CONTRIBUTION OF COMMON FACTORS TO THERAPEUTIC OUTCOMES FROM THE
CLINICIAN’S PERSPECTIVE: A MIXED METHOD STUDY TO EXPLORE COMMON
MECHANISMS OF CHANGE

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ABSTRACT

While the Common Factors (CFs) model is becoming more popular it has been criticized for the lack of empirical evidence compared to empirically supported treatments and the lack of capacity to guide clinicians on what to do and when to do it in the course of therapy. This parallel mixed methods study addressed both of these critiques. In phase one, a Common Factors Questionnaire (Karimi-CFQ) was developed to collect empirical data of CFs. In phase two, the Karimi-CFQ was administered to 391 clinicians in the United States to survey the therapists’ perspective regarding the contribution of common factors to therapy outcomes. In this phase data was also collected to assess the relationship between clinicians’ demographic characteristics and their perceived contribution of common factors to therapeutic change. The CFQ Cronbach’s Alpha and Split-half reliability were .84 and .87, respectively. Content Validity Index by expert panel, concurrent validity, and construct validity including Exploratory Factors Analysis (EFA) and Confirmatory Factor Analysis (CFA, \( \chi^2=797.96, df=326; \) RMSEA=.06; CFI=.83) evaluated the validity of the scale. Clinicians across five clinical orientations (Integrative, Cognitive Behavior Therapy, Humanistic, Psychodynamic, Postmodern) and three mental health disciplines (marriage and family therapy, psychology, counseling) attributed 69% of therapeutic change to common factors versus 31% to model-specific factors. Clinicians attributed different contributions to specific components of the CFs model: client (25%), therapist (20%), relationship (23%), hope (12%), non-theory specific (11%), and systemic (9%). Particular clinicians’ characteristics (e.g., gender, year
of experience) were found to be associated with contributions of specific components of CFs. In phase three, six CF experts were invited to respond to open-ended questions via Wiki that explored how and when experienced therapists use specific common factors in the course of therapy to reach to their therapy goals. Thematic Analysis (TA) generated a chronological map with specific themes that can guide clinicians on how and when specific CFs can be used in each of the three stages of therapy (i.e. Initial, Intermediate, Termination). Findings further indicated that CFs and model-specific factors can be operationally defined and empirically studied within the same evidence-based practice framework. Clinical and research implications of the results are also discussed.
DEDICATION

This dissertation is dedicated to my family.
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I would like to thank my committee members who were generous with their knowledge, expertise, and time. I appreciate all of their support, mentoring, and patience over the long path of this project. I learned a lot from each of them that definitely goes beyond this dissertation and will support me in my personal and professional life.
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Chapter I: Introduction

History of Therapy

In the early years of the field of psychotherapy, pioneers (such as Sigmund Freud, Otto Fenichel, Ernest Jones, and Franz Alexander, etc.) were faced with the same psychotherapy research queries that we are struggling with today. How can human psychological distress be improved? Does psychotherapy work? If so, how does therapy provide change? How can we measure the change? Though the field has continually progressed, there are still many controversial theoretical debates among scholars.

During the twentieth century, a wide range of psychotherapy theories emerged to attempt to provide answers to these questions. Most of the early treatment models were extensions of psychological theories—which were quasi-philosophical formulations of human development and personality rather than a set of techniques to be used in therapy (Anderson, Lunnen, & Ogles, 2010; Prochaska & Norcross, 2007). However, over time, treatment models were developed to meet the clients’ needs and particular clinical problems in the therapy room. Each theory, competitively, claimed a more successful model of psychotherapy. Recent decades of psychotherapy research show a serious competition in providing more evidence-based findings for specific treatment models and techniques. Such a trend has been fueled by increasing emphasis on accountability, financial, and insurance issues (Asay & Lambert, 1999; Wampold, 2010). Also, from an ethical perspective, it was discussed that clients had the right to receive safe and effective treatments and therefore there is a need to determine what works (Wilson, 1995). Division 12 of the American Psychological Association (APA) conducted a task force, the NIMH Collaborative Study of Depression, to provide support for effective treatment models,
mostly cognitive-behavioral therapy (Task Force, 1993). Interestingly, the results indicated that both cognitive behavior therapy and interpersonal therapy were equally effective (Don-Min, Wampold, & Bolt, 2006). Furthermore, the secondary analysis of the data indicated that it is easier to prove the therapist’s effectiveness than model effectiveness (Blat, Sanislow, Zuroff, & Pilkonis, 1996; Blow et al. 2007)—which suggests that an effective therapist can effect change by using different models.

While the move to evidence-based practices has developed the field of psychotherapy and provided clinicians with a range of techniques and models of intervention, it also has generated new challenges and queries about what the mechanism of change are among all effective models (Prochaska and Narcross, 2007; Sprenkle, Davis, Lebow, 2009; Wampold, 2010). Prochaska and Narcross (2007) pointed out “The field of psychotherapy has been fragmented by future shock and staggered by over-choice. We have witnessed the hyperinflation of brand-name therapies during the past 50 years” (p. 1). The recent number of psychotherapies reaches almost 400 models which usually have been presented with a rival claim of success. Such proliferation of therapies may have some advantages due to the diversity of clients, problems, situations, cultures, etc. However, such over-choice conditions confront students, trainers, and practitioners with confusion and fragmentation raising the question of what are the best theories to be studied, taught, and practiced (Prochaska & Narcross, 2007; Sprenkle et al., 2009).

The history of recent decades of psychotherapy research reflects great effort in generating evidence-based treatments and techniques. However, there has been debate about what is evidence in the field. Historically, the definition was limited to Randomized Clinical Trials (RCTs) research which deprived the field of the benefits of other types of research that could
also be evidence based. As Norcross, Beutler, and Levant (2006) stated "defining evidence, deciding what qualifies as evidence, and applying what is privileged as evidence are complicated matters with deep philosophical and huge practical consequences" (p. 7). Until recently the APA presidential task force on evidence-based practice (2006) provided a more comprehensive definition of what can be included as evidence-based practice and evidence based research. That is *Evidence-based practice in psychology* (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences*. The task force agreed that multiple research designs/methods can contribute to evidence-based practice including: clinical observation, qualitative research, systemic case studies, single-case experimental designs, public health and ethnographic research, process-outcome studies, effectiveness research, efficacy research, and meta-analysis. Also, the task force expanded the definition to include therapist’s clinical expertise and client’s characteristics. Such a definition of evidence based practice has overlaps with the components of the Common Factors (CFs) Model. Also, in the latest series of scholarly discussions in the journal of psychotherapy (2014, volume 51-4) the CFs experts emphasized operational definition of CFs to the level that can be empirically studied and considered as scientific research evidence. Such research provides an opportunity to link CFs to therapy outcome as well as to integrate CFs and model-specific factors towards a more effective therapy (Laska & Wampold, 2014; Lambert, & Ogles, 2014; Constantino & Bernecker, 2014; Hoffman & Barlow, 2014; Weinberger, 2014).

**Role of Theoretical Model**

It is obvious that each therapist, regardless of his/her theoretical model or level of experience, needs a theory to conceptualize the client’s problem and to plan interventions. Considering psychotherapy as a multilevel and interactional phenomenon, it is not so simple,
especially for an inexperienced therapist to choose his/her own best theory. Norcross (1990), as a proponent of integrative approach, pointed:

“Psychotherapy is the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable” (p. 218).

Such a complicated phenomenon requires the therapist to choose a theory to guide him/herself in therapy. Theory, in general, creates a framework to guide therapeutic actions—which prioritizes the questions which should be asked, the issues to be confronted, the way to respond to client actions, the time and way to conduct interventions, and how to assess therapeutic progress. As Wampold (2010) mentioned “Every aspect of therapy is saturated with the theoretical perspective of the therapist. As will become apparent, there is no one “best” road map for therapy; rather, there are a plethora of viable theories from which to choose” (p.4).

Therefore, clinicians in reaction to limitation of specific model in treatment of diverse problems and/or clients have to choose each time either a different treatment model for each particular client/problem or to create an integrative model that includes core principles that work across treatment models.

