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COMMON FACTORS IN COUPLE AND FAMILY THERAPY: MUST ALL HAVE PRIZES?

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> Great doubt: great awakening. Little doubt: little awakening. No doubt: no awakening.
>
> —Zen mantra

Marriage and family therapy (MFT),[1] though fashionably late, has taken a seat at the empirically validated table. Many argue that determining what is and who defines *empirically validated* entails significant implications for the field's future and its very identity (Duncan, Miller, & Sparks, 2004; Sexton, Ridley, & Kleiner, 2004; Sprenkle, Blow, & Dickey, 1999). What would seem to be common sense—use of evidence-based practice—is intertwined with politics and power. As Norcross, Beutler, and Levant (2006) put it, "defining evidence, deciding what qualifies as evidence, and applying what is privileged as evidence are complicated matters with deep philosophical and huge practical consequences" (p. 7).

This chapter furthers this discussion, exploring the question, "Does the dodo verdict—uniform not differential efficacy—hold true for systemic therapy?" For couple and family approaches, have all won and must all have prizes? A review of the evidence for absolute and relative efficacy for MFT is followed by a critical analysis of major comparative trials. Next, the role of

[1]This chapter uses *marriage and family therapy* and *couple and family therapy* interchangeably, recognizing that although MFT is a common identifier, marriage does not represent all couples.

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common factors in the MFT empirical literature is examined. The chapter concludes with implications for practice, training, and research.[2]

EFFICACY OF COUPLE AND FAMILY THERAPY

Absolute efficacy, the effects of treatment compared with no treatment, addresses the question "Does it work?" (Wampold, 2001; see chap. 2, this volume). Historical and current data indicate the answer to be an unequivocal "yes." Shadish and Baldwin (2002) meta-analyzed 20 published and unpublished meta-analytic studies of family, couple, and couple enrichment intervention. They found an average effect size (ES) of 0.58 for 12 meta-analyses comparing MFT with no-therapy controls. These findings approximate the 0.51 ES for the 70 trials comparing MFT with controls in Shadish et al. (1993). In answer to the question of clinical significance (Jacobson & Truax, 1991), Shadish and Baldwin (2002) indicated that MFT clients moved from distressed to nondistressed ranges 40% to 50% of the time. Confirming this estimate, in a large study of 134 couples, Christensen et al. (2004) reported that 48% of couples reached recovered status.

Controlled outcome studies for drug abuse, conduct disorders, delinquency, alcoholism, relationship enhancement, marital difficulties, schizophrenia, and other problems show robust efficacy for family and couple interventions (Sprenkle, 2003). Carr (2000a, 2000b) examined reviews and controlled trials for family intervention through the 1990s and found effects superior to no treatment. Cottrell and Boston (2002) also reported favorable results for family therapy over no treatment for conduct disorders,[3] substance misuse, and eating disorders. Finally, in a review of home-based family treatment, Diamond and Josephson (2005) found superiority of family intervention over no treatment both as a stand-alone and augmentation modality for youth depression, anxiety, conduct and attention-deficit disorders, and drug abuse.

Noteworthy is the finding that marital therapy ESs are somewhat larger than those for family therapy. In Shadish and Baldwin (2002), the average ES for marital therapy was 0.84 compared with 0.58 for family therapy. Regarding specific approaches, Shadish and Baldwin (2005) meta-analytically examined randomized trials of behavioral marital therapy (BMT) and found it significantly more effective than no treatment ($d = 0.59$). Gollan and Jacobson (2002) identified five couple treatments

[2]This chapter does not exhaustively or historically review all the studies concerning covered topics but rather chooses more contemporary studies that are representative of the issues at hand.

[3]The word *disorder* is used only to report the research findings and in no way endorses the science or ethics of diagnosis.

in addition to BMT with proven efficacy over no treatment: emotionally focused therapy (EFT; Greenberg & Johnson, 1988); integrative couple therapy (Jacobson & Christensen, 1996), cognitive–behavioral marital therapy (CBMT; Baucom & Epstein, 1990), strategic therapy (Goldman & Greenberg, 1992); and insight-oriented marital therapy (IOMT; Snyder & Wills, 1989). Finally, Christensen et al. (2004) found an ES of 0.86 for traditional behavioral couple therapy (TBCT) and integrative behavioral couple therapy (IBCT).

In sum, it can be justifiably concluded that family and couple therapy, in comparison with no treatment, is efficacious in alleviating a range of symptomatic complaints. Although posttest treatment gains tend to diminish somewhat at follow-up and as many as half of clients do not progress to nonclinical functioning, when compared with no treatment, MFT offers a viable opportunity for positive change. The only qualification to these conclusions concerns the dearth of data collected in real-world practice settings (Addison, Sandberg, Corby, Robila, & Platt, 2002; Shadish & Baldwin, 2002) and whether current research encompasses the diversity of a growing segment of family and couple clientele (Northey, 2002).

Relative efficacy, the effects produced by comparing two treatments, addresses the question, "Does one work better than another?" (Wampold, 2001). Unlike the response to the question of absolute efficacy, the answer here is controversial. Is the dodo bird correct or mistaken in declaring that all are winners and all must have prizes? If models contain unique ingredients that are responsible for outcome effects, then variations in efficacy will be found in comparative trials (differential efficacy). If common factors are responsible for outcome, then outcomes will generally be homogenous in head-to-head model comparisons (uniform efficacy).

On one hand, some have reported differential effects of one approach over another. For example, summarizing the findings of all examined trials at the time, Pinsof and Wynne (1995) concluded that there was convincing evidence for MFT superiority over individual approaches for certain problems and populations. They particularly noted studies that revealed superior outcomes for persons diagnosed with schizophrenia who received psychoeducational family therapy compared with treatment as usual (TAU; Goldstein & Miklowitz, 1995). Similarly, Stanton and Shadish's (1997) meta-analysis of 15 drug abuse outcome studies found superior effects for family–couple interventions over individual and group therapies. Some see these findings as just scratching the surface. For example, Sexton, Ridley, and Kleiner (2004) expressed the belief that future meta-analyses that examine approaches adhering to treatment-specific protocols will confirm the relative efficacy of models and the critical relationship between technique and outcome.

On the other hand, meta-analyses over the past 17 years and recent comparative investigations have not found evidence for differential efficacy nor the predicted advantage of models adhering to specific protocols. The Shadish et al. (1993) meta-analysis of 163 randomized trials did not find significant differential effects of couple and family therapy over individual therapy or differences between various MFT orientations. In a later review of 20 meta-analyses of MFT interventions, Shadish and Baldwin (2002) similarly found few significant differences among various models. When comparing MFT approaches with alternative treatments, any differences were small and tended to get smaller over time. Confirming this conclusion, a recent meta-analysis of differential efficacy in the treatment of youth disorders, including family therapy, found some differences in efficacy among treatments, but the upper bound of the difference was small (Miller, Wampold, & Varhely, 2008

Couple therapy follows suit. In Dunn and Schwebel's (1995) meta-analysis of BMT, CBMT, IOMT, and EFT, weighted mean ESs were not significantly different at either posttreatment or follow-up on marital behavior, including target complaint. IOMT was significantly better on relationship ratings at posttreatment, but not at follow-up. Christensen and Heavey's (1999) review of couple therapy noted that the few studies showing the superiority of one treatment over another favored the investigator's treatment and had not been replicated. They concluded, "In short, there is no convincing evidence at this point that any one couple therapy is better than another" (p. 173). Confirming that conclusion in a comparison of TBCT and IBCT, Christensen et al. (2004) reported, "For the most part, TBCT and IBCT performed similarly across measures, despite being demonstrably different treatments" (p. 188).

