

The Legacy of Saul Rosenzweig: The Profundity of the Dodo Bird

Barry L. Duncan

Nova Southeastern University

This article provides commentary on Saul Rosenzweig's classic 1936 paper, "Some Implicit Common Factors in Diverse Methods of Psychotherapy," with particular emphasis on his clever and prophetic invocation of the dodo bird verdict from Alice in Wonderland. The impact of this seminal contribution is discussed by a comparison of Rosenzweig's original common factors proposal with modern formulations of common factors. The paradox inherent to the tenacious veracity of the dodo bird verdict and the pursuit of empirically validated treatments are explored. In the spirit of Rosenzweig's legacy and the wisdom of the dodo, this article suggests that psychotherapy abandon the empirically bankrupt pursuit of prescriptive interventions for specific disorders based on a medical model of psychopathology. Instead, a call is made for a systematic application of the common factors based on a relational model of client competence.

The great tragedy of Science—the slaying of a beautiful hypothesis by an ugly fact.—Thomas Henry Huxley (1825–1895)

Although long enamored of common factors and their practical application to psychotherapy practice and integration (Duncan, Hubble, & Miller, 1997; Duncan & Miller, 2000b; Duncan & Moynihan, 1994; Duncan,

Barry L. Duncan, School of Social and Systemic Studies, Nova Southeastern University. I am indebted to Scott Miller, Jacqueline Sparks, and Mark Hubble for our many collaborations, the results of which are intertwined throughout this article. I also thank Jacqueline Sparks for invaluable comments on this article and Roberto Quiroz for library assistance.

Barry L. Duncan is now at the Institute for the Study of Therapeutic Change, Tamarac, Florida.

Correspondence concerning this article should be addressed to Barry L. Duncan, P.O. Box 26231, Tamarac, Florida 33320. E-mail: barrylduncan@cs.com

Solovey, & Rusk, 1992; Hubble, Duncan, & Miller, 1999b; Miller, Duncan, & Hubble, 1997), I only recently read Saul Rosenzweig's classic 1936 paper, "Some Implicit Common Factors in Diverse Methods of Psychotherapy." Heretofore, I appreciated the article for its historical significance as the first known articulation of common factors in psychotherapy, which I had gleaned through others' reference and interpretation (e.g., Goldfried & Newman, 1992; Luborsky, 1995; Weinberger, 1995). When the contribution to this volume motivated a long overdue first-hand look, I was more than surprised to find the dodo bird verdict from *Alice in Wonderland* used as an epigraph to begin Rosenzweig's paper (see his explanation for that choice in this issue [Duncan, 2002]).

Recall that in *Alice in Wonderland*, Lewis Carroll (1865/1962) tells the story of a race that was run to help the animals dry off after they were soaked by Alice's tears. The animals ran off helter-skelter in different directions, and the race was soon stopped. The dodo bird was asked, "Who has won?" And he finally exclaimed the now famous verdict, "Everybody has won, and all must have prizes." The dodo bird's pronouncement has become not only a metaphor for the state of psychotherapy outcome research but also a symbol of a raging controversy regarding the privileging of specific approaches for specific disorders based on demonstrated efficacy in randomized clinical trials (e.g., Chambless & Hollon, 1998; Garfield, 1996; Goldfried & Wolfe, 1998; Hubble, Duncan, & Miller, 1999a; Shapiro, 1996)—the so-called empirically validated treatments.

It is curious that few discussions of Rosenzweig's (1936) article refer to his creative application of Carroll's famous race. The often perfunctory accounts of Rosenzweig's paper have perhaps missed its most profound element: the clever invocation of the verdict to describe the equivalence of effectiveness among psychotherapies. Many have attributed the colorful and illustrative application of the dodo bird's judgment to Frank's (1973) *Persuasion and Healing*. Perhaps most, however, have credited Luborsky, Singer, and Luborsky (1975) for its use in their groundbreaking summation of comparative studies of psychotherapy.

Although Luborsky et al. (1975) cited Rosenzweig's original application in the second line of their own classic piece, most (with notable exceptions, e.g., Weinberger, 1993) are either unaware of or have overlooked or forgotten that credit. Taking nothing away from Luborsky et al., their invocation of the verdict was a perfect satiric fit because of the horse-race mentality of comparative studies, the scattered directions that various approaches uncritically traveled, and the resultant findings of no differences.

It was not until I read Rosenzweig's (1936) article that I could grasp its amazing clairvoyance—Luborsky et al. (1975) empirically confirmed Rosenzweig's crystal ball assessment of psychotherapy some 40 years earlier. He not only predicted nearly 65 years of data; Rosenzweig, in 1936,

presented the classic argument, still used today, for a common factors perspective—namely, because all approaches appear equal in effectiveness, there must be pantheoretical factors in operation that overshadow any perceived or presumed differences among approaches. In short, he discussed the factors common to therapy as an *explanation* for the observed comparable outcomes of varied approaches. His paper represents far more than an historical footnote in the evolution of a common factors perspective and deserves far more than an obligatory tip-of-the-cap reference, of which my colleagues and I are equally guilty.

This article provides commentary on Rosenzweig's prophetic paper and its impact on contemporary psychotherapy. To accomplish this task, I compare Rosenzweig's seminal contribution with modern formulations of common factors. The paradox inherent to the dodo bird verdict and the pursuit of empirically validated treatments is explored. Finally, in the spirit of Rosenzweig's legacy and the wisdom of the dodo, this article suggests that psychotherapy abandon the empirically bankrupt pursuit of prescriptive interventions for specific disorders based on a medical model of psychopathology. Instead, a call is made for a systematic application of the common factors based on a relational model of client competence.

BONFIRE OF THE VANITIES

Beware lest you lose the substance by grasping at the shadow.—Aesop (620–560 B.C.)

With Freud, psychotherapy was born. Yet, before he barely left a mark on the professional landscape, his former disciples broke ranks, proclaimed their theoretical differences, and promoted their own versions of mental life and therapy. Since those days, the divisions have multiplied. New schools of therapy now arrive with the regularity of the Book-of-the-Month Club's main selection (Hubble et al., 1999b).

Dating from the 1960s, the number of psychotherapy approaches has grown approximately 600% (Miller et al., 1997). Although the actual figures vary among observers, it is estimated that there are now more than 200 therapy models and 400 techniques (Bergin & Garfield, 1994). Veteran common factors theorist and researcher Sol Garfield (1987) said, "I am inclined to predict that sometime in the next century there will be one form of psychotherapy for every adult in the Western World!" (p. 98). Most claim to be the corrective for all that came before, professing to have the inside line on human motivation, the true causes of psychological dysfunction, and the best remedies.

Once therapists broke the early taboo against observing and research-

ing therapy, they turned to proving empirically that their therapies were the best. A generation of investigators ushered in the age of comparative clinical trials. Winners and losers were to be had. As Bergin and Lambert (1978) described this time, "Presumably, the one shown to be most effective will prove that position to be correct and will serve as a demonstration that the 'losers' should be persuaded to give up their views" (p. 162). Thus, behavior, psychoanalytic, client-centered or humanistic, rational-emotive, cognitive, time-limited, time-unlimited, and other therapies were pitted against each other in a great battle of the brands.

Nonetheless, all this sound and fury produced an unexpected bonfire of the vanities (Hubble et al., 1999b). Put another way, reiterating Huxley's epigraph introducing this article, science slew a beautiful hypothesis with an ugly fact. As Rosenzweig spelled out more than 65 years ago, the underlying premise of the comparative studies, that one (or more) therapies would prove superior to others, received virtually no support (Bergin & Lambert, 1978; Sloane, Staples, Cristol, Yorkston, & Whipple, 1975). Besides the occasional significant finding for a particular therapy, the critical mass of data revealed no differences in effectiveness between the various treatments for psychological distress. Luborsky et al. (1975) reinvoked the dodo bird to describe the findings of their review of comparative studies. Now, more than 25 years later and many attempts to dismiss or overturn it (see below), the dodo bird verdict still stands. Therapy works, but our understanding of what works in therapy is unlikely to be found in the insular explanations and a posteriori reasoning adopted by the different theoretical orientations.