Psychotherapy research indicates that most clinicians react to this over-choice of models with an integrative/eclecticism position. According to Norcross (2005b): “Psychotherapy integration is characterized by dissatisfaction with single-school approaches and a concomitant desire to look across school boundaries to see what can be learned from other ways of conducting psychotherapy. The ultimate outcome of doing so is to enhance the efficacy, efficiency, and applicability of psychotherapy”. (pp. 3–4). Research consistently shows most
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Clinicians, from different mental health professions, indicate integration/eclecticism as their most favorite orientation (Norcross & Goldfried, 2005). Research implies that when it comes to practice in the real world, clinicians choose to go beyond any specific therapy model to enhance their success and meet their therapeutic goals, even for those who verbally claim allegiance to a specific model (Minuchin, 1974; Sprenkle, et al, 2009). In fact, integrative models (such as common factors, Lazarus’ Multimodal therapy, Watchel’s integration of psychoanalysis and behaviorism, etc.) were generated as a response either to the fragmentation of the field and/or the limitations of particular treatment models to particular clients, problems, situations (Prochaska & Norcross, 2007; Sprenkle, et al, 2009).

The most popular integrative models include the Common- Factors model (CF) technical eclecticism, and theoretical integration (Norcross & Goldfried, 2005). These models, though different in ways and levels, intend to enhance therapeutic effectiveness by going beyond the frame of individual treatment models. There are limitations for each individual model to theoretically explain and practically treat all types of clinical problems, especially when it comes to diversity of client’s characteristics, preferences, and culture. In spite of important endeavors in the field of integrative psychotherapy, the field requires a higher level of conceptualization that explains processes/mechanisms of change across therapeutic models. “Lacking in most integrative endeavors is a comprehensive model of thinking and working across systems” (Prochaska & Norcross, 2007, p. 2). Such conceptualization is a difficult goal since it is supposed to synthesize not just different techniques but also some contradicting worldviews, theories of personality, psychopathology, and change process.

Critiques to Common Factors Model
The Common Factors (CFs) model (Hubbel, Duncan, & Miller, 1999; Sprenkle, et al, 2009; Wampold, 2001), suggests the effectiveness of different treatment models originated from their commonalities and shared elements more than their specific techniques and procedures (Sprenkle et al. 2009). The CFs model as main stream of integrative psychotherapy, has been criticized by some scholars because of what they perceive as lack of comprehensiveness in defining the factors and the model’s ability to function as a guiding model in the therapy's course. Some scholars (e.g., Chambless, 2002; Sexton, Ridley, & Kleiner, 2004) criticized the common factors that are a set of therapeutic variables derived from a series of meta-analyses of clinical studies and therefore, cannot theoretically, guide clinicians on what to do and when to do it in the course of therapy. For example, Sexton et al (2004) state “in fact, we worry that the common factors perspective overlooks the multilevel nature of practice, the diversity of clients and settings, and the complexity of therapeutic change”(p.2).

In addition, though there is no research evidence to indicate that the common factors do not matter, there is a real debate in the field of psychotherapy regarding the extent to which the common factors impact therapy outcome any more than model-specific factors. Scholars take different positions in this argument. For example, Hubbel and his colleagues (1999) suggested model-specific factors have virtually no impact. Others (e.g., Orlinsky, Grawe, & Parks, 1994) accepted some degree of impact, and still another group (Chambless & Ollendick, 2001; Sexton et al., 2004) argued for higher impact. Unfortunately, there is a lack of empirical research to shed light on this specific debate, and it is not a simple question that can be answered by a single study (Sprenkle et al, 2009). The current study is accordant with the moderate definition of the Common Factors Model which considers the interaction between CFs and model-specific factors generates therapeutic outcome however CFs have larger contribution than model-specific factors.
Furthermore, one of the critical issues in the field is about the data source of common factors that basically originated from meta-analysis and literature reviews. Proponents of the empirically supported treatments (ESTs) perspective mentioned there is not enough empirical evidence to support the common factors’ function within treatment models (Chambless & Ollendick, 2001; Sexton et al., 2004). Therefore, future empirical research that examines therapeutic activities and processes from the lens of therapists, clients, and/or observers can improve our understanding of the common factors’ functions across treatment models. Such a research needs to assess the link between CFs and therapeutic outcome as well as assess the interaction of CFs and model-specific factors in relation to therapy outcome.

The purpose of the current study is to address the above-mentioned research gaps and challenges in the common factors field which are: lack of empirical data collected directly from therapy participants (therapist or client), lack of empirical data about the relationship between CFs and therapy outcome, lack of empirical data to compare the therapeutic contribution of CFs versus model-specific factors in one study, and lack of theoretical framework to guide therapist what to do and when to do it in the course of therapy.

Using a parallel mixed method, the aim of the current study was: to empirically discover the most important common factors across therapy models by developing a Common Factors Questionnaire (Karimi-CFQ) based on literature and therapists’ perspectives; to administer the questionnaire in order to assess the contribution of CFs in successful therapies from the perspective of clinicians; to compare the contribution of the CFs versus model-specific factors in therapy outcome from the clinicians’ perspective; and finally, by using qualitative methods, to enhance theoretical conceptualization of the CFs model and its chronological application over the course of therapy—which could improve the CFs model as a road map in guiding clinicians
in what to do and when to do it over three stages of therapy (initial, intermediate, termination).
Using mixed methods makes this project a unique one in the field. It will provide the researcher
with an opportunity to collect descriptive quantitative data as well as explore qualitative data.
Both sets of data will interact, link, and integrate to provide better understanding of the research
questions.

The current study contributes in the field of integrative psychotherapy, specifically
common factors, in several ways. First, the researcher developed a Common Factors
Questionnaire (Karimi-CFQ) that can be used in and encourages a number of empirical common
factors studies and/or clinical trials across different theoretical and clinical models, settings, and
populations. Researchers can use Karimi-CFQ to evaluate the CFs variances that contribute to
therapeutic change in each stage of therapy or in general course of therapy. It also can be used in
clinical trials across different treatment models, clients, and types of problems to study how CFs
interact with these variables to generate therapeutic change.

Second, it was one of the first empirical studies that quantitatively links specific
categories of common factors (client, therapist, relationship, hope, non-theory specific, systemic)
to therapy outcome—which provides empirical evidence for the CFs model. It is important to
study how each specific component of CFs contribute more or less in therapeutic change
regarding particular problems, clients, and treatment models. For example, in what clinical
problems hope’s component contribute more, or in what client population the therapist’s factors
are more important to generate therapeutic change.

Third, it provides empirical data regarding the relative contribution of common factors
versus model-specific factors. Using Karimi-CFQ and similar instruments allows researchers to
study both CFs and model-specific factors in integrative evidence-based practice research design, which generates important results towards an effective integrative therapy.

Fourth, the qualitative phase of the study explored therapists’ decision making and conceptualization about what and how common factors were used over three stages of therapy in their successful relational cases. Such an exploration shed light on how all effective treatments really work—which may improve integrative psychotherapy in general, and the common factors model specifically.

Research indicates that particular processes are more effective and necessary during specific stages of therapy (Johnson, 2002). For example, joining and accommodation with the family in structural therapy is the most crucial process in initial stage of therapy (Minuchin, 1974). From the CFs lens it is hypothesized that all effective therapies, and probably effective therapists, apply those particular stage-related processes to reach their therapeutic goals. Description, explanation, and integration of stages and related processes of change are an important and crucial step of the development of integrative models (Prochaska & Norcross, 2007). By combining quantitative and qualitative findings the current study explored some of those crucial processes that may contribute to integrative psychotherapy.

**Defining Key Terms**

In order to have a better understanding of the current study, the following definitions are provided for the key terms used in the study. There are a variety of definitions of *common factors* and related components by different scholars. For the purpose of the current study, the common factors model is based on Sprenkle and Blow (2004a, b) and Sprenkle and colleagues (2009) moderate definition of the Common Factors Model (CFM)—which include: clients’ factors,
therapist’s factors, relationship factors, hope and expectancy factors, non-theory specific treatment factors (that are introduced by Karasu (1986) as behavioral regulation, emotional experiencing, and cognitive mastery), and systemic factors. According to moderate definition CFs interact with model-specific factors to generate therapeutic change outcome.

Therapy/Psychotherapy refers to all forms of therapeutic models and modules (e.g., individual, couple, family, group, children, etc.) since the common factors model identifies mechanisms of change across all therapeutic models. However, in the current study the clinicians were asked to consider one of their relational cases (couple or family therapy) when they were responding to the Common Factors survey and Karimi-CFQ. So in result and discussion section the term of therapy/therapy outcome refers to the outcome of successful relational cases.