In the Cannabis Youth Treatment (CYT) Study (Dennis et al., 2004), considered by many to be the largest and most methodologically sound investigation of adolescents to date, 600 adolescents were assigned either to treatment with motivational enhancement therapy plus cognitive–behavioral therapy (5 or 12 sessions), family education and therapy, adolescent community reinforcement approach, or multidimensional family therapy (MDFT). Comparisons between conditions found roughly equivalent significant pre–post treatment effects that were stable in terms of days of abstinence and percent in recovery by the end of the study. The similarities in outcome in the CYT, the authors noted, are consistent with studies with adults comparing multiple interventions for substance abuse.[4]

[4]Cost-effectiveness comparisons did indicate moderate to large differences between treatment conditions, with motivational enhancement therapy, cognitive–behavioral therapy, and adolescent community reinforcement the most cost effective, and family education and therapy and MDFT the least.

MUST ALL HAVE PRIZES?

Although the preponderance of the evidence suggests the dodo verdict to be true to form in MFT, the view that some approaches are better than others persists. To resolve this apparent conundrum, one must take a closer look at what constitutes claims of superiority in those studies that report differential efficacy. Two factors must always be kept in mind when a report of differential efficacy is advanced: allegiance factors and unfair comparisons.

Allegiance

As noted in chapter 2 and throughout this volume, *allegiance* refers to researchers' belief in and commitment to a particular approach. Allegiance can exert a large influence on outcome in comparative studies. For example, Luborsky et al. (1999) used three types of allegiance measures (reprint method, ratings by colleagues, and researcher self-ratings) and found that allegiance explained 69% of the variance in outcomes. In Miller et al.'s (2008) analysis of differential treatment of youth disorders, researcher allegiance was found to be strongly associated with the difference in ESs; when allegiance was controlled, the differences among treatments vanished. Often, allegiance-bound therapists are compared with colleagues without similar ties to models. As a point of comparison, in the CYT mentioned above, the principal investigators had no particular allegiance to the models compared, and the therapists believed their approach to be superior and were equally committed to their models. As a result, no differences were found.

One step further, when therapists in trials are trained and supervised by the model advocate, at a site where the model is taught, and in a study designed by a model proponent, they most likely will have allegiance to the researcher or trainer's model (Wampold, 2001). Consider the role of allegiance in findings for the efficacy of EFT. Johnson (2003) referred to a meta-analysis of four EFT studies (Johnson, Hunsley, Greenberg, & Schindler, 1999), indicating an ES of 1.3. This estimate significantly outstrips the 0.84 reported by Shadish and Baldwin (2002) for couple therapy. Calling the dodo bird verdict the "dodo cliché," Johnson (2003) explained, "Some researchers . . . believe that, like the Dodo bird, the idea of some models of intervention being more effective than others is extinct" (p. 367). Setting aside this erroneous interpretation of the dodo bird verdict, an examination of allegiance in the meta-analyzed studies addresses the assertion that "EFT appears to demonstrate the best outcomes at present" (Johnson, 2003, p. 365).

First, two trials of the four compared EFT with a wait-list control group and predictably found superior outcomes; demonstrations of efficacy over placebo or no treatment are not comparisons with other approaches and

therefore have no bearing on the dodo verdict. Two studies investigated differential effects. In Johnson and Greenberg (1985), EFT was superior to problem-solving treatment on 6 of 13 outcome indices at termination and 2 of the 5 reported at 8-week follow-up. Both EFT and problem-solving treatment achieved significant differences over the waitlist and clinically significant change (recovery into a nondistressed range), with equivalent maintenance of that change. This article acknowledged that the first author had served as a therapist in the study and that the authors developed EFT, raising concerns about therapist allegiance to the contrasted approach conducted in an EFT hotbed. In the second trial addressing differential efficacy, Goldman and Greenberg (1992), researchers had comparable allegiance to the treatments delivered—EFT and integrated systemic therapy—and no significant differences were found.

Researcher allegiance may lead to distortions (Wampold, 2001). For example, Johnson (2003) described the EFT meta-analysis as follows: "This analysis found that EFT was associated with a 70% to 73% recovery rate for relationship distress" (p. 367). However, in the meta-analysis, Johnson et al. (1999) stated that "in most studies, over half of the EFT treated couples met criteria for recovery (i.e., no longer maritally distressed)" (pp. 71–72). Recovery rates for the four meta-analyzed trials averaged 57.5%, a figure comparable with other estimates for couple intervention. The quoted rates of 70% to 73% are, in fact, rates of improvement, not recovery.[5] Christensen and Heavey (1999) have suggested that measurement of durability is essential in determining an intervention's true effect. However, follow-up data from the four analyzed studies was selective in Johnson et al., with the omission of the striking posttreatment regression for EFT clients in Goldman and Greenberg (1992). EFT couples failed to maintain gains on the Dyadic Adjustment Scale (DAS), Target Complaints (TC), and Goal Attainment Scale (GAS) at 4 months posttreatment, whereas the comparison approach (integrated systemic therapy) held onto posttest levels.

In all four EFT studies cited by Johnson et al. (1999), authors are model developers or developers' students or trainees, and study sites are locations where model creators trained, facts acknowledged by the authors. It is worthy to note that in the only direct comparison of EFT with another couple approach in which the comparative model was delivered by therapists with equal allegiance, no differences in outcomes were reported. Magnitudes of ESs and claims of superiority in the EFT meta-analysis clearly must be interpreted with allegiance as a point of reference. The robust impact of allegiance factors

[5]These percentages were reported by Johnson et al. (1999) in only two of the original studies. Only one original study indicated attrition rates, making it difficult to determine if recovery and improvement rates were derived from the intent-to-treat sample or completers only.

illustrated in these instances suggests that the portion of outcome variance attributable to allegiance factors in the MFT literature in general warrants close scrutiny in evaluating claims of differential efficacy.

Unequal Comparisons

Inequality in important attributes between treatments constitutes a significant confound in evaluating comparative trial findings (Duncan et al., 2004; Wampold, 2001). Looking for unfair comparisons speaks to the old but relevant question, "Compared with what?" Unequal comparisons significantly inflate the meanings often attributed to results. For example, on average, any systematically applied treatment is 4 times more effective than no treatment (Lambert & Ogles, 2004). So when a study of functional family therapy (FFT) reported a 41% recidivism rate in the no-treatment group whereas FFT achieved a 9% rate (Gordon, Arbuthnot, Gustafson, & McGreen, 1988), the findings are laudable but nothing more than would be expected. Moreover, comparisons with no treatment have no relevance to differential efficacy.

The meta-analysis claiming differential efficacy conducted by Stanton and Shadish (1997) further illustrates unequal comparisons. Synthesizing drug abuse outcomes for 13 studies, this investigation compared MFT with non-MFT modalities. Five studies (one study report could not be located) found a difference between MFT and non-MFT intervention. First, in McLellan, Arndt, Metzger, Woody, and O'Brien (1993), methadone plus minimal counseling and methadone plus individual counseling were compared with an enhanced package of methadone, individual counseling, medical or psychiatric service, employment, and family therapy. The sheer amount of time given to the enhanced group would increase the chances that participants would fare better than those in other groups. This study cannot say, however, whether the key ingredient responsible for better outcomes is family therapy, only that the entire array of intervention proved superior. Next, in Stanton, Todd, and Associates (1982), outcome results (days abstinent from opiates), from most to least effective intervention, were paid family therapy, unpaid family therapy, paid family movie, TAU. Here, TAU is compared with the carefully coordinated efforts of family treatment teams who contacted families, elicited engagement, and provided a well-defined treatment modality supervised by approach advocates. The study reported that TAU therapists were skeptical that clients would respond positively to treatment, whereas clinicians in the family conditions believed that significant change was possible. This study teaches much about the value of an intensive and hopeful response to addiction. Whether it constitutes a head-to-head comparison and definitive evidence for superiority of family intervention is questionable.