COMMON FACTORS: 1980 AND BEYOND

There is no new thing under the sun.—Eccles. 1:9

Weinberger (1995) observed that after 1980, an outpouring of writing began to appear on the common factors. Grencavage and Norcross (1990) collected articles addressing common factors and noted that a positive relationship exists between year of publication and the number of common factors proposals offered. Perhaps in response to the comparative studies and reviews of the 1970s and 1980s (e.g., Luborsky et al., 1975; Shapiro & Shapiro, 1982; Smith, Glass, & Miller, 1980; Stiles, Shapiro, & Elliot, 1986) reflecting the equivalence of outcome, the 1980s gave rise to more prominence to common factors ideas, particularly in the eclecticism-integration movement. Many noteworthy common factors proposals have appeared (e.g., Arkowitz, 1992; Garfield, 1980; Goldfried, 1982; Miller et al., 1997; Patterson, 1989; Weinberger, 1993).

Perhaps the most significant modern contribution to a common factors perspective was made by Michael Lambert. After an extensive review and analyses of decades of outcome research, Lambert (1992) identified four therapeutic factors (extratherapeutic, common factors, expectancy or placebo, and techniques) as the principal elements accounting for improvement in psychotherapy. Inspired by Lambert's proposal, Miller et al. (1997) expanded the use of the term *common factors* from its traditional meaning of nonspecific or relational factors to include four specific factors: client, relationship, placebo, and technique. It is interesting that this interpretation of common factors represents a return to Rosenzweig's original formulation. On the basis of this broader conceptual map of the common factors, Hubble et al. (1999b) assembled leading outcome researchers to review four decades of investigation and reveal its implications for practice. The results favored an increased emphasis on the client's contribution to positive outcome and provided a more specific delineation of clinical guidelines (Duncan & Miller, 2000b; Hubble et al., 1999a, 1999b). The following is a snapshot of the findings compared with Rosenzweig's 1936 formulations.

Client Factors: The Heroic Client

Until lions have their historians, tales of hunting will always glorify the hunter.—
African proverb

Clients have long been portrayed as the “unactualized” message bearers of family dysfunction, manufacturers of resistance, and, in most therapeutic traditions, targets for the presumably all-important technical intervention. Rarely is the client cast in the role of the chief agent of change or even mentioned in advertisements announcing the newest line of fashions in the therapy boutique of techniques (Duncan & Miller, 2000b). Tallman and Bohart's (1999) review of the research makes clear, however, that the client is actually the single, most potent contributor to outcome in psychotherapy—the resources clients bring into the therapy room and what influences their lives outside it (Miller et al., 1997). These factors might include persistence, openness, faith, optimism, a supportive grandmother, or membership in a religious community—all factors operative in a client's life before he or she enters therapy. They also include serendipitous interactions between such inner strengths and happenstance, such as a new job or a crisis successfully negotiated.

Assay and Lambert (1999) ascribed 40% of improvement during psychotherapy to client factors. This hefty percentage represents a departure from convention, considering that, as Tallman and Bohart (1999) indicated, most of what is written about therapy celebrates the contribution of the

therapist, therapist's model, or technique. Revisiting the dodo bird verdict, Bohart (2000) decried the field's persistent attempts to refute it and took the common factors interpretation of the verdict one step further. He asserted that therapies work equally well because they share one very important but classically ignored ingredient—the client and his or her own regenerative powers. The dodo bird verdict rings true, Bohart suggested, because the client's abilities to change transcend any differences among models.

If this is so, reasoned Tallman and Bohart (1999), then other examples of the equivalence of outcome should occur. And they do. The dodo bird verdict prevails not only across different approaches to therapy but also between professionals and paraprofessionals (Strupp & Hadley, 1979), experienced and inexperienced therapists (Christensen & Jacobson, 1994), psychotherapy and self-help (Arkowitz, 1997), and self-help approaches (Gould & Clum, 1993).

If what was provided in therapy was the real deal, then widespread uniform results would not be the norm. The data point to the inevitable conclusion that the engine of change is the client (Tallman & Bohart, 1999). Tallman and Bohart's review strongly suggests that the field reconsider its infatuation with model and technique and invest more wisely in researching ways to use the client in the process of change. Bergin and Garfield (1994) noted: "As therapists have depended more upon the client's resources, more change seems to occur" (pp. 825–826).

Rosenzweig (1936) spoke to the natural sagacity of the client to take what therapy offers and make the best of it. First, he argued that therapist formulations of the problem need only have enough relevance to impress the client to begin the work of rehabilitation; therapy serves to get the process of change started and need not be totally "adequate." Once started, Rosenzweig suggested that change ripples through the "whole" of the individual's personality. Because of the interdependent organization of personality, explanations of various theoretical origins may be effective because change in one area affects the person's entire life. Rosenzweig's comments reflect a basic belief in the client's capacity for change and the enlistment of the client in the change endeavor. In the era of Rosenzweig's common factors article, there seemed to be more respect for the potentialities of clients as well as a stated appreciation of the uniqueness of the individual (Duncan, 2002; Watson, 1940).

It is unfortunate that this perspective seems to have been replaced by a psychopathological view of clients. Although some may take offense to this characterization, psychotherapy has largely evolved a perspective of clients as either "pathological monsters" or "dimwitted plodders" (Duncan & Miller, 2000a). Of course, no psychotherapist would say that he or she views clients as monsters or plodders. Psychotherapists would deny char-

acterizing clients as pathological monsters while simultaneously diagnosing them with equally devastating labels reflecting equally noncomplimentary descriptions. They would bristle at any assessment of their clients as dim-witted plodders while concurrently prescribing empirically validated treatments, relegating the client to a disembodied illness to be intervened upon instead of a contributing, resourceful partner with whom to discuss options. One only has to examine the texts of therapist talk, the countless number of therapist's tales of conquest over client psychopathology, to discover the cult of client incompetence so pervasive in our field. The hyperbolic depiction of clients as monsters or plodders opens up the hidden assumptions of psychotherapy—the heroic therapist riding a white stallion of expert knowledge brandishing a sword of validated treatments, rescuing the poor dysfunctional patient plagued by the dragon of mental illness—to examination.

Clients are the main characters, the heroes and heroines of therapeutic stage, and they are the most potent contributor to psychotherapeutic change (Bohart & Tallman, 1999; Duncan & Miller, 2000b). This common factor suggests that therapists eschew the five Ds of client desecration (diagnosis, deficits, disorders, diseases, and dysfunction) and instead find ways to enlist the client in service of client goals. Whatever path the psychotherapist takes, it is important to remember that the purpose is to identify not what clients need but what they already have that can be put to use in reaching their goals (see Hubble et al., 1999b, for practical clinical suggestions for enrolling client factors).

Relationship Factors: On the Shoulders of Carl Rogers

Some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician.—
Hippocrates

The next class of factors accounts for 30% of successful outcome variance (Assay & Lambert, 1999) and represents a wide range of relationship-mediated variables found among therapies no matter the therapist's theoretical persuasion. Therapist-provided variables, especially the core conditions popularized by Carl Rogers (1957), have not only been empirically supported but are also remarkably consistent in client reports of successful therapy (Lambert, 1992). Bachelor and Horvath (1999) convincingly argued that next to what the client brings to therapy, the therapeutic relationship is responsible for most of the gains resulting from therapy:

Rosenzweig (1936) comments on the power of therapist provided variables: the personality of the therapist would be sufficient in itself, apart everything else, to

account for the cure of many a patient by a sort of catalytic effect. Since no one method of therapy has a monopoly on all the good therapists, another potentially common factor is available to help account for the equal success of avowedly different methods. (p. 413)

Further, client perceptions of the relationship are the most consistent predictor of improvement (Gurman, 1977). For example, Blatt, Zuroff, Quinlan, and Pilkonis (1996) analyzed client perceptions of the relationship in the Treatment of Depression Collaborative Research Project (TDCRP). Like many other studies, improvement was minimally related to the type of treatment received (even drug treatment) but substantially determined by the client-rated quality of the relationship. Its significance transcends our cherished theoretical schools, our favorite techniques, our most worshipped gurus, and even the privilege attributed to medication.

