Abstract

This paper offers a look into the concepts of common factors theory. Within common factors theory a discussion of the individual concepts is provided and how they are distinct yet integrated. Furthermore, an overview of the idea of evidence-based practices in psychotherapy treatment and the evidence-based movement is delivered. This paper also compares and contrasts the evidence-based movement in therapy with the ideals and concepts of the common factors theory. It is purported that evidence-based practices and common factors need not be mutually exclusive; yet broader and more inclusive terms may be needed for future research into why therapy is successful and what lies behind particular aspects of this success. Also, an exploration into Adlerian theory and some Adlerian concepts is offered. Finally, an overview of the link between Adlerian theory and common factors theory is provided.
Table of Contents

Abstract 2
Introduction 4
Common Factors Theory Overview 5
  Therapeutic Relationship/Alliance 9
  Hope and Expectations of Positive Change 12
  Empathy/Unconditional Positive Regard 15
  Client Motivation 17
  Extra-therapeutic Factors 18
Placebo Effect/The Dodo Bird Hypothesis 20
Evidence-based Movement Overview 22
Mutually Exclusive or Combinable 27
Adlerian Psychotherapy Overview 30
  The Need to Belong 34
  Social Interest and Social Embeddedness 36
  Inferiority Feelings and Encouragement 37
  Mistaken Beliefs 39
  Everything Can Also be Different 41
  Early Recollections and the Process of Change 43
  Teleology/All Behavior is Purposeful 45
Common Factors and the Adlerian Link 47
In Summary 49
References 53
Common Factors Theory and Evidence-Based Practice, and Alfred Adler’s Holistic Concepts and Interventions

Common factors theory and the concept of evidence-based practice have long seemed to be at opposite ends of the spectrum concerning efficacious therapeutic treatment. The literature abounds supporting therapist’s use of common factors and therapeutic success (Messer & Wampold, 2002). There is also literature in support of evidence-based practices and therapeutic achievement (APA Presidential Task Force on Evidence-Based Practice, 2006).

Empirically supported treatments (ESTs) are another aspect of therapeutic technique research. ESTs encompass stricter criteria than evidence-based practices and, for the sake of clarity, are grouped together with evidence-based practices within this review and referred to as the “evidence-based movement” (Wampold & Bhati, 2004, p. 563). Though the aforementioned concepts are different in overall criteria needed, they are still similar regarding the idea of evidence necessitating the use of any particular technique or theory. It is beyond the scope of this paper to detail the full criteria for empirically supported treatments, yet it is important to note ESTs leave little room for the impact of unique human variables on the therapeutic experience (Smith, 2009).

Evidence-based practice (EBP) also encompasses particular criteria that must be met in order for a therapeutic technique to be considered an EBP. Yet, there is room within the concept of EBPs for unique client and therapist variables to be considered during psychotherapy (Prendergast, 2011). In simpler terms, “Evidence-based practice is the integration of research with clinical expertise in the context of the client’s characteristics, culture, and preferences. Empirically supported treatments are treatments with at least two randomized controlled clinical trials that demonstrate their efficacy” (Thomason, 2010, p. 30).
The incorporation of the terms ESTs and EBPs is for ease of comparison between the evidence-based movement and the more general yet efficacious common factors approach to therapy. This is not to infer that ESTs and EBPs are interchangeable based on merit or definition. In general, evidence-based practice is much more in line with common factors and takes client uniqueness and presentation of issues into account. Regarding the main differences of these two classifications, the APA Task Force on Evidence-Based Practice (2006) states:

EBPP [evidence-based practice in psychology] is the more comprehensive concept. ESTs start with a treatment and ask whether it works for a certain disorder or problem under specified circumstances. EBPP starts with the patient and asks what research evidence (including relevant results from RCTs) will assist the psychologist in achieving the best outcome. (p. 273)

Though common factors theory and evidence-based practices may seem to be incompatible, through the therapist skillfully combining both, the theories can successfully be used in conjunction with one another (Sexton, 2007). This literature review attempts to define some specifics of the common factors theory and the evidence-based movement, as well as compare and contrast these concepts. Furthermore, a brief look into the placebo effect and the dodo bird hypothesis, where common factors originated, will be provided (Duncan, 2002).

Finally an overview into some of the concepts of Adlerian theory will be delivered, as well as an in-depth look into Adlerian concepts that correlate with the ideal of the common factors theory.

**Common Factors Theory Overview**

Common factors theory proposes that a therapist’s relational skills and way of being within therapeutic sessions are the main contributors to change within clients (Wampold, 2012). This theory is credited as being set in motion based on information provided by Saul Rosenzweig
in his 1936 paper, “Some Implicit Common Factors in Diverse Methods of Psychotherapy” (Rosenzweig as cited in Duncan, 2002, p. 32). The aforementioned paper brought about the dodo bird hypothesis and the research to follow regarding common factors, the alikeness of psychotherapeutic theories, and questions into what really creates change in psychotherapy (Weinberger, 2002).

Common factors are the factors that are considered inherent in all, or at least most, quality therapeutic encounters (Thomas, 2006). Common factors are not aligned with any technique or particular theoretical orientation as they are humanistic relational factors (Lambert, 2005). One main idea behind common factors theory is that the healing process that takes place within the therapeutic environment can be attributed to the relationship between the client and the practitioner and not due to particular theories or techniques that may be imposed (Wampold, 2012). As will be introduced later, Adlerian theory encompasses many of the concepts from the common factor theory; both theories maintain that relationships and socialness are at the center of mental health and the quality of change.

There is no defined list of agreed upon common factors and many of the research studies on this theory discuss differing categories of what is to be considered within the common factors system. This literature review will focus on six frequently written of common factors: therapeutic alliance/relationship; hope and the expectation of positive change; therapist empathy and unconditional positive regard; client motivation; and external therapeutic factors (Elliott, Bohart, Watson, &Greenberg, 2011; Thomas, 2006; Ward, Linville, & Rosen, 2007). Within common factors theory, it is purported that humans heal through connection and through the act of social acceptance and a sense of belonging (Wampold, 2012). The connection between the therapist and client is considered one of the main needed catalysts for change. This connection however,
may need to be authentic and genuine. As will be highlighted, Adlerian theory brought forth the concept of the need to belong and its link to therapeutic change and increased mental health (Mosak & Maniacci, 1999).

This review investigates six overlapping common factors. Common factors theory overall, encompasses the unique relationship between client and therapist, which will change with each client and even within each individual session. Much like Adlerian therapy concepts and interventions, common factors are organic in nature; meaning that both have elements and concepts that fit together amicably as part of a larger and necessary whole. Also, both maintain that the uniqueness of the individual client is to be at the forefront of each therapeutic encounter. Regarding factor overlap, Fife, Whiting, Bradford, and Davis (2014) state, “Common factors are not independent entities, and researching or practicing one factor without implicating others is impractical, if not impossible” (p. 21). The main idea behind common factors theory is that the traits of the therapist such as empathy, positive regard, hopefulness, and the expectation of positive change, are the vehicles through which change takes place and not any particular theoretical interventions which may be used (Fife et al., 2014).

An important caveat to remember regarding common factors theory is that this theory is not proposing that no theoretical orientation or techniques are needed and that only interaction in a supportive environment is necessary for change. Even the term common factors theory is at times misrepresented as it is not a theory of distinct treatment in the typical sense, but a gathering of traits and concepts that can be incorporated into any theory (Laska & Wampold, 2014). Yet, at times, these traits are also seen as effective in and of themselves. As stated by Laska and Wampold (2014), “There is no such thing as a ‘common factor’ treatment. One of the aspects of all treatments is that the patients are provided an explanation for their disorder and that there are
treatment actions consistent with that explanation” (p. 520). Also regarding an often repeated misnomer of common factors theory, Laska, Gurman, and Wampold (2013) state, “The CF [common factors] perspective does not suggest that a mere ‘relationship’ with a therapist is sufficient” (p. 469). The authors discussed Barlow (2010) and Foa (2013) studies about common factor treatment and concluded, “A valid test of specific versus common factors overlooks the important point that the CF approach states that any therapy with all CF ingredients will be efficacious” (p. 469).

Based on the review of literature for this paper, a rift seems to exist between proponents of particular theories, those that purport common factors as the main agent of change for clients, and those that align with all theories and or techniques being evidence-based and or empirically tested. Yet, the aforementioned concepts are not mutually exclusive and it is likely in the best interest of research moving forward that they be viewed in conjunction with one another (Blow, Sprenkle, & Davis, 2007). This can be accomplished by creating new concepts and categories that can encompass all that is necessary to review the true impact of multi-faceted and client-centered theories and techniques (Blow et al., 2007).

Therapeutic techniques and theories are valuable and necessary along with common factors and can be seen as one in regards to how the therapist is using a theory to guide their overall practice with clients (Sexton, 2007). Regarding the importance of theory being linked to common factors, Sexton (2007) states:

Simon (2006) suggested that ‘both sides’ of the common factors vs. specific model debate have missed a critical element: the self of the therapists in committing themselves to a therapy model of proven efficacy whose underlying model closely matches their own worldview. (p. 104)
The concept of the therapist being fully committed to a theory and having this be an outgrowth of their worldview is directly related to Adlerian therapy and the need for a phenomenological approach to therapy for the client, yet also for the therapist.