Two trials involving multisystemic therapy (MST) in Stanton and Shadish's (1997) analysis found differences between family and nonfamily approaches (see chap. 6, this volume, for further critique of MST). MST therapists meet in the home and engage the targeted clients' significant social and community networks. The first study, Henggeler, Melton, and Smith (1992), compared MST with probation monitoring and therefore was not a fair contest but rather a control or no-treatment comparison. The second study (Borduin et al., 1995) described MST conducted in the home, involving parents and other interacting systems, by therapists with limited caseloads (students of principal investigator) who were regularly supervised (2.5 hr per week by a founder of the approach). MST was compared with therapy of the adolescent only, conducted in a clinic by therapists with no special supervision or allegiance and with full caseloads. These therapists, supposedly to remain true to an individual orientation, involved only the adolescent in services more than 90% of the time. Regardless of orientation, it is a questionable practice to ignore relevant individuals and systems (parents, schools, courts) in the treatment of adolescents (especially parents). This comparison goes beyond just a TAU contrast and enters the realm of a sham treatment comparison, one that is unlikely to be delivered in actual practice.

In Joanning, Thomas, Quinn, and Mullen (1992), family drug education (FDE) and adolescent group therapy had outcomes inferior to family therapy. FDE provided educational material to families, whereas "discussion of problems or concerns unique to a particular family was discouraged" (p. 349); it is obvious that this was not a bona fide treatment designed to be therapeutic. The other comparison, adolescent group therapy, was delivered by two students in a family therapy doctoral program in which one or more study researchers presumably taught and supervised. As the authors noted, "A possible confounding factor in the study was the fact that all therapists and one of the two FDE leaders were doctoral students in a family therapy program" (p. 348). The final study favoring family therapy is unpublished, though Stanton and Shadish (1997) described the comparison condition as "teacher sponsor," clearly not an intervention and not on a par with family therapy. Stanton and Shadish's meta-analysis stated the obvious: When more time is spent, more systems are involved, and with approaches intended to be therapeutic, outcomes improve.

Psychoeducation (Goldstein & Miklowitz, 1995) has been cited as superior to other forms of intervention for the treatment of schizophrenia (e.g., see McFarlane, Dixon, Lukens, & Lucksted, 2003; Pinsof and Wynne, 1995), though inclusion of it in evidence-based practice lists for serious mental illness, including bipolar diagnoses, primarily focuses on its efficacy relative to standard individual approaches (Dixon et al., 2001). An inspection of unequal comparisons challenges differential efficacy. Psychoeducation as a

model involves multiple components in addition to psychoeducation, including early engagement of the family in a no-fault atmosphere' recommendations for coping, communication, and problem-solving training; and crisis intervention. Goldstein and Miklowitz (1995) acknowledged that without empirically comparing varying aspects of treatment strategies, evidence that psychoeducation (or some other ingredient) produces reduction in relapse cannot be determined (Goldstein & Miklowitz, 1995). Moreover, Goldstein and Miklowitz reported a narrowing of differences between the experimental and comparison conditions in their 1995 review.

A later review (McFarlane et al., 2003) suggested that core elements of family psychoeducation are even more extensive: minimum 6 months intervention, social network expansion, behavioral skills, employment training, and cultural and contextual adaptations (p. 231). Sprenkle (2003) noted that "subsequent research has demonstrated that, when these core ingredients are present, disparate methods work about equally well" (p. 93). In sum, psychoeducation is a multifaceted, time- and resource-intensive modality, obviously not comparable to, and more likely to succeed than, the most frequent comparison condition: individual, office- or institution-based therapy.

A critical review of the differential efficacy data demonstrates few exceptions to the dodo verdict when allegiance is considered, comparisons are fair, and bona fide treatments are contrasted, eroding claims of differential efficacy and giving credence to the claim that all have won prizes. Indeed, Sexton, Alexander, and Mease (2004), in their comprehensive review of family therapy efficacy, appeared to concur, "The results of these treatments [evidence based] appear to be maintained in relation to treatment-as-usual control groups but have not been found to be superior to other alternative treatments" (p. 633).[6]

MFT AND THE COMMON FACTORS: EXTRATHERAPEUTIC (CLIENT) FACTORS AND TREATMENT EFFECTS

The lack of meaningful differences among MFT approaches, as suggested by Rosenzweig (see Prologue, this volume) so long ago, points to aspects found across all couple and family interventions that account for outcome. To understand these common factors, it is first necessary to separate the variance due to

[6]This conclusion begs the question of financial pragmatics. Costs of implementation of evidence-based treatments are not insignificant. For example, FFT costs for training only one working group has been cited at $47,500, excluding expenses (National Center for Mental Health Promotion and Youth Violence Prevention, n.d.). Considering this cost in the context of the usual high therapist turnover rate in agencies challenges the practicality of implementing evidence-based treatments in a continually changing environment.

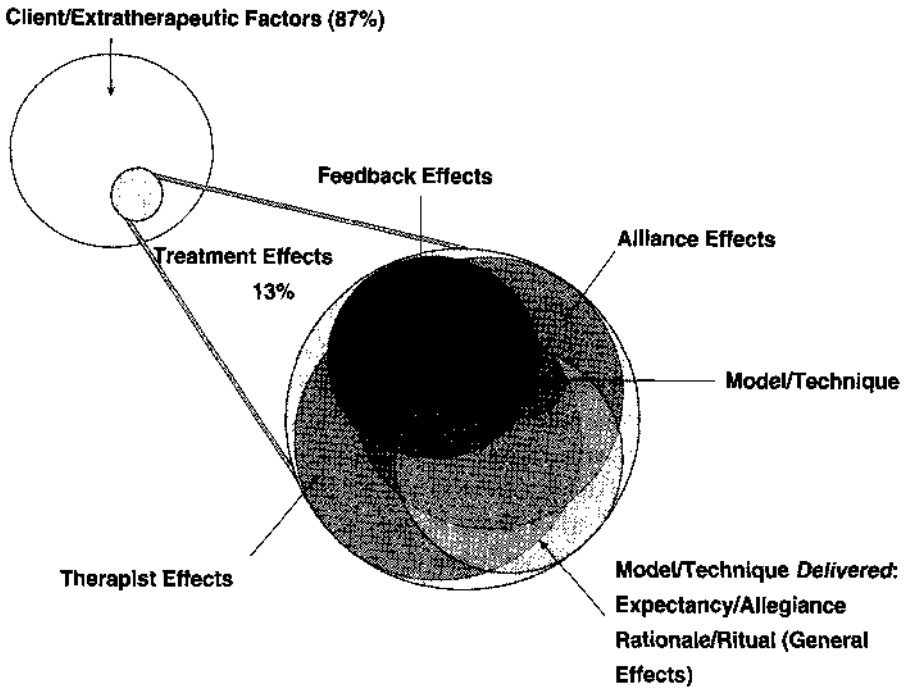

Figure 12.1. The common factors with a proposed feedback factor.

therapy from that attributed to extratherapeutic factors: those variables incidental to the treatment model, idiosyncratic to the specific client, and part of the client's life circumstances that aid in recovery despite participation in therapy (Asay & Lambert, 1999). These variables consist of the client's strengths, struggles, motivations, distress, supportive elements in the environment, and even chance events. Client factors, including unexplained and error variance, account for 87% of the variance of change, leaving 13% accounted for by treatment (Wampold, 2001). An inspection of Figure 12.1 reveals that the proportion of outcome attributable to extratherapeutic factors and treatment is represented by the circle on the left. The variance accounted for by treatment is depicted by the small circle nested within client factors (at the lower right side of the figure). For the sake of perspective, consider that model and technique differences have an ES of 0.2 at best, equating to only about 1% of the overall variance of outcome. Consequently, the impact of extratherapeutic factors on outcome flies in the face of the oft-told story: The heroic therapist galloping in on the white stallion of theoretical purity brandishing a sword of empirically supported treatments to rescue the helplessly disordered patient or dysfunctional family terrorized by the psychic dragon of mental illness. On the basis of the data, Duncan et al. (2004) called for a recasting of the therapeutic drama to assign clients their rightful "heroic" roles in change.