Researchers have expanded the relationship beyond the therapist-provided variables to the broader concept of the *alliance*. The alliance speaks to both therapist and client contributions and emphasizes the partnership between the client and therapist to achieve the client's goals (Bordin, 1979). Research on the power of the alliance reflects over 1,000 findings (Orlinsky, Grawe, & Parks, 1994) and is particularly noteworthy when taken from the client's perspective. For example, Krupnick et al. (1996) analyzed data from the TDCRP and found that the alliance was most predictive of success for all conditions. In another large study of diverse therapies for alcoholism, the alliance was also significantly predictive of success (Connors, DiClemente, Carroll, Longabaugh, & Donovan, 1997). Moreover, the data suggest that the alliance quality itself is an active factor (Gaston, Marmar, Thompson, & Gallagher, 1991). Thus, the relationship *produces* change and is not only a reflection of beneficial results (Lambert & Bergin, 1994).

This *unequivocal* link between the client's rating of the alliance and successful outcome makes a strong case for a different emphasis in psychotherapy—on tailoring therapy to the client's perceptions of a positive alliance. To do this on day-to-day basis requires avid attention to the client's goals and careful monitoring of the client's reaction to comments, explanations, interpretations, questions, and suggestions. It also demands a higher measure of flexibility on the part of the therapist and a willingness to change one's relational stance to fit with the client's perceptions of what is most helpful (Norcross & Beutler, 1997). Offering a primitive version of Norcross and Beutler's notion of relationships of choice, Rosenzweig (1936) discussed the importance of finding the best match between the client's and psychotherapist's personality.

Some clients, for instance, will prefer a formal or professional manner to a casual or warmer one. Others might prefer more self-disclosure from their therapist, greater directiveness, a focus on their symptoms or a focus

on the possible meanings beneath them, a faster or perhaps a more laid-back pace for therapeutic work (Bachelor & Horvath, 1999). It is clear that the one-approach-fits-all is a strategy guaranteed to undermine alliance formation (see Hubble et al., 1999a, for practical clinical suggestions for enhancing relationship factors).

Placebo, Hope, and Expectancy: Remoralization Is the Key

One should treat as many patients as possible with a new drug while it still has the power to heal.—Sir William Osler (1849–1919)

Following client and relationship factors, comes placebo, hope, and expectancy. Assay and Lambert (1999) estimated its contribution to psychotherapy outcome at 15%. In part, this class of therapeutic factors refers to the portion of improvement deriving from a client's knowledge of being treated and assessment of the credibility of the therapy's rationale and related techniques. Expectancy parallels Frank's (1973) idea that in successful therapies both client and therapist believe in the restorative power of the treatment's procedures or rituals. These curative effects, therefore, are not thought to derive specifically from a given treatment procedure; they come from the positive and hopeful expectations that accompany the use and implementation of the method. Frank's classic discussion of remoralization as the final common pathway of all therapeutic intervention speaks to the power of hope to counter the most demoralized client.

Rosenzweig (1936) spoke to the power of expectation invoked by the therapist's belief in the method when he wrote, "The very one-sidedness of an ardently espoused therapeutic doctrine might on these grounds have a favorable effect" (pp. 413–414). In his 1940 panel presentation (Watson, 1940), Rosenzweig discussed faith and confidence of the client as part and parcel to the success of the therapist's suggestions, and a factor common to all therapies.

Rituals are a shared characteristic of healing procedures in most cultures and date back to the earliest origins of human society (Frank & Frank, 1991). Their use inspires hope and a positive expectation for change by conveying that the user—shaman, astrologer, or psychotherapist—possesses a special set of skills for healing. That the procedures are not in and of themselves the causal agents of change matters little (Kottler, 1991). What does matter is that the participants have a structured, concrete method for mobilizing the placebo factors. From this perspective, any technique from any model may be viewed as a healing ritual, rich in the possibility that hope and expectancy can inspire (see Hubble et al., 1999b, for practical clinical suggestions for enhancing expectancy factors).

Model/Technique Factors

Do not become the slave of your model.—Vincent van Gogh (1853–1890)

Models and techniques are the last of the four factors. Like expectancy, Assay and Lambert (1999) suggested that they account for 15% of improvement in therapy. In a narrow sense, model/technique factors may be regarded as beliefs and procedures unique to specific treatments. The miracle question in solution-focused therapy, the use of thought restructuring in cognitive-behavioral therapy, hypnosis, systematic desensitization, biofeedback, transference interpretations, and the respective theoretical premises attending these practices are exemplary.

In concert with Frank and Rosenzweig, model/technique factors can be interpreted more broadly as therapeutic or healing rituals. When viewed as a healing ritual, even the latest therapies (e.g., eye-movement desensitization response, or EMDR) offer nothing new. Healing rituals have been a part of psychotherapy dating back to the modern origins of the field (Wolberg, 1977). Whether instructing clients to lie on a couch, talk to an empty chair, or chart negative self-talk, mental health professionals are engaging in healing rituals. Because comparisons of therapy techniques have found little differential efficacy, they may all be understood as healing rituals—technically inert, but nonetheless powerful, organized methods for enhancing the effects of placebo factors.

They include a rationale, offer a novel explanation for the client's difficulties, and establish strategies or procedures to follow for resolving them. Depending on the clinician's theoretical orientation, different content is emphasized. Rosenzweig proposed that whether the therapist talks in terms of psychoanalysis or Christian Science is unimportant. Rather, what counts is the formal consistency with which the doctrine used is adhered to, thereby offering a systematic basis for change and an alternative formulation to the client.

In his conclusions, although making the point that common factors are primary, Rosenzweig predicted modern integrative efforts when he suggested that therapists have a repertoire of methods to draw on to adapt to the individual case (technical eclecticism; e.g., Lazarus, 1992). In his 1940 presentation, Rosenzweig again suggested that the content of any alternative conceptualization was unimportant. Remarkably, he noted the status of relativism in psychotherapy and the importance of "fitness" of special procedures to special clients—an early version of matching characteristics (Beutler & Clarkin, 1990), or what Duncan and Miller (2000a) called honoring the client's theory or change.

How exactly should models be viewed when so much outcome variance is controlled by other factors—85% to be exact (40% client factors, 30%

relationship factors, and 15% expectancy factors)? In addition to the provision of novelty to clients, models and techniques provide alternative ways of conceptualizing and conducting therapy *for therapists* when progress is not forthcoming. With over 400 models and techniques from which to choose, there is little reason for continued allegiance to a particular approach when it is not producing results. No blame need be assigned; psychotherapists and clients can simply change their minds, go back to the smorgasbord, so to speak, and make another selection (Hubble et al., 1999a).

The different schools of therapy, therefore, may be at their most helpful when they provide psychotherapists with novel ways of looking at old situations, when they empower therapists to *change* rather than *make up* their minds about clients (Miller et al., 1997). Models that better enlist the client's unique talents, help the therapist approach the client's goals differently, establish a better match with the client's own theory of change (Duncan & Miller, 2000a), or utilize environmental supports are likely to prove the most beneficial in resolving a treatment impasse.

It is helpful to stand back from the squabbles over whose form of therapy is best and consider what it means to regard models and techniques as part of the pantheoretical factors shared by all effective therapies. When viewed from this vantage point, models and technique no longer reflect a particular theoretical doctrine or school. Instead, as Simon (1996) suggested, they become "a practice which teaches the therapist, through naming, enactment, and talking to colleagues, the attitudes and values from which [therapeutic] work is generated" (p. 53).

Therefore, models and techniques help provide therapists with replicable and structured ways for developing and practicing the values, attitudes, and behaviors consistent with the core ingredients of effective therapy. This nontraditional role for models/techniques suggests that their principal contribution to therapy comes about by enhancing the potency of the other common factors: client, relationship, and placebo (see Hubble et al., 1999a, for a discussion of developing techniques from a common factors perspective that honor the client's theory of change).