Model-specific factors refer to those specific techniques or interventions that are identified as part of particular theory or treatment model (e.g., dream analysis in psychodynamic, emotion validation in emotion-focused therapy, miracle questioning in solution-focused therapy, etc.). Clinician/therapist refers to all licensed or licensed eligible mental health clinicians in the United States who are legally and professionally are allowed to provide mental health therapeutic services for clients. Therapist perspective refers to the clinician’s recall and observation of the interactions that happened during the course of therapy with specific client(s). Successful therapy/outcome refers to clinician’s view regarding the achievement of therapeutic goals (70% improvement)—which is defined as desired outcomes of therapy (desired cognitive, emotional, behavioral, and relational changes that improve life functioning) that are collaboratively being developed by therapist and client (Prochaska & Norcross, 2007; Sprenkle et al, 2009). This criterion (70% improvement) was included in the survey instruction that was taken by clinicians.
Also, the term *Components of CFs* refers to six subscales of Karimi-CFQ with 5-point Likert scale, and the term *Categories of CFs* refers to six percentage categories of CFs in the second section of survey in which clinicians compared the percentage contribution of six categories of CFs out of 100% therapeutic change.
Chapter II: Literature Review

This literature review begins with an overview of psychotherapy history and the concept of change as the optimal goal of different kinds of psychotherapies. Then, the history of common factors is reviewed in general in the field of psychotherapy. Model effectiveness research is then discussed with debates between ESTs and common factors camps. A moderate view of common factors is reviewed. Using common factors literature, the current components of the common factors are outlined, and proposed unique common factors in the field of marriage and family therapy (MFT) are discussed. The current research gaps in the field of CFs and the importance of the current study are discussed, which is lack of empirical data to show the contribution of CFs in therapy outcomes and lack of theoretical map to guide clinicians over the course of therapy. Finally, the goals of the current study and research questions and hypotheses are outlined.

What Is Responsible for Therapeutic Change?

Throughout the history of psychotherapy there has been a challenging debate regarding what psychotherapy actually is. The practice of psychotherapy as a legitimate treatment is a new one compared to the practice of medicine which goes back to ancient times (Prochaska & Norcross, 2007; Sprenkle, et al, 2009; Wampold, 2010). It was only about a century and a half ago since Freud introduced the talking cure. Psychotherapy models basically came to explain human functioning and the process of change. In the early of 20th century, Freud’s psychoanalysis model introduced a psychological explanation for human behavior, mental disorders, and their treatment that was challenged by behavioral, humanistic, and cognitive approaches in the next decades. Thereafter, as a trend, each new theory offered a particular lens to see particular dimensions of human functioning with specific explanations regarding
Consequently, if one asks clinicians why therapeutic change occurs, they would basically explain the process in terms of their preferred therapy model. In fact, it has been the paradigm of the field to look for the most effective model of therapy (Wampold, 2010) without sufficient attention to main mechanisms of change work across models. Most of the research in the field focused on Randomized Clinical Trials (RCTS) and outcome of competitive models, while the best psychotherapy science and knowledge can be generated by process research that links mechanisms of therapeutic change in pivotal moments of therapy to the outcome of therapy (Kazdin, 2009; Prochaska & Norcross, 2007). The study of these processes and mechanisms that generate change across different models can explain how and when therapeutic change occurs. Such knowledge is very informative for clinicians, trainers, and researchers towards an integrative therapy. Because of the dominant research paradigm that focused on RCTs, more than 400 different models of psychotherapy have been developed—a trend that continues and creates more challenge for clinicians and trainers to choose among the vastly different options, that is what model should be taught to students, what model should be applied to clients, etc.

As Messer (2004) mentioned, psychotherapy has a dual heritage originating from scientific and the humanistic traditions. Psychotherapy received its legitimacy and validity in the health care system by scientific tradition through collecting evidence of effectiveness. The humanistic tradition has provided grounds for meaning-making and empathic dimensions of the psychotherapy practice. A review of psychotherapy history indicates that “this dual heritage has often divided the discipline, scientists and practitioners emphasizing different aspects of the
same endeavor” (Wampold, 2010, p. 16), though both groups are pursuing the same goal: helping people to overcome their problems and experience more meaningful and fulfilled lives.

In the field of psychotherapy, process is defined “as representing a middle level of abstraction between a complete theory or system of psychotherapy and the techniques proposed by the theory” (Prochaska & DiClemente, 1984, p. 33). Some psychotherapies (Adlerian, existential, cultural-sensitive therapies, etc) have predetermined formal content-specific aspects, though they also utilize the same processes and mechanisms that process-based psychotherapies (e.g., eclectic, systemic, solution-focused, etc.) utilize (Held, 1991; Prochaska & Norcross, 2007). Therefore, exploring such common and underlying processes of change is an important step to develop integrative therapy that goes beyond specific content of each model.

In the middle of the 20th century the double-blind placebo control group design became the gold standard for testing the efficacy of medical and psychological interventions (Wampold, 2010). Now it is known that therapy is responsible for changes that can be emotional, cognitive, behavioral, social, educational, and physical dimensions of functioning (Lambert & Ogles, 2004; Sprenkle et al, 2009; Wampold, 2001, 2010), though there is little knowledge of how and why our treatment works, and through what mechanisms and processes (Kazdin, 2007; Prochaska & Norcross, 2007). Unless it is explored what is critical to provide desired change therapists are at a bit of a loss. Though enormous progress in psychotherapy research has been made and many evidenced-based treatments developed, “after decades of psychotherapy research, we cannot provide an evidence-based explanation for how or why even our most well studied interventions produce change, that is, the mechanism(s) through which treatments operate” (Kazdin, 2007, p 1). According to the moderate definition of the CFs model the all effective treatment models and their specific techniques work in the context of optimal CFs, that is, without that context and the
interactions between CFs and model-specific factors, the desired therapeutic change will not be generated. Therefore, process research is needed to explore the functions of CFs over the stages of therapy to define the context of change. Also, mixed qualitative and quantitative research design can generate a more comprehensive picture of what, why, and how therapeutic change occurs.

One of the main controversial questions in the field of mental health and psychotherapy is “where is the site of pathology?” To answer this question many psychotherapy theories put different emphasis on specific content, instead of process, as their zone of pathology that should be addressed during the course of therapy. It is noticeable that “the distinction between process and content in psychotherapy is a fundamental one” (Prochaska & Norcross, 2007, p.18). The emphasis on specific content has been the main factor in the discrepancy in the psychotherapy field. In other words, psychopathology and personality theories usually point to what needs to be changed, while theories of process show us how change occurs (Prochaska & Norcross, 2007). Over the last five decades of research probably there could have been more effective treatments and advanced psychotherapy science if the focus had been on change mechanisms and therapeutic processes, instead of competing content specific evidence-based treatments. In fact, “Understanding mechanisms of treatment is the path toward improved treatment” (Kazdin, 2009, p. 426). Exploring the mechanisms of change across effective treatments will provide order and parsimony to the existing over-choice of psychotherapies (Kazdin, 2007; Sprenkle et al, 2009; Wampold, 2010).

According to the systemic perspective that includes and connects the microsystems (biochemical and physiological, psychic/intrapersonal, interpersonal) and the macrosystems (psychosocial, international, and global systems), every change in one level contributes to the
change or stability of the others (Goldenberg, & Goldenberg, 2004). Especially, at the level of the human being with analogical language and with extracerebral and intracerebral minds, the effort to exclusively specify the location of pathology inside or outside the person is not meaningful (Bateson, 1972, 1979; Minuchin, 1974). Based on systemic view processes that maintain a problem are more important than content of the specific problem that might be identified in specific spot in a system. Such a perspective is accordant with integrative therapy and the CFs model that emphasize processes of change across treatment models which emphasize different specific content. Qualitative research like the current study can explore these therapeutic processes to generate information that may result in an integrative theory of change.