Perhaps the quintessential representation of client preexisting resources is found in pretreatment change (PTC). Weiner-Davis, de Shazer, and Gingerich (1987) published the original family therapy study about PTC and found that 66% of their clients reported positive, treatment-related gains prior to the formal initiation of therapy when asked about such change at the beginning of their first session. Other research has established a link between PTC and outcome. For example, solution-focused researchers Beyebach, Morejon, Palenzuela, and Rodriguez-Arias (1996) found that clients who reported PTC were 4 times more likely to finish treatment with a successful outcome. In Allgood, Parham, Salts, and Smith (1995), PTC predicted whether therapy termination was planned or unplanned; when clients reported no PTC, the therapy was likely to end prematurely. These findings suggest that clients harness pretherapy personal, interpersonal, or social resources to begin reaching their own particular change objectives.

That clients far outweigh specific technique in relative contribution to outcome is supported by the empirical literature (see chap. 3, this volume). Despite this, systemic research about the client's contribution to change is sparse. Client demographic characteristics (age, gender, race, ethnicity, education) have not shown consistent influence on outcome (Hampson & Beavers, 1996; Snyder, Mangrum, & Wills, 1993). Johnson & Talitman (1997) found that only one demographic factor, male age, was related to outcome in their study of EFT. Older men were more likely to be maritally satisfied 3 months after therapy than their younger counterparts, though the authors acknowledged that this may reflect more a match between the client and the approach than the ability of younger men to benefit.

One review of dropout in the MFT literature found that client socioeconomic status (SES) was associated with premature termination of therapy; clients of lower SES had higher rates of dropout than those with higher incomes (Bischoff & Sprenkle, 1993). However, in another study of 88 couples, SES did not predict marital outcome variance (Waldron, Turner, Barton, Alexander, & Cline, 1997). Bischoff and Sprenkle (1993) found that dropout rates were higher when the ethnic backgrounds of the therapist and client diverged. Although there is some empirical evidence that ethnic and racial matching may enhance outcome, ethnicity and race are likely only two among many characteristics that influence a good client–therapist fit (Zane, Hall, Sue, Young, & Nunez, 2004). One study found that although different client–therapist matching on race and gender impacted couples' perceptions of early sessions, this effect decreased over time, indicating that these variables were not static (Gregory & Leslie, 1996).

Client characteristics that are responsive to therapy appear to play larger roles in systemic therapy outcomes. These include pretherapy relational patterns and degree of system distress as well as those attributes specific to the

therapy (e.g., motivation and engagement). Jacobson and Christensen (1996) found that BMT was best suited for clients who were highly committed to each other, had similar goals, and high emotional engagement. In a study of 55 couples receiving either BMT or IOMT, high levels of relationship distress predicted poorer outcomes at termination and at a 4-year follow-up, though the predictive value of this variable was greater for shorter term outcomes (Snyder et al., 1993). In contrast, Johnson and Talitman (1997) found that initial levels of marital satisfaction only modestly predicted outcome. This study found that couples with men who were unlikely to seek out their partners for comfort and support, and men who were rated as inexpressive by their partners, made the most gains. The alliance was found to be the largest predictor of outcome in this study, suggesting that the degree to which couple or individual client characteristics influenced outcome can be viewed as nested within this variable.

In a study of 434 families, families scoring high on measures of family competence fared better than those scoring low prior to therapy (Hampson & Beavers, 1996). There is some evidence that the level of expressed emotion (rejection, protectiveness, fusion) in families is predictive of whether family therapy is beneficial for persons experiencing psychotic-type symptoms (Askey, Gamble, & Gray, 2007). A recent study, however, found that expressed emotion levels varied according to the severity of the family member's symptoms rather than existing prior to, or precipitating, psychotic-type experiences (McFarlane & Cook, 2007).

Although the research appears to be a hodgepodge of findings, investigating client factors is hampered by largely ex post facto analysis and the complexity of the topic (see chap. 3, this volume). Clarkin and Levy (2004) suggested that disentangling client, therapist, and alliance variables is difficult at best and that "pretreatment variables have a plausible impact on the therapy, but as soon as therapy begins, the client variables are in a dynamic and ever changing context of therapist variables and behavior" (p. 215). The findings also suggest that the largest source of variance is not easily generalized because these factors differ with each client. These unpredictable differences can only emerge one client, one therapist, and one alliance at a time.

Therapist Factors

Figure 12.1 also illustrates the second step in understanding the common factors. It depicts the overlapping elements that comprise the 13% of variance attributable to treatment (the second circle in the center of the figure). Visually, the relationship among the common factors, as opposed to a static pie-chart depicting discreet elements adding to a total of 100%, is more accurately represented with a Venn diagram, using overlapping circles

and shading to demonstrate mutual and interdependent action. The factors, in effect, act in concert and cannot be separated into disembodied parts (Duncan, Solovey, & Rusk, 1992).

First, consider *therapist factors*, defined as the amount of variance attributable not to the model wielded but rather to who the therapist is. Variability among therapists is the rule rather that the exception (Beutler et al., 2004). In the individual literature, therapist factors have emerged as potent and predictive aspects of therapeutic services, capturing more of the variance of outcome than any treatment provided and accounting for 6% to 9% of the variance (Wampold & Brown, 2005), or in other words, about 6 to 9 times more than model differences. Although a growing area of research, the only couple or family therapy investigation to parcel out therapist effects has been the Norway Couple Feedback Project (Anker, Duncan, & Sparks, 2009; Anker, Owen, Duncan, & Sparks, 2009; Anker, Sparks, Duncan, & Stapnes, 2009; Owen, Anker, Duncan, & Sparks, 2009). Limited to only 10 therapists, Anker et al. (2009) reported somewhat smaller therapist effects than reported in the individual literature, about 4% of the variance. However, Owen et al. (2009), with a larger pool of therapists (20) reported that 8% of the variance was attributed to therapist effects.

Little has been known about what differentiates practitioners, but interesting findings are beginning to emerge after a period of a dearth of results. Traditionally, systemic researchers have explored therapist characteristics associated with outcome. Bischoff and Sprenkle (1993) could not find evidence that therapist static traits impacted retention in marriage and family therapy. In a study of 434 families receiving family therapy, therapist income level, ethnicity, and gender did not discriminate between families that improved and those that did not (Hampson & Beavers, 1996). Research on the impact of matching client preferences for ethnically or racially similar therapists is inconsistent. Beutler et al. (2004) concluded, "Whatever small advantages might be attributable to ethnic similarity are not consistent across ethnic groups and are thereby a very weak basis for definitive conclusions" (p. 234). However, research on the importance of therapist qualities of warmth, empathy, and the ability to structure is more conclusive and has been found to be related to positive outcomes (Green & Herget, 1991). Counselor use of interpersonal skills (empathy, warmth, etc.) and direct influence skills predicted positive treatment outcomes in a meta-analysis of relationship variables in child and family therapy (Karver, Handelsman, Fields, & Bickman, 2006). Qualitative reviews of client perceptions have added to the evidence that clients feel connected to therapists whom they view as empathic, accepting, caring, supportive, and personable (Bischoff & McBride, 1996). Moreover, Owen et al. (2009), in a study of 20 couple therapists and 250 couples, found that increases in alliance ratings accounted for approximately 40% of the variability between therapists. Therapist ability to manage

the alliance appears to be an important contributor to therapist differences in couple therapy. Although more research is needed, this finding follows recent trends in the individual literature (e.g., Baldwin, Wampold, & Imel, 2007).

