# SYSTEMS OF PSYCHOTHERAPY

## A Transtheoretical Analysis

EIGHTH EDITION

James O. Prochaska
John C. Norcross

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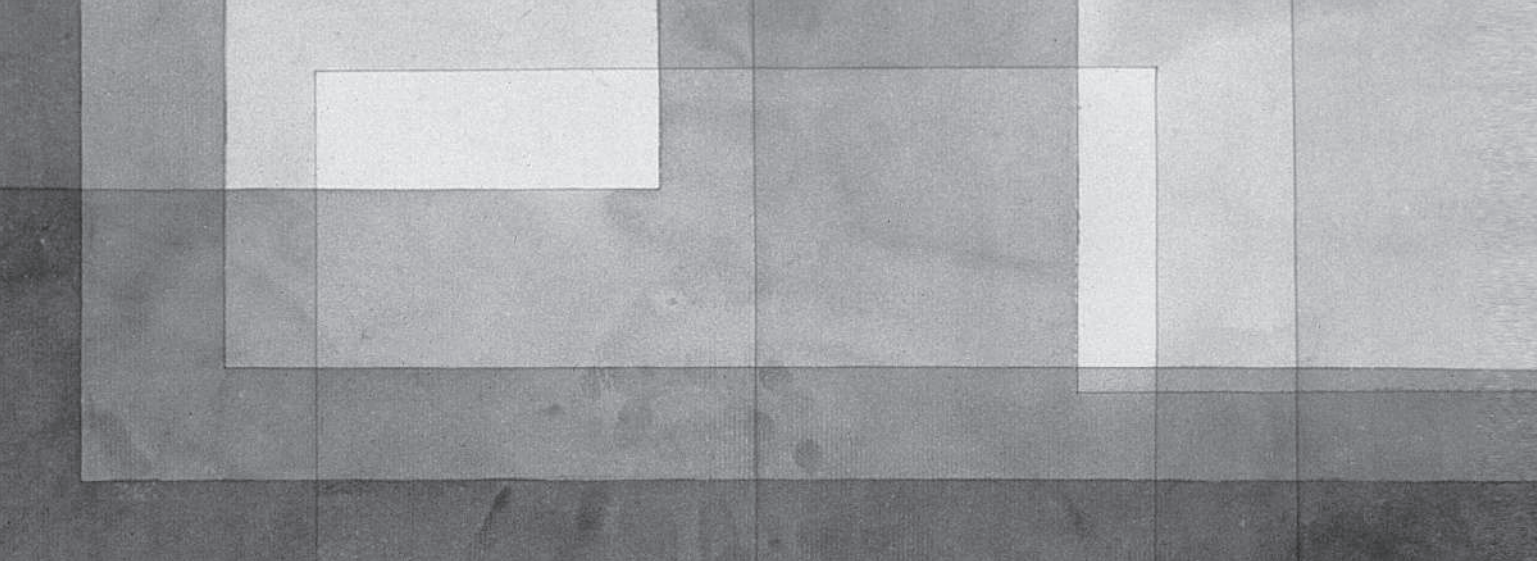

# Systems of Psychotherapy
## *A Transtheoretical Analysis*

EIGHTH EDITION

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**James O. Prochaska and John C. Norcross**

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*To Jan and Nancy*

# Brief Contents

# Detailed Contents

# Preface

Welcome to the eighth edition of *Systems of Psychotherapy: A Transtheoretical Analysis*. Our abiding hope is that our book will inform and excite you. Inform you about valuable psychotherapy theories and excite you to conduct powerful psychotherapy for the enrichment of fellow humans.

Our book provides a systematic, comprehensive, and balanced survey of the leading systems of psychotherapy. It is designed, however, to be more than just a survey, as we strive toward a synthesis both within each psychotherapy system and across the various systems. Within a particular system of therapy, this book follows the integrative steps that flow from the system's theory of personality to its theory of psychopathology and culminates in its therapeutic process and therapy relationship. Across the various systems of therapy, our book offers an integrative framework that highlights the many similarities of therapy systems without blurring their essential differences. The comparative analysis clearly demonstrates how much psychotherapy systems agree on the processes producing change while disagreeing on the content that needs to be changed.

*Systems of Psychotherapy: A Transtheoretical Analysis* is intended, primarily, for advanced undergraduate and graduate students enrolled in introductory courses in psychotherapy and counseling. This course is commonly titled Systems of Psychotherapy, Theories of Counseling, Psychological Interventions, or Introduction to Counseling and is offered to psychology, counseling, social work, psychiatry, nursing, human relations, and other students. Our volume is intended, secondarily, for psychotherapists of all professions and persuasions seeking a comparative overview of the burgeoning field of psychotherapy. We have been immensely gratified by the feedback from readers who have used this text in preparing for comprehensive exams, licensure tests, and board certification as well as from those who have found it instrumental in acquiring a more integrative perspective.

## Our Objectives

The contents and goals of this eighth edition embody our objectives as psychotherapy practitioners, teachers, researchers, and theorists. As practitioners, we appreciate the vitality and meaning of different clinical approaches. We attempt to communicate the excitement and depth of these psychotherapy systems. Accordingly, we avoid simple descriptions of the systems as detached observers in favor of immersing ourselves in each system as advocates.

