Common Factors Affecting Psychotherapy Outcomes: Some Implications for Teaching Psychotherapy

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The number of psychotherapies classified as "empirically supported treatments" has increased significantly. As the number and scope of empirically supported treatments multiply, it has become impossible to train therapists in all of these specific modalities. Although the current Accreditation Council for Graduate Medical Education requirements for psychiatric residents follow an approach based on specific schools of psychotherapy (emphasizing competency in cognitive-behavioral therapy, psychodynamic therapy, and supportive treatments), evidence suggests that we are failing even in these efforts. In developing a specialized Psychotherapy Scholars Track in the residency program at the University of Colorado School of Medicine, we opted to focus initially on teaching the common factors in psychotherapy that positively affect psychotherapy outcomes. This article reviews 6 such broad common factors. (*Journal of Psychiatric Practice 2015;21; 180–189*)

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In *Alice in Wonderland*, the Dodo bird famously declaimed, "Everybody has won, and all must have prizes!" The same phrase, the so-called "Dodo Bird Verdict," has been applied to controversies surrounding the comparative effectiveness of all psychotherapies. The "Dodo bird verdict," which is contested, does not mean that all of the over 400 forms[1] of psychotherapy are equally effective. An excellent review of many meta-analyses[2] conducted in the past 5 to 7 years summarizes the relative superiority of various "empirically supported treatments (ESTs)" for specific conditions or problems. As codified by the Society of Clinical Psychology (Division 12 of the American Psychological Association), the standards for designating a psychotherapy as evidence-based require that a psychotherapy "has been defined in manuals and found efficacious in at least 2 controlled clinical trials with random assignment, that include a control condition of psychotherapy, placebo, pill, or other treatment and samples of sufficient power with well-characterized patients."[3] Although these standards and the EST literature are significant, from a psychotherapy training perspective, the list of therapies meeting this gold-standard has grown so rapidly that attempting to teach the numerous forms of ESTs is now impractical, if not impossible. Interested readers may wish to peruse http://www.apa.org/about/policy/resolution-psychotherapy.aspx for an up-to-date list of psychotherapies considered by this group, their assessments of the degree of supporting evidence, and the extent of controversy associated with each therapy.

Current attempts to teach even 3 different forms of psychotherapy as currently required by the Accreditation Council of Graduate Medical Education (ACGME)—cognitive-behavioral therapy, psychodynamic psychotherapy, and supportive psychotherapy—have been disappointing. A survey of psychiatric residencies in the United States[4] indicated that residents graduate from training "knowing" much about 1 and sometimes 2 forms of the required psychotherapies. This means that, at best, residents graduate with competence in 1 form of psychotherapy and know a little about one other school of psychotherapy.

As teachers of psychotherapy what are we to do? Should we apply the "Dodo Bird Verdict" to training in empirically supported psychotherapies? Should we be expected to teach the 10 to 20 forms of

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designated psychotherapies when psychiatric residents are not yet widely successful at achieving competence in the minimum of 3 forms of psychotherapy required by the ACGME?

To contend with these challenges, 1 popular strategy adopted by many training programs has been to teach easier to learn school-based psychotherapies first. This approach emphasizes basic school-specific psychotherapy concepts and skills, and then adds teaching and supervision for more complex forms of psychotherapy during advancing stages of training. The McMaster Psychotherapy Program[5] has used this strategy. Their system begins by teaching emotion-focused psychotherapy early in training because it is foundational, emphasizing listening, empathy, and understanding emotions as basic skills required for practicing other forms of psychotherapy. This program progresses in its teaching to cognitive-behavioral therapy, to psychodynamic psychotherapy, and on to other more specialized forms of treatment.

