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Where Are the Commonalities Among the Therapeutic Common Factors?

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There is little convergence or empirical research on factors shared by diverse psychotherapies. We reviewed 50 publications to discern commonalities among proposed therapeutic common factors. The number of factors per publication ranged from 1 to 20, with 89 different commonalities proposed in all. Analyses revealed that 41% of proposed commonalities were change processes; by contrast, only 6% of articulated commonalities were client characteristics. The most consensual commonalities across categories were development of a therapeutic alliance, opportunity for catharsis, acquisition and practice of new behaviors, and clients' positive expectancies. The frequency of selected commonalities is presented and directions for future research are outlined.

Mental health professionals have long observed that disparate forms of psychotherapy share common elements or core features (Goldfried & Newman, 1986; Thompson, 1987). As early as 1936, Rosenzweig, noting that all forms of psychotherapy have cures to their credit, invoked the famous Dodo Bird verdict from *Alice in Wonderland,* "Everybody has won and all must have prizes," to characterize psychotherapy outcomes. He then proposed as a possible explanation therapeutic common factors, including psychological interpretation, catharsis, and the therapist's personality. In 1940, Watson reported the results of a meeting held to ascertain areas of agreement among psychotherapy systems (Sollod, 1981). The participants, including such diverse figures as Saul Rosenzweig, Alexandra Adler, Frederick Allen, and Carl Rogers, concurred that support, interpretation, insight, behavior change, a good therapeutic relationship, and certain therapist characteristics were common features of successful psychotherapy approaches (Watson, 1940).

More recently, the so-called common-factors approach has been recognized as one of the three central thrusts of the psychotherapy integration movement (Arkowitz, 1989; Beitman, Goldfried, & Norcross, 1989; Norcross, 1986), in addition to theoretical integration, which aims to synthesize diverse theoretical systems, and technical eclecticism, which uses a variety of therapeutic methods regardless of theoretical parentage. The common-factors approach seeks to determine the core ingredients shared by the different therapies with the eventual goal of developing more efficacious treatments based on these components. This long-considered "noise" in psychotherapy research is being reconsidered by some as the main "signal" element of treatment (Norcross & Grencavage, 1989; Omer & London, 1988). Indeed, the identification of common factors across therapeutic perspectives has been labeled one of the most significant trends in psychotherapy in the 1980s (Bergin, 1982; Gurman, 1980).

It has not been possible to show that one therapeutic approach is clearly superior to another (Lambert, Shapiro, & Bergin, 1986; Landman & Dawes, 1982; Smith, Glass, & Miller, 1980). There are few conditions in which the therapy system leads to differential success in outcome, and, with some exceptions, there is little compelling evidence to recommend the use of one type over another in the treatment of a specific problem. Thus, a paradox has emerged from the equivalence conclusion: no differential effectiveness despite technical diversity (Stiles, Shapiro, & Elliott, 1986).

If indeed the multitude of different psychotherapy systems can legitimately claim equal success, then perhaps they are not as diverse as they appear on the surface. They probably share certain core features; further, these common elements may be the "curative" elements—those responsible for therapeutic success, accounting for most of the gains resulting from psychological intervention (Lambert, 1986). As Goldfried (1980) wrote: "To the extent that clinicians of varying orientations are able to arrive at a common set of strategies, it is likely that what emerges will consist of robust phenomena, as they have managed to survive the distortions imposed by the therapists' varying theoretical biases" (p. 996).

However, the common factors posited to date have been "numerous and varied" (Patterson, 1989) in both composition and characterization (Karasu, 1986; Lambert, 1986). Different authors focus on different domains or levels of psychosocial treatment, and as a result, diverse conceptualizations of these commonalities have emerged. For example, two authors (Bromberg, 1962; Hynan, 1981) argued that there is only one factor common to all psychotherapies and, ironically, pointed to the client in one case and the therapeutic relationship in the other. Truax and Carkhuff (1967) enumerated three commonalities, all ap-

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plying to the psychotherapist. At the other extreme, as many as 20 common factors encompassing client characteristics, change processes, and elements of the treatment structure have been set forth (Castonguay & Lecompte, 1989; Lambert, 1986).