Integration of neuroscience and psychotherapy theories, which is an example of a systemic approach, suggests the human brain is a social organ that experiences the optimal development and integration when it experiences safe and supportive relationships in an environment with optimal stress or mild to moderate levels of arousal (Cozolino, 2010; Hayes & Strosahl, 2004). In addition, all effective treatments promote, in different ways, the emotional regulation process that requires integration of emotion and cognition (Amini et al., 1996; Cozolino, 2010; Liggan, & Kay, 1999). These findings are consistent with the neuroscience principle that “neurons that fire together, wire together” (Hebb, 1949; Shatz, 1990; as cited in Cozolino, 2010, p. 47). Different theoretical models in their terminology emphasize apparently one of either cognitive, behavioral, or emotional aspects of human life. However, what is happening in actual therapy session is an experience that activates and links these three psychological aspects to an optimal level. The non-theory specific component of the Common Factors Model refers to such new emotional, cognitive, and behavioral experiences that work beneath all model-specific techniques. Such healing experiences can occur by a wide range of
model-specific techniques (Prochaska, & Norcross, 2007). In addition, according to Acceptance and Commitment Therapy (ACT), based on a behavioral theory of language and cognition, there are core processes involved in psychopathology and emotion dysregulation (Hayes & Strosahl, 2004). That is, “experiential avoidance” leads to a position that controls or changes the form, persistence, and situational awareness of feelings, thoughts, and sensations, that might result in personal and interpersonal problems (Hayes & Strosahl, 2004). Therefore, the function of many techniques and procedures in psychotherapy, such as relaxation, exposure, differentiation of self, family sculpture, etc., can be translated based on shared processes, while each technique may apparently emphasize one of the behavioral, cognitive, emotional, or relational dimensions. Therefore, research should focus on variables and conditions that facilitate such non-theory specific factors that are basic experiences of therapeutic change.

Interestingly, even some advocates of Empirically Supported Treatments (ESTs), such as Allen, McHugh, and Barlow (2008), are working on a unified approach of etiology and treatment on emotional disorders. They propose a shared or spectrum of psychopathology across the disorders as well as high rates of comorbidity that suggest significant overlap among disorders. In addition, they point to research that shows the observed effects of current therapeutic models on comorbid conditions which indicate almost a non-specificity of treatment response. Allen and his colleagues (2008) in their discussion on emotional disorders, that include a wide range of clinical disorders, conclude “[i]n summary, the existing literature supports several arguments for stepping back from individual DSM-IV diagnostic categories and associated specific psychological protocols”(p. 220). They suggested that the current research on the nature of emotional disorders and emotion dysregulation suggests a more unified approach of therapy which addresses shared principles of change across different emotional disorders. A review of
current cognitive behavioral therapy (CBT) protocols for emotional disorders can be summarized in three broad principles of change: alteration of emotional misappraisals of significant events, avoidance prevention related to negative-emotional internal and external triggers, and modification of emotion-driven behaviors. Such conclusion is a research evidence that supports the CFs model in general and specifically its assumption regarding non-theory specific component of the model.

In other words, theoretical and empirical research suggests that even if therapeutic techniques are defined as cognitive, behavioral, or emotional it does not, in the real world, separate the link and reciprocal pathways among psychological dimensions (cognition, emotion, behavior, biochemical, etc.) or between intrapersonal and interpersonal aspects of life. Furthermore, proponents of integrative models (Sprenkle et al, 2009; Prochaska & Norcross, 2007) suggest that the common or intermediate processes of change contain human functions that people utilize, consciously or unconsciously, to alter emotions, cognitions, behaviors, and relationships both in therapeutic situations and life in general. It is observed that some people, self-changers, can improve and change their symptoms or problems without attending therapy (Prochaska & Narcross, 2007). According to the CFs model, the next research step towards an integrative therapy is to explore such intermediate processes that are responsible for therapeutic change across treatment models as well as different clinical problems and clients.

Consequently, it is the time for the psychotherapy field to focus on process-based conceptualizations of change that also fits with systemic perspective. A body of theoretical and empirical research (Kazdin, 2007) indicates that optimal change can be achieved through apparently different techniques/interventions that are interrelated by shared processes of change. Though a randomized control trial (CRT) may show a treatment, compared to no treatment, can
cause therapeutic change, it does not indicate why and how the intervention created the change. Clinical studies usually conceptualize mediators and moderators to explain the causality between variables and therapy outcome. Researchers use statistical relations, between variables in a model, but they may not precisely explain the process and intervening steps through which change comes about (Kazdin, 2007). Many scholars (Greenberg & Pinsof, 1986; Johnson, 2003; Kazdin, 2007; Sprenkle & Piercy, 2005; Wampold, 2001) ask for the study of mechanisms and processes of change that result in greater levels of specificity; that is, intervening steps and processes, in the course of therapy. Such research can delineate the similarity of change mechanisms across models. As Wampold (2010) mentioned, despite the discrepancy among psychotherapy theories, there are similar questions and challenges around the psychotherapy process, which is how psychotherapy works? What are the main ingredients of change and how they interact to each other? How do CFs (therapist’s variables and client’s variables) interact with model-specific techniques, etc.?

**History of Common Factors Research and Theory**

Although since the early years of psychotherapy, the dominant paradigm has emphasized differences in theory and practice, the first idea of common factors of therapy emerged in the 1930s. Saul Rosenzweig (1936) presented the first prominent paper on common factors. He suggested that the effectiveness of psychotherapy models originated from their commonalities and shared elements more than their specific techniques and procedures (Sprenkle et al. 2009). He suggested that therapy basically works because of the relationship between therapist and client along with a therapeutic explanation—which justifies the rationale of therapeutic activities. By therapeutic explanation the client believes that therapy would help and provide particular tasks which result in desired therapy goals.
The landmark contribution of Jerome D. Frank (1961), *Persuasion and Healing*, introduced common elements that he believed work across all human healing activities, including psychotherapy, medical treatments, and even traditional healing activities. Frank suggested four key dimensions of healing relationships: “(1) an emotionally charged confiding relationship with a helping person, (2) a context that is believed to be therapeutic, (3) a credible rational and conceptualization that provides a plausible explanation for the client’s problems and how to resolve them, and (4) a procedure or ritual that asks active participation of client and therapist and is believed to be a means of solution” (Sprenkle, et al. 2009, p.19). These four factors, according to Frank, are main mechanisms that are responsible for therapeutic change across psychotherapy models. They basically provide a context that helps to remoralize demoralized people—which means the critical component of all psychotherapies, according to Frank, is the generation of hope (Frank & Frank, 1991; Sprenkle et al, 2009). Though Frank’s work did not hinder the model-specific movement, it had significant influence in the field of psychotherapy, and provided a ground for future integrative approaches. Frank & Frank (1991) stated:

“Two such apparently different psychotherapies as psychoanalysis and systematic desensitization could be like penicillin and digitalis – totally different pharmacological agents suitable for totally different conditions. On the other hand, the active therapeutic ingredient of both could be the same analogous to two aspirin-containing compounds marketed under different names. We believe the second alternative is closer to the truth” (p. 39).

Carl Rogers (1957, 1961), the founder of client-centered therapy, contributed to the field of psychotherapy and common factors. Though Rogers’ school of therapy introduced a
therapeutic manual that can be considered as empirical treatment, his method basically emphasizes the common characteristics of healing relationships that go beyond specific psychotherapy models (Norcross, 2002b; Sprenkle et al, 2009; Wampold, 2010). Rogers outlined three essential characteristics of the therapist that create healing context: empathy, positive regard, and congruence (Rogers, 1957, 1961). These therapist’s characteristics (e.g., being congruent, accepting, empathic, respectful, understanding, etc) create specific qualities for the context of healing relationship and also inspire specific qualities (freedom to explore new experiences, self-understanding, feels understood and accepted, etc.) in the client—which are consistent with recent classification of common factors (Sprenkle et al, 2009).

Orlinsky and Howard (1987) introduced a “generic” approach of psychotherapy that contributed in the field of common factors and integrative psychotherapy. They suggested four general domains within which psychotherapies can be conceptualized: co-oriented activity (referring to therapist’s and client’s behavioral interactions), concurrent experience (referring to the therapist’s and client’s phenomenological perceptions of their social interactions), dramatic interpretation (referring to the symbolic formulations of meaning and values regarding the treatment and goals), and regular association (referring to the normative conventional patterns of therapeutic relationship and contract). Orlinsky and Howard work mainly contributed to the field by introducing different levels of functioning in psychotherapy, and the specific role of the treatment contract in therapy success (Sprenkle et al., 2009).

One of the most controversial and cited articles in the field, is a paper by Luborsky et al., (1975). Luborsky and his colleagues (1975) studied the impact of different treatments on clients to see if is it true that “everyone has won and all must have prizes”? (which he referred to as the “dodo bird verdict). Their findings indicated that all treatments showed the equal level of
therapeutic effect, on average—three of every four clients meaningfully improved. Based on their findings Lubrosky and his colleagues concluded that effectiveness of psychotherapy models basically depends more on the common factors that function across all effective treatments than on the specific methods and techniques of the models.