An alternative strategy for teaching psychotherapy is to focus on the common factors that positively affect psychotherapy outcomes. By distilling and summarizing the common features of many schools of psychotherapy, this perspective can generate its own core principles regarding psychotherapy education, training, and practice. These principles can be translated into specific instructional and clinical practice goals and objectives; these principles have informed our curriculum and are described elsewhere.[6] Learning multiple psychotherapies simultaneously often leads the novice resident to feel confused and overwhelmed.[7] The common factors approach offers the potential advantage of decreasing such confusion and can facilitate resident acquisition of foundational therapeutic skills.

In addition, and of great practical importance, the common factors approach relieves programs of the burden of finding "good" patients to match the particular form of treatment the residents are trying to learn. In this approach, all patients are "good" patients for learning something about psychotherapy. The common factors approach encourages clinicians to focus on specific patients and problems at specific points in time, utilizing specific interventions and tactics from various schools. It places interventions at center stage in psychotherapy training and practice rather than emphasizing theories or schools of psychotherapy. Thus, only after common foundational concepts and skills are acquired during the first 2 years of residency does our Psychotherapy Scholars Track at the University of Colorado Medical School also address specific schools of psychotherapy.

The literature reviewed below has helped us develop the core principles that serve as our foundation for teaching psychotherapy.

SIX COMMON FACTORS AFFECTING PSYCHOTHERAPY OUTCOMES

In his classic analysis, *Persuasion and Healing*, first published in 1961 and revised in a third edition with his daughter Julia as co-author, Jerome Frank[8] argued that change in psychotherapy occurs when factors that are common to all forms of psychotherapy operate in concert. His list of common factors included an emotionally charged confiding relationship; the presence and encouragement of hope; placebo effects; a healing setting; a mutually accepted conceptual scheme and belief system about the causes and cures of the maladies shared by both healer and patient; therapeutic ritual; a warm, inspiring, and socially sanctioned therapist; explorations of one's inner world; opportunities for catharsis and acquisition and practice of new behaviors; therapeutic suggestions; and interpersonal learning. *Persuasion and Healing* stands as a cornerstone of scholarship into the common factors, and this book is required reading for all residents in our Psychotherapy Scholars Track.

Consistent with Frank's initial writings a large body of research has further contributed to our understanding of common factors affecting psychotherapy outcomes, and several models using these factors in psychotherapy teaching have appeared. For example, the Y model[9] offers an integrated model for teaching psychotherapy competencies across the 3 required schools of therapy (supportive, psychodynamic, and cognitive-behavioral therapies). The stem of the Y refers to the common features of psychotherapy shared across schools and includes within it supportive therapy, whereas the branches of the Y refer to the unique defining features of psychodynamic therapy and cognitive-behavioral therapy. According to the Y model, the common features across schools are alliance, assumptions about effectiveness, combined

TABLE 1. Factors That Affect Psychotherapy Outcomes

Effective in improving psychotherapy outcomes
- Certain patient characteristics improve the chances for positive psychotherapy outcomes
- Hawthorne effects[1]
- Hope and instilling positive expectations[1]
- Positive alliances in individual and youth psychotherapy[11,12]
- Positive alliances in family therapy[11,12]
- Cohesion in group therapy[11,12]
- Empathy[12,13]
- Therapist characteristics: empathy and collecting client feedback[12]

Probably effective in improving psychotherapy outcomes
- Goal consensus[12,14]
- Collaboration[12,14]
- Therapist characteristic: positive regard for his or her patients[14,15]

Promising as effective in improving psychotherapy outcomes
- Therapist characteristics: congruence/genuineness[12,16] and emotional intelligence[17]
- Therapist behaviors: repairing alliance ruptures[18,19] and managing countertransference[19,20]

Areas for further research
- Attachment pattern and the alliance[21,22]
- Psychological mindedness[23]
- Reflective functioning/mentalization[24]

Extratherapeutic factors affecting psychotherapy outcomes[1,25]
- External life events (eg, marriage, a new job) can foster a positive psychotherapy outcome
- External life events (eg, trauma, loss) can lead to negative psychotherapy outcomes

medication and psychotherapy, brief psychotherapy, and supportive therapy. In a later paper using the Y model, several universal factors were identified that represent crucial points of teaching and learning that are easily graspable by a resident early in training.[10] These are interviewing, formulation, treatment planning, alliance, frame and boundaries, listening, reflection, techniques (interventions), and stages of treatment.