**Therapeutic Relationship/Alliance**

The therapeutic relationship, used interchangeably in this paper with therapeutic alliance, is often considered the most important variable in determining successful change for clients within the common factors therapy environment (Fife et al., 2014). The authors discuss studies from Lambert and Barley (2001) noting that the therapeutic alliance explains roughly 30% of change in client effect in regards to treatment (2014). Though the quantitative effectiveness of the therapeutic relationship varies some from study to study, Joyce, Wolfaardt, Sribney, and Aylwin (2006) state, “The overall alliance-outcome effect size (r=0.26) is modest, but it has emerged as consistently important . . .” (p. 805). Discussing a 1994 study by Greenberg and colleagues, Fife et al. (2014) concluded that a therapist’s authentic nature, such as empathy and warmth had an overall correlation of around .43 in relation to client change.

As revealed through the aforementioned varying outcomes, even though the exact percentages and correlations of change may be disputable to a degree, the therapeutic alliance needs to be considered important. Though this relationship is necessary, and in this writer’s opinion imperative for change, the concept is often difficult to define. Numerous definitions abound regarding what the therapeutic alliance truly is and what it must or must not entail.

In the vaguest of terms, the therapeutic alliance is the relationship that is built and maintained between the therapist and client (Fife et al., 2014). Though the therapeutic alliance is a common factor in and of itself, it also encompasses other common factors such as empathy and unconditional positive regard. Without the empathy and unconditional positive regard, reaching a
therapeutic alliance would be either superficial or unattainable. Within the concept of therapeutic alliance, lies the ideals of empathic responsiveness, collaboration with the client on goals and overall therapeutic endeavors, and connection in general (Karson & Fox, 2010). The main idea of the therapeutic alliance is that there is a trusting and collaborative relationship between the practitioner and the client (Manso & Rautkis, 2011). Manso and Rautkis (2011), discussing a review by Doucette and Bickman (2001), concluded that an alliance may encompass “a positive emotional bond, mutual agreement on therapeutic tasks and goals, and perceived openness and truthfulness” (p. 46).

As an Adlerian oriented practitioner, this writer believes that the need for all humans to feel a sense of belonging with one another is innate and of paramount importance (Ferguson, 2010). The therapist and client alliance can provide this needed sense of belonging for a client who may feel this lack of attachment to others, and this feeling of belonging for clients is linked to greater mental health (Ferguson, 2010). This alliance begins from first contact with the client and needs to be maintained throughout the entire length of the relationship in order for trust and security to pervade the therapeutic environment. A true alliance can be described as “a therapeutic relationship that is characterized by trust, warmth, understanding, acceptance, kindness, and human wisdom” (Lambert, 2005, p. 856).

Though this therapeutic alliance is considered important to a client’s experience of therapy and the process of change itself, it may be difficult to measure its effectiveness. Yet it is likely that a therapeutic alliance improves the probability of change for clients and that “the therapy relationship makes substantial and consistent contributions to psychotherapy outcome independent of the specific type of treatment” (Norcross & Wampold, 2011, p. 98).
inclusion, it would be quite difficult to define and measure the therapeutic relationship as this alliance varies with each and every client as well as with every interaction with each client.

It seems essential that the therapeutic relationship be fluid by nature of the concept itself, as it is about being present with each individual client and tending to a unique relationship based on client needs within each moment of each session. This is not stating that skill, theory, and technique are not needed and useful, yet they are possibly not advantageous if used outside of a strong therapeutic relationship. Fife et al. (2014) state, “The effective use of skills and techniques rests upon the quality of the therapist-client alliance, which in turn is grounded in the therapist’s way of being, a concept that reflects a therapist’s in-the-moment stance or attitude toward clients” (p. 21).

There is research that supports the importance of the therapist and client relationship. As mentioned earlier, in a large meta-analysis originally conducted by Lambert in 1992, it was found that 30% of change for a client could be attributed to the therapeutic alliance or the client/therapist relationship (Ward et al., 2007). On the topic of common factors, which encompasses the therapeutic relationship, Chwalisz (2001) states, “Wampold (2001) estimated specific effects to account for 8% of the variance in psychotherapy outcome, general (common factors) effects to account for 70%, and unexplained effects to account for 22%” (p. 263). A study conducted by Ward et al. (2007) found that client’s feeling heard and truly listened to by the therapist was the most important component regarding the creation and maintenance of a therapeutic alliance. Regarding the overall assumption of the aforementioned study, Ward, et al. (2007) state, “Paradoxically, to connect with clients, therapists may need to focus less on their theoretical orientation and goals and simply be present” (p. 39). As summed up succinctly by
Yalom (2005), “Ultimately it is the therapist more than the model that produces benefits” (p. 562).

**Hope and Expectation of Positive Change**

As with the other common factors included in this review, hope and the expectation of change is encompassed within the concept of the therapeutic relationship and also set apart as an independent common factor. In the opinion of this writer, this dual conceptualization being complex in nature does not detract from the need for this common factor to be independent from the relationship in general. The therapeutic relationship is however important to the concept of hope since “it is through the emotionally charged therapeutic relationship that the client comes to accept the therapist’s belief that positive change is possible” (Larsen & Stege, 2010, p. 288).

Hope and expectations of change have many different facets and conceptualizations, such as implicit and explicit hope: as well as the innate hope and positive expectancy that come from a genuine and caring relationship with an authentic practitioner of therapy.

The concept of hope may be broadly viewed as involving expectation within a client and also the “interaction of thinking, acting, feeling, and relating” is aimed toward positive change that is significant to the individual (Stephenson as quoted in Larsen & Stege, 2010, pp. 271-272). As this definition implies, the concept of hope is more significant and detailed than just the idea of a brighter tomorrow. Writing on the importance of hope, Yalom (2005) states, “Not only is hope required to keep the client in therapy so that other therapeutic factors may take effect, but faith in a treatment mode can in itself be therapeutically effective” (p. 4). Furthermore, hope encompasses the concept of positive expectancy, yet this writer believes that positive expectancy is based mostly in cognitions as one thinks internally that positive outcomes will occur. Whereas
hope lies in thoughts and actions such as an individual contemplating about a hopeful outcome as well as partaking in hopeful behaviors like taking chances and making changes.

This paper concentrates mostly on the concept of hope, yet this does not detract from the importance of positive expectancy. Clients with positive expectancy that therapy will work are far more likely to stay with the therapeutic process and therefore far more likely to be successful regarding permanent change (Larsen & Stege, 2010). The authors researched studies by Frank and Frank (1991) and Hanna (2002) and concluded that “When introduced early in therapy, hope may strengthen and empower the client to believe that a better future is possible” (Larsen & Stege, 2010, p. 273). An important aspect of expectancy is that the control of it needs to lie within the self of the client as they need to govern the power over their changes; as stated by Wampold (2012), “It is the belief that one’s own efforts are responsible for the control over one’s problems that are critical” (p. 447). Regarding the importance and necessity of expectancy and hope, Thomas (2006) states in the study on common factors, “Hope and expectancy was estimated to account for 15% of change in the therapeutic process” (p. 207).

The significance of hope provided by the therapist and internalized by the client is an important common factor that probably needs to be included in the therapeutic endeavor regardless of the therapist’s theoretical leaning or use of technique (Larsen & Stege, 2010). In general terms, the concept of hope is important yet not necessarily to be overthought. Hope is, as is commonly understood, to believe in the possibility of change, a greater and brighter future, a new successful approach, and eventually hopeful behaviors. The power of hope is often obvious when one looks at medical placebo trials and it is shown that actual physiological changes can and do take place purely through the mechanism of hope in a placebo treatment (Yalom, 2005).
As mentioned previously, the overall concept of hope consists of implicit hope and expectancy and explicit hope and expectancy: this can come from within the client or from messages from the therapist (Larsen & Stege, 2010, part I; Larsen & Stege, 2010, part II). Implicit hope is as it appears, implicitly held by the client or asserted via the therapist through relationship, nonverbal communication, and internal belief in their therapeutic process. Explicit hope is hope that is suggested outright to the client or by the client. Explicit hope is purposefully introduced into the therapeutic environment.

Larsen and Stege (2010) contend that hope is highly correlated with positive outcomes in therapy, yet it is a difficult variable to research due to the varying descriptions of the concept of hope as well as individual perceptions of hope that may vary from person to person and practitioner to practitioner. In Larsen and Stege’s 2010 research, hope was investigated via case study. Case studies may not be seen as an evidence-based or empirically supported treatment design, yet they seem to offer pertinent information regarding common factors such as hope and therapeutic outcome. Regarding the importance of hope, Larsen and Stege (2010) discussing studies by Asay and Lambert (1999), Hubble and Miller (2004), and Lambert (1992) concluded that “Research reviews confirm hope as one of four important variables that account for therapeutic effectiveness across theoretical orientations” (pp. 272-273). Each client we work with is unique and views the world in a way that may not be able to be replicated through large scale studies that seem to examine the approach of a technique to a disorder rather than to a human being.

Hope can coexist with evidence-based practices and particular theories (Ward et al., 2007). Hope can be conveyed to clients through a therapist’s genuine belief in the theory being used and the belief that the particular theory will bring forth change (Ward et al., 2007). It
appears it is client’s hope as well as therapist’s hope working together that are the powerful forces behind hope as a common factor and successful contributor to client success.