THE DODO BIRD VERDICT PERSISTS

If a man will kick a fact out the window, when he comes back he finds it again in the chimney corner.—Ralph Waldo Emerson (1842)

Luborsky et al.'s (1975) analyses of comparative studies still ring true. Later sophisticated comparative clinical trials and comprehensive reviews have drawn similar conclusions (e.g., Elkin et al., 1989; Lambert & Bergin,

1994). A *Consumer Reports* survey, too, offered no evidence for differential effectiveness of therapies for any disorder (Seligman, 1995). Moreover, the most recent meta-analyses, an impressive investigation designed specifically to test the dodo verdict, once again has reconfirmed the bird's wise judgment (Wampold et al., 1997). Finally, a real-world study conducted by managed care giant Human Affairs International of over 2,000 psychotherapists revealed no differences in outcome among various approaches, including medication (Brown, Dreis, & Nace, 1999). The miniscule numbers of studies that have demonstrated superiority of one model over another are no more than would be expected by chance (Wampold, 1997).

Thus, despite the fortunes spent on weekend workshops selling the latest fashion, the competition among the more than 250 therapeutic schools, to expand on Frank's classic analogy, amounts to little more than the competition among aspirin, Advil, and Tylenol. All of them relieve pain and work better than no treatment at all. None stands head and shoulders above the rest. Why is the dodo bird's wisdom ignored? Bohart (2000) asserted:

There is so much data for this conclusion that if it were not so threatening to special theories it would long ago have been accepted as one of psychology's major findings. Then it would have been built upon and explored instead of continually being debated. The data call for a change in how we view therapy, but the field continues to stick to the old technique-focused paradigm. (p. 129)

There are two other reasons why the field is model maniacal. The quest for the Holy Grail presses onward because of the desire to find some definitive answer about ameliorating human suffering—keeping psychotherapists dangerously enamored of flashy techniques and the promise of miracle cures. Exploiting such strivings as well as fears of managed care, workshop brochures and book announcements regularly bombard clinicians with what is new and different.

Unfortunately, finding *the* cure always seems just out of reach. Therapists learn finger tapping, finger waving, miracle questions, and other highly publicized methods of treatment. Self-proclaimed experts present mysterious scans of brains showing incontrovertible truth that “mental illness” exists and medical science is on the verge of conquering it. But when reality sets in, therapists know that they can never produce the epic transformations witnessed on videos or reported in edited transcripts. Psychotherapists painfully recognize that colorized brain images will not help when they are alone in their offices facing the pain of people in dire circumstances. Amid explanations and remedies aplenty, beleaguered and growing in cynicism, therapists courageously continue the search for designer explanations and brand name miracles. They become distracted and disconnected from the power for change that resides in their clients and the quality of partnership that can be achieved.

The other reason that the dodo bird verdict is ignored is that clinicians are indoctrinated to privilege model and technique by graduate programs, professional organizations, and managed care companies. Political and economic factors loom large. Along with the explosion of treatment methods, there has been an unprecedented expansion in the number of mental health practitioners. With so many to choose from, the inevitable competition for jobs, prestige, and influence markedly spiraled.

Psychiatrists, arguably better positioned because of their historical hegemony in health care, have prepared and distributed practice guidelines targeting specific treatments (drugs) for specific disorders. To ensure their continued viability in the market, psychologists have rushed to offer magic bullets to counter psychiatry's magic pills, to establish empirically validated or supported treatments (EVTs). EVT's are promoted as the rallying point, a "common cause" for a clinical profession fighting exclusion (Nathan, 1997, p. 10). The now famous (or infamous) task force of the American Psychological Association (APA; Task Force on Promotion and Dissemination of Psychological Procedures, 1995) was given the job of cataloguing treatments of choice for specific diagnoses. To make the EVT list, an approach need only demonstrate its efficacy, or superiority over placebo, in two studies.

EMPIRICALLY OR POLITICALLY VALIDATED TREATMENTS?

Seek facts and classify them and you will be the workmen of science. Conceive or accept theories and you will be their politicians.—Nicholas Maurice Arthus (1862–1945)

The good intentions of saving psychology's market share notwithstanding, declaring an approach to be an EVT and suggesting that it should therefore be the prescribed treatment of choice is empirical bankruptcy. After their extensive meta-analytic reconfirmation of the dodo bird verdict, Wampold et al. (1997) concluded:

Unfortunately, the empirical validation strategy weakens support for psychotherapy as a mental health treatment rather than strengthens it. Why is it that researchers persist in attempts to find treatment differences, when they know that these effects are small in comparison to other effects . . . or treatment versus no treatment comparisons. . . ? (p. 211)

EVTs equate the client with the problem and describe the treatment as if it is isolated from the most powerful factors that contribute to change: the client's resources, perceptions of the alliance, and participation. The EVT position virtually ignores 40 years of outcome data about common factors and the veracity of the dodo bird verdict. Model factors are pale in com-

parison with client and relationship factors; efficacy over placebo is not differential efficacy over other approaches. Shapiro (1996) suggested, “The Task Force might build a better case for psychotherapy from common factors research than by citing a rather short list of ‘validated’ methods” (p. 257).

The EVT house of cards is built on the foundation of the medical model: diagnosis plus prescriptive treatment equals symptom amelioration (see Bohart, 2000). George Albee (1998), vociferous critic of the medical model, suggested that psychology made a Faustian deal with the medical model over 50 years ago when it uncritically accepted the call to provide psychiatric services to returning veterans. The medical model was perhaps permanently stamped, however, at the famed Boulder conference in 1949, when psychology’s bible of training was developed with an acceptance of medical language and the concept of mental disease (Albee, 2000).

Later, with the passing of freedom-of-choice legislation guaranteeing parity with psychiatrists, psychologists learned to treat clients in private offices and collect from third-party payers requiring only a psychiatric diagnosis for reimbursement. Soon thereafter, the rising tide of the medical model of mental health reached dangerous levels of influence. Drowning any possibilities for other psychosocial systems of understanding human challenges, the National Institute of Mental Health (NIMH), the leading source of research funding for psychotherapy, decided to apply the same methodology used in drug research to evaluate psychotherapy (Goldfried & Wolfe, 1996)—the randomized clinical trial (RCT).

Commenting on the RCT, Goldfried and Wolfe (1996) stated:

psychotherapy outcome researchers may have overreacted and moved the field in the wrong direction . . . it has become overly dependent on the “clinical trials” method to determine how to best treat “disorders.” In addition to condoning the medicalization of psychotherapy, psychotherapy researchers may unwittingly be playing into the hands of third-party payers in placing unwarranted emphasis on the putative fixed efficacy of specific interventions. (p. 1007)

Adopting the RCT methodology for evaluating psychotherapy had profound effects. It meant that a study must include manualized therapies (to approximate drug protocols) and *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., *DSM-IV*; American Psychiatric Association, 1994) defined disorders to be eligible for an NIMH-sponsored research grant (Goldfried & Wolfe, 1998). The result: Funding for studies not related to specific disorders dropped nearly 200% from the late 1980s to 1990 (Wolfe, 1993). In addition to these limiting effects, force fitting the RCT on psychotherapy research is empirical tyranny and bereft of scientific reasoning.

The RCT compares the effects of a drug (an active compound) with a

placebo (a therapeutically inert or inactive substance) for a specific illness. The basic assumption of the RCT is that the active (unique) ingredients of different drugs (or psychotherapies) will produce different effects with different disorders. The field has already been there and done that—the dodo bird verdict is a reality, and the active ingredients model (or drug metaphor, Stiles & Shapiro, 1989) borrowed from medicine does not fit (Wampold et al., 1997).