Although the Y model emphasizes treatment modalities and technique for teaching, our own design for teaching psychotherapy led us to broadly consider 6 common factors that affect psychotherapy outcomes. Although there may be room for debate as to which common factor categories should be taught or emphasized, we were guided in our choices by the strength of evidence we found in research studies associated with each of these factors, as documented in Table 1. On the basis of our literature review, we selected 6 common factor categories to review: (1) patient characteristics; (2) the Hawthorne effect; (3) hope and positive expectations; (4) the therapeutic alliance; (5) therapist characteristics and behaviors; and (6) the impact of extratherapeutic events (major external life events).

Patient Characteristics

The patient's contribution to the success of psychotherapy is substantially more important than the school of psychotherapy, treatment method, or the therapy relationship.[11,23,26] Patient characteristics can be invariant (eg, age, sex, birth order), relatively stable (eg, personality traits, socioeconomic factors), variable (eg, motivation to change, acuteness), or related to a particular diagnosis and relevant comorbid conditions, which together are termed prescriptive factors.[23] More than 161 patient characteristics have been identified that can affect psychotherapy outcomes.[1,23] These include facilitative patient variables, such as cognitive complexity, psychological mindedness, interpersonal relatedness, which contrast with inhibitory patient variables, such as poor ego functioning, primitive object relations, maladaptive attachment behaviors, and personality disorders. The patient's readiness for change is also an important factor that is often insufficiently considered when beginning treatment. Miller and Rollnick's[27] simple measures of importance and competence, which are rated on a scale of 1 to 10, or Prochaska's stages of change[28] are reasonable predictors of a patient's willingness to make changes and can be useful to monitor over the course of psychotherapy.

Patient characteristics that most successfully lead to change include: (1) a strongly stated desire and genuine intention to change; (2) the presence of

minimum obstacles to change; (3) possession of necessary skills and confidence to change; (4) positive feelings and beliefs that change will create benefits; (5) changes that are consistent with self-image and social norms; and (6) the presence of reminders and encouragement from valued people in a supportive community or environment.[29]

Hawthorne Effect

The Hawthorne effect describes how workers demonstrate greater productivity when physical circumstances under which they operate are changing, for example, under conditions when lighting or temperature in a factory is altered (either increased or decreased).[30] Researchers have suggested that what was actually causing the increased productivity was not these physical changes but the fact that someone was paying attention to the workers and observing them as their environment changed. Similarly, psychotherapists from all theoretical orientations routinely set up an equivalent to the Hawthorne effect, which facilitates changes in patients, to a limited degree, simply by virtue of the fact that they are being observed and listened to in an environment of undivided attention.[1] For some patients, just the promise of entering into a relationship in which caring and understanding is being offered leads to early psychotherapeutic improvement. Far from the arbitrary changes in the physical environment, as in the original Hawthorne effect studies, these changes in interpersonal environmental conditions help explain why a patient's symptoms and sometimes functioning can improve just from the process of entering into psychotherapy. These experiences of sharing observations in the presence of a supportive "other" are universal experiences in all forms of psychotherapy. Estimates suggest that the Hawthorne effect accounts for 10% to 20% of the effectiveness of psychotherapy.[1,31]

Hope and Positive Expectations

Generating an atmosphere of hopefulness and communicating expectations for positive outcomes to the patient are also important universal components present in all forms of effective psychotherapy. The positive effects of instilling hope and expectations for recovery have also been widely demonstrated in medicine and surgery.[32,33] It is estimated that hope and positive expectation offered in the context of a relationship are necessary but nonsufficient factors, and that they account for approximately one-third of successful psychotherapy outcomes.[1,31]