**Empathy/Unconditional Positive Regard**

Empathy, as with hope and expectancy, can be seen as a part of the therapeutic relationship and it is also a unique common factor in its own right (Elliot, Bohart, Watson, & Greenberg, 2011). Elliot et al. (2011) put forth that empathy is a major change factor within the process of therapy. Empathy and unconditional positive regard are encompassed within one common factor within this paper; though they have some separation they are similar and according to this writer best when used in conjunction with one another (Rogers, 1980). Empathy is often brought back to the original writings of Carl Rogers and humanistic psychology, the concept of unconditional positive regard.

Rogers was a champion for empathy and unconditional positive regard and empathy has been a topic of concern for therapists long before Rogers: Carlson, Watts, and Maniaci (1999) acknowledge the work that Carl Rogers has done for the concept of empathy and acknowledge that Rogers also studied with Alfred Adler during his earlier career. Alfred Adler brought forth the concepts of encouragement, Social Interest, Community Feeling, and acceptance. These concepts highly translate to the idea of empathy in relation to each person’s unique worldview by having the ability to “see with the eyes of another, to hear with the ears of another, to feel with the heart of another (Ansbacher & Ansbacher, 1956, p. 135). Regarding this link to Adlerian theory and Rogers’ concept of empathy and unconditional positive regard, Feller and Cottone (2003) state, “Watts (1996) and Watts and Pietrzak (2000) presented evidence showing that Rogers was influenced by Adler’s concepts of encouragement and social interest” (p. 54). Regardless of where the ideal of empathy originated, empathy is a major factor that need be
considered regarding client change and positive outcome, and also continually researched and defined.

Defining empathy is an arduous task and there are varied definitions throughout the research and seemingly no completely agreed upon classification (Elliot et al., 2011). An overall basic definition, though vague in nature, is that empathy is about truly entering the realm of a client’s perspective or worldview (Elliot et al., 2011). Empathy is to be able to see as the client sees and convey this empathic connection genuinely back to the client through various means (Elliot et al., 2011). Being authentically empathic with clients and offering unconditional positive regard is a way of genuinely relating to a client’s struggles and successes. Elliot et al. (2011) purport that there are many different tenets within the ideal of empathy as a category: empathy is the relationship built with the client through acceptance and trust, it is the being in the here-and-now of the moment and staying truly present within the client’s experience, and it is continually working to see what is taking place in therapy from the client’s perspective.

Though objectively studying or defining empathy as a distinct concept may be difficult, this does not take away the importance of empathy needed for therapeutic success and there is research supporting empathy as a necessary factor in therapeutic change. Regarding a client’s view of empathy, Elliott et al. (2011) discussing a study by Peabody and Gelso (1982) concluded that, “With respect to affective simulation and emotion regulation, therapists who were open to conflictual, countertransferential feelings were perceived as more empathic by clients” (p. 46). In other words, therapists must be willing to be vulnerable yet professional and enter the world of the client, versus only following a prescribed technique or treatment that is related to a disorder not a unique human being and their experiences of the world.
Feller and Cottone (2003) report on numerous meta-analysis studies that are high in evidence regarding the importance and effectiveness of empathy in therapy. Regarding a meta-analysis created by Patterson in 1984, Feller and Cottone (2003) state, “Patterson’s (1984) conclusions enthusiastically supported the value of empathy and the other core conditions to positive therapeutic outcome” (p. 58). The authors also acknowledge unfortunately that research surrounding empathy has slowed greatly since the 1980s. Regarding an overall view of empathy and available research, the authors state, “The empirical evidence strongly suggests that counselor use of empathy and related constructs within the therapeutic alliance contributes significantly to therapeutic outcome” (2003, p. 58). Acknowledging that empathy is a necessary factor regarding therapy retention as well as change, is not to say that empathy in and of itself is the only technique or concept needed for client change. Yet, possibly without empathy any other modes to change would be moot or at least much more ineffectual.

Client Motivation

Client motivation may not be a common factor that is necessarily within a therapist’s control, yet is an important factor in therapy and therapeutic change. Furthermore, though this factor lies within the client themselves, this does not mean that a therapist cannot assist with client motivation by using other common factors such as the therapeutic relationship, empathy, and unconditional positive regard. Client motivation is considered an important extra-therapeutic factor that has a distinct impact upon therapy success (Thomas, 2006). Client motivation can be enhanced through using the other common factors highlighted in this review. Though only mentioned briefly in this paper, it is necessary to consider client motivation as a factor affecting therapeutic success. Realizing the impact of client motivation, practitioners can strive to use the other common factors available to enhance client motivation when possible.
Extra-therapeutic Factors

Though extra-therapeutic factors would encompass the concept of client motivation, it has a much broader overall conceptualization. Client motivation is considered a unique common factor within this review due the nature of the concept itself and the impact it can have on client change. This being said, all extra-therapeutic factors impact a client’s likelihood of success with psychotherapy and are actually considered one of the largest contributing factors when taken as a whole (Thomas, 2006). The idea of extra-therapeutic factors can contain many variables yet often include “client strengths, capabilities, resources, social supports, and fortuitous events that weave in and out of a client’s lives . . .” (Dohaney & Miller, 2000, p. 222). Regarding the large impact of client factors Thomas (2006), discussing a study by Miller et al. (1997) concluded that, “Client extra-therapeutic factors are estimated to contribute 40% to change” (p. 203). Whether the percentage of impact is to a degree debatable or not, client extra-therapeutic factors and therapy outcome effects are likely in need of attention when working toward client change.

A client’s outside support system is vital to their ability to continue on with therapy and likely feel safe within the therapy environment. It seems reasonable that if a client’s support system is against the client attending therapy versus being supportive this will have an impact on the client’s therapeutic experience, at least in the initial stages of therapy. Thomas (2006) through review of a study by Hubble et al. (1999) expands on the list of extra-therapeutic factors by adding “faith, persistence, supportive family members, community involvement, job, or crisis situation” (p. 203).

Basically, all factors that can impact a client’s life in and outside of therapy are extra-therapeutic factors and deserve attention within the therapy process. A therapist may not be able to control the outside factors a client walks into therapy with but certainly can work to help the
client understand these factors, their impact, as well as ways to build up resiliency factors. These extra-therapeutic factors are considered a common factor due to the reality that they are present in all clients regardless of presenting issue and have no relation to the theoretical orientation of the therapist themselves. However, attending to outside client factors may link the common factors theory to particular techniques and theories, as different theoretical orientations have different approaches to investigating and strengthening a client’s outside life factors. For instance, Dohaney and Miller (2000) offer four suggestions to tending to a client’s outside forces in a therapeutic and enhancing way: being change focused with clients, alerting client’s to changes present and future, keeping the client’s competence and control for change in the forefront, and using the client’s world outside of therapy as a true support system that can be included within the therapeutic process.

Another large component that may be considered an extra-therapeutic factor is the client’s preference for the type of treatment. It may be trite not to consider that a client’s preference would have an impact on their response to therapy. Regarding a meta-analysis previously conducted by Swift and Callahan (2010), “this review found that clients who were matched to their preferred treatment were about half as likely (odds ratio [OR] = 0.58) to prematurely terminate compared with other clients” (p. 1218). We may not be able to predict an individual’s response or connection to particular types of therapy via evidence-based practice, so this may need to be gauged through the use of careful questioning throughout therapy as well as careful observation by an empathic therapist. In further support of the importance of client preferences as an important extra-therapeutic factor, Swift and Callahan (2010) regarding their study of 57 adult clients’ state:
It was found that clients were willing to receive a significantly less effective intervention by (a) 49% to ensure that their therapist was empathic and accepting, (b) 38% to ensure that a therapeutic relationship could be developed, (c) 35% to ensure that sessions were client directed, and (d) 26% to ensure that their therapist was more experienced. (p. 1226)

This evidence is in support of the fact that client preference, as well as other extra-therapeutic and common factors, are significant when considering what types of treatment to use with clients whether they are considered evidence-based or more humanistic in nature.

Another extra-therapeutic factor is focusing on a client’s unique change process, as this is one way to bridge a client’s outside life forces with the therapy session. Clients will likely change more outside of therapy than they will within the therapy session based on the much larger amount of time spent outside of therapy. Discussing outside transformations and reflecting on the client’s belief about how they are affecting their own change may be beneficial in linking therapy to short and long-term changes, as well as fostering client hope and belief in their own ability.

**Placebo Effect/The Dodo Bird Hypothesis**

As stated in the common factors overview, the *dodo bird* hypothesis was brought forth by Saul Rosenzweig’s 1936 article, and though this was a short paper of only four pages, the implications for psychology research and the concept of success in therapy was forever changed (Hansen, 2005). The idea behind the *dodo bird* hypothesis comes from Rosenzweig’s relating varying psychotherapeutic techniques and theories to the dodo bird in Alice and Wonderland who proclaimed that “everybody won, and all must have prizes” (Rosenzweig as cited in Hansen, 2005, p. 210). The idea behind this concept is that it is not the theory or particular techniques that a therapist uses or aligns with that contributes to the success or failure of psychotherapy, but
the common factors that a therapist embodies regardless of their theoretical stance. Rosenzweig therefore started the entire concept of common factors as well as the still raging debate of whether certain techniques or theories are superior to others; he concluded that “there may be common factors that cut across the different treatments and these may account for the effectiveness” (Rosenzweig as cited in Weinberger, 2002, p. 68).