There is little apparent agreement or empirical research on therapeutic commonalities. Without such accord, however, it is difficult to discuss them intelligibly or to apply them clinically. To our knowledge, there are no systematic reviews of the topic. Toward this end, the present investigation was designed to review the extant literature in order to address the question, Where are the commonalities among the therapeutic common factors? In this article, we present the most frequently proposed common factors and outline future research directions.

Method

Fifty publications[1] were secured for this study, largely from professional books ($n = 15$), journal articles ($n = 13$), a special journal section ($n = 10$), and chapters in edited books ($n = 7$). All entries were published in the English language, focused primarily on individual psychotherapy, and encompassed at least three therapeutic systems. Thirty-nine of the 50 articles were sole authored; the remaining 11 were coauthored. Thirty-seven of the sole or primary authors were psychologists, and 11 were psychiatrists. Year of publication ranged from 1936 to 1989 ($M = 1976$, $Mdn = 1980$).

The entries were obtained through a computer-assisted data-base search and cross-referencing of available entries. Individual authors were allowed only one entry. In the case of authors with multiple publications on therapeutic commonalities, such as Sol Garfield, Hans Strupp, and Jerome Frank, we included their most recent or representative publication in the data set.

Coding Scheme

As previously stated, there are many ways to conceptualize common factors. Our literature review yielded four extant coding schemes. Castonguay and Lecompte (1989) organized common factors in terms of four dimensions of the therapeutic interaction: its framework, basic processes, dimensions, and functions. Cornsweet (1983) proposed a three-category scheme, in terms of those factors concerned with the patient–therapist relationship, the cognitive set, and the therapist's personality. Korchin and Sands (1983) divided common factors into two broad classes, the therapeutic climate, defined as a set of basal conditions that of themselves are capable of producing change, and therapeutic processes, defined as specific strategies or events in therapy. Lambert (1986) conceptualized commonalities in terms of support factors, learning factors, and action factors.

We developed our coding system following initial review of approximately 20 sources and these four schemas. We used five superordinate categories: client characteristics, therapist qualities, change processes, treatment structure, and relationship elements.

Procedure

All proposed commonalities were assigned to one of the aforementioned five superordinate categories.[2] In cases of ambiguity, consultation between the authors successfully resolved the question of placement. The process of enumerating and coding the common factors was, predictably, complicated. In some cases, the common factors were listed numerically or tabularly, which was straightforward. In other cases, however, they were discussed throughout the text (e.g., Garfield, 1980; Rosenzweig, 1936; Schofield, 1964), and subjectivity entered into the classification. To take the earliest publication as an illustration, Rosenzweig (1936), in the conclusion of his article, listed three common factors. We, in reading the text, arrived at four, and Goldfried and Newman (1986) came up with three, although their three were slightly different than Rosenzweig's three. We acknowledge the possibility that other investigators could read the same article and arrive at a slightly different number or coding of the commonalities.

A number of limitations in our data sampling and methodological design lend caution to the interpretation and generalization of the findings. First, the publications were restricted to those written in the English language. Second, the vast majority of our sample consisted of entries in which the authors reported what they do or perceive in psychotherapy, not empirical analyses of what observers or clients experienced. Third, each psychotherapeutic tradition has its own jargon, a clinical shorthand among its adherents, which widens the precipice across differing orientations (Goldfried & Newman, 1986; Norcross, 1987). This "language problem," as it has become known, confounds understanding of each other's constructs and, in some cases, even leads to active avoidance of those constructs. In this article, we try to use generic or theoretically "neutral" terms to avoid the confusion and restriction often encountered with theory-laden jargon.