The placebo effects of psychotherapy[33–36] actually encompass the Hawthorne effect, hope, positive expectation, and other attributes[34] such as a positive transference. These common factors are "active" rather than "inert" placebo effects, as they comprise important components of what makes psychotherapy work. According to Beecher's estimates, "approximately 35% of a given medical treatment group will respond to a placebo (psychological aspects) as to a medication, if the placebo effect is a benefit derived from the expectation encouraged by the receipt of treatment and registered in the form of feeling better."[33] In psychotherapy, the act of empathically listening to a suffering patient's symptoms and grievances will likely help most patients feel better, by "inspiring the patient's hopes and combating demoralization."[8,35]

Therapeutic Alliance

The greatest area of theoretical convergence among diverse psychotherapy schools is agreement regarding the importance of developing a strong therapeutic alliance. According to Bordin,[37] "the working alliance is defined as being formed by the convergence of goals, tasks, and mutual bonds." Gelso and Hayes[38] defined the alliance relationship as "the feelings and attitudes that therapists and clients have toward one another, and the manner in which these are expressed." Results of studies assessing the importance of the alliance to treatment outcomes have varied depending on the definition used and the quality and frequency of alliance measures taken over the course of treatment. According to 2 large meta-analytic reviews,[39,40] the quality of the relationship between therapist and patient accounts for 5% of the variance in outcome. A differing view, espoused by Norcross and colleagues[41–43] and Crits-Christoph et al,[44] discounts these results as gross underestimates of the importance of the alliance. Norcross's critique of these earlier meta-analyses was that these reviews[39,40] used randomized-controlled trials that assessed the alliance measurements only once or

twice, early in the course of a treatment episode. In his view, using this inadequate measurement strategy resulted in a tendency to minimize the alliance as a central feature of the change. Crits-Christoph et al[44] measured the alliance in a more fine-grained manner, using multiple patients per therapist and measuring the alliance during a minimum of 4 treatment sessions over the course of an entire treatment. These authors estimated that the quality of the relationship elements accounted for approximately 15% of the outcome variance. Positive alliances in individual psychotherapy, positive alliances in family therapy, and cohesion in group therapy have all been significantly associated with improved psychotherapy outcomes.[41]

The attachment pattern of patients and therapist may also significantly affect the working alliance. Ainsworth et al[45] and Main and Weston[46] identified 5 major patterns of attachment: secure/autonomous, insecure anxious-resistant, insecure anxious-avoidant, disorganized/disoriented, and unclassifiable. These attachment patterns in adults reliably predicted the behavior of their children in the "Strange Situation"[46] (an attachment research procedure in which a child's attachment behaviors with regard to his or her parents are observed during 20 minutes of play while caregivers and strangers enter and leave the room).

When adult attachment is considered in relation to the therapeutic alliance, secure attachment is associated with positive therapeutic alliances, both of which predict therapeutic change. Levy et al[47] speculated that the capacity to develop a positive therapeutic alliance is enhanced by a client's level of attachment security. Concurrently, the formation of a positive therapeutic alliance may lead to more attachment security that leads to better psychotherapy outcomes. Fonagy et al[21] reported that dismissive/resistant patients showed greater improvement in psychotherapy than preoccupied/avoidant patients. Others[24] have described the opposite pattern. However, it is generally agreed that patients showing disorganized attachment are the most difficult to engage in a therapeutic alliance. Ongoing research in this area is exploring whether the match of patient and therapist attachment styles also affects psychotherapy outcomes.[22] At this point, data are insufficient to definitively determine how important attachment styles are to the development of the therapeutic alliance and psychotherapy outcomes.

Therapist Variables and Behaviors: Activities That Affect Psychotherapy Outcomes

Over 27 therapist variables[48] have been studied in relation to psychotherapy outcomes, and this list continues to grow. Variables examined to date include facilitative skill, experience, persuasive ability, genuineness, credibility, religiousness, maturity, emotional well-being, and attractiveness, among others. It is useful to categorize such traits as those that are invariant (cannot be modified), those that are difficult to modify, and those typical behaviors and activities that can be more readily taught and learned.