For example, most EVT's come from the cognitive-behavioral therapy (CBT) schools (Chambless, 1996). Not only have the active ingredients of CBT failed to be validated (Jacobson et al., 1996), but they also have been found to have a negative correlation to outcome when emphasized (Castonguay, Goldfried, Wisner, Raue, & Hayes, 1996). The ascendancy of CBT on the EVT list speaks more to its privilege of being researched than to any privilege it has earned by being researched. Despite the dodo bird verdict and the difficulty in validating specific effects, the task force, not unlike the pigs in George Orwell's *Animal Farm*, continues to assert that some therapies are more equal than others. Guild and market pressures, not science, motivate this assertion.

Further, the RCT measures outcome by a symptomatic reduction of *DSM-IV* disorders, but the RCT itself suffers from diagnostic disorder (Duncan & Miller, 2000b). Characteristics are the following: (a) It has notoriously poor reliability (Carson, 1997; Kirk & Kutchins, 1992); (b) it has poor validity—the *DSM-IV* neither selects the appropriate treatment (Garfield, 1986) nor predicts outcome (Beutler & Clarkin, 1990; Brown et al., 1999); (c) it does not capture the variety of reasons for which people seek therapy (e.g., relational difficulties, unrealized potential, and the struggles of everyday existence); and (d) it does not describe the diversity of ways that success is defined (e.g., satisfactory relationships, increased self-esteem, or a plan for the future; Beutler & Clarkin, 1990; Goldfried & Wolfe, 1998).

Finally, the findings of RCT's are profoundly limited because they do not generalize to the way psychotherapy is conducted in the real world. Efficacy in RCT's does not equate to effectiveness in clinical settings; internal validity does not ensure external validity (Goldfried & Wolfe, 1998). The RCT randomly assigns members of a homogeneous group of clients—sorted by their diagnosis—to manualized treatment conditions.

Doing therapy by a manual is like having sex by a manual. Perhaps the desired outcome is achieved if instructions are technically followed. But the nuances and creativity of an actual encounter flow from the moment-to-moment interaction of the participants, not from Step a to Step b. Experienced therapists know that psychotherapy requires the unique tailoring of any approach to a particular client and circumstance (Watson, 1940). Simply put, psychotherapists do not do therapy by the book. When they do, it

does not go very well (Castonguay et al. 1996; Henry, Strupp, Butler, Schacht, & Binder, 1993).

The conclusion is inescapable. The RCT is inadequate for empirically validating psychotherapy as practiced in the real world (Seligman, 1995). Unlike the RCT, in actual clinical practice, manuals are not used, therapies are not ever purely practiced, clients are not randomly assigned to treatments, and clients rarely, if ever, enter therapy for singular *DSM*-defined disorders or experience success solely as diagnostic symptom reduction.

The EVT position is not only selective science at its worst, it is another brick in the wall of medical model privilege in psychotherapy. The end result of our Faustian deal with the medical model: Psychotherapy is now almost exclusively described, researched, taught, and practiced in terms of pathology and prescriptive treatments and is firmly entrenched in our professional associations, licensing boards, and academic institutions. It is so taken for granted that it is like the old story about a fish in water. You ask a fish, "How's the water?" and the fish replies, "What water?"

Concurrently, psychotherapists of all flavors find themselves at their most undervalued point in history. The reality is, as former APA president Nicholas Cummings (1986) predicted a decade and a half ago, nonmedical helping professionals have become "poorly paid and little respected employees of giant health care corporations" (p. 426). This is not a coincidence.

Many blame managed care. Managed care, however, is not the real problem (Duncan & Miller, 2000b). Managed care companies are merely bouncers who strong-arm clinicians into using proper diagnoses and prescriptive treatments. Managed care has only reified practices that before were merely annoyances to endure for reimbursement. Though grotesque, managed care is, like Frankenstein, a monster made by our complicity in our own image—a misunderstood but dangerous set of empirically dead standards pieced together running amok and terrorizing the locals.

For example, managed care increasingly dictates the approach therapists must use with specific diagnoses to receive reimbursement. One need only look in the mirror to see where managed care got the idea that certain approaches are more effective than others, or that specific intervention is causally related to psychotherapeutic change. Further, diagnosis is perhaps the most significant covenant of our Faustian deal, the mainstay of getting paid by insurance companies. Curiously, psychotherapists have hated the *DSM* since its inception. Surveys of therapists of all stripes well into the 1980s show that a substantial majority had a basic contempt for it on ethical, scientific, and practical levels (Kirk & Kutchins, 1992). Yet, despite this traditional discomfort with diagnoses, there has been no charge mounted to dethrone it as king of reimbursement.

The growing preference for medication among managed care compa-

nies is another painful example. With a few recent exceptions, the debate that once raged over the value of psychotropic drugs has all but disappeared. Like Dr. Frankenstein, we have only ourselves to blame for the damage inflicted by our creation. APA continues to press for prescription privileges for psychologists, an endorsement of medication to say the least. *The APA Monitor* not only regularly pummels the reader with prescription privilege updates and photo ops for its politicians but also now includes drug company advertisements. What is ironic about psychology's "prescription envy" is the lack of scientific support of drug efficacy, especially over psychotherapy (Duncan & Miller, 2000b; Fisher & Greenberg, 1997; Greenberg, 1999; Kirsch & Sapirstein, 1998), and the appalling problem of conflicts of interest with pharmaceutical companies (Duncan, Miller, & Sparks, 2000). Like Frankenstein, the frenzy to gain prescriptive authority is based more on folklore than data, more on science fiction than scientific fact. What is particularly ironic is that APA prides itself on its empirical heritage.

Managed care is not the problem. The medical model is not the problem. Privileging the medical model over the data is the problem. The medical model does not explain the process of change in psychotherapy (client and alliance factors most important, not treatment technique), select the appropriate treatment (the dodo bird verdict), predict probable outcomes (neither diagnosis nor type of treatment predicts outcome, but client ratings of the alliance do), or permit the questions about psychotherapy that research could address (the RCT or drug metaphor is inherently limiting).

PSYCHOTHERAPY'S FUTURE

Whoever acquires knowledge and does not practice it resembles him who ploughs his land and leaves it unsown.—Sa'di Gulistan (1258)

In time, if current fashions continue, the continued diminution of psychotherapy looks assured. Unless we come together, we may find ourselves sharing the same status as the real dodo bird of Mauritius and Reunion: extinct, or perhaps even worse, totally medicalized, disconnected from any separate identity, absorbed by the conglomerate of managed health care.

Charles Kiesler, noted psychologist and public policy analyst, recently foretold the future of psychotherapy (Kiesler, 2000). In 1988, he predicted many of the changes about to be ushered by the managed health care revolution (Kiesler & Morton, 1988). Kiesler has once again gazed into his crystal ball and sees a more substantial set of changes in the near future. Thus far in the managed care system, mental health and substance abuse

services have been separately considered from general health care. Keisler predicts a sweeping change in the future that “carves in” these services, following the pattern of other specialty medical services once considered as “carve-outs.” Advantages include increased cost-effectiveness, increased efficiency, an integrated database, and better tracking and coordination of care.

The implications are the following: The patient of the future will encounter an integrated system of mental and medical care—a partnership of behavioral health providers, physicians, and nurses under one roof. Patients will have one point of entry by means of the family physician and enjoy one-stop shopping for all their mental and medical health care needs. Kiesler (2000) recommended that mental health professionals begin now to prepare themselves by developing more protocols for specific disorders and standards of care for those patients resistant to having their problems identified as mental. The psychotherapist of the future will be a specialist in treating specific disorders with highly standardized psychotherapeutic interventions—empirically validated protocols for *DSM* diagnoses.

Evidence of Keisler’s premonition already exists. In the May 2000 *New England Journal of Medicine*, an editorial advised physicians to refer patients to therapists proficient at manualized cognitive-behavioral therapy for chronic depression (Scott, 2000). Unfortunately, physicians have not been educated about the dodo bird verdict, nor do they understand what the data say about how change occurs in psychotherapy.