Several investigations of systemic treatments have focused on the therapist's adherence to the model and treatment outcome (Sexton, Alexander, & Mease, 2004). For example, Huey, Henggeler, Brondino, and Pickrel (2000) found that youth, caregiver, and therapist ratings of therapist adherence to MST protocol, as assessed on the MST Adherence Measure, were significantly associated with improved family relations and decreased delinquent behavior. Huey et al. (2000) stated, however, that treatment adherence is not a unitary concept; MST guidelines are "flexible and intended to fit the individual needs and strengths of the family" (p. 464). The conflation of alliance and model variables and the fact that therapist behaviors may vary considerably yet still qualify as adhering to protocol suggest that these studies may represent evidence for common factors rather than for any unique aspect of MST. What observers saw conformed with what studies across many modalities have indicated: the importance of the alliance and therapist ability to establish relationships, even in the midst of conflict and with multiple family members.

The direction of the link between therapist experience and outcome is equivocal. On one hand, Raytek, McCrady, Epstein, and Hirsch (1999) found a significantly positive association between therapist experience and observer ratings of the alliance and completion of treatment for a spouse's substance use, though not for overall outcome. Owen et al. (2009) found that therapist experience in couple therapy accounted for more than 50% of the variability in outcomes among therapists, suggesting that experience may matter more in couple work. On the other hand, others have found the evidence for the value of experience weak and even have reported that paraprofessionals may do as well as professionals (Beutler et al., 2004; Christensen & Jacobson, 1994). The lack of a consistent association between therapist experience and outcome can be viewed as an indication of the role of nonspecific variables in psychotherapy and systemic therapy. It appears that the person of the therapist, his or her own style of engaging with others and appreciating clients, and general attributes of warmth and communicated caring are strong contributors to success, as is the therapist's ability to form strong alliances.

Alliance Factors

Researchers repeatedly have found that a positive alliance is one of the best predictors of outcome in psychotherapy (see chap. 4, this volume). Depending on which meta-analysis is cited, the amount of variance attributed to the alliance ranges from 5% (Martin, Garske, & Davis, 2000) to 7% (Horvath & Symonds, 1991), 5 to 7 times the impact of model and technique.

Karver et al.'s (2006) meta-analysis of relationship variables in youth and family therapy examined 49 studies and found that counselor interpersonal and direct influence skills as well as youth and parent willingness to participate and actual participation in treatment were the best predictors of outcome. In the CYT, client self-report of the alliance early in treatment predicted substance-related problems at 3- and 6-month follow-up (Tetzlaff et al., 2005). Shelef, Diamond, Diamond, and Liddle (2005) examined adolescent–therapist and parent–therapist alliances, dropout, and outcome in the MDFT condition of the CYT. Positive parent–counselor alliance scores predicted retention, and adolescent alliance predicted fewer substance abuse symptoms, accounting for 7% of the variance; the Adolescent × Parent alliance interaction accounted for an additional 6% of the variance. In addition, early adolescent alliance predicted days of drug use during the 90 days immediately following treatment, accounting for 14% of the variance. Shirk and Karver's (2003) meta-analytic review of relationship factors in child and adolescent therapy confirmed the robust effect of this variable. The authors concluded that "in this respect, it appears that the therapeutic relationship represents a hardy nonspecific factor in therapy" (p. 461).

In couple therapy, the therapeutic relationship, with variations based on gender in heterosexual couples, has predicted outcome. The alliance explained as much as 22% of outcome variance in a study of EFT (Johnson & Talitman, 1997). Keep in mind that treatment accounts for, on average, 13% of the variance. The alliance in this study accounted for more of the variance by itself, illustrating how the percentages are not fixed and depend on the particular context of client, therapist, alliance, and treatment model.

Quinn, Dotson, and Jordan (1997) found that couples' views of the alliance at the third session predicted outcome. In a study of 80 people treated with marital therapy, the alliance did not predict progress at the individual level but accounted for 5% to 22% of the variance of improvement in marital distress (Knobloch-Fedders, Pinsof, & Mann, 2007). Women's midtreatment alliance was a better predictor of improvement in marital distress than early treatment alliance, but couples who had strong first-session alliances were more likely to remain through Session 8. Additionally, treatment response was uniquely correlated with women's perceptions of the couples' alliance to treatment. The authors speculated that these findings indicate that alliances in couple therapy form early, are relatively stable, and account for treatment participation.

Of interest to systemic therapy researchers are assessments of these variables from multiple sources in the expanded treatment system (Sprenkle et al., 1999). Systemic instruments (e.g., Pinsof & Catherall's, 1986, integrative alliance scales) measure the alliance not only on the dimensions defined

by individual therapy (Bordin, 1979) but also the clients' perceptions of the therapist's relationship with other family subsystems and the family as a whole. Family alliance research considers systems conflict, coalitions, hierarchy (Karver et al., 2006; Sprenkle et al., 1999), and the impact of differences in alliance scores within subsystems (Pinsof & Catherall, 1986). Robbins, Alexander, Turner and Perez (2003) looked at the relationship between alliance and retention in family therapy for adolescents with behavior problems. For the 34 families studied, discrepancies between adolescent–therapist and parent–therapist alliances (unbalanced alliances) predicted dropout. In a study of 40 families, the majority of families that dropped out had a moderately or severely split alliance in at least one session (De La Peña, Freidlander, & Escudero, 2009). Symonds and Horvath (2004) found that mutual agreement between marital partners regarding the strength of the alliance and alliance increases for both partners between Sessions 1 and 3 were robust predictors of outcome. In Knobloch-Fedders et al.'s (2007) study, when men scored the alliance higher at Session 8 than did their partners, couples showed greater overall improvement. Nonetheless, outcomes for couples with a *split alliance* (difference of 1 standard deviation or more on one subscale alliance measure) did not significantly differ from those with an *intact alliance*, though this finding is limited by the study's small sample size. Anker, Owen, et al. (2009), in contrast, in a study of 250 couples, found that split alliances (mild, moderate, and severe) at the first session had no impact on outcome whereas those alliances that were moderately or severely split at the last session had diminished outcomes. Further, they reported that first session alliances were not predictive of outcome whereas last session alliance scores were and that men's alliance scores at the last session predicted both their own and their partners' outcomes better than women's alliance scores at the last session. In a small study, Quinn et al. (1997) found evidence for differential impacts on outcome when wives disagreed with their husbands on the tasks dimensions of the alliance and in perceptions of their husbands' relationship to the therapist. In a 6-month follow-up qualitative analysis of 742 client responses about their experiences of couple therapy, Anker, Sparks, et al. (2009) confirmed the importance of the relational dimension of the alliance to both genders but also found the most complaints to be associated with an aspect of the alliance that is not often studied: the nuts and bolts aspects of the task dimension, such as scheduling, cancellation, and between-session contacts.

The plethora of views, often at odds with one another, encountered with more people in the room compounds the complexity of alliance influences and negotiations. Findings from the current couple and family therapy literature, however, suggest that the alliance is a potent predictor of treatment success and accounts for a measurable portion of variance.

Model and Technique Delivered: Expectancy, Allegiance, and General Effects

Consider that the delivery of any model or technique has both general and specific effects. Specific effects, or the amount of variance attributable to model differences, accounts for about 1% of the variance of change (ES of 0.2). In the CYT, model differences accounted for less than 1% with an ES of 0.1. The general effects of delivering a model of treatment include the client's expectation for recovery (placebo or expectancy) and the therapist's belief in the intervention administered or allegiance factors. Model and technique are considered here as acting in concert with allegiance, expectancy, and placebo factors, as the model and technique delivered.

Breaking down this constellation of variables, consider the general aspects of treatment models. Model and technique factors are the assumptions and procedures unique to specific treatments. Although differing in content, all include a rationale, an explanation for the client's difficulties, a ritual, and strategies to follow for resolving them (Frank & Frank, 1991). Whether instructing clients to talk to one another, alter their communication styles, or understand family dynamics, couple and family therapists are engaging in healing rituals. In both medicine and psychotherapy, when the placebo or technically inert condition is offered in a context that creates positive expectations, it reliably produces effects almost as large, or as large as the treatment itself (Wampold, Minami, Tierney, Basking, & Bhati, 2005).