As practitioners, we are convinced that any treatise on such a vital field as psychotherapy must come alive to do the subject matter justice. To this end, we have included a wealth of case illustrations drawn from our combined 75 years of clinical practice. (When one of us is speaking from our own experience, we will identify ourselves by our initials—JOP for James O. Prochaska and JCN for John C. Norcross.) We demonstrate how the same complicated psychotherapy case—Mrs. C—is

formulated and treated by each system of psychotherapy. This and all of the case examples counterbalance the theoretical considerations; in this way, theories become pragmatic and consequential—relevant to what transpires in the therapeutic hour. The details of individual clients have been altered, of course, to preserve their privacy and anonymity.

As psychotherapy teachers, we recognize the complexity and diversity of the leading theories of psychotherapy. This book endeavors to present the essential concepts clearly and concisely but without resorting to oversimplification. Our students occasionally complain that theorists seem to have a knack for making things more complicated than they really are. We hope that as you move through these pages you will gain a deeper appreciation for the complexity of the human condition or, at least, the complexity of the minds of those attempting to articulate the human condition.

Our decades of teaching and supervising psychotherapy have also taught us that students desire an overarching structure to guide the acquisition, analysis, and comparison of information. Unlike edited psychotherapy texts with varying writing styles and chapter content, we use a consistent structure and voice throughout the book. Instead of illustrating one approach with Ms. Apple and another approach with Mr. Orange, we systematically present a detailed treatment of Mrs. C for each and every approach.

As psychotherapy researchers, the evidence has taught us that psychotherapy has enormous potential for impacting patients in a positive (and occasionally a negative) manner. In this view, therapy is more analogous to penicillin than to aspirin. With psychotherapy expected to produce strong rather than weak effects, we should be able to demonstrate the effectiveness of psychotherapy even in the face of error caused by measurement and methodological problems. We thus include a summary of controlled outcome studies and meta-analytic reviews that have evaluated the effectiveness of each therapy system.

Research and practice have further taught us that each psychotherapy system has its respective limitations and contraindications. For this reason, we offer cogent criticisms of each approach from the vantage points of cognitive-behavioral, psychoanalytic, humanistic, cultural, and integrative perspectives. The net effect is a balanced coverage combining sympathetic presentation and critical analysis.

As psychotherapy theorists, we do *not* endorse the endless proliferation of psychotherapy systems, each purportedly unique and superior despite the absence of research evidence. What our amorphous discipline *does* need is a concerted effort to pull together the essentials operating in effective therapies and to discard those features unrelated to effective practice. From our comparative analysis of the major systems of therapy, we hope to move toward a higher integration that will yield a transtheoretical approach to psychotherapy.

And from comparative analysis and research, we hope to contribute to an inclusive, evidence-based psychotherapy in which treatment methods and therapy relationships—derived from these major systems of therapy—will be tailored to the needs of the individual client. In this way, we believe, the effectiveness and applicability of psychotherapy will be enhanced.

## Changes in the Eighth Edition

Innovations appear and vanish with bewildering rapidity on the psychotherapeutic scene. One year's treatment fad—say, neurolinguistic programming—fades into oblivion in just a few years. The volatile nature of the psychotherapy discipline requires regular updates in order for practitioners and students to stay abreast of developments.

The evolution of this book closely reflects the changing landscape of psychotherapy. The first edition in 1979 was relatively brief and only hinted at the possibility of integration. The second edition added sections on object relations, cognitive, and systems therapies. The third edition brought new chapters on gender-sensitive therapies and integrative treatments, as well as John C. Norcross as a coauthor. The fourth edition featured a new chapter on constructivist therapies and the addition of material on motivational interviewing, EMDR, and psychotherapy for men. The fifth edition brought more material on experiential therapies and on interpersonal psychotherapy (IPT). The sixth edition provided a separate chapter on multicultural therapies (formerly combined with gender-sensitive therapies), and the seventh edition featured new sections on dialectical behavior therapy and relational psychoanalysis.

This eighth edition, in turn, brings a host of changes that reflect trends in the field. Among these are:

- a new chapter on third-wave therapies, including acceptance and mindfulness approaches (Chapter 11)
- a reorganization of the chapter on experiential therapies (Chapter 6) to focus equally on Gestalt and emotion-focused therapy
- a new section on the emerging evidence-based family therapies (Chapter 12)
- more attention to attachment-based therapies in both the psychodynamic and experiential chapters
- enlarged consideration of the transtheoretical model (Chapter 17)
- updated reviews of meta-analyses and controlled outcome studies conducted on each psychotherapy system
- continued efforts to make the book student friendly throughout (see the following section)

With these additions, the text now thoroughly analyzes the 16 leading systems of psychotherapy and briefly surveys another 31, thus affording a broader scope than is available in most textbooks. Guiding all these modifications has been the unwavering goal of our book: to provide a comprehensive, rigorous, and balanced survey of the major theories of psychotherapy. Expanding the breadth of *Systems of Psychotherapy* has been accomplished only within the context of a comparative analysis that seeks to explicate both the fundamental similarities and the useful differences among the therapy schools.

