

## IS WHO DELIVERS THE TREATMENT MORE IMPORTANT THAN THE TREATMENT ITSELF? THE ROLE OF THE THERAPIST IN COMMON FACTORS

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*In this article, we discuss the role of the therapist in change in couple and family therapy. We argue that the therapist is a key change ingredient in most successful therapy. We situate our discussion in the common factors debate and show how both broad and narrow common factor views involve the therapist as a central force. We review the research findings on the role of the therapist, highlight the strengths and weaknesses of this literature, and provide directions for future research. We then use this review as a foundation for our recommendations for theory integration, training, and practice.*

It seems obvious that therapists differ in their effectiveness. Wampold (2001) notes that just as some lawyers achieve better results, some artists create more memorable sculptures, and some teachers facilitate greater student achievement, it makes sense that some therapists will achieve better results than others. For this reason, when most of us consider referring a close friend or relative to a therapist, we are more likely to consider the competence and expertise of the therapist more than his or her theoretical allegiance.

In spite of the significant role of therapists in therapeutic change, the research literature (reviewed below) points to significant gaps in our knowledge. We still know surprisingly little about the variables and characteristics that exemplify a skilled and effective marital and family therapist (MFT; Holmes, 2006), and we know even less about how these therapist variables interact with varying therapy approaches, clients, or presenting problems (Davis & Piercy, 2007a, 2007b).

We situate this article in the context of debates about change in MFT (Sexton & Ridley, 2004; Sexton, Ridley, & Kleiner, 2004; Sprenkle & Blow, 2004a, 2004b). As common factors researchers, we believe that MFT works largely because of common elements found in effective models of therapy and the process of therapy itself, rather than because of specific ingredients found in models. On the other side of the debate, Sexton and his colleagues criticize common factors and suggest that they are merely a static list of variables, that they derive their conclusions from meta-analyses of weak clinical studies, and that they are not able to inform the therapist about what to do and when in the process of therapy (Sexton & Ridley, 2004; Sexton et al., 2004). They instead argue that the unique change ingredients found in mature clinical

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models explain the bulk of change in therapy and that these models inform the thinking and decision making of the therapist.

In a recent article, Simon (2006) proposed that the bridge between the common factors versus models dilemma takes place in the self of the therapist. This occurs, in his view, when a therapist becomes aware of his or her worldview and adopts an effective model of change that is congruent with this worldview. This congruency between worldviews (model and therapist) allows the therapist to reach his or her potential in that therapy becomes a personalized vehicle for self-expression. Furthermore, the model's intended change qualities are maximized at the same time because they are authentically practiced through the person of the therapist. Simon concludes in his argument that this synergistic effect will lead, in theory, to the best possible treatment for the client.

In an editorial discussing the common factors debate along with the argument of Simon (2006), Ivan Eisler (2006) suggests that this debate regarding change in MFT is one of critical importance for the future of research, theorizing, and training in the couple and family therapy field. In reading his editorial, it becomes clear that there remains confusion about change in therapy. Therefore, it is our intent in this article to expand and clarify our understanding of the role of the therapist in common factors in relation to therapeutic change.

We agree in several areas with Simon's premise about the therapist's role in change. We believe that a competent therapist is a central ingredient of effective therapy. We acknowledge that it is usually important that a therapist is in tune with, enthusiastic about, and allegiant to the model or part of a model that he or she is practicing at any point in therapy. We believe that this enthusiasm for a treatment approach is typically crucial for the confident, authentic, and precise delivery of therapeutic interventions. Eisler (2006) says it well when he states, "Doing something we are wholeheartedly committed to must surely be more effective than something we only half believe in . . ." (p. 330). We also agree that therapist awareness of his or her worldview and relevant personal issues is an important component of therapist training, development, and effectiveness (Timm & Blow, 1999). We further concur with Simon that it is the human therapist-client encounter that provides the best explanation as to *how* treatment works in most<sup>1</sup> of psychotherapy and that it falls on the therapist to connect the dots in terms of how change occurs within specific treatment models, with specific clients, and with specific presenting problems (Blow & Distelberg, 2006).

In spite of this agreement, we have several concerns about Simon's (2006) ideas. We believe that Simon provides a somewhat constricted, one-sided view of the change process, especially when one considers working with diverse families in complicated contexts. We side with Eisler (2006), who believes that Simon's view "leads to the same narrow vision that so much of psychotherapy research suffers from—namely that it is just asking another *what works* question rather than *how it works* questions" (Eisler, 2006, p. 331). Further, we believe that having the therapist choose an effective model that closely matches his or her worldview is out of step with current research on the role of the therapist, particularly research on the therapeutic alliance that suggests the importance of the fit between the model and the *clients'* worldviews (e.g., Johnson & Talitman, 1997).

In this article, we will expand our work on common factors by stressing the crucial role of the therapist. In the *broad* sense of the term "common factors," which includes all aspects of the therapeutic context that contribute to change (see Hubble, Duncan, & Miller, 1999, and Sprenkle & Blow, 2004a, for these distinctions), we will argue that being a competent therapist is itself a major common factor. In the more *narrow* sense of the term, where common factors refers to the common mechanisms of change that are embedded in all effective models of therapy, we will stress the therapist's role in activating these change mechanisms. Just as many common factors work through models, models in turn work through therapists. We will argue that most key changes in therapy are either initiated by the therapist or influenced by the

therapist and that a therapist's ability to identify and maximize these change opportunities largely determines the therapist's—and hence the therapy's—effectiveness. In this regard, we emphasize both what a therapist *does* in the therapy context to facilitate change along with *how* he or she goes about the process of intervening in therapy. We will also review research on the role of the therapist in MFT and outline the paradigm shift in therapist training and the role of theory in practice that we believe our stance justifies. We begin with a review of the literature on the role of the therapist in change. We follow this review with a discussion of the role of the therapist in effective models. The article concludes with implications of our stance for training and research.