Allegiance and expectancy are mirror images: the belief by both the therapist and the client in the restorative power of the therapy's rationale and related rituals. The degree to which the therapist delivering the treatment believes the chosen therapy to be efficacious, as noted earlier, weighs in as a strong determinant of outcome in clinical trials. Meta-analytic investigations of allegiance have generally found effects ranging up to an ES of 0.65 (Wampold, 2001). Therapist allegiance to an approach contributes to the client's coming to believe in a treatment as well. Placebo factors may also be fueled by a therapist's belief that change occurs naturally and almost universally; human beings, shaped by millennia of survival, tend to find a way out of their difficulties, even out of the heart of darkness (Sparks, Duncan, & Miller, 2007).

Allegiance and expectancy effects cannot occur independently of model and technique. The clinician must have a model in which to place his or her faith (one hopes many models), and a rationale and ritual is required to satisfy the client's expectation that he or she is being treated by a credible psychotherapist. Given this interdependence, the act of administering treatment becomes the vehicle that carries allegiance and placebo effects in addition to the specific effects of a given approach. Although findings regarding expectancy loom large in treatment effects in individual therapy (Baskin, Tierney, Minami,

& Wampold, 2003), research on expectancy variables in the MFT literature are scant but reinforcing (Sprenkle et al., 1999).

Regarding specific technique, Orlinsky Rønnestad, and Willutzki (2004) noted that some effective treatment interventions, although housed in contrasting "treatment packages," appear largely similar; this sheds light on the comparability of results from one model to another (p. 363). For example, providing a nonblaming rationale for the presenting problem (*reframing* or *reattribution*) has been found to be helpful across treatment contexts (Robbins, Alexander, Newell, & Turner, 1996) and in the reduction of family negativity (Sexton, Alexander, & Mease, 2004). Orlinsky et al. (2004) further asserted that experimental designs, largely used to test specific techniques, are not well-suited to answering many of the questions posed in process–outcome research. Friedlander and Tuason (2000) noted that process–outcome research largely consists of ex post facto observations of verbal behavior. Correlations between process and outcome do not provide information about important contextual variables, and caution regarding interpretation is warranted. For example, Hogue, Dauber, Somuolis, and Liddle (2006) connected process to outcome using observational ratings of therapist interventions to predict outcomes at 6 and 12 months for 63 families receiving MDFT. The study found that a high-dose mix of both family and adolescent techniques predicted reduction of adolescent externalization and family conflict at 6-month follow-up; greater use of family-focused techniques was related to decrease in adolescent internalizing symptoms at 6 months and family cohesion at 1 year. The description of MDFT techniques in this study encompassed broad domains of therapist–client process, including the engagement of the adolescent and parent and the facilitation of changes in interactional patterns, activities found in many family approaches. The authors noted that the focus on technical aspects of treatment in the study excluded nontechnical components that may be as much or more responsible for outcomes.

Feedback

The measurement and management of change, from the client's perspective, has been catapulted to the forefront of research and practice, and for good reason: Monitoring client-based outcome, when combined with feedback to the clinician, significantly increases the effectiveness of services (see chap. 8, this volume). Although the individual literature has seen an expanding body of research on feedback, couple and family research has produced very little in this area. This may be due in part to the fact that feedback is a relatively new development but also because measuring outcome with couples and families can be inherently cumbersome. Most available outcome measures, although reliable and valid, are long and intended more for over-

sight or research purposes, thereby presenting an arduous task for both clinicians and clients. A small recent study of feedback in wraparound services for youth and families (Ogles et al., 2006) found that provision of feedback using the 48-item Ohio Scales (Ogles, Melendez, Davis, & Lunnen, 2001) did not contribute to improved youth outcomes or family functioning in comparison with a no-feedback group. Feedback, however, was restricted to just four times over the course of the treatment process.

Conversely, a strong feedback effect was found in a recent couples study. Anker et al. (2009) conducted the only randomized clinical trial to date that compared feedback with a nonfeedback condition with couples. In the largest randomized clinical trial ever conducted with couples, Anker et al. recruited 205 couples in a naturalistic setting to examine the effect of feedback in routine practice. The Outcome Rating Scale (ORS; Miller, Duncan, Brown, Sparks, & Claud, 2003), a reliable and valid four-item, self-report instrument, provided outcome feedback, and the Session Rating Scale (SRS), also a reliable, valid, four-item, self-report measure (Duncan et al., 2003), provided alliance feedback. The study shared several characteristics with Lambert's feedback trials: use of consecutive cases seen in routine care regardless of diagnosis; random assignment of client to feedback and nonfeedback conditions; provision of different models and techniques; variations in clinician experience and discipline; use of the same therapists in feedback and nonfeedback; and determination of the length of care by therapists and clients rather than by the research design. Noteworthy is the fact that this study attempted to control for allegiance effects in addition to therapists serving as their own controls; therapists were naive to formal feedback and held attitudes about feedback that ranged from neutral to positive.

Feedback substantially increased positive outcomes (ES = 0.50), accounting for approximately 10% of the variability in change while simultaneously reducing the number of at-risk clients. The proportion of clients responding to treatment in the TAU group was 41.7% (both in couple, 22.6%) and in the feedback group was 64.6% (both in couple, 50.5%). The strong effect of feedback seems particularly noteworthy given the relative simplicity of the intervention and in light of the fact that the comparison group was in an active treatment. Feedback couples reached nondistressed levels nearly four times more than nonfeedback couples. The feedback condition maintained its advantage at 6-month follow-up and achieved nearly a 50% less separation or divorce rate.

Speaking directly to the issue of therapist variability discussed above, the effect of feedback varied significantly across therapists. Anker et al. (2009) reported that the correlation between the variability in the effectiveness of a therapist with no feedback and variability in the effect of feedback was unusually high ($r = -.99$). Although the authors cautioned that the small

number of therapists (10) significantly limits any conclusions that can be drawn, it does suggest that the less effective therapists (those who had the worst outcomes without feedback) benefited more from feedback than the most effective therapists. Feedback, therefore, seems to act as a leveler among therapists, raising the effectiveness of lower or average therapists to that of their more successful colleagues. In fact, a therapist among the lower effectiveness group without feedback became the therapist with the best results with feedback![7] Nine of 10 therapists benefited from the effects of feedback.

On the basis of their findings, Anker et al. (2009) suggested continued reflection about the transportability of specific couple therapy approaches to clinical settings. As noted, couple therapy research has robustly demonstrated superiority over no-treatment controls for several approaches but has failed to find reliable superiority of one over another or TAU, especially at follow-up. At the same time, the financial investment for agency-wide implementation of a particular couple therapy orientation is substantial. For example, certification in emotionally focused couple therapy (EFCT) requires a minimum of 42 hours training and 32 hours of supervision with a certified EFCT supervisor (see International Centre for Excellence in Emotionally Focused Therapy, 2007). Conversely, the feedback condition in Anker et al.'s (2009) study demonstrated superior results to TAU at posttreatment and follow-up. Feedback methods are generic in nature and not tied to a single therapy modality and therefore represent a lower commitment of staff and money to implement. Therapists received only 17 hours of training in Anker et al.'s study. The authors concluded, "Feedback, therefore, seems more easily transportable to community settings compared with specific treatment packages, and more likely to yield a return on investment" (p. 701).

Feedback studies with families are in their infancy, hampered by a lack of feasible instruments that reliably track change from a youth's perspective. Until recently, persons under the age of 13 years have not had an opportunity to provide formal feedback to helpers about their views. To fill this void, the Child Outcome Rating Scale (CORS; Duncan, Sparks, Miller, Bohanske, & Claud, 2006) was developed. The CORS is similar in format to the ORS but contains child-friendly language and graphics to aid the child's understanding. With such instruments, children and their families can benefit from client-informed

[7]This finding, although preliminary, challenges the practice of giving referrals to only the most effective therapists as suggested in chapter 9, this volume, or providing incentives in general for therapist performance. Such policies risk turning therapists against measuring outcomes and could perhaps encourage therapists to cheat the system to ensure referrals and to gain a competitive edge. Given that feedback seems to act as a leveler of therapist performance that enables nearly all therapists to achieve good outcomes, such practices seem unnecessary and perhaps counterproductive. See chapter 14 of this volume for more discussion of the downsides of institutional data collection and provider profiling.

practice, and researchers have a tool for examining the impact of services at individual, family, and systems-wide levels.