The “dodo bird verdict” of Luborsky and colleagues has been questioned by proponents of ESTs, though Luborsky (2002) mentioned that reanalysis of these data and a body of psychotherapy research support their conclusion. According to Luborsky et al., (2002) the uncorrected low effect size (.20) indicated small or non-significant difference among active treatments, especially after correction for the researcher’s allegiance. They found a high correlation coefficient (.85) between researcher’s allegiance and treatment outcomes.

Based on his review of empirical studies on therapeutic outcome, Lambert (1992) suggested a four-factor model of common factors (extra-therapeutic change factors, common factors, technique factors, and expectancy factors) which contained estimated percentages for each category. Though the percentages were educated estimations of the impact of the common factor on therapeutic change, they have been interpreted and cited by researchers as factual percentages of variance accounting for change (Sprenkle & Blow, 2004). His model suggested that 40% of variance of treatment can be attributed to extratherapeutic factors in the client’s life, 30% of variance attributed to relationship factors that refer to the alliance between therapist and client, 15% of variance attributed to positive expectancy and placebo factors, and 15% attributed to techniques and treatment factors. Miller, Duncan, and Hubble (1997) modified Lambert’s four-factor model. The outlined all categories under the common factors label and changed the estimated percentages. They categorized them as: client and extra-therapeutic factors; relationship factors; model or techniques, and expectancy factors (Sprenkle & Blow, 2004).
Client and extra-therapeutic factors estimated to contribute 40% to therapy outcomes, relationship factors estimated to contribute 30% to therapy outcomes, model or techniques estimated to contribute 15% to therapy outcomes, and expectancy factors estimated to contribute 15% to therapy outcomes.

In addition, Lambert (1992) introduced another insightful conceptualization of common factors that proposes a chronological model of therapeutic change. His work divided the common factors into three categories or stages: support factors, learning factors, and action factors. That is, the support and secure relationship provides a stage for learning that in turn results in new actions. This division includes emotional, cognitive, and behavioral dimensions of different therapeutic interventions as well as points to sequencing of these factors (Lambert, 1992; Spreckle et al, 2009). Lambert and Ogles (2004) explain the developmental sequence of the common factors over the course of therapy: the common factors create a collaborative working situation in which clients feel more sense of trust and security plus tension and anxiety reduction, that result in changes in client’s conceptualization of his/her problems, and finally lead to actions, risk taking and new intrapersonal and interpersonal experiences.

There are some other scholars (Grencavage & Norcross, 1990; Goldfried & Padaver, 1982; Gurman, 1978; Karasu, 1986) that introduced insightful theories and conceptualizations of change mechanisms that underlie psychotherapy models. For example, Golfried and Padaver (1982) suggested three differentiated levels of interventions in psychotherapy that include: theories, strategies, and interventions. Theories are the highest abstract and conceptual themes address different point of views regarding human functioning and pathology. Strategies are in the middle level of abstraction which can be activated by apparently different interventions/ techniques. Techniques/interventions have the lowest abstraction and are related to specific
theory. According to their perspective, though clinicians apparently provide different treatment due to their theoretical concepts and formulations but in practice there is a great deal of overlaps among their therapy when it comes to the level of strategies and interventions. In other words, seemingly different interventions activate almost the same strategies (mechanisms of change) across different theoretical models. Consistent with Goldfried and Padaver, Prochaska and Norcross (2007) believe that one way of defining common factors is to consider a level of abstraction between theory and technique. They suggest that this intermediate level of abstraction be called a change process that functions as a heuristic guide for the experienced therapist. The experienced therapist may use seemingly different techniques from different models to trigger the same change process or mechanism.

**The Move to Establish Model Effectiveness and Its Unanticipated Result**

During the 1950s and 1960s, British psychologist Hans Eysenck (1961, 1966) came to the conclusion that mental health professions are ineffective. He contended that approximately two thirds of the clients with neurotic problems improved after two years of psychotherapy. He pointed out that the same percentage of clients also improved without receiving treatment. However, he later stated that, whereas psychotherapy (i.e., psychoanalysis, eclectic) is not effective and sometimes harmful, behavior therapy is a scientific and, consequently, superior approach (Wampold, 2011). Such repeated criticism triggered a huge number of theoretical and empirical debates and research in the field of psychotherapy (Hubble et al., 1999). Therefore, many psychotherapy models and their developers or proponents put a lot of effort into testing and verifying the effectiveness of their models. It became a trend to demonstrate that one model was more effective and superior than another (Davis, 2005; Sprenkle & Blow, 2004; Wampold, 2010). Such a trend has been expedited in recent years because of more emphasis on
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accountability by insurance agencies and third party payers (Asay & Lambert, 1999). Despite the flaws in Eysenck’s claim, his work was important since it was the first to use evidence for measuring relative efficacy of treatments (Wampold, 2011).

In response to the psychotherapy debate, Smith and Glass (1977) reviewed all controlled studies in the psychotherapy field. Using an index of effect size, they determined that the outcome of those people who received treatment was superior, by .80 standard deviation units, than those people who not receive treatment. Their findings indicated that behavioral therapy was not superior to other psychotherapy models. However, some scholars (Eysenck, 1978, 1984; Landman & Dawes, 1982) criticized the Smith and Glass findings for omitting some important behavioral studies, for including some studies that lacked strong design, and for the mildly distressed participants in some the studies.

In response to Eysenck’s claim, several psychotherapy researchers have indicated that not only it is effective, but it is as effective as medical treatments for many disorders (Barlow, Gorman, Shear, & Woods, 2000; Imel, Malterer, Mackay, & Wampold, 2008; Wampold, 2010). In addition, it appears that the effects of psychotherapy lasts longer than medical treatments (Hollen, Stewart, & Strunk, 2006). This is probably because it provides clients with skills to cope with the world and their psychological problems (Wampold, 2010). Furthermore, compared to medication, psychotherapy is less resistant to additional courses of treatment and with lower inconvenient side effects (Leykin, et al., 2007).

Proponents of ESTs believe that while a body of empirical and meta-analysis studies showed that psychotherapy is efficacious, we need to improve model effectiveness for specific problems and clients (Chambless & Ollendick, 2001). In 1993, American Psychological Association (APA) issued the most comprehensive evidence-based study to date. A special task
force of Division 12 of APA was formed to “disseminate important findings about innovations in psychological procedures” (Chambless, 1996; Task Force Report on Promotion and Dissemination of Psychological Procedures, 1993, p. 1). Sprenkle and Blow (2004) state that “[t]his was arguably the most carefully done and most expensive study in the history of psychotherapy. The investigators randomly assigned 250 patients to four different treatment groups in three cities” (p. 118). The result was unanticipated—there were no differences among all forms of treatment (cognitive behavioral therapy, interpersonal therapy, medication with management, and placebo plus clinical management) (Blatt, Zuroff, Bond, & Sanislow, 2000; Chambless & Ollendick, 2001), though depressed clients in both psychotherapy groups showed more positive life adjustment in the 18-month follow up than other groups (Chambless & Ollendick, 2001). The results of this Task Force triggered more challenges in the field. As Davis (2005) mentioned, the findings of the Task Force split up the field more than before. The advocates of Division 12 Tack Force were happy to show the effectiveness of their treatment models, while others pointed out that the researchers’ claim was an overbearing superiority and the conclusion was oversimplified.

A review of recent psychotherapy research shows that as the number of evidence-based and model specificity studies accumulated, the other camp (common factors advocates) found more chances to conduct more meta-analyses of these studies—which resulted in a loop of research efforts between two camps (Sprenkle et al. 2009; Wampold, 2010). To date, all major meta-analysis studies, both in psychology and MFT fields, showed the same conclusion that Smith, Glass, and Miller (1980) reached in their most comprehensive (N=475 studies) meta-analysis of the time:

"We did not expect that the demonstrable benefits of quite different types of psychotherapy would be so little different. It is the most startling and intriguing
finding we came across. All the psychotherapy researchers should be prompted to ask how it can be so. If it is truly so that major differences in technique, count for so little in terms of benefits, then what is to be made of volumes devoted to the careful drawing of distinctions among styles of psychotherapy? And what is to be made of the deep divisions and animosities among different psychotherapy schools? "(p.185).

Therefore, following the results of both psychotherapy research camps, one may ask how similarly or differently all therapy models work to generate desired therapeutic change? There are probably three ways to explain these results: First, perhaps different models bring about the same efficacy but through different mechanisms of change (Lambert & Ogles, 2004; Sprenkle & Blow, 2004). Though at present the field lacks enough related evidence to verify this assumption (Johnson, 2002; Pinsof & Wayne, 2000; Prochaska & Norcross, 2007).