## Student and Instructor Friendly

The 30-plus years since the first edition of this book have repeatedly taught us to keep our eye on the ball: student learning. On the basis of feedback from readers and our students, we have introduced aids to enhance student learning. These include:

- a list of key terms at the end of each chapter to serve as a study and review guide
- a series of recommended readings and websites at the end of each chapter
- a student companion website at cengagebrain.com, which includes mini-chapters on transactional analysis and implosive therapy, as well as elements to help with review and mastery of the textbook material.
- a set of PowerPoint slides for each chapter (coordinated by Rory A. Pfund, Krystle L. Evans, and John C. Norcross, all at the University of Scranton)
- an expanded *Test Bank and Instructor's Resource Manual* coauthored by two exceptional teachers, Drs. Linda Campbell (University of Georgia) and Anthony Giuliano (Harvard Medical School). Available to qualified adopters, the manual lists filmed therapy demonstrations of the psychotherapy systems featured in the text, more than 400 activity/discussion ideas, and additional case illustrations for use in class or on

examinations. The manual also presents 2,000+ original exam items.
- an alternative table of contents as an appendix for those who wish to focus on the change processes cutting across theories, rather than the psychotherapy theories themselves
- a Theories in Action video, developed by Ed Neukrug (Old Dominion University), that presents short clips illustrating the systems of psychotherapy in action. Available to qualified adopters.

## Acknowledgments

Our endeavors in completing previous editions and in preparing this edition have been aided immeasurably by colleagues and family members. In particular, special appreciation is extended to our good friends and close collaborators, Dr. Carlo DiClemente and Dr. Wayne Velicer, for their continuing development of the transtheoretical approach. We thank Allison Smith for her contributions to the chapter on multicultural therapies (Chapter 14) in previous editions. We are indebted to Rory Pfund and Donna Rupp for their tireless efforts in word processing the manuscript and in securing original sources.

We are also grateful to the following reviewers of the eighth edition:

Sheli Bernstein-Goff, West Liberty University

David Carter, University of Nebraska Omaha

Melody Bacon, Argosy University

Mark Aoyagi, University of Denver

Barbara Beaver, University of Wisconsin–Whitewater

We are amused and strangely satisfied that reviewers occasionally find our book to be slanted toward a particular theoretical orientation—but then they cannot agree on which orientation that is! One reviewer surmised that we disliked psychoanalysis, whereas another thought we carried a psychoanalytic vision throughout the book. We take such conflicting observations as evidence that we are striking a theoretical balance.

Three groups of individuals deserve specific mention for their support over the years. First, we are grateful to the National Institutes of Health, the University of Rhode Island, and the University of Scranton for their financial support of our research. Second, we are indebted to our clients, who continue to be our ultimate teachers of psychotherapy. And third, we are appreciative of the good people at Brooks/Cole and Cengage Learning for seeing this new edition of *Systems of Psychotherapy: A Transtheoretical Analysis* to fruition.

Finally, we express our deepest appreciation to our spouses (Jan; Nancy) and to our children (Jason and Jodi; Rebecca and Jonathon), who were willing to sacrifice for the sake of our scholarship and who were available for support when we emerged from solitude. Their caring has freed us to contribute to the education of those who might one day use the powers of psychotherapy to make this a better world.

James O. Prochaska

John C. Norcross

# About the Authors

**James O. Prochaska, PhD**, earned his baccalaureate, master's, and doctorate in clinical psychology from Wayne State University and fulfilled his internship at the Lafayette Clinic in Detroit. At present, he is Professor of Psychology and Director of the Cancer Prevention Research Consortium at the University of Rhode Island. Dr. Prochaska has over 45 years of psychotherapy experience in a variety of settings and has been a consultant to a host of clinical and research organizations. He has been the principal investigator on grants from the National Institutes of Health totaling over $90 million and has been recognized by the Association of Psychological Science as one of the most cited authors in psychology. His 50 book chapters and over 300 scholarly articles focus on self-change, health promotion, well-being, and psychotherapy from a transtheoretical perspective, the subject of both his professional book, *The Transtheoretical Approach* (with Carlo DiClemente), and his popular book, *Changing for Good* (with John C. Norcross and Carlo DiClemente). An accomplished speaker, he has offered workshops and keynote addresses throughout the world and served on various task forces for the National Cancer Institute, National Institute of Mental Health, National Institute of Drug Abuse, and American Cancer Society. Among his numerous awards are the Rosalie Weiss Award from the American Psychological Association (APA), Innovators Award from the Robert Wood Johnson Foundation, SOPHE Honorary Fellow Award from the Society for Public Health Education, Beckham Award for Excellence in Education and Inspirational Leadership from Columbia University, and the Fries Health Education Award from the Society for Public Health Education; he is the first psychologist to win a Medal of Honor for Clinical Research from the American Cancer Society. Jim makes his home in southern Rhode Island with his wife, Jan. They have two married children and five grandchildren living in California.