The concept of common factors were provided by the aforementioned conceptualization regarding what really causes change, and this has spurred continually changing categories of common factors as well as research regarding their effectiveness. The original factors provided by Rosenzweig have changed over the years and have been expanded and re-titled, yet the underlying concept of all therapeutic ideologies being equally successful if they include common factors has survived (Weinberger, 2002). Regarding the therapeutic alliance, Weinberger (2002) states, “Hovarth and Symonds (1991) conducted a meta-analysis on empirical studies examining the therapeutic alliance and found a reliably positive effect across all forms of treatment” (p. 69). It is possible that all theoretical orientations have some facet of forming a therapeutic relationship and this is just one part of any theory. Yet this does not take away from the research showing that therapeutic alliance is highly correlated to successful change in therapy.

For an Adlerian psychotherapist it is refreshing to consider the *dodo bird* hypothesis as Adlerian theory encompasses all of the common factors and is dedicated to seeing the individual as truly unique. Much of Adler’s concepts and views relate greatly to the idea that a theory is only as complete as its ability to be holistic and flexible in order to meet the needs of each unique client. The *dodo bird* hypothesis, contrary to some beliefs, is not stating that psychotherapy is a placebo treatment and that any type of random talk or communication will
suffice. Regarding the overall effectiveness of psychotherapy, not a particular theory or technique, Hansen (2005) states:

Smith (1982) provided an overview of the original work and some subsequent refinements. The average effect size for psychotherapy was found to be 0.85, a large effect. This meant that the average person who received psychotherapy was better off than 80% of those who did not . . . (pp. 210-211)

It is important that the profundity of the dodo bird hypothesis not be overshadowed by claims that this concept has anything to do with psychotherapeutic effectiveness as a whole. The placebo effect may only be valid in controlled medical drug trials in this writer’s opinion, as one may not be able to control for all variables in a psychotherapeutic setting with unique human beings and their one of a kind worldviews.

Duncan (2002) reflecting on a study by Bergin and Garfield (1994) concludes that “Although the actual figures vary among observers, it is estimated that there are now more than 200 therapy models and 400 techniques” (p. 34). With this number of available techniques and therapies it is likely not beneficial, if not antithetical, to continually compare the minute details of one against another. This is not to say that continuing to seek evidence regarding theories and techniques is not necessary and credible, but that there may be more that combines theories than that which separates. If the competition can be disregarded and the dodo bird hypothesis embraced to an extent, than all theories can work in a united approach to incorporate common factors into each and every concept and technique. Through this united front, differing theories can also work as a unified system that looks at the overall benefit to clients through working together and linking, not dividing, ideas.
Evidence-based Practice Overview

There are specific criteria that must be met in order for a therapeutic intervention or factor to be considered an evidence-based practice. The technical list is extensive and detailed and encompasses; at least “two between-groups design experiments” showing that a particular treatment is “either (a) statistically superior to pill or psychological placebo or to another treatment or (b) equivalent to an already established treatment in experiments with adequate sample sizes” (Norcross & Wampold, 2011, p. 100). Empirically supported treatments (ESTs) encompass an even more extensive list of standards that must be met for a technique to fit within the title of EST. It appears at times that the term adequate sample size is open to interpretation based on those reviewing the study. Additionally, there must be treatment manuals explaining the exact process of the intervention and these studies must be “conducted by at least two different investigators” (Wampold, 2012, p. 100). There are more stipulations beyond these guidelines if an intervention or factor of change is to be included in SAMHSA’s National Registry of Evidence-based Programs and Practices (Wampold, 2012).

In more general terms, evidence-based therapies and techniques are looked at in regards to “efficacy” and “clinical utility” (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 272). Efficacy regarding evidence-based practice is based in the idea that particular techniques or treatments are efficacious in treating the disorder(s) that they are designed to treat (APA Presidential Task Force on Evidence-Based Practice, 2006). Regarding the broad concept of clinical utility, The APA Task Force on Evidence-Based Practice (2006) writes, “The clinical utility dimension includes a consideration of available research evidence and clinical consensus regarding the generalizability, feasibility (including patient acceptability), and costs and benefits of interventions” (p. 272).
Clinical consensus is a broad term and may allude to certain techniques being characterized as more generalizable and feasible than others possibly based on financial backing or the clinicians behind the technique. This is of course the opinion of this writer, yet it seems that theories and techniques with larger outputs of income often find their way into being considered efficacious treatments possibly based on the ability to be studied in a way that fits into the model considered evidence-based. Evidence-based practices also consider cost benefit ratio regarding the theory or technique being studied. Stating more about cost and efficacy, the APA Task Force on Evidence-Based Practice (2006) writes, “The goals of evidence-based practice initiatives to improve quality and cost-effectiveness and to enhance accountability are laudable” (p. 273).

Not to state that cost efficiency is not important or that accountability is not necessary, yet these terms may need to be redefined for the field of psychotherapy and not translated over from the medical model itself. These terms and variables may be valid categories within a medical model of treatment, yet regarding psychotherapy it seems tenuous to think that the successes regarding therapeutic endeavors can be assessed based on cost effectiveness. Especially since some efficacious treatments have yet to be labeled in a way that allows for the adequate study of an intervention, such as the aforementioned common factors of therapy.

Much of the evidence-based movement has a valid reason for implementation of this scientific medical model process. As stated by the APA Task Force on Evidence-Based Practice (2006), “A perception existed in many corners of the health delivery system that psychological treatments for particular disorders were either ineffective or inferior to pharmacological treatment” (p. 272). It appears as a defense against psychology being discredited, some researchers and clinicians partook in attempting to bring psychology into the accepted realm of
the medical sciences via folding the unique concept of psychotherapy into the existing paradigm of the medical model, which deals with pharmaceuticals and surgery, not the depths of an unknown psyche. Thomason (2010) discussing research from Hunsberger (2007) concludes that using only the EST model may be unwise and may create even more overlap between the medical model and psychotherapy, which may eventually lead to psychotherapy no longer being a separate science. The idea of the evidence-based movement is not necessarily without merit, yet maintaining psychotherapy as a unique and separate entity from the medical field may be greatly beneficial to the science of psychotherapy as well as to those clients whom are treated.

Acknowledging the previously highlighted need for a distinct psychological science, evidence-based practices and empirically supported treatments do still have a place within the umbrella of psychological treatments. Researching technique and theory in order to further the available knowledge for therapy practitioners is likely a necessary requirement in continually providing high quality care to clients and promoting life-long learning. Regarding the overall definition of responsible and important research efforts, Collins, Leffingwell, and Belar (2007) state, “Research evidence refers to the most recent clinically relevant scientific knowledge with special attention to issues of effectiveness, power, accuracy, and safety” (p. 658). This definition provides the outline for why evidence-based practice and research is vital, as practitioners desire to provide effective and safe treatment to clients that have the highest likelihood of success.

The issue may lie in whether a third party payer is the deciding factor on whether a practitioner uses particular theories, techniques, or approaches. If a therapist must prove within strict parameters that a therapeutic approach is always more successful with each client, or more likely successful with particular disorders, then the uniqueness and true humanity embedded within the ideal of psychology could be lost. In order for treatments to be seen as evidence-based
or empirically supported, it seems that clients must be seen through the lens of a disorder in need of treatment versus a unique human being with ever-changing needs.

The evidence-based movement has benefits and is not to be disregarded due to the focus on disorders versus people. Evidence-based practices do allow for clinical expertise, client preferences, and the uniqueness of the individual to be considered when judging treatments that are shown to be evidence-based (APA Task Force on Evidence-Based Practice, 2006). Regarding this flexibility within the evidence-based movement, Clement (2013) discussing the 2006 study by the APA Task Force, acknowledges that psychotherapists must judge the evidence that is attained from research and consider their unique style as well as the client they are working with when deciding if a technique is right in a certain situation and realize that many factors are involved in therapeutic success and not just the technique itself.

An important reminder regarding the evidence-based movement is that research into quality treatments needs to continue and simultaneously the individuality necessary for authentic psychological interactions must be researched and maintained in high esteem as well. Though common factors have shown to be of high importance regarding change in psychotherapy, therapeutic training must also teach practitioners the importance of research and learning about evidence-based treatments; why they are effective and the need to continue to be accountable for techniques and theory’s used with clientele (Collins et al., 2007). Evidence-based practice can be undertaken in an individualized way while simultaneously staying true to the facets of what it means to be evidence-based. Collins et al. (2007) purport that evidence-based research and practice must encompass, not just the technique or theory that has been proved effective, but also the individuality of clinical skill held by each practitioner and the worldview and values of each client as well. This broader definition of EBP allows researched techniques to continue to be
lauded as necessary and important, allows for the continuing need for evidence-based research and study designs, and allows for psychotherapy to remain separate from the medical model or the one size fits all designs of many drug trials.

**Mutually Exclusive or Combinable**

Common factors theory, evidence-based practices and empirically supported treatments appear to be mutually exclusive regarding research, reviews, and treatment. Yet, this writer believes they can be used in conjunction with one another through using a wider lens when investigating treatments in general. Furthermore the need for competition must be considered likely detrimental in regards to theory research and practice. As the *dodo bird* hypothesis had put forth, all are winners and therefore all must have prizes. This statement is often taken to say that theory and technique have no purpose, yet this is not the point behind this declaration; it is purporting that there are underlying factors that contribute to the success or failure of each technique and theory. Broadening research to encompass common factors that lead to higher therapeutic success is the point behind the hypothesis, not to charge that no theories should exist. The conclusion seems to be that theories could be considered insufficient in and of themselves, or that common factors are always at play even if they are not given credit or included in the research (Laska & Wampold, 2014).