The second assumption is to say, perhaps there are significant differences in therapeutic outcome across effective models, but we have not been able to discover those differences because of inappropriate research questions or insufficient research methods (Sprenkle & Blow, 2004). Some scholars (Chambless & Ollendick, 2001; Kazdin, 2007; Paul, 1967; Sprenkle & Blow, 2004) assume the assertion that meaningful differences in outcome of treatments can be found through specific characteristics of problems, clients, therapists, situations. However, these differences would not be enough to claim one single model is overall superior to others (Davis & Piercy, 2007; Sprenkle & Blow, 2004).

The third explanation is to say that the common mechanisms of change that work within all effective psychotherapy models can explain the therapeutic outcomes and the minimal differences we may find among them (Sprenkle & Blow, 2004).
While opponents of the common factors model refer to a huge number of individual studies showing differences among treatment models, advocates of the Common Factors Model criticize them for this reason: a high percentage of psychotherapy outcome research is conducted by the model developers and their colleagues which results in strong allegiance effects (Sprenkle & Blow, 2004; Wampold, 2001). The researchers usually make comparison between their own preferred model and some other treatments that are not equally valued (Wampold, 2010).

Consequently, the psychotherapy effectiveness debate between the ESTs and common factors camps may be solved if the researchers of the two camps focus more attention on common mechanisms of change and therapeutic process. As Kazdin (1991) has commented, “many researchers lament that the manuals, including their own manuals, are incomplete and do not reflect the complexity of treatment and scope of the exchanges between therapist and patient” (p. 293). In other words, since neither manualized ESTs nor huge meta-analysis can reveal the mechanisms of change in psychotherapy, the field needs more combined process-outcome research. Such research can explain what and how client, therapist, and relational variables in addition to model-specific factors influence therapy outcomes.

**Moderate Common Factors Approach**

Sprenkle and Blow (2004a) introduced a position related to common factors that is different from the previous extreme and traditional common factors conceptualizations suggested by Wampold (2001) and Hubble et al (1999). Their conceptualization of common factors proposes an important role for common factors but it does not mean that specific models do not contribute in therapeutic change. From their perspective, there is room for the findings of clinical trial studies as well as the meta-analysis studies that show little difference across psychotherapy outcome (Davis & Piercy, 2007a; Sprenkle et al, 2009). In other words, Sprenkle and Blow
(2004a) do not believe that “any one treatment is as good as any other” or “treatment models are unimportant”. They prefer to utilize the term “efficacious” or “relative efficacy” because of challenges from EST research criteria that might exclude many efficacious treatments (Sprenkle et al, 2009). They believe that effective models are mainly effective because they can activate or potentiate the common factors which are primarily mechanisms of change. In other words, “the models are important because they are the vehicles through which the common factors do their work” (Sprenkle & Blow, 2004, p. 126). Also, according to this moderate view of common factors (Sprenkle et al., 2009) randomized clinical trials are important and necessary to prove the effectiveness of our treatments to government, third-party payers, and other professions but it is not necessary to understand the mechanisms of change.

In addition, psychotherapy research appears to support differential effectiveness of some therapies for particular disorders, such as systemic therapy for marital conflicts (Johnson, 2002; Lambert & Bergin, 1994). Therefore, it is proposed that psychotherapy can be advanced by integrating the function of the common factors (e.g., client, therapist, relational variables) and the practicality of model-specific factors across different clients and clinical problems (Prochaska & Norcross, 2007).

Additionally, the coherence and organization of the interventions can work as a common factor across all effective treatments. A clear map regarding the treatment rationale, therapeutic assignments, and therapy goals is a common aspect of all successful therapies. It is mentioned by many scholars, both integrative and ESTs, that “the very fact that an intervention is well organized and coherent (independent of specific interventions) may make it more effective than a disorganized alternative” (Sprenkle et al, 2009, p148).

**Current Components of Common Factors**
In a broad conceptualization, common factors are all components of the therapeutic situation that can contribute in therapeutic change, including: client, therapist, relationship, expectancy, and therapeutic procedures that are not specific to a particular treatment model (Sprenkle & Blow, 2004). On the other hand, the narrow conceptualization of common factors refers to the commonalities among the diverse therapeutic interventions introduced by specific treatment models (Sprenkle et al, 2009). In other words, the narrow conceptualization is considered as a part of the broad definition of common factors. Sprenkle et al (2009) suggested five major categories of common factors though they are open to new “unrecognized factors” (as Rosenzweig stated 76 years ago) that might be discovered in future research. Obviously, the distinction between common factors components is not a factual distinction since therapy is basically a multilevel interactional process (Prochaska Norcross, 2007; Sprenkle & Blow, 2004). In the current study, the moderate definition of the common factors model is used which proposed both common factors and model-specific factors as influential factors to therapy outcome. However, the discussion of common factors in terms of distinct components/categories is necessary for professional communication and research. Below the five categories of common factors (Sprenkle et al, 2009) are reviewed:

**Client characteristics as common factors.** Current psychotherapy research indicates the critical importance of client’s characteristics on therapy outcome, and the past oversight of this important factor should be considered as “professional centrism” that caused thought in terms of models and techniques (Sprenkle et al, 2009; Tallman & Bohart, 1999). Sometimes there is failure to think of therapy function as activating the natural healing resources of clients (Perkins, 2010; Sprenkle & Blow, 2004). According to Bergin & Garfield (1994) “as therapists have depended more upon the client’s resources, more change seems to occur” (p. 826). Clients often
reconstruct therapeutic interventions offered by therapists to individualize them for their own purposes (Sprenkle & Blow, 2004; Tallman & Bohart, 1999).

Client factors are characteristics of the client (such as motivation and commitment to change, inner strength, spirituality and religious faith, cognitive ability and intelligence, self-agency, cooperation on therapeutic tasks, perseverance, awareness, expectations, etc.). Many scholars (Beutler et al, 1998; Perkins, 2010; Prochaska & Prochaska, 1999; Sprenkle & Blow, 2004; Tallman & Bohart, 1999) agree with Miller et al. (1997) that “the research literature makes it clear that the client is actually the single most potent contributor to outcome in psychotherapy” (p. 25-26).

According to Gonzales (2002), during the course of therapy, clients are very industrious in an invisible level to guide the therapy sessions, encourage therapists actions, and benefit of the process. In fact, clinicians have a general “sense” regarding who will benefit of therapy and who will not. Those clients who are motivated and tend to participate in the process of self-discovery and behavioral change can be called good clients who actively move toward desired therapeutic change (Gonzales, 2002).

Therapist characteristics as common factors. Some scholars (Elkin, Falconnier, Martinovich, & Mahoney, 2006; Garfield, 1997) stated that the therapist role in therapeutic outcome should be called the “‘neglected variable’” in research on psychotherapy. Simon (2006) pointed out that it is the therapist position that solves the dilemma between the common factors versus models. According to his view, when the therapist clarifies his/her worldview the therapist adopts an effective model of change that is congruent with that worldview. Such congruency between model and therapist gives an opportunity to the therapist to utilize the model as a personalized vehicle—which maximizes the therapist’s potentials and in turn may
serve as the best possible practice for the client (Blow, Sprenkle & Davis, 2007). The best example of this assumption comes from the best, most comprehensive psychotherapy research conducted by National Institute of Mental Health (NIMH), the Collaborative Depression Study (Elkin et al, 1989). Therapists in each group were highly trained and had allegiance to the model they practiced in the study. Results revealed that there were importance differences for therapist effectiveness though there were no differences in the outcomes of treatment models (Blow, Sprenkle & Davis, 2007). Blatt, Sanislow, Zuroff, and Pilkonis (1996) reanalyzed the data to find the therapist effectiveness as they controlled for treatment model, the setting, and even the experience level of therapists. Blatt et al (1996) found the therapist effectiveness as the main factor, and surprisingly, reported that the best result was achieved by a female psychiatrist who met clients for antidepressant or placebo treatment and clinical management. They concluded that, surprisingly, the female therapist provided the high level of therapeutic effectiveness while she was meeting clients for a short time (25 minutes per week) within a treatment plan designed as a minimal therapeutic condition, which was supposed to offer only support and encouragement for the clients.

In addition, Wampold (2001), based on a large meta-analysis on psychotherapy outcome studies, showed impressive statistical evidence that therapists’ differences contributed more (effect size of 0.65) than their treatment models (0.20) to the variance of therapy outcome.