**John C. Norcross, PhD, ABPP**, received his baccalaureate from Rutgers University, earned his master's and doctorate in clinical psychology from the University of Rhode Island, and completed his internship at the Brown University School of Medicine. He is Distinguished Professor of Psychology at the University of Scranton, Adjunct Professor of Psychiatry at SUNY Upstate Medical University, and a board-certified clinical psychologist in part-time independent practice. Author of more than 300 scholarly publications, Dr. Norcross has cowritten or edited 20 books, the most recent being *Psychotherapy Relationships That Work*, *Self-Help That Works*, *Leaving It at the Office: Psychotherapist Self-Care*, *Psychologists' Desk Reference*, *Handbook of Psychotherapy Integration*, and multiple editions of the *Insider's Guide to Graduate Programs in Clinical and Counseling Psychology*. He has also authored two self-help books, most recently *Changeology: 5 Steps to Realizing Your Resolutions and Goals.* He has served as president of the APA Division of Psychotherapy, president of the Society of Clinical Psychology, and Council Representative of the APA. He has also served on the editorial board of a dozen journals and was the editor of the *Journal of Clinical Psychology: In Session* for a decade. He is a diplomate in clinical psychology of the American Board of Professional Psychology. Dr. Norcross has delivered workshops and lectures in 30 countries. He has received numerous awards for his teaching and research, such as APA's Distinguished Contributions to Education & Training Award, Pennsylvania Professor of the Year from the Carnegie Foundation, the Rosalee Weiss Award from the American Psychological Foundation, and election to the National Academies of Practice. John lives, works, and plays in northeastern Pennsylvania with his wife, two grown children, and two new grandkids.

CHAPTER 1

# Defining and Comparing the Psychotherapies

## *An Integrative Framework*

The field of psychotherapy has been fragmented by future shock and staggered by over-choice. We have witnessed the hyperinflation of brand-name therapies during the past 50 years. In 1959, Harper identified 36 distinct systems of psychotherapy; by 1976, Parloff discovered more than 130 therapies in the therapeutic marketplace or, perhaps more appropriately, the "jungle place." Recent estimates now put the number at over 500 and growing (Pearsall, 2011).

The proliferation of therapies has been accompanied by an avalanche of rival claims: Each system advertises itself as differentially effective and uniquely applicable. Developers of new systems usually claim 80% to 100% success, despite the absence of controlled outcome research. A healthy diversity has deteriorated into an unhealthy chaos. Students, practitioners, and patients are confronted with confusion, fragmentation, and discontent. With so many therapy systems claiming success, which theories should be studied, taught, or bought?

A book by a proponent of a particular therapy system can be quite persuasive. We may even find ourselves using the new ideas and methods in practice while reading the book. But when we turn to an advocate of a radically different approach, the confusion returns. Listening to proponents compare therapies does little for our confusion, except to confirm the rule that those who cannot agree on basic assumptions are often reduced to calling each other names.

We believe that fragmentation and confusion in psychotherapy can best be reduced by a comparative analysis of psychotherapy systems that highlights the many similarities across systems without blurring their essential difference.

A comparative analysis requires a firm understanding of each of the individual systems of therapy to be compared. In discussing each system, we first present a brief clinical example and introduce the developer(s) of the system. We trace the system's theory of personality as it leads to its theory of psychopathology and culminates in its therapeutic processes, therapeutic content, and therapy relationship. We then feature the practicalities of the psychotherapy. Following a summary of

controlled research on the effectiveness of that system, we review central criticisms of that psychotherapy from diverse perspectives. Each chapter concludes with an analysis of the same patient (Mrs. C) and a consideration of future directions.

In outline form, our examination of each psychotherapy system follows this format:

- A clinical example
- A sketch of the founder
- Theory of personality
- Theory of psychopathology
- Therapeutic processes
- Therapeutic content
- Therapeutic relationship
- Practicalities of the therapy
- Effectiveness of the therapy
- Criticisms of the therapy
- Analysis of Mrs. C
- Future directions
- Key terms
- Recommended readings
- Recommended websites

In comparing systems, we will use an integrative model to demonstrate their similarities and differences. An integrative model was selected in part because of its spirit of rapprochement, seeking what is useful and cordial in each therapy system rather than looking for what is most easily criticized. Integration also represents the mainstream of contemporary psychotherapy: Research consistently demonstrates that **integration** is the most popular orientation of mental health professionals (Norcross, 2005).

Lacking in most integrative endeavors is a comprehensive model for thinking and working across systems. Later in this chapter, we present an integrative model that is sophisticated enough to do justice to the complexities of psychotherapy, yet simple enough to reduce confusion in the field. Rather than having to work with 500-plus theories, our integrative model assumes that a limited number of processes of change underlie contemporary systems of psychotherapy. The model further demonstrates how the content of therapy can be reduced to four different levels of personal functioning.

Psychotherapy systems are compared on the particular process, or combination of processes, used to produce change. The systems are also compared on how they conceptualize the most common problems that occur at each level of personal functioning, such as low self-esteem, lack of intimacy, and impulse dyscontrol. Because clinicians are concerned primarily with the real problems of real people, we do not limit our comparative analysis merely to concepts and data. Our analysis also includes a comparison of how each major system conceptualizes and treats the same complex client (Mrs. C).