Swift and Callahan (2010) acknowledge that evidence-based practice, when considered in its truest form and not convoluted by using the title to prove one technique is superior to another, does include consideration of unique client attributes. This does not necessarily take into account the myriad of common factors that may need to be considered and have shown to provide efficacious treatment outcomes, yet does allow for fluidity in applying evidence-based techniques to individuals. Client characteristics and preferences are encompassed within the
common factors under client motivation and extra-therapeutic factors, yet there are at least four other common factors that may need to be considered when looking into evidence-based research; therapeutic alliance, empathy, hope and expectancy, and unconditional positive regard.

It is quite difficult to fully separate common factors from evidence-based practices; how can we know if a therapy is due to technique or due to the relationship or empathy of the practitioner? Even in a controlled atmosphere, with a manual guiding a practitioner’s use of technique, we cannot take the humanity out of the interaction (Sexton, 2007). Psychotherapy is a human healing experience with interaction at its core, and the interpersonal process of working together with clients is deeply personal and possibly cannot be excluded from defining if a theory or technique is evidence-based. This being said, psychology is still caught in the web of needing to prove treatment efficacy in order for insurance reimbursement to continue and in order to stay competitive based on a medical model of science that has somehow been placed over the science and art of psychotherapy (Reisner, 2005). Psychotherapy is a unique human science and comparing it to medication trials or biological studies, though not necessarily forthright, may continue to be a necessity. As you can see based on the research throughout this review, it appears that proponents of evidence-based treatments may be threatened by the concept of common factors and their inclusion in the efficacy of psychotherapy, yet common factors theory does not negate the importance of evidence-based practice or purport that research should be halted.

The fear that seems to emanate throughout psychology research regarding the dodo bird hypothesis and the conclusion that psychology need not remain separate from the medical models dictations is at times prominent within research that is in support of empirically validated treatments. Regarding this fear, Reisner (2005) discussing a review from Lohr, Fowler, and
Lilienfeld (2002) determines that some practitioners will only identify with empirically supported treatments and some would even have practitioners that participate in using treatments that are not evidence-based sanctioned or reprimanded. This seems to challenge the idea that psychology must remain a unique entity and refuse to be classified by the medical models rules and regulations. With the evidence and case study support for common factors as a valid and highly important aspect of therapy, concluding that all treatments must be empirically validated and scientifically proven, may take the humanistic nature out of a humanistic endeavor such as psychology.

Ideally, there would be a blending of common factors theory and evidence-based theory within the concept of empirically validated treatments (Beutler, Forrester, Gallager-Thompson, Thompson, & Tomlins, 2012). The common factors of empathy, unconditional positive regard, extra-therapeutic factors, the therapeutic alliance, hope and expectancy, and client motivation may need to be encompassed within each evidence-based research endeavor. The separation of the two outlooks likely only leads to competition and confusion within psychology as a science and an art. This competition may inhibit the growth of psychotherapy as a humanistic science that can form its own ideas of efficacy, rather than trying to force it into the existing boundaries of a different healing practice.

Years of psychology research has often failed at distinctly setting one theory or technique above another and at best has shown certain treatments to be possibly more efficacious regarding certain disorders (Beutler et al., 2012). As a healing practice that works with the most humanistic of all endeavors, are we looking to treat a disorder or set of disorders, or are we looking to treat the human condition? Beutler et al. (2012) created a study in which they did purport that evidenced treatment techniques and common factors are not mutually exclusive and that
combining and broadening how research is conducted can bridge the two sides of this debate for the benefit of greater knowledge and client success. Regarding the division of human factors from evidence-based practices, the authors state, “It appears short-sighted to study the so-called ‘specific’ effects of psychotherapy separately from relationship and patient (so-called common) factors,” and they go on to state, “Evidence of consistently strong interdependence among relationship and treatment factors argues for more complex methodologies than the randomized clinical trial paradigms that are currently in vogue” (2012, pp. 278-279).

If psychotherapy were to take a stand as a psycho-social model of healing, possibly the joining of evidence-based and common factors could take a natural progression toward what is best for clients as individuals rather than what furthers psychotherapy as a science within medical models ideals. Psychology is a humanistic endeavor and common factors seem to play a large part in whether therapy is considered useful by clients. They are also related to therapy attrition and who can be helped if therapy is terminated prematurely do to a lack of humanity within the techniques used (Swift & Callahan, 2010)?

Psychotherapy is a social healing endeavor and this sociality should not be lost in the pursuit of proven treatment effectiveness as “there is something intimate between being human and using healing practices – the connection is made through the vector of sociality” (Wampold, 2012, p. 445). I believe Wampold (2012) sums it up fluently stating, “Psychotherapy creates change through connectedness, expectation, and mastery” (p. 446). This statement encompasses the idea that we need common factors, as we are working with unpredictable social beings. Simultaneously there is a need for mastery of theory and technique as it is more than the conversation alone that aids in the true process of longstanding change.
Adlerian Psychotherapy Overview

A brief history on Alfred Adler’s theory is provided in hopes that the reader has some reference as to how his life’s experiences likely influenced the Adlerian concepts discussed in this paper. Adlerian psychotherapy was created by Alfred Adler through a process of learning and devoting his life to the betterment of society, as well as to individual clients and their need for belonging, acceptance, and direction in life. Alfred Adler had 7 siblings and went through many health issues as a young child (Ellenberger, 1970). He also lost his brother to illness, which eventually may have propelled him into the medical field; first being licensed as a medical doctor specializing in the field of ophthalmology (Mosak & Maniacci, 1999). Adler overcame many physical limitations throughout his life and his possible compensation for these limitations and the inferiority feelings than can accompany them, may have driven him into the service of helping others. Adler was born and raised in Vienna and went to medical school at the University of Vienna in 1895 (Mosak & Maniacci, 1999). He was married in 1897 to Raissa Timofeyewna Epstein who was considered “a socialist and a feminist” which possibly contributed to some of Adler’s beliefs in the equality of all (Mosak & Maniacci, 1999, p. 2).

It is important to note Adler’s beginning as a sickly child, his perseverance into medicine, and his belief in society’s ills affecting the overall physical and mental health of each human being (Mosak & Maniacci, 1999). This belief in the social impact of one’s life on their health, mental and physical, is a thread woven throughout Adler’s work in psychology and beyond. Adler’s viewing mental health systemically seems related to the idea of common factors being important in the field of psychotherapy. Common factors take into account the socialness and worldview of each and every client, seeing the client as a whole person that is affected by their world, rather than as a diagnosis. Regarding Adler’s belief in this social link to health, Mosak
and Maniacci (1999) state, “He observed that many of the patients who sought his services suffered from diseases that traced their origin to the social situations in which they lived and worked” (p. 2). Linking the social influences of one’s life, from early childhood on, is one of the consistent beliefs that Adler contributed to the world of psychology. Common factors theory stresses the humanistic and social nature of working with clients, as did Adler, and sees psychotherapy as a social influence and humanistic endeavor (Wampold, 2012).

Adler’s theory, known as Individual Psychology, has at times been misunderstood. The name Individual Psychology is sometimes misinterpreted. Though Adler’s psychology is centered on each unique individual, it is also a social psychology that considers all of a person’s surroundings and interactions with others as pertinent to understanding the individual. Regarding the holistic and all-encompassing meaning and nature of Adler’s Individual Psychology, Carlson and Slavik (1997) state:

A cornerstone of Adlerian psychology is the belief that people are indivisible, social, creative, decision-making beings whose beliefs and behavior have a purpose. Therefore, the individual is best understood holistically as a total being whose thoughts, feelings, and beliefs are present in a consistent and unified pattern of actions. (p. xi)

Adler purported that every person had the power to heal and that seeing people as disorders versus creative human beings capable of change did little neither for the health of individuals nor for the progress of psychology as a whole. Through this review, it will become evident that Adler’s positions and concepts are well aligned with the common factors theory and the idea that psychology need not be about disorders, but about the hope and ability for change that lies within each individual regardless of their current struggles. Adler’s concepts are also behind many of today’s psychotherapeutic theories, those with evidence-based practices such as
cognitive therapies, and those more aligned with the ideals of the common factors such as humanistic psychology (Peluso, Peluso, Buckner, Curlette, & Kern, 2004). Regarding the impact of Adler’s unprecedented work in psychology, Osborn (2001) discussing a paper from Sweeney (1998) concludes that Adler’s theory can and has been thought of as a precursor for many other psychological concepts.

Though Adler died in 1937, his work has been carried on and preserved by many of his loyal followers such as, “Rudolf Dreikurs, a psychiatrist who originally studied with Adler in Vienna . . . ; Dreikurs’ colleagues, Bernard Shulman and Harold Mosak; [and] Adler’s children, Alexandra and Kurt; and Lydia Sicher” (Mosak & Maniacci, 1999, p. 7). Adlerian therapy is linked to common factors in many ways, one of them being that some purport that there is a lack of empirical evidence regarding Adlerian concepts and techniques (Watkins, 1982). This being said, Adlerian theory has shown successes case-by-case as well as empirically regarding evaluation techniques such as the BASIS-A Inventory that gathers information on an individual’s lifestyle (Peluso et al., 2004). Yet, again the question arises regarding if psychotherapy, the science of understanding and healing humans, should be subjected to a medical model of scientific proof. Within Individual Psychology there are four main stages of therapy: the therapeutic relationship, exploring the lifestyle of the client, interpreting the information psychologically, and reorientation (reframing) of the client’s beliefs and perceptions (Eckstein, 1997). The concepts reviewed in this paper and those not covered are used throughout the process of each of the aforementioned stages of Adlerian therapy.

