Limitations of common factors model psychology essay

A solid foundation of a therapeutic relationship allows for greater success as treatment develops. As such common factors models emphasize the collaborative work of therapist and client, thus the focus is on the therapist, client as well as the transaction between them and structure of treatment that is offered (Duncan, Miller, Wampold, & Hubble, 2010). This explanation assumes that it is the similarities among the many counseling approaches, not specific technical differences that explain counseling effectiveness. The common factors are not invariant, proportional fixed, or neatly addictive. They are interdependent, fluid and dynamic. It is a reciprocal process where the role and degree of influence of any one factor are dependent on the context. Much like raw materials in nature, common factors existed in an unprocessed or minimally processed. The eventual form of treatment assumes is thus entirely dependent on the materials available; the skills of therapist and most importantly, the preference and desire of the client (Duncan, Miller, Wampold, & Hubble, 2010)

The equivalency of therapy approaches has been so difficult to refute and so counterintuitive, that researchers refer to the phenomenon as the Dodo bird verdict (Wampold, 2001) after Alice in Wonderlands Dodo bird who decreed everybody has won, and all must have prizes. This means that all treatments work and do so about equally well. This explanation assumes that it is the similarities among the many counseling approaches, not specific technical differences that explain counseling effectiveness. Any treatment involves specific components but the manner in which they are conducted relies on the interactions between therapist and client. Therapist and client must work collaboratively to produce treatment.

Several conceptualizations of common factors of counseling have been proposed, beginning in 1936 by Saul Rosenzweig (Frank and Frank 1991). However, in this article, the examined common factors model is the model articulated in The Heart and Soul of Change: What Works in Therapy (Duncan, Miller, Wampold, & Hubble, 2010) which is deemed with the most practical utility for counselor educators. Under this model, there are four elements; Client/Extra therapeutic Factors, Placebo, Hope, and Expectancy Factors, Relationship Factors, and Model/Technique Factors.

Client/Extra-therapeutic Factors

As discussed all approaches are equivalent with respect to outcome, and technique pales in comparison to client and relationship factors, the clients' map of the therapeutic territory needs to be attended to before " theory" for therapy. A rapid assessment of the client's position so that the therapist could tailor all intervention accordingly (Duncan & Miller, 2000).

Client/Extra-therapeutic factors refer to both external resources and internal resources that influence change. Extra-therapeutic factors represent a broad swathe of variables that affect change efforts, including how well basic needs are met or changes in how they are met, and fortuitous events, such as winning a lottery, meeting a soul mate, getting a pay raise, or having a spiritual awakening (Leibert, 2011). Client factors include a host of both developed and undeveloped innate abilities as well as natural self-healing activities one of which is the client's own theory of change as a mean solve their own issues. Hence, Counselors would benefit from encouraging client choice in developing goals, honoring client perspectives about the source of the problem rather than strictly applying a diagnosis, co-creating solutions

rather than prescribing a treatment based on certain theoretical framework, and treating the client as a person temporarily “ stuck in a difficult situation” and not as a patient who must be treated by a doctor (Tallman and Bohart 1999). Wile (1977) believed that clients enter therapy with their own theories about their problems, how they developed, and how they are to be solved. Wile (1977) stated that ” many of the classic disputes which arise between clients and therapists can be attributed to differences in their theories of [etiology and] cure”(p. 437). He instead advocated what he called utilization: ” Exploring a patient’s individuality to ascertain what life learnings, experiences, and mental skills are available to deal with the problem. . . [and]then utilizing these uniquely personal internal responses to achieve therapeutic goals” (Erickson & Rossi, 1979, p. 1). Utilizing facilitates a favorable relationship, increases client participation, and therefore enhances positive outcome. Duncan et al. (1997) view the client’s theory of change as holding the keys to success regardless of the model used by the therapist, and especially with cases of multiple treatment failures.

Placebo, Hope, and Expectancy Factors

Freud wrote that “ expectation colored by hope and faith is an effective force with which we have to reckon . . . in all our attempts at treatment and cure” (Freud, 1905/1953, p. 289). Placebo, Hope, and Expectancy factors refer to interrelated constructs reflecting the counselor or client’s beliefs that treatment will be efficacious. When explaining hope, a cognitive framework by Snyder et al (1999) was adopted. In this framework, there are two types of thinking are present: pathways thinking and agency thinking. Pathway thinking is the perceived ability to imagine pathways towards reaching a

goal. Agency thinking, the perceived ability to initiate and persist on that pathway until the goal is met.