Nonmodifiable therapist traits include: sex, age, race, and attractiveness (although attractiveness is in the eye of the beholder and therapists can change their grooming and appearance to some extent). These invariant characteristics have not been shown, in any consistent way, to have an impact on psychotherapy outcomes. Therapist variables that are difficult to modify but that are likely to have an impact on psychotherapy outcomes include the capacity for empathy, the inclination to develop positive regard for patients, genuineness, and emotional intelligence (EI).

Empathy has been variably defined and operationalized from study to study. Brain researchers[49] have described several components of empathy: an *emotional simulation* process that mirrors the emotional elements of the other's bodily experience; a conceptual, *perspective-taking* process[50]; and an *emotion-regulation process*[49] used to soothe personal distress at the other's pain or discomfort, making it possible to mobilize compassion and helping behavior for patients. As of yet, no clinical studies have used these contemporary definitions of empathy in psychotherapy research.

Rogers[51,52] and some psychoanalytic therapists[53] have defined empathy as the term is used in most research studies, emphasizing cognitive aspects of empathy. To be empathic, in their definition, means focusing on understanding the client's frame of reference and ways of experiencing the world. A recent meta-analysis,[13] which involved studies that used this specific definition, showed that empathy had a medium effect size on psychotherapy outcome. In these analyses, the patient's and external observer's perceptions of the psychotherapist's empathy were better able to predict outcome than

the therapist's own perceptions of his or her own empathy. In other words, therapists may be less capable of accurately observing their own empathic capacities than are their patients or external supervisors. This phenomenon suggests that using patient and supervisor feedback about therapist empathy may be more useful than using the therapist's self-assessment.

Similarly, Rogers' concepts of therapists having "positive regard" for their patients and "genuineness" have both been studied[15,16] and they have been found to be associated with significant beneficial effects on psychotherapy outcomes.

EI includes the ability to identify, assess, and control one's emotions, whereas also accurately reading and effectively managing the emotions of others and groups. The results of a pilot study[17] suggested that this set of skills may be associated with positive psychotherapy outcomes. In this small preliminary study, therapists with higher ratings of EI achieved better therapist-rated outcome results and lower dropout rates compared with therapists with lower ratings of EI. Higher therapist EI was also significantly associated with increased patient-assessed treatment compliance.

Little research is available that clearly demonstrates effective ways to teach empathy better, improve the development of positive regard for patients, or enhance EI. However, teachers can model these behaviors clinically and show that they value them. Decreasing the stress of the work environment may increase empathy. Teaching cultural competence may also have an impact on developing positive regard for a broad array of patients. Therapist behaviors and activities that can be modified or taught and that also affect psychotherapy outcomes are being studied. Two clinical activities that have been shown to improve outcomes are establishing therapeutic goals with the patient and collaborating with the patient to work on those goals. When a patient and therapist agree upon "consensus goals"[14] (eg, establishing a therapeutic contract and goals), psychotherapy outcomes improve. In a recent meta-analysis of 15 studies,[14] the effect of goal consensus on psychotherapy outcome was small, but significant. Although agreeing on common treatment goals is important, it is also important that the therapist and patient collaborate in meeting their consensus goals. A second meta-analysis that examined 19 studies[14] showed that using collaborative measures, such as the working alliance, compliance scales, and homework completion, showed a small but significant effect size for collaboration as a variable that improves psychotherapy outcomes. A meta-analysis of 4 studies[14] found an effect size between small and medium, demonstrating a positive relationship between goal consensus and collaboration, and psychotherapy outcomes.