## THE DEARTH OF RESEARCH STUDIES ON THE THERAPIST IN MFT AND IN PSYCHOTHERAPY IN GENERAL

It is rather surprising, indeed shocking, that relatively little attention is paid to therapist variables as contributors to outcome. This is true in the field of psychotherapy research generally, as well as in MFT research specifically. A number of authors (Blatt, Sanislow, Zuroff, & Pilkonis; Lebow, 2006; Najavits & Strupp, 1994) have bemoaned that therapist variables are often neglected and poorly understood. Lebow (2006) summarizes these critiques:

Psychotherapy researchers typically focus exclusively on different clinical interventions while ignoring the psychotherapists who make use of them. It's as if treatment methods were like pills, in no way affected by the person administering them. Too often researchers regard the skills, personality, and experience of the therapist as side issues, features to control to ensure that different treatment groups receive comparable interventions. (pp. 131–132)

Interestingly, Beutler et al. (2004), in the most recent edition of the *Handbook of Psychotherapy and Behavior Change*, indicate that there has probably been *less* attention given to therapist factors in the past two decades due to the emphasis on testing specific therapy models in randomized clinical trials. These authors note:

In efficacy research, the focus is on maximizing the power of treatments. Thus, efforts are made to control the influences of therapist factors by constructing treatment manuals that can be applied in the same way to all patients within a particular diagnostic group, regardless of any particular clinician. This research gives scant attention to any curative role that might be attributed to therapist factors that are independent of the treatment model and procedures. (p. 227)

We have argued in an earlier debate (Sprenkle & Blow, 2004a) that clinical trials are important for the field (especially for gaining credibility from external stakeholders), and we do not want to be misinterpreted as denigrating them. However, we challenge the extent to which they overfocus on treatment variables and make often-erroneous assumptions about therapist homogeneity.

### *Why Research on Therapists Is Lacking*

In the first place, the attention to treatments at the cost of deemphasizing therapist effects reflects the “triumph” of the medical model among many prominent investigators. Many psychotherapy researchers subscribe (or at least acquiesce in order to get funding) to the belief that therapies “are analogous to medications that need to be assessed in tightly controlled research that establishes specific variants of therapy as safe and effective for the treatment of particular disorders; essentially drug research without the drugs” (Lebow, 2006, p. 31). A major implication of

the medical model is that the specific ingredients of the treatment are what are important in therapy, *not* who delivers the ingredients. If you have high cholesterol and take a statin drug, what is in the drug matters more than who prescribes or administers the drug. Wampold (2001) contrasts the medical model with what he calls the contextual view (Frank & Frank, 1991), which posits that who delivers the treatment in psychotherapy is actually far more potent than the specific ingredients of the treatment, and offers evidence (reviewed below) to support this position.

Second, the focus on treatments reflects where the money is found. Lebow (2006) states frankly in reference to medical model type research that “this kind of research makes up the preponderance of research on mental health treatment funded over the last 20 years by the National Institutes of Health” (p. 31). Beutler et al. (2004) are more caustic when they indicate that the current research emphasis may be driven more “by funding patterns and political agenda than by true promise for improving psychotherapy” (p. 291). In chasing the governmental carrot, our consideration of variables influencing therapeutic change becomes increasingly narrow. Of course, not all psychotherapy researchers subscribe to the narrow view that carefully controlled clinical trials focusing on treatments are the only or best way to inform clinical practice. Westen, Novotny, and Thompson-Brenner (2004) used the platform of the prestigious journal *Psychology Bulletin* to write a spirited critique of this approach that has become a rallying cry for those championing a broader view of research that informs practice. Nonetheless, the pressure to follow the funding seems to be dictating the research agenda.

In the third place, model developers and their students, who are understandably interested in proving that their models work, conduct the majority of efficacy research in MFT. These developers are under pressure to fund their research through contextual pressures (e.g., universities) or by demands to add credibility to their treatment approaches. Lest we sound judgmental, if we were model developers we would do the same thing! However, as we will note below, doing clinical trials does not preclude also giving attention to therapist variables, which we will argue should be an important part of clinical research agendas.

Fourth, manualized clinical trials aim to control for therapist effects. The intent is to achieve a point where all therapists in the trial operate at similar levels of competence so that therapist effects can be treated as sources of error rather than sources of variance, allowing change to be ascribed to the treatment model. Fidelity measures attempt to control for the specific contributions of the therapist. However, there is strong evidence that there is considerable variability in therapist effectiveness even in highly controlled investigations. As Beutler et al. (2004) put it, “Unfortunately, standardizing the treatment has not eliminated the influence of the individual therapist on outcomes” (p. 245).

## WHAT THE RESEARCH LITERATURE SAYS ABOUT THE IMPORTANCE OF THERAPISTS IN CHANGE

### *Therapist Belief in a Treatment (Allegiance)*

In Wampold’s (2001) thorough review of the research literature on change in psychotherapy, he devotes an entire chapter to the issue of allegiance. Therapist belief in a treatment and in its abilities to effect change is an important quality of an effective therapist, and insufficient therapist buy-in will likely jeopardize therapy outcomes (Davis & Piercy, 2007a, 2007b; Sprenkle & Blow, 2004a; Wampold, 2001). This may help explain why, when model developers test their own models (the rule, not the exception, in MFT research), therapists in control conditions often get poorer results than therapists in the experimental (preferred) condition. The model developer and close colleagues typically implement the experimental treatment, have procured funding to test the model, and generate enthusiasm for the model being tested. This unwittingly leads to a halo-type effect for the approach in the experimental condition.

Allegiance is based on the idea that when a therapist has a positive attitude toward a treatment and its healing properties, he or she will practice the treatment with higher levels of

tenacity, enthusiasm, hopefulness, and skill (Wampold, 2001). Wampold concludes that allegiance to a model by a therapist is a strong determinant of outcome in clinical trials and is typically more important than the type of treatment used.

#### *Evidence for Therapist Variability*

While treatment fidelity is often addressed in MFT research investigations, to the best of our knowledge, there are no detailed reports regarding therapist variability in outcome in MFT specific studies. However, evidence from arguably the best and most comprehensive psychotherapy outcome study ever completed, the National Institute of Mental Health (NIMH) Collaborative Depression Study (Elkin et al., 1989), is quite compelling. The therapists in this large multisite trial were carefully trained in each of the manualized treatment conditions and were not allowed to participate until they reached high standards of adherence. They were also experienced and had an allegiance to the model they represented. In spite of these attempts to control therapist factors, the results showed major differences in therapist effectiveness, even though there were only minimal differences among treatment models!