We have limited our comparative analysis to 15 major systems of therapy. Systems have been omitted because they seem to be dying a natural death and are best left undisturbed, because they are so poorly developed that they have no identifiable theories of personality or psychopathology, or because they are primarily variations on themes already considered in the book. The final criterion for exclusion is empirical: No therapy system was excluded if at least 1% of American mental health professionals endorsed it as their primary theoretical orientation. Table 1.1 summarizes the self-identified theories of clinical psychologists, counseling psychologists, social workers, and counselors.

## Defining Psychotherapy

A useful opening move in a psychotherapy textbook would be to define psychotherapy—the subject matter itself. However, no single definition of psychotherapy has won universal acceptance. Depending on one's theoretical orientation, psychotherapy can be conceptualized as interpersonal persuasion, health care, psychosocial education, professionally

**Table 1.1 Theoretical Orientations of Psychotherapists in the United States**

| ORIENTATION | CLINICAL PSYCHOLOGISTS | COUNSELING PSYCHOLOGISTS | SOCIAL WORKERS | COUNSELORS |
|---|---|---|---|---|
| Behavioral | 15% | 5% | 11% | 8% |
| Cognitive | 31% | 19% | 19% | 29% |
| Constructivist | 1% | 1% | 2% | 2% |
| Eclectic/Integrative | 22% | 34% | 26% | 23% |
| Existential/Humanistic | 1% | 5% | 4% | 5% |
| Gestalt/Experiential | 1% | 2% | 1% | 2% |
| Interpersonal | 4% | 4% | 3% | 3% |
| Multicultural | 1% | – | 1% | 1% |
| Psychoanalytic | 3% | 1% | 5% | 2% |
| Psychodynamic | 15% | 10% | 9% | 5% |
| Rogerian/Person-Centered | 2% | 3% | 1% | 10% |
| Systems | 2% | 5% | 14% | 7% |
| Other | 2% | 9% | 4% | 3% |

SOURCES: Bechtoldt et al., 2001; Bike, Norcross, & Schatz, 2009; Goodyear et al., 2008; Norcross & Karpiak, 2012.

coached self-change, behavioral technology, a form of reparenting, the purchase of friendship, or a contemporary variant of shamanism, among others. It may be easier to practice psychotherapy than to explain or define it (London, 1986).

Our working definition of **psychotherapy** is as follows (Norcross, 1990):

> *Psychotherapy is the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable.*

This admittedly broad definition is nonetheless a reasonably balanced one and a relatively neutral one in terms of theory and method. We have, for example, not specified the number or composition of the participants, as different theories and clients call for different formats. Similarly, the training and qualifications of the psychotherapist have not been delineated. We recognize multiple processes of change and the multidimensional nature of change; no attempt is made here to delimit the methods or content of therapeutic change. The requirement that the methods be "derived from established psychological principles" is sufficiently broad to permit clinical and/or research validation.

Our definition also explicitly mentions both "clinical methods and interpersonal stances." In some therapy systems, the active change mechanism has been construed as a treatment method; in other systems, the therapy relationship has been regarded as the primary source of change. Here, the interpersonal stances and experiences of the therapist are placed on an equal footing with methods.

Finally, we firmly believe that any activity defined as psychotherapy should be conducted only for the "purpose of assisting people" toward mutually agreed-upon goals. Otherwise—though it may be labeled psychotherapy—it becomes a subtle form of coercion or punishment.

## The Value of Theory

The term **theory** possesses multiple meanings. In popular usage, theory is contrasted with practice, empiricism, or certainty. In scientific circles, theory is generally defined as a set of statements used to explain the data in a given area (Marx & Goodson, 1976). In psychotherapy, a theory (or system) is a consistent perspective on human behavior, psychopathology, and the mechanisms of therapeutic change. These appear to be the necessary, but perhaps not sufficient, features of a psychotherapy theory. Explanations of personality and human development are frequently included, but, as we shall see in the behavioral, constructivist, and integrative therapies, are not characteristic of all theories.

When colleagues learn that we are revising our textbook on psychotherapy theories, they occasionally question the usefulness of theories. Why not, they ask, simply produce a text on the actual practice or accumulated facts of psychotherapy? Our response takes many forms, depending on our mood at the time, but goes something like this. One fruitful way to learn about psychotherapy is to learn what the best minds have had to say about it and to compare what they say. Further, "absolute truth" will probably never be attained in psychotherapy, despite impressive advances in our knowledge and despite a large body of research. Instead, theory will always be with us to provide tentative approximations of "the truth."

Without a guiding theory or system of psychotherapy, clinicians would be vulnerable, directionless creatures bombarded with literally hundreds of impressions and pieces of information in a single session. Is it more important to ask about early memories, parent relationships, life's meaning, disturbing emotions, environmental reinforcers, recent cognitions, sexual conflicts, or something else in the first interview? At any given time, should we empathize, direct, teach, model, support, question, restructure, interpret, or remain silent in a therapy session? A psychotherapy theory describes the clinical phenomena, delimits the amount of relevant information, organizes that information, and integrates it all into a coherent body of knowledge that prioritizes our conceptualization and directs our treatment.