Though research indicates that probably some therapists have more competency or expertise than others, there is not a clear picture of the components of therapist competency (Sprenkle et al, 2009). As Beutler, Malik, and Alimohamed (2004) mentioned, the research’s emphasis on randomized clinical trials (RCT) ignored the importance role of therapist in therapy process and outcome. It is a goal in efficacy studies to increase the power of treatments.
Therefore, researchers make a lot of effort to control the impact of therapist characteristics (and also many other possible influential factors) by developing therapeutic manuals which are supposed to be used similarly with all clients diagnosed with particular disorders, regardless of clinician’s abilities. In other words, this type of research does not give enough attention to therapeutic functions that are attributed to therapist's characteristics (Beutler, Malik, and Alimohamed, 2004; Sprenkle et al., 2009; Wampold, 2010).

Additionally, though randomized clinical trials (RCTs) try to control therapist factors as sources of error rather than sources of therapeutic variance, “unfortunately, standardizing the treatment has not eliminated the influence of the individual therapist on outcomes’ (Beutler et al., 2004, p.245).

Research suggested a set of therapist characteristics that contribute in therapeutic outcome (such as therapist positivity and friendliness, level of activity in the session, providing structure to face clients with cognitive, emotional, and behavioral issues, therapist openness, therapist’s ability to adapt to client’s preferences and expectations, ability to keep client in moderate emotional arousal, therapist’s cultural sensitivity, etc.) (Sprenkle et al, 2009; Wampold, 2010).

**Therapeutic relationship as a common factor.** This category of common factors refers to alliance phenomenon that is a mutual product of therapist and client focused on therapy process (Sprenkle & Blow, 2004). It considers both the client’s and the therapist’s perceptions of alliance since their perceptions might be different, and research indicates that the client’s rating of the relationship quality is more important in predicting therapeutic outcome (Bachelor & Horvath, 1999). It is suggested that alliance contains three elements: *Bonds* that refers to the affective qualities of therapeutic relationship such as trust, caring, warmth, etc.; *Tasks* that refers
to the comfort and agreement of clients and therapist on therapeutic activities and their credibility; *Goals* that refer to agreement and cooperation of client and therapist toward therapeutic goals (Bordin, 1979). Research indicates that early alliance ratings can predict therapy outcome even before particular therapy techniques are conducted (Lambert & Ogles, 2004; Martin, Graske, & Davis, 2000). Beck and Jones (1973) used regression analysis to assess the contribution of 11 factors in positive therapy outcome. The counselor-client relationship is the most predicting factor for therapy outcome, and it was twice as powerful a predictor as clients or service characteristics covered in their study.

**Expectancy and hope as common factors.** As Lambert (1992) mentioned, expectancy and placebo factors refer to the client’s knowledge of being in therapy as healing process, becoming helpful, and trusting in therapy credibility. Many scholars (Lambert & Ogles, 2004; Sprenkle & Blow, 2004; Sprenkle et al, 2009) prefer “expectancy” or “hope” rather than “placebo”, since in psychological treatment, versus medical treatments, it is not feasible to completely separate the specific treatment from placebo effect. Though different models and researchers may use different terms, it seems that remoralization should be built in initial stages of most effective therapies (Sprenkle & Blow, 2004), such as Functional Family Therapy (Sexton & Alexander, 2003) and Emotional Focused Therapy (Johnson, 2008). Research (Johnson & Talitman, 1997) indicates that presenting a credible treatment to the client in a way that is consistent with client expectancy significantly contributes in therapy outcome. However, more research is needed to explore the relationship between hope and change in psychotherapy (Sprenkle & Blow, 2004).

**Non-specific mechanisms of change as common factors.** This category of common factors is equivalent to the narrow definition of the model. There are some insightful models or
conceptualizations (Greencavage & Norcross, 1990; Karasu, 1986; Prochaska & Norcross, 2007) that outlined nonspecific therapeutic mechanisms of change. For example, Karasu (1986) suggested that although the models have different theoretical assumptions and languages, and apparently employ different interventions, all therapeutic interventions can be conceptualized in three dimensions: Behavioral regulation, Cognitive mastery, and Affective Experiencing.

**Proposed Common Factors in Marriage and Family Therapy**

For the first time in the field of MFT, Sprenkle et al. (1999) review the MFT research literature, and consistent with Lambert’s (1992) four categories of common factors suggested five unique MFT common factors, including: (a) relational conceptualization; (b) expanded direct treatment system; (c) expanded direct therapeutic alliance in MFT; (d) behavioral, cognitive, and affective common factors in MFT; and (e) privileging of client’s experience.

Though there is a significant overlap between individual and relational (couple and family therapy) therapies regarding the common factors and mechanisms of change, scholars (Davis & Piercy, 2007a; Sprenkle et al, 2009) suggest the common factors should be considered unique to the couple and family therapy field: (1) relational conceptualization of problems, (2) disrupting dysfunctional relational patterns, (3) expanding the direct therapeutic system, and (4) expanding the therapeutic alliance.

**Relational conceptualization of problems.** The first unique MFT common factor, relational conceptualization of problems is in contrast to DSM perspective that emphasizes on within-person pathological conditions. Based on this unique MFT common factor, relational therapies consider various subsystems that constitute the system in which the problem is surrounded (Sprenkle et al, 2009). Davis and Piercy (2007a, 2007b) provided empirical evidence
for the MFT common factor of relational conceptualization. Their findings indicate that three different relational therapies (emotional focused therapy, cognitive-behavioral couple therapy, and internal family system therapy) can bring about therapeutic change by providing their clients with conceptualization of dysfunctional interactional cycles. According to this explanation, they concluded that the model developers, their students, and their clients consider the process of therapeutic change in similar way (Davis & Piercy, 2007a, 2007b; Sprenkle et al, 2009). In addition, while each of these relational models apparently emphasize specific domain (e.g., emotion-focused on emotional domain) each model covered all three cognitive, emotional, and behavioral dimensions of dysfunctional cycles (Davis & Piercy, 2007a, 2007b).

**Disrupting relational patterns of problems.** Most relational therapies basically utilize interventions that aim to interrupt dysfunctional interactional patterns among family members or couples (Goldenberg & Goldenberg, 2004; Sprenkle et al, 2009). For example, structural therapists try to break up the sequence of dysfunctional interactions among family systems that are assumed to be the source of pathological behaviors (Minuchin, 1974), emotional-focused therapists interrupt continuing pathological emotional cycles (Johnson & Talitman, 1997), strategic therapists breaking the behavior sequences (Haley, 1987), and Bowen therapists interrupt the pathological triangulations and other intergenerational patterns (Bowen, 1978). The work of Davis and Piercy (2007a, 2007b) also indicated that though the therapists in their study conceptualized their procedures as cognitive, emotional, or behavioral, all of them sought to interrupt the pathological patterns or cycles. Therefore, it can be concluded that all effective couple and family therapy models utilize pattern interruption as their main intervention to bring about the therapeutic change (Sprenkle et al., 2009).
Expanding the direct therapeutic system. Most of couple and family therapy models and therapists prefer to involve more family members or related key persons to increase the scope of possible changes and solutions, to provide support and resources for the client, to improve the broader system itself, to evaluate the reciprocal impact of the problem/client to other family members (e.g., children in case of a depressed parent), and to understand and change the problem maintenance structure (Pinsof, 1995; Sprenkle et al., 2009). In addition, there are many studies that showed strong evidence for the superior effect of conjoint therapies for a number of problems. Examples include adolescent treatment for substance abuse (Rowe & Liddle, 2003), marital dysfunction (Johnson, 2002), and adolescent treatment for conduct disorder (Henggeler & Sheidow, 2003). However, there are discussions about the level of using this unique MFT common factor across different MFT models and it seems that this issue needs more research (Sprenkle et al., 2009). For example, Minuchin (1998) critiques postmodern family therapies, stating that, “the family, that natural interpersonal context in which people develop their views of themselves in the world, disappears from practice” (p.399).

Expanding the therapeutic alliance. Alliance between therapist and client is one of the most important therapeutic factors that have been studied well theoretically and empirically. However, when it comes to couple and family therapy it becomes a complex topic since one can imagine different, and sometimes opposite, emotional bonds between therapist and each family member in the room. Also, it is possible that each of the individuals, subsystems, and the whole family system experience different alliance positions to the therapist—which may expedite or hinder the therapeutic process and desired change (Davis, 2005; Sprenkle et al., 2009). The same assumption is imaginable for the goal dimension and task dimension of the alliance. When there is lack of agreement on therapeutic activities and goals between family members as a whole and
their therapist, probably the broadening therapeutic system is questionable—which requires the therapist to decide to involve some of them and develop indirect alliance with others (Sprenkle et al., 2009). However, a clinician can imagine how the therapy will get a strong boost if family members as individual, subsystem, and as a whole establish a coherent alliance to the therapist (Sprenkle & Blow, 2004a).