Mental health treatment assimilated into the health care Borg further aligns mental health with medicine, and psychotherapy finally abandons what remnants remain of its humanistic, relational past. At the heart of this new integrated system foretold by Keisler is an abiding mistrust of client wisdom, client resources, and the right of clients to be part of their own treatment and recovery. Psychotherapists are not only relegated to the role of technicians of protocolized treatments but are also given the part of compliance cops—responsible for those renegade patients who resist the “for their own good” treatment (Duncan, 2001).

Kiesler’s vision is the final act of the Faustian tragedy—our deal with the medical model (Albee, 1998) and the logical conclusion of the EVT position. Psychotherapy is dispensed like a medication, an intervention to order by a presiding physician at the first sign of mental illness detected during a routine physical or perusal of an integrated database (Big Brother) that reveals a relative’s mental illness. It is the ironic climax of what Ogles, Anderson, and Lunnen (1999) called the great contradiction of modern psychotherapy: namely, that training and practice is geared toward specific treatments for specific disorders despite the bulk of the data showing little real difference among approaches.

Keisler’s premonition, like Scrooge’s visit from the Ghost of Christmas

Future in the Charles Dickens classic, can provide a much-needed wake-up call for reevaluation and action. Can we grant ourselves a second chance and forestall this ghostly future?

LAST CALL FOR THE COMMON FACTORS

To follow knowledge like a sinking star,
Beyond the upmost bound of human thought.

.....
To strive, to seek, to find, and not to yield. —Lord Alfred Tennyson, “Ulysses”
(1842)

Unless revolutionary new findings emerge, the knowledge of what makes therapy effective is already in the hands of mental health professionals. More than 40 years of research already points the way toward the defining role of common factors. A common factors vision of therapy embraces change that is client directed and not theory driven, that subscribes to a relational rather than medical model, and that is committed to successful outcome instead of competent (manualized) service delivery (Duncan & Miller, 2000a).

A systematic application of the common factors starts with the recasting of the drama of therapy and retiring the script that stars the psychotherapist. Clients are the true heroes and heroines of the therapeutic stage. Miscasting therapists as the stars has only served to disconnect them from the local knowledge, strengths, and expertise of their clients, factors that far outweigh any model or technique. Applying this common factor, though, must go beyond the confines of enlisting the client and his or her resources in the therapy room. It must include entering full partnerships with clients at the multiple levels at which decisions are made—partnerships to make psychotherapy effective, accountable, and just (Duncan, 2001; Duncan & Sparks, 2002).

A psychotherapy that sees clients as heroic gives voice to what has always been present but never heard—not only in therapy itself but also in the very culture of psychotherapy. When cases are discussed without clients’ voices, when supervision occurs from the supervisor’s perspective, when the *DSM* is read without eye contact with the person being described, the client is depersonalized—becomes a cardboard cutout—and only suits the purposes of the therapist/supervisor/author. With the addition of the client’s voice, the client emerges as a thinking, deciding agent whose deliberations about his or her life and the best course of action are reasonable and well executed, a part of a never-ending story with many possible conclusions.

To fully operationalize this most potent common factor, the client, therapists must not only enroll clients’ resources, invite their perceptions,

and enlist their participation, but they must also ask “Why?” of their colleagues and institutions—when diagnosis is required, when prescriptive treatments are privileged, and when clients are portrayed as Godzillas or hapless bozos. Clients’ voices can be included and valued in supervision and case discussions, as well as case records. Clients can attend staffings and case conferences and participate in behind-the-mirror brainstorming. Psychotherapists can resist calling clients by case numbers, diagnoses, or pet case names. Simply put, we can refuse to participate in professional jargon, labeling, and preset treatment protocols that do not involve clients as equal, indeed essential, and worthy members of the treatment team.

At the same time, psychotherapists can go out of their way to support the clients’ resistance to standard procedure—to struggle and to devise plans of action that uniquely fit their preferences and goals. If clients want to “drop out” of therapy, go to their local religious advisor instead of a “mental health professional,” try a new life plan that may not include medication or therapy, then this should be trusted and encouraged. A trusting stance communicates to clients our faith in them and their choices and may perhaps be the biggest and best “intervention” psychotherapists can make.

This may be risky. Not for reasons that risk management attorneys preach but because such a stance challenges the ways of being with clients that builds in mistrust and therefore may promote marginalization by peers for stepping outside the bounds of standard practice. The belief in client capacity to conquer even extreme personal circumstances must go deep. And the belief that clients want better lives and have some general ideas about ways to get there must transcend the inherent bias toward client incapacity, unwillingness, and ignorance that a medical model therapy promotes. When psychotherapists know the data that speak to client resourcefulness (and look for and build on it in research and practice), then psychotherapists can confidently refashion a medicalized identity—from expert clinician to expert “clientician,” from a master of EVTs to a master at forming partnerships that enroll clients’ strengths and facilitate clients’ goals (Duncan, 2001; Duncan & Sparks, 2002).

Such a partnership, based on a relational model of change (Bohart, 2000; Duncan & Miller, 2000b), highlights what therapists do best and incorporates how psychotherapists contribute most to the change process. Aligning with the overwhelming data of the alliance, a relational model sees change as emerging from an empowering, collaborative interpersonal context. Psychotherapists must be skilled at showcasing client talents, forming alliances with those that others find difficult, and structuring therapy around client goals and preferences. Further, therapists basing their work on a relational model flexibly adapt any of a number of relational stances or approaches to the values and beliefs of clients, matching

their expectations with relative ease and psychological comfort. Increased choice for the client are at the heart of a relational model—including an appreciation of the diminished choices that poverty, discrimination, and exploitation bring as major sources of human dilemmas, and consequently, of human distress.

Psychotherapists also have to make a living. Let's face it: Managed care rules, and cost is king. How can psychotherapy use this simple economic fact to advantage? How do we out-manage managed care? It starts with the realization that current practices within managed care are not working that well. The micromanagement of mental health services through treatment plans, periodic reviews, and the like amounts to an enormous waste of time and resources and disburses additional sessions to cases that are *not* changing. Hardly cost-effective.

Similarly counterproductive is the indiscriminate slashing of provider pay, up to 50% in some cases. This only encourages psychotherapists to fly the coup at the first opportunity, which requires managed care to continuously replenish their panels from an endless supply of eager young therapists anxious to make it in practice and willing to work for less and less. This revolving-door bureaucratic mess obviously has little regard for the actual quality or outcome of services. It is, therefore, anything but cost-effective.

Psychotherapy must, then, offer an alternative (to the medical model) to evaluate psychotherapy services: a better system of management that is both cost-effective and based on the common factors. Partnership with clients must extend further—to partner with them not only to make therapy effective but also to make therapy accountable. The field must move away from the provision of services that are “competently delivered” to the provision of services that are outcome-informed and that are effective. Simple, reliable, and valid methods for assessing client perceptions of progress and satisfaction are readily available and easily incorporated into any approach to therapy (e.g., Outcome Questionnaire 45.2 or the Session Rating Scale; see Duncan & Miller, 2000b; Johnson & Shaha, 1996; Lambert & Burlingame, 1996; Ogles, Lambert, & Masters, 1996). Psychotherapists can monitor, with clients, the session-by-session impact in clients' lives and use that information both to enhance and to prove effectiveness.

Using accepted measures of client perceptions of progress allows both therapists and payers to know how they are doing. Are they being effective in capitalizing on the client's strengths, building relationships, and helping clients reach their goals? This type of accountability could challenge the current clinical decision-making process—no more treatment plans, psychiatric diagnoses, lengthy intake forms, approved therapeutic modalities, or any other practice that takes up time but fails to improve treatment outcome. More effective services are cost-effective.

Such a process would also make psychotherapists responsible like never before. In a therapy directed by client's perceptions, therapists are given a chance to be informed about their ability (or lack of ability) to connect with clients, catalyze client resources, and help bring about satisfactory outcomes. It is then up to them to either do more of the same or something different based on what their clients say. Those who refuse to seek out and listen to client evaluations of success risk both poor outcomes and the support of a system that now honors (and pays for) that success. Payment to mental health professionals could be based on merit, on the ability to work with clients for successful outcomes.

