed animals to build a fortress for herself in bed that would keep out the nightmares. With some help from her parents to arrange the pillows and animals in just the right way, Hannah's idea worked. She resumed sleeping in her own room and experienced no further nightmares.

Of course, it would be a mistake to extract the strategy that Hannah used to overcome her nightmares and attempt to apply it in other clinical situations. The key was not that we found the *right* technique for all complaints of childhood nightmares, but rather that we depended on the client's input, participation and involvement to determine the goals and tasks for therapy. While Hannah's example is particularly striking, all cases ultimately require a similar dependence on the client. The more conscious, deliberate and focused the attempt to draw the client into treatment, the less significant formal explanatory models and clinical techniques come to seem.

SOME MAY ARGUE THAT PAYING attention to the factors common to all therapy is, itself, a type of model or orientation. In our clinical work, however, there are no fixed techniques, no certainties or invariant patterns that emerge from the therapeutic process, no generalizations that can or need be made about our clients. Of course, there are variations in our respective personal styles and ways of interacting with clients. Compared to the commonalities of our work, however, these differences seem insignificant—we all share the same outcome figures.

We are not proposing an eclectic approach to practice, with therapists sampling from a variety of models in an attempt to individualize treatment

Rather, we are suggesting that all treatment, to the extent that it reflects these four common factors, will be successful. Good therapy, whether it's done by cognitive, behavioral or psychodynamic therapists, looks roughly the same. The common factors, like notes of written music, may be arranged in different orders and patterns and played in a variety of styles, but they are still based on a common language—a language that allows for maximum flexibility and creativity, but that still serves to unify

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rather than separate the speakers, cutting across the theoretical divisions that have characterized psychotherapy from its inception.

In this era of accountability, professional dialogue can no longer afford to be the modern equivalent of the Tower of Babel. Recently, the field has become the subject of increasing scrutiny. Besides the growing demands of third-party payers for demonstrated effectiveness, therapists now face a cascade of critical mass-market books, articles and

news stories accusing them of greed, fraud, incompetence, failed ethics and extreme susceptibility to every ephemeral fad touted in the popular culture. Serious questions have been raised about the right of therapists to practice any form of treatment that has not been empirically tested and its effectiveness validated. Indeed, legislation, ostensibly for the protection of mental health consumers, has already been proposed that would effectively ban third-party reimbursement for psychotherapy procedures that have not been documented as both safe and effective—and not by therapists, but by the scientific research community, which might or might not include practicing clinicians.

While these proposals evoke outrage in many in our field, to some extent we have only ourselves to blame. Too many exaggerated claims without experimental backing, fancy and exotic sounding techniques that come and go with the seasons and loudly publicized internecine quarrels about relative success have begun to give therapy a bad name, undercutting its very real and deeply helpful benefits.

It is possible for the field to survive into the new millennium. At the heart of the four factors that characterize all good therapy is the desire and the capacity to form helpful and healing bonds with troubled people who have, for the time being, lost their way and need some directional signals back to their own best selves. To recover the currently tarnished reputation of the field, we need to put treatment models in their place, stop speaking in the tongues of our pet theories, and learn a simpler, more accessible language. We can no longer afford to pretend that it is the treatment model and not our clients and the relationship with our clients that comprises the real substance of our clinical work. To do otherwise is to risk having the destiny of our field taken out of our own hands. But, most of all, we need to remember, as the words of one of the most cherished maxims of the field has it, that the map, however helpful, is not, never was and never will be the territory. ■

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