

What Works [Who Works], *Talking Incoherently I/I 2002*

Part D of a Synopsis

As the preceding Bulletins indicate, not everyone is happy about the idea that it is the Common Factors (i.e., the things that different treatment programs share with each other) that account for 85% of the change that clients make. In fact, most clinical experts (and most researchers in our field) still cling to the idea that it is the specific Model and its related Techniques (i.e., the Specific Factors) that *must* be the real cause of any positive change. The search goes on, then, for the Silver Bullet – i.e., the one type of treatment (probably Cognitive-Behavioural) that will solve each client problem or condition.

What could possibly be behind this reluctance to recognize the importance of the Common Factors? We can surmise that it is a combination of several things:

- ◆ There has always been a rift between researchers and clinicians. Frontline practitioners have a tendency to see researchers as “ivory tower” academics who are out of touch with the real world of programming. And researchers tend to see practitioners as “intellectually lazy mercenaries who ignore empirical findings” and who are guided by gut feelings rather than hard science.
- ◆ The Specific Factors of a therapy are the unique insights and concepts that it has on the nature of human behaviour. In other words, they are what the Model believes to be “true” above all else. It is very difficult, if you have been trained in a certain Model, to turn your back on this “truth” – i.e., to concede that it doesn’t have all that much to do with effecting change.
- ◆ In the process of learning a specific Model, a practitioner uses its unique insights and concepts to (a) bind himself to a social group of other adherents to the Model and to (b) differentiate himself from competing groups. As a result, the Specific Factors become major aspects of the practitioner’s professional *identity*. Again, it is very difficult to turn one’s back on one’s identity by admitting that it doesn’t make a huge difference in therapy.
- ◆ Mastering the specific insights & techniques of a particular Model is the basis for a practitioner’s *authority, prestige, and status* within our field. Consequently, denying (or even reducing) the effectiveness of these insights and techniques challenges the source of the person’s *authority, prestige, and status*. Why would someone voluntarily do this?
- ◆ Finally, the specific insights & techniques of a particular Model *make sense* of the jumbled, chaotic actions of the client. In doing this, they provide the practitioner with *direction, purpose, and focus* for his efforts. Again, it is difficult for a practitioner to turn his back on such a strong source of “meaning” for his professional efforts.

Truth, identity, prestige, status, and even meaning! We can now see better why it is that anything that threatens power and effectiveness of the Specific Factors might be strongly resisted.

In resisting the Common Factors, the champions of the Specific Factors often make the following points (supposedly lethal criticisms):

- ◆ The research methods that keep showing the Common Factors as most important must not be *sophisticated* enough to truly measure what’s going on in programming. [In other words, since research doesn’t come up with the results they expect and want, something must be wrong with how the research is done! The problem with this criticism is that research methods over the past thirty years have become extremely sophisticated – *and still Common Factors win out.*]
- ◆ Common Factor research lumps together too many different types of clients. These should be separated by different types of problems, complexity, and severity. This separation would probably show that some therapies are better than others. [If you think about it, this criticism is just an elaboration of the first one. Research has done exactly this kind of separation – *and the results show that there is indeed a difference between therapies: i.e., exactly the 15% that Lambert’s General Framework makes clear, but not more.*]
- ◆ This whole idea that Common Factors are the major source of therapeutic change is dangerous because it gives the impression that all therapies are equally effective – *and the result has been the growth of a lot of dangerous therapies (e.g., the recovery of repressed memories)*. [Well, it’s true that there has been an incredible boom in the treatment industry – certainly, the entire CYC profession emerged as part of this growth. However, it is very unlikely that Common Factor research had any direct or significant role in making this happen. The growth of therapy started well before such research got under way – and it was fueled by much larger social and cultural forces. Besides, Common Factor research does not prove that *all therapies work*. It only shows that *amongst those therapies that do work, there is very little difference (in fact, such difference can only account for 15% of effectiveness).*]

The champions of Specific Factors favor a model of therapy research that is unabashedly based on the *medical model for drug research*. In this model, *randomized clinical trials* (complete with ‘control groups’ and ‘double-blinds’ to ensure scientific validity) compare the effects

¹ Generally, I’m all in favor of this separation of clients. After all, we know that vastly different kinds of kids commit crime for vastly different reasons. The crime may be the same, but the reasons and motivations are worlds apart. It would be difficult to believe that the same approach should work on two different types of kids (e.g., a kid with longstanding anti-social values vs. one caught up in adolescent peer pressure). Still, the potential criteria for separating clients quickly become geometrically large. One researcher estimates that there are over 100 different types of clients and 400 or so different types of treatment procedures – giving us some 40,000 possible clinical studies (not to mention the inevitable replications and Canadian versions) – and that’s only for single-problem clients receiving single-treatment responses! Imagine the calculation required when we get into multiple-problem combinations and multiple-treatment responses (which is the more likely clinical reality)!

of (A) an *active substance* (i.e., a 'drug' or 'medicine') to (B) an *inactive or inert substance* (i.e., a 'placebo' or 'sugar pill') for (C) a *specific illness*. The 'drug' is effective to the extent that it reduces the symptoms of the specific illness more than the placebo. In using this 'gold standard' model, Specific Factors researchers simply replace the 'drug' with some specific therapeutic 'technique' or 'procedure' as the *active substance* to be tested – and they replace the 'specific illness' with the client's specific 'problem' (now called a 'diagnosis' or 'disorder'). [Therapies proving themselves effective by this process get an official stamp of approval – e.g., EBT (Evidence-Based Treatment), EVT (Empirically Validated Treatment), or the new kid on the block, EST (Empirically Supported Treatment).]