Blatt, Sanislow, Zuroff, and Pilkonis (1996) divided the therapists in the study into those who were less effective, moderately effective, and more effective based on the composite outcome scores of the clients that each treated. Their results indicate that “significant differences exist in the therapeutic efficacy among therapists, even with the experienced and well-trained therapists in the [NIMH study]” (p. 1281). In addition, they indicated that these differences were independent of the treatment model, the setting, and even the experience level of the clinician. Perhaps even more telling, Blatt et al. (1996) indicated that the most favorable results in the study were achieved by a female psychiatrist who saw clients only in the drug clinical management and placebo (half of her completed cases) clinical management conditions, and not in one of the two active clinical treatment models (Cognitive-Behavioral Therapy or Interpersonal Therapy). They add:

It is noteworthy that this therapist’s high level of therapeutic effectiveness was accomplished while seeing patients for a relatively brief time each week (approximately 25 min) as part of ... a procedure designed as a minimal therapeutic condition to provide only therapeutic support and encouragement. (p. 1281)

These findings suggest that the history of the NIMH depression study may prove to say more about “empirically validated therapists” than about empirically validated therapies.

In his book *The Great Psychotherapy Debate*, Wampold (2001) devotes an entire chapter to the critical role of therapist effects in treatment. He presents convincing statistical evidence that when therapists are assumed to achieve similar results, when in fact their results vary, Type I error is significantly increased, and treatments may appear to be significantly different when they are not. Wampold (2001) writes: “Clearly, ignoring the variability of therapists, whether in a nested [different therapists do different treatments] or a crossed design [same therapists do all treatments] produces a liberal *F*-test and overestimates treatment effects” (p. 194).

Wampold’s (2001) and Blatt and Colleagues’ (1996) work confirms earlier work by Luborsky et al. (1986), who had reanalyzed the data from four major psychotherapy projects to determine the size of therapist effects. They concluded that the therapist effects exceeded the treatment effects. Crits-Christoph et al. (1991) reanalyzed data from 15 previously published studies and reported that for all outcome measures and treatments, the effect size for the therapists’ contribution to the variance was greater than the effect sizes for the difference among treatments they practiced. Therapists accounted for about 9% of the variance in outcome. While this may not sound large, it translated into an effect size of .60, whereas the effect size for difference among treatments average at most .20 (Wampold, 2001). Crits-Christoph et al. (1991) did report that better controlled studies that used treatment manuals and were published more recently had smaller therapist effects. However, other reanalyses completed since 1991

(Luborsky, McLellan, Diguier, Woody, & Seligman, 1997; Project MATCH Research Group, 1998) support the finding that even among experienced and well-trained therapists practicing manualized treatments, there is often considerable variability in outcome.

We think the fairest conclusion is that while not all studies show significant therapist variability, the preponderance of the evidence suggests that such variability is frequently alive and well, even when therapist fidelity is carefully monitored. Until there is good evidence to the contrary, we accept Wampold's (2001) conservative estimate that therapists contribute at least 6–9% of the outcome variance in psychotherapy. The reader will note that if these numbers (reflecting the relationship between therapist competency and outcome) were expressed as correlation coefficients, they would range from .24 to .30. Of course, the variability in therapist competence in the general population of practitioners is likely much larger than the variability among therapists in research studies.

### *Research on Specific Therapist Contributions*

Beutler et al. (2004) have published the definitive review on therapist effects. In this work, the authors limit themselves to studies for which there are data to generate effect sizes relating therapist characteristics to outcome. Frankly, not many therapist characteristics have been identified which make substantial contributions to outcome. Furthermore, results are typically inconsistent and most effect sizes are small. Additionally, after reviewing these studies we believe that most do not pay sufficient attention to mediating and moderating variables that may influence the relationship between therapist characteristics and outcome. This may help to explain the small effect sizes. So, although we know there is often considerable therapist variability (as measured by therapist performance as in the NIMH Collaborative Depression Study), we do not have much solid evidence for *why* it exists.

Beutler et al. (2004) categorized the therapist variables into four categories: (a) observable traits (fixed characteristics that could be coded by an external coder and that describe the therapist independent of his or her role as a therapist) like gender, race, and age; (b) observable states (potentially changeable characteristics, specifically related to the role of therapist, that do not need to be inferred—that is, they could be potentially identified by procedures independent of the therapist) like therapist training and experience; (c) inferred traits (relatively stable characteristics that can only be inferred from information provided by the therapist but that transcend the therapist's role as a therapist) like personality, well-being, and values; and (d) inferred states (relatively changeable therapist variables that can only be inferred by information from the therapist) like the therapist's view of the therapeutic relationship.

*Observable traits.* It is relatively easy to do research on variables like the impact on outcome of therapist gender, age, and ethnicity as these data can easily be coded retrospectively. One meta-analysis, based on 58 studies (Bowman, Scogin, Floyd, & McKendree-Smith, 2001), found a significant small effect size favoring female therapists ( $d = .04$ ). Beutler et al. (2004), however, report that the most recent studies find no relationship—including no relationship for the matching of therapist and client gender, nor for the impact of gender or gender matching on dropping out of therapy. In a somewhat old review of MFT research, Bischoff and Sprenkle (1993) did find some modest evidence that matching gender of therapist and client diminishes premature termination.

The impact of therapists' age is difficult to tease out as it is confounded with experience and other variables. Some older studies, including a large MFT investigation (Beck, 1988), suggested that if therapists are much younger than clients (10 years or more) outcome is impacted negatively. However, Beutler et al. (2004) conclude that there is "little contemporary research to suggest that age or the similarity of patient and therapist contributes significantly and meaningfully to treatment outcome" (p. 231).

There is almost no outcome research on the impact of therapists' race/ethnicity alone, and not as much as one might expect on the matching of therapist and client given recent attention to

the importance of ethnicity in MFT and in psychotherapy. Beutler et al. (2004) report that in research since 1990 there are small effect size enhancements when Mexican American and Asian American therapists and clients are matched. While not a true outcome study, Gregory and Leslie (1996) found Black females (but not males) rated initial MFT sessions with White therapists more negatively than with Black therapists, but these differences vanished by the fourth session. An old but very large sample ( $N = 3,956$ ) MFT study (Beck & Jones, 1973) found that Black clients were significantly more likely to drop out if assigned to White counselors, whereas there was no impact when White clients were assigned to Black counselors. However, Beutler et al. (2004) conclude from recent research that what small effect sizes are found “cast doubt on the value of ethnic similarity as a predictor of treatment effects” (p. 234) even though in an earlier publication Beutler and his colleagues (Beutler, Machado, & Neufeldt, 1994) suggested that this variable was a promising area of investigation. Beutler et al. (2004) further note that perhaps therapist and client “cultural beliefs” or other unidentified variables may moderate the impact of racial/ethnic identity on outcome (see section on inferred traits for a discussion of therapist cultural attitudes).