Relationship Factors

The therapeutic relationship is considered essential to major schools of therapy treatment outcomes, and is one of the most studied common factors in counseling. The relationship broadly includes “ any and all motivations and activities of client and therapist, including hostility, seductiveness, humor, ingratiation, guilt, and so forth”. In some literature, therapeutic relationship is trans-theoretically constructed as therapeutic alliance, a collaborative relationship between counselor and client resulting in a bond and an agreement about the goals and tasks of treatment (Bordin 1979). The bond is characterized by mutual trust supported by necessary and sufficient conditions of empathy, warmth, unconditional positive regard, and congruence. This is what Roger advocated in his person centered approach. Counselor interventions and qualities that seem to universally enhance therapeutic alliance are active listening, empathy, respect for the client and the client’s perception of problem severity and a non-judgmental attitude.

In contrast, counselor interventions that have shown equivocal associations with a strong relationship include advice-giving, level of directiveness, use of open-ended questioning, interpretations, and self-disclosure. Qualitative research has shown that all clients do not perceive empathy the same way. An aspect of developing and maintaining strong alliances occurs when faced with client hostility, defensiveness or avoidance (Gaston et al. 1988; Muranet al. 1994). Under these conditions, counselors are vulnerable to responding counterproductively, such as communicating subtle criticisms or belittling

clients. Counselors should reinforce their clients for providing feedback, so that an open, honest treatment environment will be created and sustained. By creating this environment, disruptions in the counseling process can be worked through before the treatment alliance is damaged (Bachelor & Horvath). The alliance is a robust predictor of outcome and can make the difference between premature dropout and successful outcome.

Model/Technique Factors

Models and techniques can refer both to overall schools of counseling or to specific interventions or procedures within that counseling orientation. Although differences in models and techniques exist. However, it was felt that it is the commonalities among the models and techniques rather than their differences that make them effective. The language used may differ across approaches, but these fundamental qualities imbue all major models of counseling (Duncan, Miller, Wampold, & Hubble, 2010). This line of research strongly implies that instead of trying to decide which approach is most efficacious, it is better to determine which specific approach is most helpful for individual clients. When orientation and technique are congruent with client worldview, skills and resources, it is more likely that agreement of goals and tasks of treatment are secured. When treatment orientation is tailored to clients, hope is instilled, the relationship is enhanced, and extra-therapeutic factors are optimized (Duncan, Miller, Wampold, & Hubble, 2010).

Limitations of Common Factors model

Counseling from a common factors approach does not mean that counselors have license to haphazardly employ any intervention at any time. Counseling

models provide structure and focus in sessions, qualities considered indispensable to outcome. In contrast, adopting no strategy, or changing strategies frequently, risks interrupting the flow of counseling and interfering with meeting clients' needs. Counseling from a common factors approach does not mean model-less counseling. Rather, clinicians who practice using a common factors approach to counseling enlist their clients' strengths, resources, and unique points of view, because these factors are highly associated with counseling outcomes. Careful attention to client perceptions of the client-counselor alliance, and optimization of client hopefulness through the use of interventions that are consistent with client worldviews, are also vital components of the empirically verified common factors approach (Lebert, 2011). Caution should be exercised when interpreting the alliance-outcome link. Although the client-counselor alliance is a robust predictor of outcome, it only explains about five percent of the variance in outcome, leaving 95% of outcome variance unexplained (Libert, 2011). Indeed, evidence points to the person of the counselor as a more potent predictor of outcome. Wampold (2001) found more outcome variance explained by counselor competence (i. e., 6 -9%) than to the client-counselor alliance (i. e., 5%). Though the person of the counselor is a somewhat neglected variable, evidence reveals large individual differences in counselors (Okiishi et al. 2003).

Reflection on common factors

Counselling is a value loaded process largely influenced by western cultures and theories. Moreover, therapists will be influenced by their own beliefs systems and values which may or may not be align with the client's own

implicit theory or theory of change. From an ethical perspective, therapist should be mindful of conflicts which may arise due to differences in values and should not be clouded by their own values and use it as a viewing lens to view the clients. This would leads to poor therapeutic relationship. Instead, the common factors model is handy for practicing therapists to rely upon to suspend their values and try to build a therapeutic relationship with the client. It also serves as a reminder for therapists to be mindful of as well as to recognize the importance of building therapeutic relationship with the client in the clinical settings through the common factors in order to strengthen the therapeutic alliance which would lead to greater collaborative work between therapist and client.