While this model is wonderfully sensible and productive for the study of the effect of medicines and chemical compounds on our bodies, force-fitting it to research on therapy begs a few important questions:

- ◆ *In what way is a therapeutic 'procedure' (or 'program') like a 'drug'?* Most 'procedures' involve an action taken following a rather complicated *exchange* of communication, symbols, interpretation, and meaning *within a relationship*. Certainly, none of these things are 'substances' in the sense that drugs are.
- ◆ *In what way is a client's 'problem' like an 'illness'?* Again, 'problems' exist in the context of *meaning* and *relationships*, whereas 'illness' is confined to bodily mechanisms. Add to this the high degree of unreliability in therapy diagnoses: unlike the diagnosis of a disease, a client's condition can be differently diagnosed by different therapists (even therapists sharing the same therapeutic model).
- ◆ *In what way is 'therapy' like the 'administration of medicine'?* True, there is the broad similarity of the 'assessment → intervention → evaluation' structure to both processes. But going to a therapist or participating in a rehabilitation program is *not* like going to a doctor to get a pill.

Perhaps the most important and telling difference between the Specific Factor approach to therapy and the Common Factor approach, however, is the development of the therapeutic *manual*. The intentions behind *manualization* are fairly straightforward:

- (a) to provide "clear descriptions of treatment principles along with the operations necessary to implement those principles";
- (b) to permit the model to be rapidly implemented in new settings;
- (c) to guard the purity of the model by specifying mandatory step-by-step procedures that all therapists must follow;
- (d) to evaluate therapist compliance with the model through use of rating scales;
- (e) to *standardize* future treatment for specific disorders on a 'best practice' basis; and
- (f) to facilitate comparative research on different treatment procedures

Sounds logical and diligent, eh? – however, it also assumes that the *active* ingredient in the therapeutic process is the *model*, rather than the *therapist*, the *client*, *expectancy factors*, *extratherapeutic factors*, or some *combination* of all these things (which is the Common Factors' point). In effect, the manual attempts to reduce both (a) the role of the therapist (what is required of the therapist is simply to follow procedure – by doing so, *any* reasonably intelligent person can achieve positive outcomes) and (b) the need to respond to the unique characteristics and circumstances of each client (again, it's the

procedure that matters and the client's exposure to it – i.e., the *dosage* received).

So, do *manuals* work? Summing up the research results on the impact of manuals, one group of researchers write:

The move toward manualization of treatment is undeniable and relatively pervasive across the field. The results of such attempts are mixed, however, ranging from strong endorsements of improved outcomes as a result of increased manualization to little or no effect on treatment outcome. In the real world of clinical practice, manualization is even more likely to have a negligible impact on treatment effectiveness. In sum, little evidence substantiates the benefit of technique-based training.

Similarly, another group reports:

Alarmingly, two recent studies suggest that manualized training does nothing to promote, and sometimes even deters the development of therapists' alliance skills ... Henry et al. (1993) report that therapists' relationship skills declined following manualized training even though their technical skills improved. In addition, they observed that those therapists who adhered best to the treatment guidelines were those who tended to be more controlling, hostile, and prone to negative interactions with clients.

On the whole, doing therapy by manual doesn't make a lot of sense – except to those people trying to defend or sell a particular *model*. It is not supported by research on the effectiveness and outcome of therapy. At best, it plainly interferes with other effective factors in the therapeutic process, particularly the therapeutic alliance between counsellor and client – making it clumsy and artificial: "Doing therapy by manual is like having sex by manual. Perhaps the desired outcome is achieved if instructions are technically followed. But the nuances and creativity of an actual encounter flow from the moment-to-moment interaction of the participants, not from *step a* to *step b*. Simply put, therapists do not do therapy by the book. When they do, it does not go very well ... In effect, therapists concerned with doing therapy by the numbers develop better relationships with their manuals than their clients." [Duncan & Miller (2000)]

These, then, are the three prongs in the Specific Factors' attack on the Common Factors: (1) 'lethal' criticism; (2) force-fitting therapy research into the medical girdle of drug trials; and (3) *manualization* of the treatment process. But the criticism turns out not to be deadly, the girdle doesn't fit, and the manuals fall flat.

In the end, the Specific Factors are not able to prove that it is the unique & specific aspects of a treatment model (or associated techniques) that account for what makes therapeutic programming work. The Common Factors continue to account for 85% of therapeutic effectiveness – and they continue to be both overlooked and undervalued in clinical training. If we want to improve our service effectiveness, we would be best off identifying strategies to enhance and activate these Common Factors – rather than being charmed and dazzled by the bells & whistles of the latest trendy models.