Moreover, an accountable psychotherapy based on client perceptions could change standards for training and credentialing of therapists. In this psychotherapy, the emphasis shifts from the mastery of techniques to the ability to enter productive relationships and achieve positive outcomes with clients. Therapist training could be selected on the basis of routinely gathered and analyzed feedback from clients. Such a system, dependent as it would be on client self-report data, would finally give the users of therapy the voice that 40 years of data say they deserve. At the same time, the client's voice can begin to circulate in mental health talk and texts, no longer the missing link in understanding psychotherapy (Duncan, 2001). As a bonus, an accountability-based mental health world could align professional organizations more around helping therapists gather and process data from clients and less with partisan interests, turf wars, and marketplace competition.

Like Scrooge, psychotherapists uncomfortable with the future vision of our identity have a chance to alter the path that has been foretold. Changing the forecasted medicalized destiny requires a new identity for therapists, one that systematically applies the common factors based on a relational model of client competence. Like Scrooge, psychotherapists can choose their legacy. We can choose to honor the wisdom of the dodo bird or continue to proclaim winners in misguided attempts to save our place in health care, only to guarantee our second-class status in the medical Borg.

REFERENCES

- Albee, G. (1998). Fifty years of clinical psychology: Selling our soul to the devil. *Applied and Preventive Psychology, 7*, 189–194.
- Albee, G. (2000). The Boulder model's fatal flaw. *American Psychologist, 55*, 247–248.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Arkowitz, H. (1992). Integrative theories of therapy. In D. K. Freedheim (Ed.), *History of psychotherapy: A century of change* (pp. 261–303). Washington, DC: American Psychological Association.

- Arkowitz, H. (1997, April). *Clients as cognitive therapists for their own depression*. Paper presented at the convention of the Society for the Exploration of Psychotherapy Integration, Toronto, Ontario, Canada.
- Assay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 33-56). Washington, DC: American Psychological Association.
- Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 133-178). Washington, DC: American Psychological Association.
- Bergin, A. E., & Garfield, S. L. (Eds.). (1994). *Handbook of psychotherapy and behavior change* (4th ed.). New York: Wiley.
- Bergin, A., & Lambert, M. (1978). The evaluation of therapeutic outcomes. In S. Garfield & A. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (2nd ed., pp. 139-189). New York: Wiley.
- Beutler L., & Clarkin, J. (1990). *Systematic treatment selection: Toward targeted therapeutic interventions*. New York: Brunner/Mazel.
- Blatt, S. J., Zuroff, D. C., Quinlan, D. M., & Pilkonis, P. (1996). Interpersonal factors in brief treatment of depression: Further analyses of the NIMH Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 64*, 162-171.
- Bohart, A. (2000). The client is the most important common factor. *Journal of Psychotherapy Integration, 10*, 127-149.
- Bohart, A., & Tallman, K. (1999). *What clients do to make therapy work*. Washington, DC: American Psychological Association.
- Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice, 16*, 252-260.
- Brown, J., Dreis, S., & Nace, D. K. (1999). What really makes a difference in psychotherapy outcome? Why does managed care want to know? In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 389-406). Washington, DC: American Psychological Association.
- Carroll, L. (1962). *Alice's adventures in wonderland*. Harmondsworth, Middlesex: Penguin. (Original work published 1865)
- Carson, R. C. (1997). Costly compromises: A critique of the *Diagnostic and Statistical Manual of Mental Disorders*. In S. Fisher & R. P. Greenberg (Eds.), *From placebo to panacea: Putting psychiatric drugs to the test* (pp. 98-114). New York: Wiley.
- Castonguay, L. G., Goldfried, M. R., Wisner, S., Raue, P., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology, 64*, 497-504.
- Chambless, D. (1996). Identification of empirically supported psychological interventions. *Clinicians Research Digest, 14*(6), 1-2.
- Chambless, D., & Hollon, S. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66*, 7-18.
- Christensen, A., & Jacobson, N. (1994). Who (or what) can do psychotherapy: The status and challenge of nonprofessional therapies. *Psychological Science, 5*, 8-14.
- Connors, G. J., DiClemente, C. C., Carroll, K. M., Longabaugh, R., & Donovan, D. M. (1997). The therapeutic alliance and its relationship to alcoholism treatment participation and outcome. *Journal of Consulting and Clinical Psychology, 65*, 588-598.
- Cummings, N. A. (1986). The dismantling of our health system: Strategies for the survival of psychological practice. *American Psychologist, 41*, 426-431.
- Duncan, B. L. (2001, July/August). The future of psychotherapy: Beware the Siren call for integrated care. *Psychotherapy Networker, 25*, 25-34, 52-53.
- Duncan, B. L. (2002). The founder of common factors: A conversation with Saul Rosenzweig. *Journal of Psychotherapy Integration, 12*, 10-31.
- Duncan, B. L., Hubble, M. A., & Miller, S. D. (1997). *Psychotherapy with impossible cases: The efficient treatment of therapy veterans*. New York: Norton.

- Duncan, B., & Miller, S. (2000a). The client's theory of change. *Journal of Psychotherapy Integration, 10*, 169–187.
- Duncan, B., & Miller, S. (2000b). *The heroic client*. San Francisco: Jossey-Bass.
- Duncan, B., Miller, S., & Sparks, J. (2000, March/April). Exposing the mythmakers. *Family Therapy Networker, 24*, 24–33, 52–53.
- Duncan, B. L., & Moynihan, D. (1994). Applying outcome research: Intentional utilization of the client's frame of reference. *Psychotherapy, 31*, 294–301.
- Duncan, B., Solovey, A., & Rusk, G. (1992). *Changing the rules: A client-directed approach*. New York: Guilford Press.
- Duncan, B., & Sparks, J. (2002). *Heroic clients, heroic agencies: Partnerships for change*. Ft. Lauderdale, FL: Nova Southeastern University Press.
- Elkin, I., Shea, T., Watkins, J. T., Imber, S. D., Sotsky, S. M., Collins, J. F., Glass, D. R., Pilkonis, P. A., Leber, W. R., Docherty, J. P., Fiester, S. J., & Parloff, M. B. (1989). National Institute of Mental Health Treatment of Depression Collaborative Research Program: General effectiveness of treatments. *Archives of General Psychiatry, 46*, 971–982.
- Fisher, S., & Greenberg, R. P. (Eds.). (1997). *From placebo to panacea: Putting psychiatric drugs to the test*. New York: Wiley.
- Frank, J. (1973). *Persuasion and healing: A comparative study of psychotherapy* (2nd ed.). Baltimore: Johns Hopkins University Press.
- Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore: Johns Hopkins University Press.
- Garfield, S. (1980). *Psychotherapy: An eclectic approach*. New York: Wiley.
- Garfield, S. (1986). Problems in diagnostic classification. In T. Millon & G. Klerman (Eds.), *Contemporary directions in psychopathology* (pp. 86–113). New York: Guilford Press.
- Garfield, S. (1987). Toward a scientifically oriented eclecticism. *Scandinavian Journal of Behavior Therapy, 16*, 95–109.
- Garfield, S. (1996). Some problems associated with "validated" forms of psychotherapy. *Clinical Psychology: Science and Practice, 3*, 218–229.
- Gaston, L., Marmar, C. R., Thompson, L. W., & Gallagher, D. (1991). Alliance prediction of outcome: Beyond in-treatment symptomatic change as psychotherapy progresses. *Psychotherapy Research, 1*, 104–112.
- Goldfried, M. R. (1982). *Converging themes in psychotherapy*. New York: Springer.
- Goldfried, M. R., & Newman, C. F. (1992). A history of psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 46–93). New York: Basic Books.
- Goldfried, M. R., & Wolfe, B. E. (1996). Psychotherapy practice and research: Repairing a strained alliance. *American Psychologist, 51*, 1007–1016.
- Goldfried, M., & Wolfe, B. (1998). Toward a more clinically valid approach to therapy research. *American Psychologist, 66*, 143–150.
- Gould, R. A., & Clum, G. A. (1993). A meta-analysis of self-help treatment approaches. *Clinical Psychology Review, 13*, 169–186.
- Greenberg, R. (1999). Common psychosocial factors in drug therapy. In M. Hubble, B. Duncan, & S. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 297–328). Washington, DC: American Psychological Association.
- Grencavage, L., & Norcross, J. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice, 21*, 372–378.
- Gurman, A. S. (1977). The patient's perceptions of the therapeutic relationship. In A. S. Gurman & A. M. Razin (Eds.), *Effective psychotherapy* (pp. 503–545). New York: Pergamon.
- Henry, W., Strupp, H., Butler, S., Schacht, T., & Binder, J. (1993). Effects of training in time-limited dynamic psychotherapy: Changes in therapist behavior. *Journal of Consulting and Clinical Psychology, 61*, 434–440.
- Hubble, M. A., Duncan, B. L., & Miller, S. D. (1999a). Directing attention to what works. In M. A. Hubble, B. L. Duncan, & S. D. Miller (1999). *The heart and soul of change: What works in therapy* (pp. 407–448). Washington, DC: American Psychological Association.