In summary, studying the impact on outcome of static therapist observable trait variables has not borne as much fruit as we had hoped. Perhaps the good news is that competent, creative, and compassionate therapists can apparently often transcend whatever limits are potentially imposed by their age, gender, or skin color.

*Observable states.* In this section, we will briefly review therapist training and level of experience, and give some attention to therapist styles, like level of directiveness. For a much more comprehensive overview, see Beutler et al. (2004). Regarding disciplinary training, the findings of the large sample ( $N = 4,100$ ) Consumer Reports Study (1995) have received considerable attention. In this survey, clients reported improvement in the severity of their problems about equally when treated by psychologists and psychiatrists, somewhat better results from social workers, and somewhat worse outcomes from marriage and family counselors. What was unacknowledged is that many therapists practice marriage and family counseling with no special training, and that MFT therapists often have to reconcile incompatible agendas (e.g., one wants “in” the marriage while the other wants “out,” making it more likely that one partner will be dissatisfied). This is another example of the peril of ignoring potential mediating or moderating variables that may influence results.

Several studies suggest that overall, persons with specific mental health training do better than primary care providers, as do those with a psychological as opposed to a biomedical orientation (Blatt et al., 1996). Beutler (1997) has stressed that the impact of training cannot be accurately assessed without knowing the content of training. Rather than focusing on academic degrees, more attention must be paid to the amount of time studying specific concepts and practices.

Regarding the level of experience, several authors (Christensen & Jacobson, 1994; Tallman & Bohart, 1999) have reported the counterintuitive and somewhat depressing finding that the impact of added experience on outcome is weak at best. Stolk and Perlesz (1990) offered data that students in the second year of a strategic therapy MFT training program achieved results that were actually worse than first-year students. Other reviews (Stein & Lambert, 1995) are more sanguine about the benefits of experience. It appears that merely putting in time as a therapist does not automatically increase competence and certainly not all activities after graduate school should be considered equivalent—say working as an administrator versus extensive training and supervision on difficult cases. Beutler, Bongar, and Shurkin (1998) suggest that experience is likely more important when it comes to treating more difficult clients and complex and long-standing problems, whereas for easier cases the results between novice and expert therapists are not very different. Perhaps because not all these moderating variables have been teased out, with some notable exceptions (Blatt et al., 1996; Hupert et al., 2001), effect sizes relating experience to outcome remain relatively small.

Regarding therapeutic style, therapist positivity/friendliness is consistently associated with good outcome, and criticism/hostility has the opposite impact (Beutler et al., 2004). Another

consistent finding is the importance of therapists utilizing a sufficiently high level of activity/directiveness to prevent couples and families from simply replaying their dysfunctional patterns; and giving the session enough structure to encourage family members to face their behavioral, emotional, and cognitive issues (Bischoff & Sprenkle, 1993; Lebow, 2006). Waldron, Turner, Barton, Alexander, and Cline (1997) studied therapist defensiveness and its relationship to the process and outcome of marital therapy. They concluded that therapist defensiveness early on in therapy led to poorer outcomes for both husbands and wives.

Most aspects of therapist style are highly dependent on therapists adapting to client preferences, expectations, and characteristics. Beutler, Consoli, and Lane (2005), for example, offer strong evidence that therapists should decrease their directiveness when client resistance is high and vice versa. They also provide evidence that therapists should adjust their style to keep the client's level of emotional arousal moderate (neither too high nor too low) as moderate arousal facilitates change.

*Inferred traits.* These include therapist characteristics such as personality, coping patterns, emotional well-being, values and beliefs, and cultural attitudes (Beutler et al., 2004). Some research suggests that a fit between the personality style of the therapist and the client may lead to improved outcomes (Herman, 1998) while other research suggests the exact opposite (Berry & Sipps, 1991). Clearly further research is needed in this area, especially in MFT where therapists work with multiple family members with widely varying personality styles. Possibly this ability to juggle varying personalities at one time is what distinguishes couple and family therapists from those who are more comfortable in working with individuals alone.

In terms of the relationship between therapist emotional well-being and outcomes, Beutler et al. (2004) conclude that there is evidence showing a positive relationship between therapist well-being and client benefit. They also note that high levels of therapist emotional well-being should not be assumed (especially of therapists in research studies) and that therapists who receive their own personal therapy do not necessarily have better outcomes. We could find no studies that looked at therapist well-being from an MFT standpoint. We believe that this kind of research might provide important clues, especially in terms of how, for example, a therapist's "dead marriage" might negatively influence his or her work with couples or how a therapist's own struggles with his or her rebellious adolescent child might hurt or even help the work with adolescents in other families.

Values, attitudes, and beliefs are an important aspect of a therapist's practice and MFTs, in particular, are faced with a multitude of value-related issues. For example, clients present with a wide array of issues that may tap deeply into a therapist's most personal value systems—e.g., infidelity, drug use, and poor parenting—and yet we were unable to find any MFT specific studies that focused on therapists that shed any light on the role of values in outcomes. We note that even the issue of deciding beneficial outcomes can be value laden in that for some, divorce might be a bad outcome, and within a couple, one party may be satisfied after divorce while the other may feel extremely bitter. In referencing individual psychotherapy, Beutler et al. (2004) state, "Indeed, little progress has been made in determining what values are important to the practice of psychotherapy or how values should be integrated into psychotherapeutic practice" (p. 227). We believe that this is another area worthy of intensive study in MFT.