On the basis of a growing body of compelling empirical findings, feedback seems to improve outcomes across client populations and professional discipline, regardless of the model practiced; the feedback process is thus a vehicle to modify any delivered treatment for client benefit. Given its apparent broad applicability and lack of theoretical baggage, feedback can be argued to be a factor that demonstrably contributes to outcome regardless of the theoretical predilection of the clinician. It therefore could be considered a common factor of change.

Feedback as a Common Factor: A Proposal

At first blush, feedback may seem like an odd addition to the list of common factors. The process of attaining formal client feedback and using that input to tailor services, however, seems a worthy addition for several reasons. First, the effects of feedback are independent of the measures used; a variety of outcome instruments have demonstrated a positive impact on outcome. Second, systematic feedback improves outcome regardless of the specific process used, whether in collaboration with clients or merely giving the feedback to therapists—over the phone or face to face, paper and pencil administrations or electronic format, it matters not. Third, feedback increases client benefit across professional discipline, clinical setting, client population, and level of experience of the therapist. And fourth, feedback improves outcome regardless of the model practiced: The feedback process does not dictate what technique is used but rather is a vehicle to modify any delivered treatment for client benefit.

Finally, the conceptualization of feedback as a common factor follows the tradition of other factors that were initially recognized as important and later evolved an empirical backing and more systematic application. Consider the therapeutic alliance. Although appreciated early on (see Prologue, this volume), the alliance was not understood as a ubiquitous factor with particular components that influenced and predicted outcome until the groundbreaking research conducted in the 1980s.[8] Attaining informal client feedback about the benefit and fit of services is a common phenomenon among psychotherapies. Any goal-directed, symptom-oriented approach that openly discusses the outcome of services is incorporating informal client feedback into the therapeutic mix. Feedback speaks to an interpersonal process of give and take between the clinician and client and, at least to some extent, can be argued to be characteristic of many therapeutic encounters. Many clinicians believe that

[8]For an excellent discussion of the development of the alliance concept, see Gaston (1990).

attaining client feedback about the benefit and fit of services is part and parcel to their normal everyday activities with clients. Indeed, 9 out of 10 therapists in Anker et al.'s (2009) study reported that they already informally asked clients about progress and the relationship.

And the empirical support, as reported in this volume, is increasingly showing that feedback has an impressive impact on outcome. As Lambert reports in chapter 8, ESs for the difference between feedback and TAU ranges from 0.34 to 0.92, unusually large considering that the estimates of the ES of the difference between empirically supported and comparison treatments are about 0.20. Anker et al.'s (2009) study achieved an ES of 0.50. Feedback, then, like the alliance, has been initially viewed as an important aspect of conducting effective psychotherapy and is garnering a growing evidence base that supports a more formal understanding and systematic inclusion. Clearly, feedback is not an individual phenomenon but a systemic one, uniting multiple players in a common therapeutic process.

Figure 12.1 shows how feedback overlaps with and affects all the factors—it is the tie that binds them together—allowing the other common factors to be delivered one client at a time. Soliciting systematic feedback is a living, ongoing process that engages clients in the collaborative monitoring of outcome, heightens hope for improvement, fits client preferences, maximizes therapist–client fit, and is itself a core feature of therapeutic change.

Summary

Common factors research provides clues and general guidance for enhancing those elements shown to be most influential in positive outcomes. The specifics, however, can only be derived from the client's response to any treatment delivered: the client's feedback regarding progress in therapy and the quality of the alliance. Feedback enables a reliable and valid method of tailoring services to the individual; therapists need not know what approach should be used with each disorder, but rather whether the delivered approach is a good fit for and beneficial to the client in the moment. As such, feedback assumes a role alongside the more widely researched client, therapist, and alliance variables, emerging as a potential common factor.

ARE SOME MORE EQUAL THAN OTHERS?

Can both sides have a piece of the evidence pie? "All are equal, but some are more equal than others" is reminiscent of a well-known fable of barnyard animals in a hypothesized future society (Orwell, 1945). The "both–and" in

this tale disguises the actual workings of power, in fact, there are clear winners and losers. Until greater evidence is brought forward that disputes what has now become one of the most replicated findings in the research literature, having it both ways is untenable. With very few exceptions, all approaches in the systemic literature appear to work equally well when the conditions of the delivery of the treatment are roughly equivalent. A different both–and point of view, however, is possible. Particular change mechanisms appear to overlap in MFT models. This finding invites exploration of how these mechanisms operate in systemic practice, with the understanding that they are common factors, and one approach is not promoted at the expense of others. Mandating the provision of certain approaches at the exclusion of others limits the ability of diverse pairings of therapists and clients to flexibly devise effective treatments.

The preponderance of research suggests that specific ingredients likely to produce variations in outcome are not, in fact, meaningfully operational in the systemic literature; the dodo thrives beyond its origins in the individual psychotherapy literature. This conclusion implies that practice, training, and research centralize common factors. Although emphases on the common factors in accordance with the amount of variance each accounts for makes strong empirical sense, codifying common factors to apply across therapies transforms a transtheoretical paradigm into a level of abstraction consistent with specific models (Duncan et al., 2004; Wampold, 2001). The common factors literature suggests instead that each therapy encounter is unique: one cannot know a priori what will work best. Obtaining consistent information from clients as therapy unfolds helps ensure that common factors do not devolve into specified strategies to be applied universally. The relative importance of common factors, with attention to the role of feedback, recommends the following practice directions:

- Family clinicians in a variety of settings advocate for ways to formally give voice to clients, via client-based outcome measures as well as other methods to form partnerships with consumers of MFT services.
- Family clinicians tailor treatment on the basis of the formal collection of client feedback using measures and means consistent with the language, customs, and cultural preferences of diverse clientele.
- Therapists creatively develop ways to invite client resources and resilience into therapy.
- Therapists initiate and facilitate the transformation from mandated protocols to more flexible procedures that fit client preferences in accordance with the new American Psychological Association definition of evidence-based practice (see chap. 1, this volume).

- Therapists incorporate measures of client views of progress and the alliance at each session (including children's and adolescents' perspectives) to respond to divergent goals and enhance individual and subsystem alliances as treatment progresses.
- Therapists become skilled in several approaches that have personal resonance and enhance their sense of confidence to provide a hopeful environment for client change.
- Therapists use client feedback to recognize when a different approach is warranted and are able to make this shift midstream when required.
- Family clinicians advocate for lower caseloads, more supervision, reliable feedback about the outcome of services, and training in models that fit therapist preferences rather than more costly mandated evidence-based treatment protocols in typical family service environments.

Although teaching relational skills and helping trainees develop allegiance to several approaches is consistent with the empirical findings, manualizing these is at odds with the minor importance of specific techniques in overall outcome. Training in and use of client feedback has the potential to help student therapists adapt skills to each situation. This can enable trainees falling in average or below average ranges of efficacy to more consistently produce outcomes that are above average. The following are common factors–informed recommendations for MFT academic and training programs:

- Curricula include a focus on the empirical basis for common factors in the systemic literature and the expertise to critically evaluate outcome research.
- Clinical trainees learn how to obtain and use formal feedback via outcome tools throughout practicum and internship experiences.
- Supervisors use client feedback to assist trainees to improve outcomes, expand skills, and enhance relational flexibility.
- Training sites systematically collect client-generated data to inform improvements to overall client service and program learning initiatives.