The model of humanity embedded within a psychotherapy theory is not merely a philosophical issue for purists. It affects which human capacities will be studied and cultivated, and which will be ignored and underdeveloped. Treatments inevitably follow from the clinician's underlying conception of pathology, health, reality, and the therapeutic process (Kazdin, 1984). Systems of therapy embody different visions of life, which imply different possibilities of human existence (Messer & Winokur, 1980).

In this regard, we want to dispute the misconception that psychotherapists aligning themselves with a particular theory are unwilling to adapt their practices to the demands of the situation and the patient. A voluntary decision to label oneself an adherent of a specific theory does not constitute a lifetime commitment of strict adherence or dogmatic reverence (Norcross, 1985). Good clinicians are flexible, and good theories are widely applicable. Thus, we see theories being adapted for use in a variety of contexts and clinicians borrowing heavily from divergent theories. A preference for one orientation does not preclude the use of concepts or methods from another. Put another way, the primary problem is not with narrow-gauge therapists, but with therapists who impose that narrowness onto their patients (Stricker, 1988).

## Therapeutic Commonalities

Despite theoretical differences, there is a central and recognizable core of psychotherapy. This core distinguishes it from other activities—such as banking, farming, or physical therapy—and glues together variations of psychotherapy. This core is composed of **nonspecific** or **common factors** shared by all forms of psychotherapy and not specific to any

one. More often than not, these therapeutic commonalities are not highlighted by theories as of central importance, but the research suggests exactly the opposite (Weinberger, 1995).

Mental health professionals have long observed that disparate forms of psychotherapy share common elements or core features. 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 for roughly equivalent outcomes, a number of therapeutic common factors, including psychological interpretation, catharsis, and the therapist's personality. In 1940, a meeting of prominent psychotherapists was held to ascertain areas of agreement among psychotherapy systems. The participants concurred that support, interpretation, insight, behavior change, a good relationship, and certain therapist characteristics were common features of successful psychotherapy (Watson, 1940).

If indeed the multitude of psychotherapy systems can all legitimately claim some success, then perhaps they are not as diverse as they appear on the surface. They probably share certain core features that may be the "curative" elements—those responsible for therapeutic success. To the extent that clinicians of different theories 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 different theoretical biases (Goldfried, 1980).

But, as one might expect, the common factors posited to date have been numerous and varied. Different authors focus on different domains or levels of psychosocial treatment; as a result, diverse conceptualizations of these commonalities have emerged.

Our consideration of common factors will be guided by the results of a study (Grencavage & Norcross, 1990) that reviewed 50 publications to determine convergence among proposed therapeutic commonalities. A total of 89 commonalities were proposed. The analysis revealed the most consensual commonalities were clients' positive expectations and a facilitative relationship. In what follows, we review the therapeutic commonalities of positive expectations, the therapeutic relationship, the Hawthorne effect, and related factors.

## Positive Expectations

**Expectation** is one of the most widely debated and heavily investigated of the common (or nonspecific) variables. This commonality has been described as the "edifice complex"—the patient's faith in the institution itself, the door at the end of the pilgrimage, the confidence in the therapist and the treatment (Torrey, 1972).

A computer search yields more than 500 studies that have been conducted on patients' expectations of psychotherapy. The hypothesis of most of these studies is that the treatment is enhanced by the extent to which clients expect the treatment to be effective. Some critics hold that psychotherapy is nothing but a process of influence in which we induce an expectation in our clients that our treatment will cure them, and that any resulting improvement is a function of the client's expecting to improve. Surely many therapists wish on difficult days that the process were so simple!

The research evidence demonstrates that client expectations definitely contribute to therapy success, but is divided on how much (Clarkin & Levy, 2004; Constantino et al., 2011). Of the studies reporting expectation effects, most demonstrate that a high, positive expectation adds to the effectiveness of treatments. Up to one third of successful psychotherapy outcomes may be attributable to both the healer and the patient believing strongly in the effectiveness of the treatment (Roberts et al., 1993).

But psychotherapy can by no means be reduced to expectation effects alone. A sophisticated analysis of multiple outcome studies found that psychotherapy was more effective than common factors conditions, which in turn were more effective than no treatment at all (Barber et al., 1988). The ranking for therapeutic success is psychotherapy, placebo, and control (do nothing or wait), respectively. In fact, psychotherapy is nearly twice as effective as "nonspecific" or **placebo** treatments, which seek to induce positive expectations in clients (Grissom, 1996).

On the basis of the research, then, we will assume that expectation is an active ingredient in all systems of therapy. Rather than being the central process of change, however, a positive expectation is conceptualized as a critical precondition for therapy to continue. Most patients would not participate in a process that costs them dearly in time, money, and energy if they did not expect the process to help them. For clients to cooperate in being desensitized, hypnotized, or analyzed, it seems reasonable that most of them would need to expect some return on their investment. It is also our working assumption that therapists consciously strive to cultivate hope and enhance positive expectancies. Psychotherapy research need not demonstrate that treatment operates free from such nonspecific or common factors. Rather, the task is to demonstrate that specific treatments considered to carry the burden of client change go beyond the results that can be obtained by credibility alone.

## Therapeutic Relationship

Psychotherapy is at root an interpersonal relationship. The single greatest area of convergence among psychotherapists, in their nominations of common factors (Grencavage & Norcross, 1990) and in their treatment recommendations (Norcross et al., 1990), is the development of a strong therapeutic alliance.