Results

Review of the entries revealed a variety of terms used to describe common therapeutic components. Overall, 27 different terms were used among the 50 publications. In virtually every case, however, a number of terms were used within a single publication itself (as we do in this article). An author's preferred term was determined by cumulative count, with special emphasis accorded to terms found in titles and subsection headings. The preferred terms across studies were "common factors" ($n = 13$), "common [or universal] elements/components" ($n = 8$), and "effective principles" ($n = 5$).

Table 1 presents descriptive statistics on the total number and five superordinate categories of common factors. As shown, the number of proposed common factors per publication ranged from 1 to 20, with a total of 89 different commonalities proposed in all. Analyses revealed that 41% of proposed common factors were change processes, with 80% of authors proposing at least one commonality in this category, making it the single most frequent superordinate category. Next most frequent was therapist qualities, with 21% of all factors falling under this category, and 62% of authors proposing at least one factor here. By contrast, only 6% of the proposed commonalities were client characteristics, with 30% of authors proposing at least one factor in this category.

Tables 2 through 6 display the most frequently proposed common factors in each superordinate category. A minimum of 10% of the subsample (defined as those authors proposing at least one factor in that category) was required to list a particular commonality in the corresponding table. In the following sections we comment briefly on the superordinate categories and the most frequently identified commonalities in each.

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[1] A list of the 50 publications is available from the authors upon request.

[2] The establishment and definition of these superordinate categories constituted the greatest challenge. Although desirable in retrospect, formal estimates of interrater reliability were not calculated.

Table 1
Descriptive Statistics on the Total Number and Superordinate Categories of Common Factors

Statistic	Total	Category				
		Client characteristics	Therapist qualities	Change processes	Treatment structure	Therapeutic relationship
M	7.1	.4	1.4	3.3	1.1	.9
SD	4.9	.7	2.0	3.1	1.4	.9
Mdn	5.0	0	1.0	3.0	1.0	1.0
Range	1–20	0–3	0–11	0–13	0–7	0–4
% with one or more commonalities in this category	—	30	62	80	58	64
Average % of total	—	6	21	41	17	15

Client Characteristics

The first category, client characteristics, contained those proposed commonalities describing qualities and behaviors of the client. Overall, five common factors fell under this category; the three most frequent are presented in Table 2. The most frequent proposal was positive expectancies and hope for improvement, proposed by 26% of all authors. Torrey (1972) defined this factor as the "edifice complex," describing it as "faith in the institution itself, the door at the end of the pilgrimage" (p. 49). He pointed out that the act of seeking treatment itself makes patients feel better and increases their faith that they will, eventually, get well.

Therapist Qualities

The second superordinate category consisted of proposed commonalities associated with and exhibited by the psychotherapist. Twenty-two factors fell under this category; the six most frequent propositions are shown in Table 3. Some authors described this factor in general and impressionistic terms, whereas others elaborated on those specific characteristics they considered therapeutic. We followed the format of the author: When the author was general (e.g., Rosenzweig, 1936), the factor was listed under this category; when the author was specific (e.g., Patterson, 1989), each characteristic was coded separately. As a consequence, the statistics presented in Table 3 may mask or underestimate genuine concurrence on therapist qualities as common factors.

Most frequent was a general description of beneficial therapist qualities, with 24% of authors proposing this factor as common to the psychotherapies. Rosenzweig (1936) offered the "indefinable effect of the therapist's personality" as a potential commonality, noting that "the personal qualities of the good therapist elude description for, while the words stimulating, inspiring, etc. suggest themselves, they are far from adequate" (p. 413).

The second most frequent proposition, advanced by 20% of the authors, was the therapist's ability to cultivate hope and enhance positive expectancies within the client. Neitzel and Bernstein (1987) wrote that of all common therapeutic procedures, this is "the ingredient most frequently mentioned as a crucial contributor to therapeutic improvement" (p. 196). Significantly, the experience of hope, in terms of both client expression and therapist facilitation, recurrently emerged as an element common to the psychotherapies.