We were most hopeful about studies focused on therapists and cultural attitudes. It seems clear that therapists who are knowledgeable about and highly sensitive to the unique cultural worlds of their clients (i.e., are culturally competent) do a far better job of engaging and retaining clients in therapy and as a result achieve better outcomes. In studies of specific family therapy interventions with diverse populations, effective therapists are able to adapt and change when unique cultural mores and conditions suggest that treatment needs to be different. For example, in a summary of family therapy studies done in Miami by José Szapocznik and colleagues, Muir, Schwartz, and Szapocznik (2004) discuss working with poor African

American and Hispanic families in this city. These researchers emphasize the need for high levels of respect for minority cultures and believe that successes in engaging these families in treatment (an impressive 80% engagement rate) are largely due to specific interventions that are in step with the unique cultural values and beliefs of these communities. They refer to these as culturally syntonic (in tune)—interventions that fit well with the clients and communities in which the therapists work. In another example in a recently published study, Breuk et al. (2006) discuss the challenges of implementing Functional Family Therapy in the Netherlands. These authors discuss the important role of cultural sensitivity on the part of the therapist to ensure the effective implementation of this model in an international setting. Key to this is the ability of the therapist to match the treatment to the unique client system. In short, therapists who learn about and are sensitive to the unique cultures in which they work, and who match their interventions to these contexts, are more successful in engaging families in treatment and effecting change.

Similarly, in a recent Delphi study focused on working with lesbian, gay, and bisexual clients, Godfrey, Haddock, Fisher, and Lund (2006) concluded that the consensus of a panel of therapists and educators was that therapists need to possess certain values, qualities, and sensitivities, particularly related to being open minded and having an awareness of their comfort levels, values, biases, and prejudices about sex, gender, and sexual orientation. These therapists are also seen to need knowledge of societal ideologies related to this population as well as awareness of theories of sexual orientation formation. These authors also advocate for specific therapist preparations in working with this population as well as intensive self of the therapist work. While these therapist characteristics were not linked to outcomes in actual clients, it seems clear that when working with diverse populations, therapists need to be prepared through education about a specific group and sensitivity to unique issues within a group, and have an awareness of and control over their own personal biases and issues.

*Inferred states.* In this section, we will focus on the role of the therapist in the therapeutic relationship. The relationship was valued back in 1978 when Gurman and Kniskern (1978) stated that:

The ability of the therapist to establish a positive relationship with his or her clients, long a central issue of individual therapy, receives the most consistent support as an important outcome-related therapist factor in marital-family therapy. Therapist empathy, warmth, and genuineness, “the client-centered triad,” appear to be very important in keeping families in treatment beyond the first interview ... Apparently *it is important for the marital-family therapist to be active and to provide some structure to early interviews, but not to assault family defenses too quickly ... [A] reasonable mastery of technical skills may be sufficient to prevent worsening or maintain pretreatment functioning, but more refined therapist relationship skills seem necessary to yield truly positive outcomes in marital-family therapy.* (p. 875; italics in original)

We believe that it is in the therapeutic relationship that therapists either make or break therapy. Studies of the therapeutic relationship have shown consistently that the strength of the relationship (in the view of the client) is a significant contributor to change, especially early ratings of the relationship (Horvath & Greenberg, 1994). Horvath and Symonds (1991), in a meta-analysis involving the therapeutic alliance that involved diverse theories, found an effect size of  $ES = .26$ , concluding that the alliance is an excellent predictor of outcome. A recent study of couple therapy (Symonds & Horvath, 2004) indicates differences in alliances when working with more than one family member in the room. In their study, the alliance with the therapist seemed to be mediated by the allegiance (loyalty) that the members of a couple felt towards each other. The ability of the therapist to determine the level of agreement between partners on the strength of the alliance seems to be an important variable in working with multiple family

members. An MFT therapist needs advanced skills to keep all parties engaged, as damage to the alliance in one family member will likely lead to damage in other family alliances. Bachelor and Horvath (1999) talk about a “window of opportunity” (p. 139) that is available to therapists in order to establish and maximize the therapeutic relationship. The establishing of a sound relationship should be the number one priority for the therapist early on in treatment.

Certain qualities of therapists are essential in forming strong therapeutic relationships with clients. Asay and Lambert (1999) point out that more effective therapists demonstrate more positive behaviors and fewer negative behaviors than do their less effective counterparts. Further, they also have a style that is strong in basic capacities of human relating which include warmth and affirmation along with minimal attacking and blaming. Above all, therapists should avoid behaviors that are critical, attacking, rejecting, blaming, and neglectful.

Bachelor (1995) conducted a phenomenological study on the therapeutic relationship from the perspective of the client. She concludes that the way that clinicians and theoreticians view the alliance is not congruent with the ways in which clients view the alliance. This is important because what the therapist thinks about the therapeutic relationship is irrelevant if the client is not thinking the same as the therapist. It is important for the therapist to be attuned to the phenomenological and idiosyncratic qualities of client systems, especially when it comes to the therapeutic relationship.

Heatherington and Friedlander (1990) studied the therapeutic relationship in MFT and asked members of families to rate their emotional bonds with their therapists. Stronger bonds characterized sessions that were smoother and easier. It is unclear whether the bonds were stronger because the sessions were smoother or if the sessions were smoother because of the stronger bonds (see also Friedlander, Escudero, & Heatherington, 2006). In other studies on the therapeutic relationship in MFT, clients were found to value a caring therapist including warmth, trust, security, and informality (Bischoff & McBride, 1996; Christensen, Russell, Miller, & Peterson, 1998; Greenberg, James, & Conry, 1988; Sells, Smith, & Moon, 1996).

Research has shown that agreement on the tasks of the alliance is important in working with couples and families. For example, in Emotionally Focused Couple Therapy, the strength of the alliance is an important predictor of outcome, particularly the tasks dimension (Johnson & Talitman, 1997). It seems that therapist skill in negotiating this aspect of the alliance is critical to change in this approach.

Flexibility and a sense of relating seem to be key therapist qualities. The specific therapist responses that best foster a strong therapeutic relationship will vary from client to client. Good therapists are sensitive to clients' responses and are able to change their interactions based on this feedback (Duncan, Miller, & Sparks, 2004). Clearly, a one-approach-fits-all strategy does not work.

Santisteban, Suarez-Morales, Robbins, and Szapocznik (2006) discuss the impressive studies of engagement of reluctant family members in Brief Strategic Family Therapy by reporting on two studies. In the first study (Szapocznik et al., 1988), the group engaging families in treatment using specialized engagement techniques reported a 93% success rate compared with 42% in the engagement as usual condition. A second study (Santisteban et al., 1996) using more stringent engagement criteria reported an 81% success rate compared with 60% in the control condition. Standing out in these results is the idea that if therapists learn different ways of building alliances and engaging families, significant changes can occur (as opposed to blaming clients for being uninterested or unmotivated).