Reviewing all of Adler’s concepts would be beyond the scope of this paper and though a particular set of concepts have been chosen by this writer to be elucidated upon, this is not in any way to put forth that any Adlerian concept is more necessary or more integral to the theory as a
whole than any other. Adlerian theory has the holistic nature of being all encompassing and though the concepts are each individually important, they also flow fluently from one to the next illuminating a larger picture of humanity, social embeddedness, and mental health. Writing about the Adlerian meaning of holism and the socialness of Adlerian theory, Bitter (2007) discussing information from Ansbacher and Ansbacher (1956) concluded:

Adler used the concept [holism] in two ways: First, to keep his psychological formulations focused on the indivisible whole of the individual rather than parts or elements of a person (hence the name Individual Psychology); and second, to emphasize that individuals live in contexts (or fields) and must be understood within the social embeddedness of their lives. (p. 5)

The Need to Belong

The need to belong, or belongingness, underlies all of Adlerian psychology and works together with the other concepts; as each Adlerian concept is interconnected. This concept ties to the idea of Social Interest and social embeddedness, but is covered separately in this review as this writer believes that though it is a part of the previously mentioned components it is also a vital component within itself. The feeling of belonging is intertwined with the concept of Community Feeling (Griffith & Powers, 2007). Community Feeling is often used interchangeably with Social Interest yet they are separate concepts in this writer’s opinion. Community Feeling and belonging are more of an actual feeling or sense of being and Social Interest is more of an action or concept we become a part of. The need to belong starts in early childhood within one’s family unit and continues throughout the lifespan. The need to belong regards a person feeling as if they truly are a part of something bigger than themselves, as well as accepted and needed within the family, community, and eventually the world at large (Ferguson,
2010). Many have purported that Rudolf Dreikurs coined the concept of the need to belong, yet he was a student of Adler and was possibly trying to take an abstract concept and create a more understandable term for Americans and future proponents of Adlerian psychology. This is not to say Dreikurs has not been insurmountably important to the movement of Adlerian psychology and has contributed enormous gains to Adlerian concepts and the overall theory as a whole.

The concept of the need to belong can stand alone, as it is quite straightforward that one must feel accepted and as if they belong to a greater whole in order to deal with the complexities of life and strive for mental health and acceptance. Yet, this concept also overlaps with the ideas of inferiority and the inescapable fact that we are social beings (Ferguson, 2010). The need to belong and community feeling are in-depth beliefs within oneself that we belong within the world and are accepted for who we are, as well as a needed and a contributing force for all humankind. Bitter (2007) succinctly describes Community Feeling as being within the individual stating, “Community feeling is related to the feeling of being in harmony with the universe and with the development of life throughout time” (p. 14).

This need to belong, as stated, starts within the family as a young child; we need to feel as if we truly fit in to the fabric of the family and are a necessary and loved member of the group. This belongingness then extends beyond family to include peers, community, those we work with, and eventually the world in general. Regarding the importance of the need to belong, Ferguson (2010) states, “Feeling belonging is crucial for the mental health of the individual, and at the societal level it is crucial that all members of the community feel belonging” (p. 2).

As with the majority of Adler’s concepts, the need to belong goes beyond the individual desiring change, and takes into account the health and well-being of all communities at large and the world as a whole. There is evidence that the need to belong is an important factor regarding
mental health and research that displays belongingness being correlated with decreases in depression and stress (Curlette & Kern, 2010). The need to belong can also be linked to the next concept of Social Interest and social embeddedness as “Adler’s advice to a depressed individual [was] to help someone else. Helping someone else helps a person feel belonging” (Curlette & Kern, 2010, p. 40). A sense of belonging, in this writer’s opinion, links closely with the common factors of the therapeutic relationship, empathy, hope and expectancy, and unconditional positive regard. These common factors may aid in a client’s initial sense of belongingness, which can then further the client’s ability to undertake therapy on a more authentic level. This may then help clients bring this sense of belonging out into their everyday lives knowing that they are accepted.

**Social Interest and Social Embeddedness**

Social Interest is as it sounds by the name, being socially interested in others and using this social interest to reach out and help others through service. As mentioned previously, Social Interest is interwoven with the concept of Community Feeling and belonging. Some see them as interchangeable concepts, yet this writer believes they are different. Social Interest involves a state of feeling socially interested in others as well as actions involving interaction with others. The concepts of belonging and community feeling are sentiments deep within an individual of unconditional acceptance and oneness with others. Carlson, Watts, and Maniaci (2006) describe the difference and relation between Social Interest and Community Feeling by surmising that Community Feeling is mostly an attachment emotion between others and Social Interest is the actions that take place due to this feeling of interconnectedness. As you can see, possibly Community Feeling cannot be obtained without Social Interest and Social Interest not obtained without Community Feeling; so they are likely irrevocably combined.
Within Social Interest are the Adlerian ideas of socially useful and socially useless behavior (Carlson et al., 2006). Socially useful behavior is what compels others to partake in helping one another and humanity in general and these actions bring the reward of belonging and being a part of a community (Carlson et al, 2006). Also within the concept of Social Interest is the Adlerian idea of social embeddedness. We are all social beings and our issues come forth in social contexts and therefore, as with Social Interest, healing must take place within social contexts. The idea of Social Interest, at its core, is about individuals helping others and therefore stepping outside of themselves. This is not necessarily about volunteering or direct acts of work for one another, though it certainly can and does encompass this, yet it is also thinking about others and the world at large and how one can contribute to friends, families, communities, and the planet.

All problems regarding mental health may need to be considered in the social realm and therefore social solutions, as well as individual unique solutions, may need to be correlated together to help individuals receive change and healing (Griffith & Powers, 2007). Regarding the necessity of seeing individuals holistically and within their social worlds, Griffith and Powers (2007) state, “Individual Psychology accepts the viewpoint of the complete unity and self-consistency of the individual whom it regards and examines as socially embedded. We refuse to recognize and examine an isolated human being” (p. 28). Taking Adler’s idea of social embeddedness into account it seems likely that Individual Psychology led the way regarding the numerous social psychologies that were to follow.

**Inferiority Feelings and Encouragement**

Inferiority feelings and encouragement are linked due to the fact that through encouragement and the courage to be imperfect, one can overcome inferiority feelings.
Inferiority feelings are another concept within Adlerian psychology that is at the heart of the theory and works with the other concepts holistically and also stands alone as an integral concept. Adler believed that children were born into a position of inferiority, as they must rely on others for all of their needs including the utmost need of survival (Griffith & Powers, 2007). Describing the overall definition of the Adlerian concept of inferiority feelings, Griffith and Powers (2007) state “Inferiority feelings . . . are those universal human feelings of incompleteness, smallness, weakness, ignorance, and dependency included in our first experiences of ourselves in infancy and early childhood” (p. 60).

Inferiority feelings are not neurotic in and of themselves and are not to be confused with an inferiority complex. Due to space allowed, the inferiority complex will not be highlighted in this review. All human beings, in every part of the world, experience some form of inferiority feelings and the aforesaid concepts of belonging and Social Interest are ways that one can cope with the inevitability of inferiority feelings. This is related to the overall idea of common factors as an empathic therapist genuinely bonding with a client may be the beginning of the client feeling accepted and therefore being able to confront inferiority feelings.

Beyond the scope of this paper is the realization that inferiority feelings are linked to the striving for superiority amongst all people, particularly those separated from Community Feeling (Bitter, 2007). Though the concept will not be fully discussed, it is important to note that working with the realization of inferiority feelings in our clients and bringing in the concept of belonging can help alleviate the clients’ desire and necessity to strive for perfection and superiority; which may ultimately lead to disconnection and dissatisfaction. Realizing that all people have inferiority feelings does not make them unimportant as this understanding is possibly needed regarding quality mental health and psychotherapeutic practices.
Accepting the idea of inferiority feelings and knowing they exist in all clients is where the concept of encouragement comes in and becomes an important therapeutic tool. Encouragement is highly related to the ideals of the common factors theory, which will be eluded to again later in this review. Encouragement is a straight forward word, yet encompasses more than just a systematic routine of offering verbal encouragement to clients in the face of their struggles (Carlson & Slavik, 1997). Encouragement needs to be authentic and provided to the client via genuine transference of belief in their ability and also belief in the control they have over their lives, thoughts, feelings, and changes.

The opposing side of encouragement is the concept of discouragement. Clients facing inferiority feelings can become discouraged in the face of life, which may create a feeling of separateness from others. Encouragement comes in many forms, from the explicit expression of genuine encouragement for our clients, psychoeducation regarding the courage to be imperfect, and implicit encouragement through a therapist’s internal beliefs in clients’ abilities and their nonverbal transference of this belief. Regarding encouragement in action and group therapy clients, Carlson, et al. (2006) state, “It is the ability of the therapist to discover the assets and abilities of each group member. From that knowledge, encouragement helps the members to consider alternatives” (p. 226). Though this relates to group therapy, the same concept takes place in individual therapy. Clients struggling with mental health issues are often saturated in discouragement and negative life narratives. Through genuine encouragement from therapist to client, a client may be able to see new and or more useful narratives or explanations for situations in their lives, as well as seek out new experiences and strive for acceptance among others and themselves.
Mistaken Beliefs

Mistaken beliefs seem to be related to what today is considered cognitive therapy. Adler believed that through an individual’s unique perceptions of the world, their experiences were categorized and defined, which then formed a client’s belief system. These beliefs are not always formed out of reality or in the best interest of the client; they may be formed out of a client’s perception of their life experiences, particularly early childhood experiences. Mistaken beliefs are linked to common factors theory as therapist empathy and the therapeutic relationship are both possibly impacted by mistaken beliefs. A therapist needs to be willing to enter the client’s private world, through empathy and the relationship, in order to learn about a client’s interfering ideas.