Change Processes

Our third superordinate category consisted of change processes or change principles, broadly defined as transtheoretical means by which change occurs in psychotherapy (Goldfried, 1980; Prochaska, 1984). The level of analysis of a change process/principle is an intermediate one, between global theories and specific techniques.

In all, 28 commonalities fell under this category; the 16 most frequent proposals are displayed in Table 4. The most common proposal was the opportunity for catharsis. Whether it is called emotional ventilation, dramatic relief, tension release, abreaction, or catharsis, clients experience comfort through the ventilation of their problems in the low-risk environment of psychotherapy. Next in frequency was the acquisition and practice of new behaviors, proposed by 32% of all authors to be common

Table 2
Frequency of Selected Client Characteristics Identified as Common Factors

Client characteristic	Raw frequency	% of subsample[a] ($n = 15$)	% of total ($N = 50$)
Positive expectation/hope or faith	13	87	26
Distressed or incongruent client	2	13	4
Patient actively seeks help	2	13	4

[a] Composed of authors who proposed at least one factor in this category.

Table 3
Frequency of Selected Therapist Qualities Identified as Common Factors

Therapist quality	Raw frequency	% of subsample[a] ($n = 31$)	% of total ($N = 50$)
General positive descriptors	12	39	24
Cultivates hope/enhances expectancies	10	32	20
Warmth/positive regard	8	26	16
Empathic understanding	7	23	14
Socially sanctioned healer	5	16	10
Acceptance	4	13	8

[a] Composed of authors who proposed at least one factor in this category.

to all psychotherapies. Davison (1980) referred to this as the "try it—you'll like it" principle, adding that clients must be encouraged to attempt something they may have never before considered, to see what it feels like and what risks and benefits it holds. Regarding this commonality, Karasu (1986) argued that "the final criterion of therapeutic change eventually resides in behavior change" (p. 692).

Third in frequency in this category was the provision of a therapeutic rationale or psychological interpretation, advanced by 24% of all authors as a common therapeutic component. Frank (1981) defined this factor as "a rationale, conceptual scheme, or myth that provides a plausible explanation for the patient's symptoms and prescribes a ritual or procedure for resolving them" (p. 20). Torrey (1972) called it the "Rumpelstiltskin principle," maintaining that the very act of naming the problem results in therapeutic benefit to the client. Early on, Rosenzweig (1936) observed that the interpretation need not be the "correct" or true one—just one that the client is able to accept and understand: "If it is true that mental disorder represents a conflict of disintegrated personality constituents, then the unification of these constituents by some systematic ideology, regardless of what that ideology may be, would seem to be a *sine qua non* for a successful therapeutic result" (p. 413).

Treatment Structure

The fourth superordinate category comprised elements of the treatment structure itself. Twenty-three factors fell under this category; the seven most frequent proposals appear in Table 5. The use of concrete techniques and rituals was the most frequently proposed treatment structure, advanced by 14% of the authors. Frank (1981) pointed out that a function of rituals often overlooked by therapists is their "face-saving" value as an excuse for the patient to abandon a symptom or complaint, for "to relinquish a symptom without adequate external reason would carry the implication that it was trivial or that the patient had produced it for some ulterior motive" (p. 20).

Next in frequency was a focus on the inner world and emotions of the client. Phares (1988) wrote, "The traditional psychotherapist has typically sought to bring about improvement in patients by inducing changes in their feelings, their motives, and their expectations," and that although "it is true that different theoretical conceptions demand that the inner world be viewed in different ways. . . . The shared bond of the various views lies in an emphasis on personality factors as the enduring determinants of behavior" (p. 321).