### *What Therapists Do in Sessions*

There is a growing body of process research that uses methods such as discourse analysis, conversation analysis, and content analysis to discover what therapists do in therapy (Couture & Sutherland, 2006; Gale & Newfield, 1992; Kogan & Gale, 1997; McGee, Del Vento, & Beavin Bavelas, 2005; Rober, van Eesbeek, & Elliot, 2006). Although an in-depth review of this body of

research is beyond the scope of this article, this type of research points to the complex processes involved in therapy, and that the therapist is working in a context that involves clients and the myriad responses they have to what the therapist offers. In this research, it appears that adept therapists are able to respond to what clients offer in ways that move the therapy forward in the direction of the clients' goals. For example, Couture and Sutherland (2006) suggest that even a slight change in what a therapist says, or when he or she says it, can change the meaning of the interaction. In essence, every therapy encounter is interactive, leading to forward-moving conversations that are generative and ultimately therapeutic. In the future, this kind of research will be important as our understanding grows of the role of therapists in the "how" of change.

### *The Role of the Therapist in Effective Models*

While randomized clinical trials attempt to control for therapist variables by having therapists practice the treatment at similar levels of effectiveness, therapists play a prominent role in manualized treatments. For example, Blow and Distelberg (2006) did a review of four evidence-based treatment models focused on working with adolescent substance abusers. The four models are Brief Strategic Family Therapy (BSFT; Szapocznik, Hervis, & Schwartz, 2003), Functional Family Therapy (Sexton & Alexander, 2003), Multidimensional Family Therapy (Liddle, 2002), and Multisystemic Therapy (Sheidow, Henggeler, & Schoenwald, 2003). Blow and Distelberg conclude that in these four manualized treatments, the role of the therapist is critical. The therapist is highly active in engaging family members and preparing them for a change; works to create a strong fit between him- or herself and the clients (matching); is able to negotiate with clients; is flexible, responsive, creative, and committed; and has competent decision-making abilities related to how to best proceed in therapy at any given moment in the process. We believe that reviews of other evidence-based models would lead to similar findings about the role of the therapist in manualized treatments.

### *Summary*

It is clear that the therapist is intertwined with change in many ways. From a broad common factors perspective, the therapist is central in most models of change, and from a narrow common factors perspective, the therapist decides when and how change mechanisms play out in the therapy process.

## THE INTEGRATION OF THEORY IN THE PERSON OF THE THERAPIST

We believe that Simon's (2006) stance that the congruence between a therapist's worldview and his or her model is of primary importance to outcome fails to take into account a myriad of other relevant variables. We also reject the notion that the unique contributions of a mature MFT model are the main contributors to therapeutic change (Sexton & Ridley, 2004). So what is the relationship between the therapist, common factors, and the MFT model in effective therapy? We believe that effective clinical models are an indispensable part of good therapy—not because a particular model contains unique healing power, but because models provide the vehicle through which many common factors are potentiated (Davis & Piercy, 2007a, 2007b; Sprenkle & Blow, 2004a, 2004b). We further believe that models work through—and therefore largely as well as—the therapist. Models are words on paper, and as such are not "effective" in and of themselves; rather, models help *therapists* be effective. Similarly, therapists help models appear effective. Models either come alive or die through the therapist.

### *Effective Therapists' Mastery of Principles of Change*

At any given moment in therapy, a therapist is interfacing with thousands of bits of information (Watzlawick, Beavin, & Jackson, 1967). A model helps guide therapy as it suggests how therapists should handle that information—what should be accentuated, downplayed, reframed,

reprocessed, ignored, redirected, and so forth as well as how these acts should be accomplished. However, no model is—or ever will be—capable of telling a therapist what to do and how to do it in every clinical situation. It is up to the therapist to decide what to do, how to do it, and when to do it. Rather than relying on rigid guidelines for making those decisions, many effective models provide guidance through *principles of change* (Christensen, Doss, & Atkins, 2005). Beutler (2002) says that principles of change:

... identify the conditions, therapist behaviors, and classes of intervention that are associated with change under identified circumstances and for particular kinds of patients. Principles are not theories—they are descriptions of observed relationships. They are more general than techniques and they are more specific than theories. They are the “if ... then” relationships that tell us when to do and what to do, and who to do it to. (p. 3)

Said differently, principles are concentrated “truths” of therapeutic change, applicable to a wide variety of clinical circumstances and present *across* diverse models of therapy. An example of a principle of change in relational therapies would be, “Couples enjoy greater relationship satisfaction as they free themselves from destructive interactional cycles by slowing down the process, standing meta to themselves and their partner, and taking personal responsibility for altering their role in the cycle” (Davis & Piercy, 2007a). We propose that effective therapists have an understanding of many principles of change (and the models within which these principles lie) and that a therapist’s skill will improve with a more thorough understanding of principles of change (see Castonguay & Beutler, 2006, for a thorough discussion of principles of change; Christensen et al., 2005, provide a discussion on principles of change in MFT).

We believe that effective therapists understand principles of change from several models well enough to be able to adapt to a wide variety of clients and presenting problems. Having a solid grasp on principles of change from many different models allows therapists to follow their intuition (Piercy & Nelson, 2000/2001) yet be theory driven at the same time. Furthermore, we believe that effective therapists integrate knowledge of principles of change with a wide array of other relevant knowledge such as normative development, how to establish a therapeutic alliance, healthy in-session processes, and so forth. A common factors framework provides guidance through this course of action, thus becoming a dynamic part of therapy rather than merely static lists of variables, as critics often charge (Sexton & Ridley, 2004).

## TRAINING THE NEXT GENERATION OF FAMILY THERAPISTS: A PARADIGM SHIFT

### *A Shift Away From “Choose Your Favorite Model”*

When meeting an MFT colleague for the first time, “What model do you use?” can be as predictable a question as “Where are you from?” or “Where did you get your degree?” Many MFT training programs socialize students early on to choose their favorite model, communicating the assumption that there is one model with which a student will do his or her best work (Simon, 2006). Our field’s theory battles can reinforce this notion (Sprenkle & Blow, 2004a). The ideas we have discussed so far suggest a shift in our thinking away from encouraging a student to be passionate about *a theory* towards being passionate about *theory*.