- Hubble, M. A., Duncan, B. L., & Miller, S. D. (1999b). *The heart and soul of change: What works in therapy*. Washington, DC: American Psychological Association.
- Jacobson, N., Dobson, K., Truax, P., Addis, M., Koerner, K., Gollan, J., Gortner, D., & Prince, S. (1996). A component analysis of cognitive-behavioral treatment for depression. *Journal of Consulting and Clinical Psychology, 64*, 295-304.
- Johnson, L. D., & Shaha, S. (1996). Improving quality in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 33*, 225-236.
- Kiesler, C. (2000). The next wave of change for psychology and mental health services in the health care revolution. *American Psychologist, 55*, 481-487.
- Kiesler, C., & Morton, T. (1988). Psychology and public policy in the "health care revolution." *American Psychologist, 43*, 993-1003.
- Kirk, S. A., & Kutchins, H. (1992). *The selling of DSM: The rhetoric of science in psychiatry*. New York: Aldine.
- Kirsch, I., & Sapirstein, G. (1998). Listening to Prozac but hearing placebo: A meta-analysis of antidepressant medication. *Prevention & Treatment, 1*, Article 0002a. Retrieved November, 11, 2001, from <http://journals.apa.org/prevention/volume1/pre0010002a.html>
- Kottler, J. (1991). *The complete therapist*. San Francisco: Jossey-Bass.
- Krupnick, J. L., Sotsky, S. M., Simmens, S., Moyher, J., Elkin, I., Watkins, J., & Pilkonis, P. A. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Project. *Journal of Consulting and Clinical Psychology, 64*, 532-539.
- Lambert, M. J. (1992). Implications of outcome research for psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94-129). New York: Basic Books.
- Lambert, M. E., & Bergin, A. E. (1994). The effectiveness of psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 143-189). New York: Wiley.
- Lambert, M. J., & Burlingame, G. M. (1996). *Outcome Questionnaire (OQ 45.2)*. Stevenson, MD: American Professional Credentialing Services.
- Lazarus, A. (1992). Multimodal therapy: Technical eclecticism with minimal integration. In J. Norcross & M. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 231-263). New York: Basic Books.
- Luborsky, L. (1995). Are common factors across different psychotherapies the main explanation for the dodo bird verdict that "everyone has won so all shall have prizes"? *Clinical Psychology: Science and Practice, 2*, 106-109.
- Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that "everyone has won and all must have prizes"? *Archives of General Psychiatry, 32*, 995-1008.
- Miller, S. D., Duncan, B. L., & Hubble, M. A. (1997). *Escape from Babel*. New York: Norton.
- Nathan, P. E. (1997). Fiddling while psychology burns? *Register Report, 23*(2), 1, 4-5, 10.
- Norcross, J., & Beutler, L. (1997). Determining the relationship of choice in brief therapy. In J. N. Butcher (Ed.), *Personality assessment in managed health care: A practitioner's guide* (pp. 124-149). New York: Oxford University Press.
- Ogles, B., Anderson, T. T., & Lunnen, K. (1999). In M. A. Hubble, B. L. Duncan, & S. D. Miller (1999), *The heart and soul of change: What works in therapy* (pp. 407-448). Washington, DC: American Psychological Association.
- Ogles, B., Lambert, M., & Masters, K. (1996). *Assessing outcome in clinical practice*. Boston: Allyn & Bacon.
- Orlinsky, D. E., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy--noch einmal. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 270-378). New York: Wiley.
- Patterson, C. H. (1989). Foundations for a systematic eclectic psychotherapy. *Psychotherapy, 26*, 427-435.
- Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95-103.

- Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry*, 6, 412–415.
- Rosenzweig, S. (1940). Areas of agreement in psychotherapy. *American Journal of Orthopsychiatry*, 10, 703–704.
- Scott, J. (2000, May 18). Treatment of chronic depression. *The New England Journal of Medicine*, 342, 1518–1520.
- Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The *Consumer Reports* survey. *American Psychologist*, 50, 965–974.
- Shapiro, D. (1996). “Validated” treatments and evidence-based psychological services. *Clinical Psychology: Science and Practice*, 3, 256–259.
- Shapiro, D. A., & Shapiro, D. (1982). Meta-analysis of comparative therapy outcome studies: A republication and refinement. *Psychological Bulletin*, 92, 581–604.
- Simon, D. (1996). Crafting conscientiousness through form. In S. Miller, M. Hubble, & B. Duncan (Eds.), *Handbook of solution-focused brief therapy* (pp. 44–62). San Francisco: Jossey-Bass.
- Sloan, R., Staples, F., Cristol, A., Yorkston, W., & Whipple, K. (1975). *Short-term analytically oriented psychotherapy vs. behavior therapy*. Cambridge, MA: Harvard University Press.
- Smith, M. L., Glass, G. V., & Miller, T. I. (1980). *The benefits of psychotherapy*. Baltimore: Johns Hopkins University Press.
- Stiles, W., & Shapiro, D. (1989). Abuse of the drug metaphor in psychotherapy process–outcome research. *Clinical Psychology Review*, 9, 521–543.
- Stiles, W., Shapiro, D., & Elliot, R. (1986). Are all psychotherapies equivalent? *American Psychologist*, 41, 165–180.
- Strupp, H. H., & Hadley, S. W. (1979). Specific vs non-specific factors in psychotherapy: A controlled study of outcome. *Archives of General Psychiatry*, 36, 1125–1136.
- Tallman, K., & Bohart, A. (1999). The client as a common factor: Clients as self-healers. In M. Hubble, B. Duncan, & S. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 91–131). Washington, DC: American Psychological Association.
- Task Force on Promotion and Dissemination of Psychological Procedures, Division of Clinical Psychology of the American Psychological Association. (1995). Training and dissemination of empirically-validated psychological treatments: Report and recommendations. *The Clinical Psychologist*, 48, 3–23.
- Wampold, B. E. (1997). Methodological problems in identifying efficacious psychotherapies. *Psychotherapy Research*, 7, 21–44.
- Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, “all must have prizes.” *Psychological Bulletin*, 122, 203–215.
- Watson, G. (1940). Areas of agreement in psychotherapy. *American Journal of Orthopsychiatry*, 10, 689–709.
- Weinberger, J. (1993). Common factors in psychotherapy. In G. Stricker & J. Gold (Eds.), *Comprehensive handbook of psychotherapy integration* (pp. 43–56). New York: Plenum Press.
- Weinberger, J. (1995). Common factors aren’t so common: The common factors dilemma. *Clinical Psychology: Science and Practice*, 2, 45–69.
- Wolberg, L. (1977). *The technique of psychotherapy* (3rd ed.). New York: Grune & Stratton.
- Wolfe, B. E. (1993). Psychotherapy research funding for fiscal years 1986–1990. *Psychotherapy and Rehabilitation Research Bulletin*, 1, 7–9.