Table 4
Frequency of Selected Change Processes Identified as Common Factors

Change process	Raw frequency	% of subsample[a] ($n = 40$)	% of total ($N = 50$)
Opportunity for catharsis/ventilation	19	48	38
Acquisition and practice of new behaviors	16	40	32
Provision of rationale	12	30	24
Foster insight/awareness	11	28	22
Emotional and interpersonal learning	10	25	20
Feedback/reality testing	9	23	18
Suggestion	9	23	18
Success and mastery experiences	9	23	18
Persuasion	6	15	12
Placebo effect	6	15	12
Identification with the therapist	5	13	10
Contingency management	5	13	10
Tension reduction	5	13	10
Therapist modeling	4	10	8
Desensitization	4	10	8
Education/information provision	4	10	8

[a] Composed of authors who proposed at least one factor in this category.

Table 5
Frequency of Selected Treatment Structures Identified as Common Factors

Treatment structure	Raw frequency	% of subsample[a] (n = 29)	% of total (N = 50)
Use of techniques/rituals	7	24	14
Focus on "inner world"/exploration of emotional issues	5	17	10
Adherence to theory	4	14	8
A healing setting	4	14	8
There are participants/an interaction	3	10	6
Communication (verbal and nonverbal)	3	10	6
Explanation of therapy and participants' roles	3	10	6

[a] Composed of authors who proposed at least one factor in this category.

The therapist's adherence to a theory was proposed to be a common treatment structure by 8% of all authors. This factor was related, but not identical, to the provision of a rationale, coded as a change process. If the author stated that actual therapeutic benefit came about through the naming of the illness (e.g., Torrey, 1972), then it was included as a change process. If the provision of a rationale was offered as a common factor in the sense of being "an alternative life perspective" (Mahrer, 1989) or "a more or less elaborated conception of the nature of man which they, in essence, teach to the client" (Hobbs, 1962, p. 746), it was included as a treatment structure.

Therapeutic Relationship

A total of seven proposed commonalities fell under the category of therapeutic relationship; the three most frequent proposals are shown in Table 6. The most frequent was the development of a therapeutic relationship or working alliance between the client and therapist, endorsed by 56% of all authors as a component common to diverse psychotherapies. In discussing what it is about the relationship that has therapeutic impact, Hobbs (1962) wrote, "It is the fact that the client has a sustained experience of intimacy with another human being without getting hurt and that he or she is encouraged, on the basis of this concrete learning experience, to risk more open relationships outside of therapy" (p. 743). The process of engagement was proposed by 10% of all authors to be common therapeutic element. Kempler (1980) described this process as moving toward or in relation to another human being, and argued that it is the essential common component in psychotherapy, as the potential for change exists only in the context of a relationship with another person.

Statistical analyses were performed in order to illuminate historical trends in the articulation of therapeutic commonalities. Pearson product–moment correlations revealed a positive relationship between the year of publication and the number of articulated commonalities (r = .28, $p < .05$). The year of publication and the number of change processes (r = .26, $p < .05$) were also significantly related.

Discussion

Where, then, are the commonalities among the therapeutic common factors? Across all categories, the most consensual commonalities were the development of a therapeutic alliance (56% of all authors), the opportunity for catharsis (38%), the acquisition and practice of new behaviors (32%), clients' positive expectancies (26%), beneficial therapist qualities (24%), and the provision of a rationale as a change process (24%). These consensual commonalities cut across nearly all aspects of psychological treatment, in that four of our five superordinate categories were represented.

Change processes received the greatest endorsement as a level of potential convergence among psychotherapists of disparate orientations. This superordinate category contained the greatest number of identified commonalities (41%), contained the largest number listed by a single author (13), and was most frequently used by the authors (i.e., 40 of the 50 proposed at least one commonality here). Further, the positive correlation between the number of change processes proffered as commonalities and the article's year of publication indicates a recent trend in this direction. The pattern lends support to Goldfried's (1980) proposition that the most fruitful level of abstrac-

Table 6
Frequency of Selected Relationship Elements Identified as Common Factors

Relationship element	Raw frequency	% of subsample[a] (n = 32)	% of total (N = 50)
Development of alliance/relationship (general)	28	88	56
Engagement	5	16	10
Transference	5	16	10

[a] Composed of authors who proposed at least one factor in this category.

tion in which to locate common principles is an intermediate one between global theories and specific techniques.