The race to win prizes in the evidence-based treatment (EBT) contest has produced results distracting from the factors most associated with change and, in some cases, misinformation for therapists and funders. Recognizing the preeminence of common factors in outcome entails a redirection of the research agenda to include the following:

- Exploration into how clients, families, and their communities mobilize resources to achieve preferred goals.

- A shift from the search for the best model for a given targeted group, problem, or therapist trait, to how therapists can best engage clients in each unique encounter.
- Greater attention to the role of therapist effects in couple and family practice.
- Continued exploration of the dynamics of multiple, interacting variables and therapeutic alliance in systemic work.
- Research into the role of feedback conditions in improving retention, recovery, and treatment durability.
- Increased qualitative research that can develop rich descriptions and give voice to people speaking from nondominant social locations.
- The inclusion in research of diverse individuals, couples, and families that reflect the changing demographics of family therapy's clientele and practice communities.

Wampold (2002) noted that RCTs are designed to show efficacy of treatments and not factors, such as who delivers them, who receives them, and their relationship. He concluded that the inclusion of minority groups in trials is based on the erroneous assumption that specific ingredients need to be tested for their interaction with set categories (e.g., race), without a critical examination of the social construction of those categories and the complexity of variables (e.g., values, attitudes, SES, gender) within them. A critical research lens, whether qualitative or quantitative, can undermine traditional diagnostic categories and focus analysis on factors such as discrimination, poverty, and the differential operations of social and institutional power, areas of inquiry consistent with the field's ecosystemic paradigm.

Inviting clients' voices to be part of the literature regarding what works and what is needed can only enrich treatment strategies and improve outcomes. Engaging clients as the most potent common factor requires a "culture of feedback" (Duncan et al., 2004) grounded in knowledgeable and affirming practice (Brown, 2006) and an appreciation of context. It also entails asking for, listening to, and valuing each client's meanings, hopes, and preferred forms of help at each therapy encounter. Tailoring intervention to each person and family ensures that clients' unique worldviews and values are not only respected but central.

There are now decades of family and couple practice and a venerable history of clinicians, scholars, and researchers elaborating systemic principles. Clearly, the systemic lens provides a compelling basis for effective psychotherapy across a spectrum of problems. Proving its worth may no longer be a necessity. And yet, the current emphasis on EBT insists on more: proving superiority. What is created is a context of competition. The "all must have prizes" verdict

is singularly out of step in this environment. It would be useful to establish a dialogue that considers the impact of this development on the field, with voices pro and con. The stance proposed here is that a focus on common factors is empirically informed, enhances the viability of systems therapy in the market, facilitates a framework for training and research, and is accountable to clients, respecting their unique diversity.

QUESTIONS FROM THE EDITORS

1. *You have made a strong case for the dodo verdict in MFT. Aren't EBTs, however, superior to TAU, and therefore shouldn't they be implemented?*

EBTs, actually, have not shown their superiority over usual care (UC) or TAU. For example, in a meta-analysis of 32 studies comparing EBT with TAU for child problems, Weisz, Jensen-Doss, and Hawley (2006) reported an ES of 0.30 in favor of EBT (see chap. 11, this volume). This meager difference becomes even more so when considering the following: (a) When the EBT was not added to the UC, which is a fairer comparison than comparing the combination with UC, the effect was smaller; (b) if the dose of EBT was not greater than the dose of UC, the difference became nonsignificant; and (c) several of the comparisons were between EBT and a UC that was not a psychotherapy (e.g., case management or minimal contact). When the UC was a psychotherapy, the effect was not significantly different from zero. Further, many comparisons did not draw the therapists for EBT and UC from the same pool. Given that it is likely that the EBT therapists were selected for their skill and that therapists differ consistently in their outcomes, this would advantage the EBT. When therapists were drawn from the same pool, the superiority of EBT was nonsignificant.

A recent investigation of Parent Management Training, the Oregon Model (PMTO) further illustrates. After an uncritical account of reviews claiming PMTO efficacy (see chap. 6, this volume, for the problems with such reviews), Ogden and Hagan (2008) reported that PMTO was effective in reducing parent-reported child externalizing problems, improving teacher-reported social competence, and enhancing parental discipline over TAU. They concluded that "the findings thus indicate that PMTO is an effective treatment program . . . with children exhibiting serious behavioral problems and moreover that an EBT program can be transported successfully to a new participant group" (p. 617).

The initial analysis that compared PMTO with TAU included 16 outcome measures. Only 4 found a difference favoring PMTO. On 1 of the 4 measures reporting a significant effect for PMTO (the Child Behavior Check List Total), the difference between the means at the end of treat-

ment of PMTO versus TAU was 1.92 points. On another (Child Behavior Check List Externalizing Total), the difference between posttreatment means was 1.53 points. The clinical significance of these differences is questionable at best. The secondary analysis looked at treatment differences by age of the child. Once again, they found a superior finding for PMTO on 4 of 16 measures for children 7 years of age and younger only. No differences between TAU and PMTO on 15 of 16 measures for children 8 years of age and older; 1 measure favored TAU over PMTO. In other words, for children over 7 years of age, there was only one significant finding and that was for TAU.

In addition to these underwhelming results, the PMTO therapists received 18 months of training and ongoing support and supervision during the study, whereas the TAU therapists received no additional training, support, or supervision. Finally, the dose of treatment favored PMTO (work with parents; 40 vs. 21 hours). The meager results, no findings on 12 of 16 measures, and no effects favoring PMTO for children 8 years of age and over, combined with the confounds of the differential training and support of the two therapist groups and unequal doses of treatment, cast significant doubt on this study's conclusions. The cost effectiveness of implementing an approach that requires 18 months of training while yielding minimal results is dubious.

2. *You have asserted that including the client's voice is an important issue in graduate training. What are you (Jacqueline A. Sparks) doing in your MFT program at the University of Rhode Island?*

The MFT Program at the University of Rhode Island recently instituted an outcome-informed protocol that emphasizes the importance of systematically monitoring client feedback throughout therapy. Trainees are taught to collect, score, and use brief, valid measures of progress and relationship (ORS, SRS, CORS; see http://www.heartandsoulofchange.com) at each session to enhance therapist flexibility, evaluate outcome, and improve overall effectiveness. Additionally, our program uses a software system that allows automated data entry from the ORS, SRS, and CORS and real-time warnings to therapists when client ratings of either the alliance or outcome fall significantly outside of established norms. The program uses algorithms based on large normative samples to help trainees and supervisors identify clients who are at risk for a negative outcome or dropout. It allows data to be stored and analyzed efficiently, providing an extensive base for faculty and student research. Most important, therapists and clients receive immediate feedback about therapy progress, enhancing student learning and client engagement. The Family Therapy Program at the University of Rhode Island is one of only a handful of clinical training programs that can claim to train not only competent but effective clinicians.

3. *You mention that feasibility is important to the feedback process. Are you saying that at the practice level, outcome measures have to be brief?*

Yes. Long measures are largely impractical in the real world, especially in work with families. Consider our experience in our validation study of the CORS (Duncan et al., 2006). The 30-item instrument used as a measure of concurrent validity made the completion of this study doubtful at times. In one school site, following a donation to the school, 500 youth–parent dyads volunteered for the study. At the first assessment, only 200 completed the measures. Of that 200, only 25 returned for a second assessment. In total, over 2,500 research packets were disseminated that finally resulted in a nonclinical sample of 199 dyads, illustrative of the feasibility issue.

On the practitioner side of things, many therapists see outcome measurement as an add-on separate from actual clinical work and relevant only to management and other overseers. In addition to wanting measures to be brief, to be easy to integrate, and to have face validity, therapists want measures that are clinically useful. Is the measure intended to improve the effectiveness of rendered services or merely monitor them? Most youth outcome measures were developed primarily as pre–post or periodic outcome measures. Such instruments provide an excellent way to measure program effectiveness but are not feasible to administer frequently and, therefore, do not provide real-time feedback for immediate treatment modification before clients drop out or suffer a negative outcome; in short, they are not clinical tools as much as they are oversight tools.

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