This most robust of common factors has consistently emerged as one of the major determinants of psychotherapy success. Across various types of psychotherapy, at least 12% of psychotherapy outcome—why patients improve in psychotherapy—is due to the therapeutic relationship (Norcross, 2011). To summarize the conclusions of an exhaustive review of the psychotherapy outcome literature (Bergin & Lambert, 1978): The largest variation in therapy outcome is accounted for by pre-existing client factors, such as expectations for change and severity of the disorder. The therapeutic relationship accounted for the second largest proportion of change, with the particular treatment method coming in third.

Still, the relative importance of the therapeutic relationship remains controversial. At one end of the continuum, some psychotherapy systems, such as the radical behavior therapies, view the relationship between client[1] and therapist as exerting little importance; the client change in therapy could just as readily occur with only an interactive computer program, without the therapist's presence. For these therapy systems, a human clinician is included for practical reasons only, because our technology in programming therapeutic processes is not developed fully enough to allow the therapist to be absent.

Toward the middle of the continuum, some therapy schools, such as cognitive therapies, view the relationship between clinician and client as one of the preconditions necessary for therapy to proceed. From this point of view, the client must trust and collaborate with the therapist before being able to participate in the process of change.

At the other end of the continuum, Rogers's person-centered therapy sees the relationship as *the* essential process that produces change. Because Carl Rogers (1957) has been most articulate in describing what he believes are the necessary conditions for a

[1]We will employ the terms *client* and *patient* interchangeably throughout this textbook because neither satisfactorily describes the therapy relationship and because we wish to remain theoretically neutral on this quarrelsome point.

therapeutic relationship, let us briefly outline his criteria so that we can use these for comparing systems on the nature of the therapeutic relationship.

1. The therapist must relate in a genuine manner.
2. The therapist must relate with unconditional positive regard.
3. The therapist must relate with accurate empathy.

These—and only these—conditions are necessary and sufficient for positive outcome, according to Rogers.

Then there are those psychotherapy systems, such as psychoanalysis, that see the relationship between therapist and patient primarily as the source of content to be examined in therapy. In this view, the relationship is important because it brings the content of therapy (the patient's interpersonal behavior) right into the consulting room. The content that needs to be changed is thus able to occur during therapy, rather than the person focusing on issues that occur outside of the consulting room.

In light of these various emphases on the role of the therapeutic relationship, it will be necessary to determine for each therapy system whether the relationship is conceived as (1) a precondition for change, (2) a process of change, and/or (3) a content to be changed. Moreover, in each chapter that follows, we will consider the relative contribution of the therapeutic relationship to treatment success, as well as the therapist behaviors designed to facilitate that relationship.

## Hawthorne Effect

Psychologists have known for years that many people can improve in such behaviors as work output solely as a result of having special attention paid to them. In the classic Hawthorne studies (Roethlisberger & Dickson, 1939) on the effects of improved lighting on productivity in a factory, it was discovered that participants increased their output by simply being observed in a study and receiving extra attention. Usually such improvement is assumed to be due to increases in morale, novelty, and esteem that people experience from having others attend to them—a phenomenon that has come to be known as the **Hawthorne effect**.

One commonality among all psychosocial treatments is that the therapist pays special attention to the client. Consequently, attention has been assumed to be one of the common factors that impact the results of therapy. Anyone who has been in psychotherapy can appreciate the gratification that comes from having a competent professional's undivided attention for an hour. This special attention may indeed affect the course of therapy—including those occasional cases in which patients do not improve because they do not want to surrender such special attention.

Researchers have frequently found that attention does indeed lead to improvement, regardless of whether the attention is followed by any other therapeutic processes. In a classic study (Paul, 1967), 50% of public-speaking phobics demonstrated marked improvement in their symptoms by virtue of receiving an attention placebo intended to control for nonspecific variables such as attention. (In psychotherapy studies, an attention placebo control group receives a "treatment" that mimics the amount of time and attention received by the treatment group but that does not have a specific or intended effect.) Years of research demonstrate that attention can be a powerful common factor in therapy.

To conclude that any particular psychotherapy is more effective than an attention placebo, it is necessary that research include controls for attention effects or simply the passage of time. It is not enough to demonstrate a particular therapy is better than no treatment, because the improvement from that particular therapy may be due entirely to the attention given to the patients.

Several research designs are available to measure or control for the effects of attention in psychotherapy. The most popular design is to use

placebo groups, as in Paul's study, in which control participants were given as much attention as clients in therapy but did not participate in processes designed to produce change. An alternative design is to compare the effectiveness of one treatment with that of another, such as psychoanalytic therapy with cognitive therapy. If one therapeutic approach does better than the other, we can conclude that the differential improvement is due to more than just attention, because the less effective treatment included—and therefore controlled for—the effects of attention. However, we do not know whether the less effective therapy is anything other than a placebo effect, even if it leads to greater improvement than no treatment. Finally, in such comparative studies, if both therapies lead to significant improvement, but neither therapy does better than the other, we cannot conclude that the therapies are anything more than Hawthorne effects, unless an attention placebo control has also been included in the study. To be considered a controlled evaluation of a psychotherapy's efficacy, studies must include controls for the Hawthorne effect and related factors.