We believe that encouraging a therapist to be passionate about only one theory may unwittingly give a therapist the proverbial hammer with which he or she must turn every client into a nail before treatment can proceed. We advocate that a more client-centered approach would be to encourage the therapist to have a thorough familiarity with several diverse models so that he or she can adapt to his or her clients’ contexts rather than vice versa. Research suggests that ensuring a fit between the model and the client’s worldview can influence whether or not the

client remains in treatment (Johnson & Talitman, 1997; Muir et al., 2004). Clients should not have to add “figure out how to adapt to my therapist” to their already lengthy list of challenges.

We do not propose that a therapist forsake all study of models, as the famous dodo bird verdict stating “all models have won and must have prizes” implies (Rosenzweig, 1936). Rather, we believe that having a coherent model the therapist is passionate about and the client is comfortable with is an indispensable component of good therapy (Davis & Piercy, 2007a, 2007b; Sprenkle & Blow, 2004a). Having such a model gives a therapist and client a common language with which to talk about the client’s difficulties, orients the therapist to processes that need to be addressed, provides interventions to help a therapist guide the client from dysfunction to health, and—through providing a new way of relating to the problem that is credible to the client—can be an integral part of establishing hope (Davis & Piercy, 2007a, 2007b). We agree with Simon (2006) that a therapist needs to be passionate about his or her model—a therapist cannot sell what he or she does not believe in. However, we believe that problems can arise when therapists only have *one* model that they know well enough or are comfortable with in order to be able to accomplish the above-mentioned tasks. Therefore, we believe that training should shift from “choose your favorite model” to “become thoroughly familiar with and passionate about several models (effective, traditional, and promising) and change principles so you can adapt to your clients rather than vice versa.”

We acknowledge that it could be correctly argued that model developers practice only one particular model and that they are good therapists. On the surface, most models appear unique. At a closer look, however, many models are themselves quite integrative. For example, Emotionally Focused Therapy (EFT) is a blend of structural, strategic, Satir experiential, and other approaches (Johnson & Denton, 2002). Integrative Behavioral Couple Therapy (Jacobson & Christensen, 1996) is, as the name implies, an integrative blend of behavioral, cognitive, emotion-focused, strategic, and narrative therapies. The Internal Family Systems model (Breunlin, Schwartz, & Mac Kune-Karrer, 2001) is a blend of structural/strategic, psychodynamic, Bowenian, and postmodern therapies, to name a few. So, at first glance many models seem to stand independent of their predecessors. In reality, however, many models are developed in response to perceived limitations of existing models and as a result contain significant elements of those models. Model developers know several models well enough to see the models’ strengths and limitations, use feedback from their clients to understand how the strengths of one model complement the weaknesses of another, and use that knowledge to build a new model.

We propose that an in-depth knowledge of several theories is part of what makes model developers such good therapists and suggest that others would do well to follow suit. The risk comes when it is implied that a newly developed model has no limitations, and that it is therefore the only model a therapist needs to learn. We believe that all models—even integrative models designed to address inadequacies in earlier models—have limitations in areas where others have strengths. No one model is so comprehensive that it precludes mastery of another.

Mastering several different models can seem daunting at first, both to trainees and educators. We believe that a common factors lens lends itself well to such a training approach. A common factors approach proposes that when it comes to conceptualizations of dysfunction, treatment goals sought, and interventions used to reach those treatment goals, seemingly diverse models have much more in common than often appears at first glance (Davis & Piercy, 2007a, 2007b; Sprenkle & Blow, 2004a). By helping therapists have a solid grasp of these commonalities, educators may be able to train therapists in diverse models more efficiently. Commonalities across models may never be noticed, and a therapist’s resultant flexibility may be hindered should a therapist be encouraged to pick one model and stick with it.

For example, I (SD) once saw a client who was struggling with establishing a healthy relationship with her mother. My client and her husband had recently moved near her parents after

being away for several years, and she saw her mother as being too intrusive. I thought that Bowen therapy would fit well, as my client showed an aptitude for using abstract concepts as a guide for changing her behavior. I had her buy a book on Bowenian concepts, and we focused sessions on practical applications of those concepts. After three sessions, she was excited about the prospect of setting up boundaries with her mom by taking a more differentiated stance with her, but she expressed discomfort with Bowenian terminology. Her discomfort was strong enough that it was hindering her progress. As I knew that structural therapy could provide a different means (i.e., language, interventions) to reaching the same end (i.e., setting up healthy boundaries with her mother), I switched to structural therapy. She loved it, and made excellent progress towards setting up healthy boundaries with her mother.

This simple example does not suggest that structural therapy is superior to Bowen therapy. Rather, it suggests that both models focus at least partially on similar processes and that the therapist's job is to be familiar enough with each model to recognize that and to switch comfortably between the two models (or others) based on client feedback. We believe that emphasis in clinical training should be altered accordingly.

### *A Shift of Emphasis in Training*

If what we have written above has any validity, then therapist training needs to shift in areas of focus related to theoretical knowledge and therapist development. We briefly suggest competencies in five areas.

*Therapist competence in common factors.* We believe therapists' training should be grounded in common factors. Therapists should achieve positive outcomes in the areas of alliance building, client engagement, hope and expectancy generation, relational conceptualization of problems, changing meanings, matching to the unique worlds of clients, and the like (see Davis & Piercy, 2007a, 2007b, and Sprenkle & Blow, 2004a, for an exhaustive list).

*Therapist competence in evidence-based clinical models and the traditional models on which they are based.* We advocate that therapists be knowledgeable of empirically supported models and the traditional models upon which they are based. We believe that this immersion in models is critical for the ability of therapists to match to a wide variety of clientele and for the understanding of important change principles found in many of these approaches. From an evidence-based perspective, we would like to see more therapists possess knowledge of current best practices. Further, we believe that grounding in these theories will address some of the difficulties in transporting evidence-based models into real-world settings in that therapists will be trained in these approaches from the outset of their training.

*Therapist competence in other relevant nonclinical research information related to the human experience.* We believe that therapists should have a thorough grasp of theory and research related to topics of human development, culture, gender, aging, relationships, family studies, spirituality, human communication, and the like.