Mistaken beliefs are also often defined as interfering ideas and though it is debated whether these are separate concepts, for the sake of this review the concepts are used interchangeably to encompass the wide array of ideas a client may hold as true that are in fact created by them. Individuals hold mistaken beliefs surrounding their idea of themselves, their view of others, and their view of the world. All individuals create mistaken beliefs, yet some are more useful and less harmful than others; whereas others are more insidious and detrimental to a client’s overall mental health.

Within the concept of mistaken beliefs, is the concept of biased apperception. Biased apperception is the unique perspective of each individual and their ability to define and perceive all events as they choose. Adlerians see clients as the actor and the creator within their life, and though they have accumulated mistaken beliefs, they also have the power to change these beliefs. There is a connection between biased apperception and the common factors model that will be further examined in this review. Mistaken beliefs and biased apperceptions fall within the
Adlerian concept of the *lifestyle*, it is beyond the scope of this paper to define lifestyle, yet it is important to know that *lifestyle* links all that an individual knows, believes, feels, and perceives to their overall assumptions of life (Carlson et al., 2006).

Overall, mistaken beliefs are created by clients, not in a purposeful type of deception to themselves or others, but based on an attempt to make sense of their world. This creation is directed by that which the client chooses to perceive. Some beliefs are in benefit of the client and other interfering beliefs are a disservice to the client and need to be dissected and replaced in order for the client to move forward with a healthier life view. Reframing is a concept that is helpful regarding mistaken beliefs, and though used in widespread psychology today, is based on the Adlerian concept of reorientation and reeducation (Eckstein, 1997). An Adlerian therapist strives to understand an individual’s mistaken beliefs and then to offer alternative perspectives that perhaps the client had not considered previously or even knew were possible (Eckstein, 1997). In describing how the Adlerian concept of reorientation and reeducation can assist clients with replacing interfering ideas, Eckstein (1997) discussing research from Strong and Clairborn (1982) determines:

> The counselor presents a point of view that is discrepant from the client’s frame of reference and attempts to lead the client to experience a new perspective and coherent meaning. If the counselor’s alternative and discrepant point of view is assimilated by a client through an interpretation, the individual begins to construe phenomena differently, and as a consequence, is positioned to act more adaptively. (p. 419)

This is a technique of Adlerian therapy, yet is still in line with the common factors of empathy and hope and expectancy, as it involves acknowledging the client’s perception of their issues while working collaboratively toward change, improved courage, and greater mental health.
**Everything Can Also be Different**

The concept of everything can also be different is an important caveat and a reminder that therapists are not to see clients as disorders or assume they know what a client is going through based on experience or representation of issues. Every client has a unique way of viewing the world and therefore a unique way of comprehending problems, stressors, and issues presented in therapy. If we are to only rely on evidence-based practices looking to solve a particular diagnosis or problem, we may be missing the true uniqueness of each client and the fact that no client may ever truly be known; or at least not categorized based on behaviors and reported thoughts and beliefs.

Assumptions about client issues, whether this includes diagnosis or other factors, may be a mistake and one that could lead to an over belief in particular techniques or theories. This is where a possible issue with evidence-based treatments used in a blanket fashion becomes an issue, as being that everything can also be different, particular techniques cannot theoretically be used on all people with similar issues since they are each unique. Regarding the uniqueness of each and every client, which leads this writer to have cautions regarding widespread use of techniques for disorders over individuals, Griffith and Powers (2007) quoting Adler state:

> Perception can never be compared with a photographic apparatus; it always contains something of the individual’s uniqueness. Not everything one sees is also perceived, and if one asks for the perceptions of two persons who have seen the same picture, one receives the most varied answers. The child perceives in his* environment only that which . . . fits his previously formed uniqueness (p. 210). (p. 6)

This statement regarding unique perception pertains to the client as well as the therapist. The therapist is after all a human being who holds their own biases and perceptions and this is the
reason the concept of everything can also be different is important to remember, including when using evidence-based techniques and theories. As regardless of evidence, we cannot be sure that we are seeing a client and their struggles in the pureness that they are truly experiencing them.

**Early Recollections and the Process of Change**

Early recollections are an Adlerian specific technique that have a projective quality and they use seeming past memories or dreams to provide insight into client’s current issues, mistaken beliefs, struggles, strengths, and current states of being. Gathering an early recollection (ER) pertains to having a client tell, in detail and from the time remembered, a specific story (memory) from a particular time in their life. The recollection is usually recalled from sometime in earlier childhood or early adolescence. The material obtained through the ER and its overall use is related to the fact that in an ER, “persons reveal through the remembered incidents and their feelings about them, their nascent attitudes toward themselves, their relationship to others, and their views of life” (Carlson & Slavik, 1997, p. 305). In other words, though the recollections are brought forth based on past memories, through an Adlerian lens, they actually represent how the client is currently relating to the world around them. The stories clients remember or bring forth are those that mirror their present day assumptions and issues as well as their present day strengths, dreams, and goals.

Regarding one evidence-based study of early recollections (ERs) that was undertaken by Eckstein in 1976, Watkins (1982) discusses that Eckstein found pronounced changes in ERs that clients provided post-therapy as compared to those provided pre-therapy and that the differences in the ERs represented a valuable assessment option for determining levels of change in therapy and possible types of change regarding beliefs, strengths, and behaviors. Being that actual recall of remembered events have been shown to undergo change post-therapy, lends credence to the
idea that early recollections are related to a client’s present time perceptions and functioning. Taylor (1975) in her article, “Early Recollections as a Projective Technique: A Review of Some Recent Validation Studies,” provides brief highlights of numerous studies that had positive results regarding the effectiveness of early recollections and their ability to predict symptoms and issues, as well as changes within clients. It is beyond the scope of this review to go into detail regarding each study represented in Taylor’s (1975) article, yet the reader is encouraged to review this material regarding evidence supporting the use of ERs as a projective technique, as well as an indicator of changes made in therapy. Most fascinating in the aforementioned article are the studies that were conducted regarding themes of ERs and their correlation to particular disorders (Taylor, 1975). Though the findings cannot be considered conclusive and were mostly correlational, they offer consistent patterns regarding a concept that deserves further research (Taylor, 1975).

Early recollections have many uses from the aforesaid projective technique all the way to rearranging the narrative of a client’s ER in order to help them overcome current problematic feelings and themes in their daily lives. Early recollections are a form of narrative provided by the client and therefore can be adapted and altered so the client can have a new more adaptive narrative to represent areas of their lives (Maniacci et al., 1998). ERs are most related to common factors when looking at the ability to create changes in client narratives and therefore changes in client beliefs. Helping clients take ownership of their narratives and change them for the better is related to building hope and the expectancy of positive change. One technique regarding ERs is the Willhite technique which is a reframing technique regarding client narratives (Maniacci et al., 1998). Regarding this technique and its benefits to the client, Maniacci et al. (1998) state, “As a therapeutic tool, reframing is a process that encourages clients
to begin to contemplate and voice the values that are likely to form the substance of their creative
movement toward more satisfying ways of being” (p. 459). The client, through proactively
changing presented early recollections, can identify how they would want to perceive a situation
and see other available alternatives to their current coping styles. One of the main concepts
behind the Willhite technique is that clients are contrasting their self-concept and current way of
perceiving with their self-ideal and the way they would ultimately like to see themselves, their
surroundings, and their abilities to deal with the world (Maniaci et al., 1998).

Overall it is important to remember that early recollections are considered related to a
client’s present state of being and keep the client in touch with their perceived goals of life and
the meaning they bestow presently to themselves, the world, and others. The common factor of
empathy can be seen as related to gathering early recollections from clients. A therapist showing
genuine interest in the clients recollection provides an empathic environment and also may help a
client feel unconditional positive regard, as the client is not judged regardless of the details of the
memory brought forth. ERs, along with other Adlerian techniques, are also related to the
common factor of the therapeutic alliance: Kern, Stoltz, Gottlieb-Low, and Frost (2009) state,
“One could propose that specific techniques employed by Individual Psychology clinicians . . .,
such as birth order, early recollections, and the social context, could be viewed as methods and
procedures that focus not only on the therapeutic alliance but also the core factor referred to as
client resources” (p. 111).

**Teleology/All Behavior is Purposeful**

According to Adlerian therapy, all behavior has a purpose and none is partaken via
happenstance. This is not to say that all behaviors have a conscious purpose. Quoting Adler
regarding the concept of teleology and purposeful behavior, Mosak and Maniaci (1999) write,
“As Adler (1927/1957) wrote, the ‘first thing we discover in the psychic trends is that the movements are directed toward a goal . . . . This teleology, this striving for a goal, is innate in the concept of adaptation’ (p. 28)” (p. 16). The concept of teleology is basically continuing in a distinct line toward a final goal regardless of changes in surroundings.