Although estimates show that up to 65% of patients improve substantially from psychotherapy,[31] an estimated 5% to 10% of adults in clinical psychotherapy trials actually get worse. This number is even higher in child and adolescent populations.[54] Although deterioration in patient functioning during treatment is often attributed to external life events, therapists must also attend to their own potential contributions to a patient's decision to drop out of treatment. Three specific therapist behaviors that can reduce adverse psychotherapy outcomes can be taught and learned. These include collecting client feedback, repairing alliance ruptures, and managing countertransferences.

The utility of collecting patient feedback for improving outcomes depends on the discrepancy between the patient's and the therapist's view of the treatment. Greater patient-therapist disagreement about how helpful treatment has been provides greater opportunity to initiate corrective practices and to reestablish successful treatment.[54] Feedback to therapists is most useful when the therapists are committed to improving their performances. Getting patient feedback provides an opportunity for the motivated therapist to do a "kick save" of a treatment going badly. Several methods for obtaining and providing feedback in a psychotherapy context are described elsewhere.[55]

An alliance rupture is defined as a "breakdown in the collaborative relationship between patient and therapist."[18] Repairing ruptured alliances is extremely important, both to prevent unwanted terminations and to improve psychotherapy outcomes. Viewed through the lens of Bordin's[37] definition of the alliance, quoted earlier, relationship ruptures can be described as disagreements about treatment goals, tasks, or stresses in the patient-therapist relationship. Problems in the working alliance often occur when the patient believes the therapist is missing something important or has been insensitive or insulting. Common rupture repairing techniques that can be taught include repeating the reason for the therapy; modifying the tasks or goals of the

treatment; clarifying the current misunderstanding; exploring the transference, past relationships, and life themes that are affecting the therapeutic relationship; and providing a new model for a new relationship.[18] In a recent meta-analysis by Safran et al,[18] the presence of rupture-repair episodes was associated with a moderate effect size in promoting positive treatment outcomes. In a different meta-analysis of 8 studies by the same authors,[18] the impact of rupture resolution training or supervision on patient outcomes was also positive, demonstrating a large pre-post effect size. Both meta-analyses highlight the fact that repairing and preserving the alliance, in all forms of treatment, will tend to improve psychotherapy outcomes.

Countertransference has been defined in multiple ways. Freud initially described countertransference as representing unwanted reactions to the patient based on the therapist's unresolved conflicts.[56] Countertransference in this definition can be managed by discussions with supervisors, treating clinicians working on these issues in their own treatment, or, as in our program, by discussing these issues in a weekly countertransference group designed specifically for residents and led by senior faculty. More recent broader conceptions called "global countertransferences"[57] refer to therapists' reactions to unconscious communications engendered by the patient's use of projection and projective identification. Global countertransferences often cannot be avoided, and, in fact, they can be used as valuable information about how the patient affects others globally. However, from the research perspective,[20] countertransference as originally defined by Freud has been studied and needs to be corrected or managed so that the therapist's unwanted reactions do not adversely affect psychotherapy outcome. A meta-analysis of 7 studies that used Freud's definition and a well-validated version of the Countertransference Factor Inventory[58] found that countertransference management resulted in significant and large effects in enhancing psychotherapy outcomes. The clinical implications for all forms of psychotherapy are worth considering. Countertransference matters, and it may have a greater impact on various forms of psychotherapy across the board than specific schools of psychotherapy often acknowledge. Psychotherapists can likely improve their outcomes by managing and acknowledging their maladaptive countertransference reactions as part of repairing ruptured alliances.

Perhaps more than any other common factor, modifiable therapist variables can help residents in training maximize their influence and feel competent. Collecting client feedback, repairing alliance ruptures, and managing countertransferences are factors woven into more than 1 common factor category. They affect the patient's subjective sense of the Hawthorne effect, sense of hope, and the alliance.