### Other Commonalities

In his classic *Persuasion and Healing*, Jerome Frank (1961; Frank & Frank, 1991) posited that all psychotherapeutic methods are elaborations and variations of age-old procedures of psychological healing. The features that distinguish psychotherapies from each other, however, receive special emphasis in the pluralistic, competitive American society. Because the prestige and financial security of psychotherapists hinge on their being able to show that their particular system is more successful than that of their rivals, little glory has traditionally been accorded to the identification of shared or common components.

Frank argues that therapeutic change is predominantly a function of common factors: an emotionally charged, confiding relationship; a healing setting; a rationale or conceptual scheme; and a therapeutic ritual. Other consensual commonalities include an inspiring and socially sanctioned therapist; opportunity for catharsis; acquisition and practice of new behaviors; exploration of the "inner world" of the patient; suggestion; and interpersonal learning (Grencavage & Norcross, 1990). Many observers now conclude that features shared by all therapies account for an appreciable amount of observed improvement in clients.

So powerful are these therapeutic commonalities for some clinicians that explicitly common factors therapies have been proposed. Sol Garfield (1980, 1992), to take one prominent example, finds the mechanisms of change in virtually all approaches to be rooted in the therapeutic relationship, emotional release, explanation and interpretation, reinforcement, desensitization, confronting a problem, and skill training. We shall return to common factors approaches in Chapter 16 (Integrative Therapies).

### Specific Factors

At the same time, common factors theorists recognize the value of unique—or specific—factors in disparate psychotherapies. A psychotherapist cannot practice nonspecifically; specific techniques and relationships fill the treatment hour. Indeed, research has demonstrated the differential effectiveness of a few therapies with specific disorders, such as exposure therapy for obsessive-compulsive disorder, parent management training for conduct problems, and systemic therapy for couples conflict. As a discipline, psychotherapy will advance by integrating the power of common factors with the pragmatics of **specific factors**. We now turn to the processes of change—the relatively specific or unique contributions of a therapy system.

## Processes of Change

There exists, as we said earlier in this chapter, an expanding morass of psychotherapy theories and an endless proliferation of specific techniques. Consider the relatively simple case of smoking

cessation: In one of our early studies, we identified more than 50 formal treatments employed by health professionals and 130 different techniques used by successful self-changers to stop smoking. Is there no smaller and more intelligible framework by which to examine and compare the psychotherapies?

The **transtheoretical**—across theories—model reduces the therapeutic morass to a manageable number of processes of change. There are literally hundreds of global theories of psychotherapy, and we will probably never reach common ground in the theoretical or philosophical realm. There are thousands of specific techniques in psychotherapy, and we will rarely agree on the specific, moment-to-moment methods to use. By contrast, the **processes of change** represent a middle level of abstraction between global theories (such as psychoanalysis, cognitive, and humanistic) and specific techniques (such as dream analysis, progressive muscle relaxation, and family sculpting). Table 1.2 illustrates this intermediate level of abstraction represented by the processes of change.

It is at this intermediate level of analysis—processes or principles of change—that meaningful points of convergence and contention may be found among psychotherapy systems. It is also at this intermediate level that expert psychotherapists typically formulate their treatment plans—not in terms of global theories or specific techniques but as change processes for their clients.

Processes of change are the covert and overt activities that people use to alter emotions, thoughts, behaviors, or relationships related to a particular problem or more general patterns of living. In fewer words, processes are how people change, within psychotherapy and between therapy sessions. These processes were derived theoretically from a comparative analysis of the leading systems of psychotherapy (Prochaska, 1979). In the following sections, we introduce these processes of change.

**Table 1.2 Levels of Abstraction**

| LEVEL | ABSTRACTION | EXAMPLES |
|---|---|---|
| High | Global theories | Psychodynamic, Gestalt, behavioral |
| Medium | Change processes | Consciousness raising, counterconditioning |
| Low | Clinical techniques | Interpretation, two-chair technique, self-monitoring |

## Consciousness Raising

Traditionally, increasing an individual's consciousness has been one of the prime processes of change in psychotherapy. **Consciousness raising** sounds so contemporary, yet therapists from a variety of persuasions have been working for decades to increase the consciousness of clients. Beginning with Freud's objective "to make the unconscious conscious," all so-called insight psychotherapies begin by working to raise the individual's level of awareness. It is fitting that the **insight** or **awareness therapies** work with consciousness, which is frequently viewed as a human characteristic that emerged with the evolution of language.

With language and consciousness, humans do not need to respond reflexively to every stimulus. For example, the mechanical energy from a hand hitting against our back does not cause us to react with movement. Instead, we respond thoughtfully to the information contained in that touch, such as whether the hand touching us is a friend patting us on the back, a robber grabbing us, or a partner hitting us. In order to respond effectively, we must process information to guide us in making a response appropriate to the situation. Consciousness-raising therapies attempt to increase the information available to individuals so they can make the most effective responses to life.

For each of the change processes, the psychotherapist's focus can be on producing change either at the level of the individual's experience or at the level of the individual's environment. When