However, the single most frequent commonality was the development of a collaborative therapeutic relationship/alliance. This emphasis reflects the often asserted notion that techniques are inextricably embedded within the relationship. In fact, all client, therapist, technical, and relationship elements are unavoidably interrelated. Fine lines of distinction drawn in research do not exist in actual practice. One prime illustration is positive client expectancies. In one sense, it is clearly a client characteristic. In another sense, it is also a therapist behavior, because the therapist exerts a significant influence on the instillment and maintenance of client expectations. Treatment structures and setting variables also influence client expectancies, because impressive surroundings serve to increase the prestige of the therapist and thus clients' hope.

These coding quandaries reminded us that a clinical intervention is inextricably bound to the relational context in which it is applied. Hans Strupp (1986) offered the following analogy to illustrate the inseparability of the constituent elements of psychotherapy: Suppose you want a teenage son to clean his room. One technique for achieving this is to establish clear standards. Fine, but the effectiveness of this technique will vary depending upon whether the relationship between you and the boy is characterized by warmth and mutual respect or by anger and distrust. This is not to say that the technique is useless, merely that how well it works depends upon the people and context in which it is applied.

We were struck that the difficulties encountered in our research efforts to identify and categorize therapeutic common factors paralleled the impediments to bridging diverse theories of psychotherapy. For example, is Marmor's (1976) "emotional support from the therapist" similar enough to psychotherapist "warmth" to be coded the same? Conversely, is "modeling" different enough from "therapist identification" to be coded separately? In both cases, we decided in the affirmative, but anticipate that some colleagues may take us to task for failure to preserve the technical distinction in the first case and making it in the second.

Before we can agree or disagree on a given matter, we need to ensure that we are in fact discussing the same phenomenon (Norcross, 1987). Punitive superego, negative self-statements, and poor self-image may indeed be similar phenomena, but we cannot know with certainty until they are defined operationally and consensually (Stricker, 1986). Thus, we echo the call for the use of a relatively theory-neutral or generic language in practice and an "Esperanto" in research (Pinsof, 1986).

It is evident that different authors were addressing different domains of clinical practice when proposing common factors. Less than half of the authors spoke of client characteristics, and no commonality approached 100% endorsement. Obviously, it is difficult to discuss common factors intelligibly or, more important, to apply them clinically when some authors focus on one level of treatment and other authors focus on a different level. The present research does demonstrate, however, encouraging convergence in searching for common components at the level of change processes and principles.

Although consensus is no epistemic warrant, the commonalities delineated in this study provide a direction for future research and application. First, the robust commonalities identified by clinical observation should be confirmed by empirical examination of psychotherapists' actual practices. In the final analysis, what psychotherapists actually do in practice must form the basis for empirical investigation, as opposed to what they profess they do (Wolfe & Goldfried, 1988). Second, more precision is required in the definition and demonstration of genuine commonalities. Mahrer (1989) proposed that researchers designate those psychotherapy theories that share the commonality (it need not be universal), describe the commonality in terms that are reasonably concrete and specific (rather than loose and general), and demonstrate that the therapists use the commonality under similar clinical conditions and to effect similar consequences. Third and final, in response to criticisms of the common factors or nonspecific approach (e.g., Butler & Strupp, 1986; Haaga, 1986; Jones, Cumming, & Horowitz, 1988; Mahrer, 1989; Messer, 1986; Messer & Winokur, 1980, 1981; Norcross, 1981; Wilson, 1982), we must operationalize specific clinical behaviors associated with common factors within the contextual interaction of psychotherapy for purposes of both research and education. One cannot function "nonspecifically" in therapy or training (Omer & London, 1988). Herein lie the challenges for future endeavors.

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