Extratherapeutic Factors Affecting Psychotherapy Outcomes

Estimates suggest that extratherapeutic effects, or life events, have greater impact on psychotherapy outcomes than all of the other single factors that affect outcome.[1,25,59] Life events can serve as turning points that can close or open treatment opportunities, create a lasting change in the person's environment, or change a person's self-concept, beliefs, and expectations.[59] The effect of life events on psychotherapy outcomes is most important to consider when treatments do not proceed as expected. External life events can accelerate expected improvements or, conversely, can lead to partial success, dropouts, or treatment failures. From a therapist-centric vantage point, it is crucial to remember the effects of extratherapeutic factors as this can help restrain our grandiosity when taking too much credit for the success of psychotherapy or, alternatively, help us avoid accepting inaccurate or excessive blame for some treatments that fail.

PRINCIPLES OF TEACHING: COMMON FEATURES OF ALL PSYCHOTHERAPIES

In educating new therapists or psychiatric residents, we believe that emphasizing common factors of psychotherapy is preferable to initially focusing on specific schools or specific theories of psychotherapy. On the basis of our review of the literature, we derived 8 principles that guide our teaching about common factors:

(1) Teach patient-centered psychotherapy, focusing on the patient's needs, problems, diagnosis, or functional capacity. Do not focus *initially* on a school or theory of psychotherapy.
(2) Work toward using a common language for all of psychotherapy, which describes common clinical phenomena. The corollary: help students

understand how different schools of psychotherapy, which use totally different languages, describe *similar* clinical phenomena. For example, the concept of "resistance" in psychodynamic therapy is called "treatment interfering behavior" in dialectical behavioral therapy. The psychoanalytic concept of internalized object relations is similar to concepts used in schema-focused therapy.

(3) Acknowledge how all schools of psychotherapy have borrowed or modified useful concepts from one another; stop reinforcing the notion propagated by new schools of psychotherapy that they have discovered something *brand new*, when, in fact, they most often keep reinventing a similar wheel with occasional improvements—lots of old wine in new packaging.

(4) Tailor the psychotherapy for individual patients, utilizing specific interventions that target precise patient needs, diagnosis, problems, or other aspects of patient functioning for each episode of treatment.

(5) Develop criteria for selecting an appropriate context for treatment, starting with considerations regarding whether individual, group, and/or family/systemic treatment is appropriate.

(6) Begin teaching psychotherapy by choosing a broad treatment modality that utilizes many common factors, such as crisis intervention, supportive psychotherapy, group, or family therapy. These treatments may be among the best clinical strategies for fostering awareness of common factors, psychotherapy outcomes, and the clinical integration of school-specific psychotherapies.

(7) Teach the different major and traditional forms of psychotherapy later in training, emphasizing what they have in common and their differences, and illustrating how some individual forms of treatment can be modified for group or family treatments.

(8) Teach the comparative effectiveness of empirically supported treatments for specific patients, conditions, or problems.[2]

DISCUSSION

We reviewed 6 well known and widely researched common factors in psychotherapy: (1) patient characteristics; (2) the Hawthorne effect; (3) hope and positive expectations; (4) the therapeutic alliance; (5) therapist characteristics and behaviors; and (6) extratherapeutic variables. These factors led us to formulate and implement foundational principles for education and clinical practice in our psychotherapy training program. These principles enable therapists to focus better on their clients' needs and to better understand the commonalities and differences among and between different schools of psychotherapeutic thought. Learning common factors early in training allows our therapists/residents to tailor their treatment modalities to patient needs as they move from the common factors approach to learning more specific schools of psychotherapy later in their training.

CONCLUSIONS

This article reviewed common factors that foster positive psychotherapy outcomes. The common factors approach led us to make specific recommendations for teaching and psychotherapy training. As Castonguay[60] observed: "The assumption that building on plurality and convergences can improve psychotherapy outcome is based on two obvious premises: that this type of rapprochement can widen the scope of our understanding and the repertoire of our practice, as well as increase our confidence in interventions or constructs that are supported by different perspectives of knowledge." Laska et al[19] also argued that a common factors approach improves quality assurance by facilitating better training, feedback, alliance, and therapist variables. We believe that this approach allows therapists/psychiatric residents to become more effective and confident early in their training.

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