*Therapist skills and aptitudes.* What are the standards that guide our field's selection of trainees in training settings? By far, in our academic training programs, we have favored criteria of intellectual intelligence—including Graduate Record Examination scores, Grade Point Averages, and writing skills. However, individuals who do a good job of talking and writing about therapy are not necessarily proficient in the therapy room itself. As discussed earlier, there are likely several qualities that make couple and family therapists proficient, and finding ways to identify and recruit those with inherent talent would serve our clients and field well.

*Resolution of self of the therapist issues.* Intense self of the therapist work is required that will bring to awareness the unresolved issues and biases that contribute to lack of effectiveness with clients, as well as therapist strengths and resources that can help the therapist be more effective (Timm & Blow, 1999). We believe that this should be an ongoing part of all therapist training and development, both for beginning and seasoned practitioners.

## IMPLICATIONS FOR RESEARCH

### *An Increased Focus on the Study of Therapists Separate From the Study of Models*

We need to study therapists. It may be better to talk about empirically supported therapists than models. We are encouraged to hear that prominent family therapy researchers are beginning to include measures of therapist variables in their clinical trials. In describing their research on BSFT, Santisteban et al. (2006) report:

...we are also empirically examining the training process and training outcomes. Therapists' characteristics prior to training (e.g., professional experience, recovery status, theoretical orientation) and their conceptualization and implementation of BSFT will be examined to identify those factors that predict BSFT skill-acquisition trajectories. (p. 268)

We applaud these efforts, and hope to see similar research increase.

### *The Inclusion of Therapist Variables as Mediators and Moderators in Future Research*

Given the widely held belief that randomized clinical trials are the gold standard for clinical research, and the funding support for them, it is not likely this method will be minimized anytime soon. However, we urge investigators to consider therapist variables as mediators and moderators in such trials.

Kraemer, Wilson, Fairburn, and Agras (2002) offer an excellent discussion of mediators and moderators in clinical trials. They define mediators as variables that explain why and how treatments have effects. As we noted (for example, in our discussion of the NIMH Collaborative Study of Depression), there is strong evidence in some studies that therapist competence may indeed explain why treatments work. We strongly urge that in all future clinical trials, investigators assess and report the relative results of therapists, and when differences exist, adopt the appropriate statistical procedures (see Wampold, 2001) to avoid inflating the impact of treatment differences.

Moderators identify the circumstances under which treatments have effects. We believe that some of these moderators may be therapist variables, or more often therapist variables in interaction with client variables. For example, going back to the tasks of the alliance in EFT, Johnson and Talitman (1997) demonstrated that EFT effectiveness is moderated by the ability of the therapist to create an alliance with the client around (even more than other aspects of the therapeutic alliance) the "tasks" of therapy. That is, the effectiveness of EFT is likely moderated by the extent to which the therapist makes this approach (particularly emotional processing) appear credible to the clients.

Kraemer et al. (2002) note that identifying mediators and moderators is often a post hoc process that is hypothesis "generating" rather than hypothesis testing, and journals should not dismiss these conclusions as mere "fishing expeditions," even though subsequent hypothesis testing may be required to substantiate these findings. Also, given the general low level of knowledge about therapist variables, we argue for other hypotheses-generating methods like multiple case studies of highly competent therapists, or comparisons of novice and expert therapists using qualitative (Holmes, 2006) or mixed (Sprenkle & Piercy, 2005) methods. Process research, which explores the mechanisms of change, and qualitative inquiry, can also be embedded in clinical trials and we strongly encourage these activities. It will probably take a variety of research methods to begin to untangle the complex issue of why and how therapist variability contributes to the outcome of therapy.

### *Recommendations of the American Psychological Association (APA) Presidential Task Force*

In 2006, the APA Presidential Task Force on Evidence-Based Practice (2006) made some recommendations for the field of psychology that we believe are important for the MFT field

and which support what we have written above. In short, the task force recognizes the importance of the therapist along with methodological plurality in studying clinical phenomena. The task force concludes that

The individual therapist has a substantial impact on outcomes, both in clinical trials and in practice settings ... The fact that treatment outcomes are systematically related to the provider of the treatment (above and beyond the type of treatment) provides strong evidence for the importance of understanding expertise in clinical practice as a way of enhancing patient outcomes. (p. 276)

Therefore, the report stresses the need to understand the personal attributes and interventions of therapists and their relationship to strong outcomes. Recommendations include studying practices of clinicians in community settings who achieve consistently good outcomes and their technical skills in delivering interventions. Further, the report advocates building on our knowledge of clinical expertise, and developing a list of competencies that promote positive therapeutic outcomes. These include competencies in the following: (a) assessment, diagnostic judgment, systematic case formulation, and treatment planning; (b) clinical decision making, treatment implementation, and monitoring of patient progress; (c) interpersonal expertise; (d) continual self-reflection and acquisition of skills; (e) appropriate evaluation and use of research evidence in both basic and applied psychological science; (f) understanding the influence of individual and cultural differences on treatment; (g) seeking available resources (e.g., consultation, adjunctive, or alternative services) as needed; and (h) having a cogent rationale for clinical strategies. MFTs will do well to focus their research and clinical efforts on similar therapist practices.

## CONCLUSION

We agree with Eisler (2006) that

Once we move away from simply asking what are the most important factors and what works best, to questions of how treatments work, how different factors interact to enhance or interfere with the process of change, we stop being driven towards focusing all our research on randomized trials, which although important are not the only way of moving our understanding forward. (p. 332)

Therefore, we believe that an intensified focus on the role of the therapist in change is warranted. Such a focus would include therapist inherent and learned qualities, how therapists think and make decisions in therapy, and how therapists choose to shine light on some things but not on others so that therapy moves forward and deepens. This shift could provide answers to many of our dilemmas about change. In essence, we believe that models are important and that common factors are the best explanation for how models work. However, as a skillful therapist is the point of convergence for models and common factors, it is up to the therapist to bring to life a model's change mechanisms with clients, to know what to do when, with what clients, with their specific presenting problem, and in their specific familial and cultural context. We hope to have provided guidance in those efforts.

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#### NOTE

<sup>1</sup>We use the word *most* here because we acknowledge that many clients or potential clients are able to find ways to change without entering into psychotherapy of any kind. We also are aware that some clients are able to change in spite of an inept therapist (Tallman & Bohart, 1999). Our statement is particularly pertinent to that group of clients who are having difficulty changing on their own and who seek out a therapist to help them with their dilemmas.