In other words, Adlerians purport that all behavior is purposeful and in the service of a client’s, likely subconscious, goal in life. A client is continually making adjustments in their life (through purposeful behavior) in order to bring themselves back in alignment with the path that leads to their fictional final goal. Though the purposes of human behavior, as well as the aforementioned final fictional goal, are likely out of a client’s consciousness, this is not to say that they cannot become aware of what is guiding their behaviors. This can seemingly be a contradiction in circumstance, being out of conscious awareness yet of one’s own construction and maintenance, yet they can and do coexist regarding movement and behaviors.

The goal behind teleology and purpose of movement, from an Adlerian perspective, is likely formed in very early childhood through the child’s interactions with others and the world and then the child’s perceptions of these interactions. Some believe that these life goals are more distinctly formed in adolescence and continually updated to an extent throughout early adulthood (Bitter, 2007). The existence of this life goal is not to state that this goal cannot change with awareness and therapeutic help through the process of cognitive change and insight into why clients may act as they do. What is important to remember is that teleology and purposeful behavior links to the previously reviewed Adlerian concepts, as well as to those not included in this review. This concept is a part of the overall holistic theory of Alfred Adler, and though is a concept in and of itself, it is interlinked with the other concepts. Teleology can be seen as one of many ways of learning about each unique client and working toward therapeutic change in a way
that puts each client’s individuality at the center of all treatment. Teleology is in line with the common factors of unconditional positive regard and empathy. With empathy and unconditional positive regard, one is more likely to learn about a client’s final fictional goal as well as gain the trust necessary to help client’s reorient this goal and their teleological path if necessary.

**Common Factors and the Adlerian Link**

All of the common factors covered in this review connect in one way to another to Adlerian concepts and theory. Though Adlerian theory is a holistic theory that stands on its own, it is also a theory that fully encompasses common factors. This is not to say that Adlerian theory is superior to other theories, as this would lead us back to the debate surrounding evidence-based practices and empirically supported treatments. This debate has not necessarily helped the field of psychology further itself as a unique field. What is to be considered by the connection of Adlerian theory and common factors is that due to the holistic nature of Alfred Adler’s theory, the common factors are built into each stage and concept within Individual Psychology.

The therapeutic relationship or alliance, considered one of the most prominent and important of the common factors is considered the first stage of Adlerian therapy when working with clients. Regarding the vital nature of this first stage of Adlerian therapy, Kern et al. (2009) state, “Lambert estimated that 30% of the explained variance in the change process can be attributed to the presence of the therapeutic alliance” (p. 111). Though this percentage changes by small amounts from research to research, it is still difficult to deny the correlation between a strong therapeutic relationship and therapeutic success, particularly regarding client attrition rates. Adlerian therapists focus on collaboration with clients as well as providing encouragement, unconditional positive regard, and a sense of belonging. All these traits are considered important regarding the therapeutic alliance and Kern et al. (2009) discussing research from Dinkmeyer,
Dinkmeyer, and Sperry (1987), Dreikurs (1967), and Mosak (2000) concluded, “Adlerian practitioners focus on the common factor of the therapeutic alliance with their emphasis of respect, mutual trust, cooperation and the importance of a collaborative approach with clients…” (p. 111).

The Adlerian concepts of the need to belong, Social Interest, and social embeddedness are also connected to the common factors of empathy, unconditional positive regard, and the therapeutic relationship. In providing clients with a safe place where they may experience fulfillment of the need to belong without judgment, Adlerian therapists are providing clients with empathy and unconditional positive regard. The idea of everything can also be different is tied to the common factor of unconditional positive regard as Adlerian therapy purports that we cannot assume we know anything about another’s struggles from a glimpse into their lives or diagnoses. Therapists must always strive to respect each client as a one-of-a-kind individual.

Social Interest is the concept of contributing to others and the world, not always through deeds, yet an overall viewpoint that is interested in others and society in general. This Adlerian concept lies within the common factor of extra-therapeutic factors. Since extra-therapeutic factors are “estimated to contribute 40% to change” (Miller et al., 1997), it would be incomplete to not consider them when looking at common factors and their link to Adlerian therapy. Though extra-therapeutic factors are not always known or in a therapist’s or client’s control, helping a client to learn about Social Interest and their need for connection to others can definitely help with issues such as building a support system outside of the therapeutic environment.

Finally, the acknowledgment of inferiority feelings and the concept of encouragement are linked to the common factors of hope and the expectations of change, unconditional positive regard, and client motivation. Adlerian encouragement is more than just words spoken to a
client. Encouragement is a true belief in the client that they hold the power to change and that they desire to live the best life possible. Regarding the link between the common factor of client motivation and the Adlerian concept of encouragement, Watts and Carlson (1999) state, “Encouragement helps clients believe in themselves and develop self-efficacy and the ‘can-do’ spirit. Encouragement creates a positive self-fulfilling prophecy that may provide the necessary momentum to move a client toward goal resolution” (p. 35). It is the opinion of this writer that Adlerian concepts and the common factors that may be necessary for successful therapeutic change are uniquely intertwined.

**In Summary**

The *dodo bird* hypothesis was stating that all theories are equal and that regardless of the interventions or beliefs held, if the common factors were in place, the theory could show success. This concept and the common factors it introduced was a profound statement produced by Saul Rosenzweig back in 1936 that set forth a debate regarding evidence-based practices versus common factors, as well as a seemingly endless drive of certain theories working to protect their superiority as valuable and needed (Hansen, 2005). The work surrounding common factors theory is profound, yet this does not negate the need for continued research into evidence-based practices. Furthermore, the common factor theory and its proponents do not reason that theories and techniques are not necessary for therapeutic efficacy.

The common factors discussed in this review show impact on therapy success and Chwalisz (2001) discussing research conducted by Wampold concludes that “Wampold (2001) estimated specific effects to account for 8% of the variance in psychotherapy outcome, general (common factors) effects to account for 70%, and unexplained effects to account for 22%” (p. 263). This research is significant, yet much further research is needed regarding defining
common factors and if it is even possible to separate them from evidence-based practice research. Future research would benefit from more distinctive definitions of each of the common factors as well as designs that can alienate one common factor from another.

Evidence-based practices and empirically validated treatments will continue to be a necessity within psychology, particularly since the medical model seems to be driving research and insurance reimbursement within the field. Though evidence-based research is vital, future research may benefit from greater separation from the medical model and striving to create unique language and research designs that are unique to the science of psychology. This may consist of deconstructing the current system of what is considered needed when conducting research; or possibly creating a new system of research variables that can remain separate but equal to those considered necessary for evidence-based techniques. In other words, it may take building new types of research parameters and rules that are distinct and separate from those currently in use.

Issues can take place when evidence-based or empirically validated treatments become the only considered option for therapists. Such as a loss of flexibility for clinicians to use judgment in determining at times what is in the best interest of a unique client. Control of psychotherapy itself may be in danger of lying in the hands of policies, politics, and insurance companies whom are often considering cost-effectiveness or the medical model ideals when deciding what will be allowed regarding client mental health and well-being (Chwalisz, 2001). Ideally the evidence-based movement would strive to encompass common factors within research endeavors and realize it is not techniques or theories that need defending, but the right of clients to the best individualized treatment that psychology can offer.
Though it may appear that common factors theory and the evidence-based movements are at odds, this does not need to be a necessary division. As mentioned previously, they are not mutually exclusive and could work together for the best interest of clients. Psychology as a diverse and unique science could possibly lose importance and value in the face of camps divided.

The *dodo bird* hypothesis and advocates of common factors do not believe that theory and technique are not of great value and do not imply that conversation and empathy alone are therapeutically salient (Laska & Wampold, 2014). What may be necessary regarding differing theories and techniques is that the therapist believe wholeheartedly in the theory they subscribe to as the change agent for clients and that they embed common factors within all of their therapeutic approaches. Fife et al. (2014), referencing a study conducted by Wampold in 2001, which many believe is an attempt to state that only common factors are important and not technique or theory state, “Wampold’s study suggests that an effective therapist (a) offers a credible rationale for understanding the client’s symptoms and (b) offers a plausible procedure – including relevant and effective techniques – for addressing the symptoms (see also Davis & Piercy, 2007a)” (p. 23).

What is important regarding theory and technique is that the therapist’s worldview be in line with the theory they support and that they fully believe the theory can and will produce change, as well as the therapist blending the common factors into their therapeutic work as it appears one cannot be successful without the other (Lundh, 2009). Ideally psychology as a field will attempt to alter the ways that theory and technique are studied and break free from the dictates put forth by the medical model of research as:
If one gives up the belief that psychotherapy treatments are analogous to medications and places faith in the scientific evidence that psychotherapy in general is extremely efficacious (Lambert & Bergin, 1994) but that relative differences are minimal, research in psychotherapy would differ considerably from the present focus on clinical trials. (Wampold, Mondin, Moody, Stich, Benson, & Ahn, 1997, p. 203)

There is benefit to blending common factors and evidence-based practice, and further benefit to allowing psychology to break free from the medical model of research and controlled insurance reimbursement. Future research may be best focused on how to change the look of research all together and how to continually assert psychology as a separate entity from the medical model; unique and efficacious in a separate but yet important way.
References


Common Factors


18. doi: 10.1080/02791072.2011.601984