**Summary**

There are three main purposes of this study. First, is to develop an instrument to measure specific components of the Common Factors Model that clinicians attribute to successful therapeutic outcomes. The second purpose is to assess certain demographic characteristics of clinicians that associated with the use of common factors in therapy. Lastly, the third purpose is to improve the theorization of the Common Factors Model by exploring how and when advocates of the Common Factors Model utilize specific common factors during three stages of therapy to bring about desired therapy outcomes.

**Research Questions and Hypotheses**

**Aim 1: To develop a Common Factors Questionnaire (CFQ) that can measure the specific components of the Common Factors Model**

**RQ1:** Does the Karimi-CFQ demonstrate sufficient psychometric properties (reliability, content and construct validity)?

**Aim 2: To assess the clinicians’ perceived contribution of common factors in therapy outcomes**

**RQ 2:** To what extent do therapists perceive Specific Components of Karimi-CFQ contributed to therapeutic change?
**Hypothesis 1**: Based on Karimi-CFQ results, there will be a significant difference between specific components of Karimi-CFQ regarding their contribution to therapy outcomes.

**RQ 3**: Based on the results of survey section 2, to what extent do therapists perceive specific percentage categories of the Common Factors Model contributed to therapeutic change?

**Hypothesis 2**: Based on survey section 2, there will be significant difference between six categories of the Common Factors Model regarding the contribution to therapeutic change.

**RQ 4**: Based on the results of survey section 3, what is the relative degree to which total common factors compared to total model-specific factors contribute in therapy outcomes?

**Hypothesis 3**: Clinicians would attribute higher contribution of total common factors to therapy outcomes than total model-specific factors.

**Aim 3**: To assess the relationship between clinicians’ demographic characteristics and clinicians’ perceived contribution of common factors in therapy outcome

**RQ 5**: Are there gender differences in the perceived contribution of common factors to therapeutic change?

**Hypothesis 4**: Female clinicians would attribute higher perceived contribution of common factors in Karimi-CFQ.

**Hypothesis 5**: Female clinicians would attribute higher contribution to relationship category and to total common factors than male clinicians.

**RQ 6**: Are there clinical experience differences in the perceived contribution of common factors to therapeutic change?
**Hypothesis 6:** Clinicians with higher clinical experience would attribute higher contribution to therapist category and also to total common factors than clinicians with low clinical experience.

**RQ 7:** Are there field of study differences in the perceived contribution of common factors to therapy outcome?

**Hypothesis 7:** Clinicians with different fields of study would attribute significant different contribution of total common factors to therapy outcome.

**RQ 8:** Are there clinical orientation differences in the perceived contribution of common factors to therapeutic change?

**Hypothesis 8:** Based on Karimi-CFQ results, clinicians with different clinical orientations would attribute significant different contribution of common factors to therapeutic change.

**Hypothesis 9:** Based on survey section 3, clinicians with different clinical orientations would attribute significant different contribution of total common factors to therapy outcome.

**Aim 4:** To improve the theorization of the Common Factors Model by exploring the chronological use of common factors by experienced common factors therapists.

**RQ 9:** When and How do therapists use specific common factors in the course of therapy (initial, intermediate, termination) to reach to their desired therapeutic outcomes?

**RQ 10:** To what extent are findings from the CFQ survey and open-ended questions consistent?
Chapter III: Method

Using mixed method research, this study applied both positivist and constructivist paradigms to answer the research questions and was conducted in three phases. Phase 1 included development of the Common Factors Questionnaire (named Karimi-CFQ). In Phase 2 Karimi-CFQ was administered to survey the therapists’ perspective regarding the contribution of common factors in therapy outcome. In this phase, data was also collected to assess the relationship between clinicians’ demographic characteristics and their perceived contribution of common factors in therapeutic change. Finally, in Phase 3, common factor experts were invited to respond to open-ended questions that explored how and when experienced therapists use specific common factors in the course of therapy to reach to their therapy goals.

Phase 1: Karimi-CFQ Instrument Development

Initial item pool from the literature. The first step of any instrument development is to determine “what” the instrument aims to measure. The purpose of the Karimi-CFQ was thus to capture the clinicians’ perspective regarding the contribution of common factors in therapy outcomes—with reference to their current successful or effective relational cases of therapy. The reason for considering the clinicians’ current successful cases was to anchor their responses to real, not hypothetical therapy scenarios.

Thus, in the first phase, the researcher first reviewed integrative psychotherapy models, especially the literature on common factor models, to provide an initial organizational structure for common mechanisms/factors of change that are utilized by a wide range of theorists and therapists to achieve therapeutic goals. In the current study Sprenkle’s et al. (2009) moderate definition of common factors was considered as a theoretical framework which includes six
categories of common factors (client, therapist, relationship, hope, non-theory specific, and systemic; see Figure-1). Each item was generated and cross-referenced with these six categories. The initial item pool included 43 items that resulted from common factors literature (See Appendix A). This pool was reviewed by the researcher’s committee members who are trained in marriage and family therapy and research methodology before it was sent to an expert panel.

![Figure 1. Structure of Common Factors Model](image)

**Expert panel.** The expert panel included faculty, researchers, and mental health practitioners who have published in the field of common factors and integrative psychotherapy and family therapy. The inclusion criteria to participate in this first phase were: had a Ph.D. in the mental health field and have authored at least two publications (either book, article in peer reviewed journals, or a Ph.D. dissertation) in the field of common factors and integrative therapy. During the literature review the email addresses of experts were collected and they were
contacted by email to participate in the review of the item pool. Twelve experts were emailed, out of which four of them replied and agreed to participate in the review of pilot 34-items CFQ via email (33% response rate). Also, two other experts agreed to participate using a paper-and-pencil format. The suggestions from the expert panel were reviewed and implemented to form the pilot version of common factors questionnaire (CFQ) which comprised a total of 34 items in six categories (See Appendix-C). The Virginia Tech IRB approval was provided at the time of experts’ consultation.

In addition, after implementing the suggestions from the expert panel, five Ph.D. students at Virginia Polytechnic Institute and State University’s Marriage and Family Therapy program who were familiar with common factors model and practicing therapy for at least three years were invited to check the items for clarity, readability, relevance, and dimensionality. Three provided comments and suggestions, which were used to further refine and rework the items on the CFQ.

**Survey content.** Based on the common factors and integrative therapy literature, 43 items were created to characterize the 6 factors of the common factors model (See Appendix-A). Ten items were used to characterize the client’s factor, 16 items were included to characterize therapist’s factor, 3 items were utilized to characterize relationship factor, 4 items were included to describe the hope factor, 6 items to characterize non-theory specific factor, and 4 items were included to characterize systemic factor. These 43 items were reviewed with three common factors experts for relevancy and readability. This procedure resulted in deletion of nine items and rewording the remaining 34 items. In the next step, the pilot 34-items CFQ was rated by the expert panel for content validity and relevancy.
In the current study the full common factors survey included two other sections which were not sent to the experts for relevancy rating, including: section two which contains a percentage question to compare six total categories of common factors to each other, and the third section of the survey which includes a percentage question to compare total common factors versus total model-specific factors. Sections 2 and 3 were reviewed and reworded by my committee members and two other common factors experts. In order to develop the Common Factor Questionnaire (CFQ) only the first section of the survey (34-items) was rated by the expert panel.

**Response format.** In the second step of instrument development, the researcher chose a 5-point Likert-type response frame. The choices ranged from “very little”, “little”, “some”, “much”, and “very much” that represent scores from 1 to 5 for the relevancy of each item.

**Analysis.** A panel of six experts reviewed the pilot common factors questionnaire (CFQ) using the 5-point scale to rate each item for its degree of relevancy to the objectives of CFQ and ability of the item to capture the specific component it represents. The experts’ ratings were used to refine the instrument. The experts’ ratings of relevancy for each item were combined to create a content validity index (CVI; see Appendix-B) which indicates the degree of agreement among the reviewers (Davis, 1996; DeVillis, 2003).

**Phase 2. Administration of CFQ**

In Phase 2 of the study, the Karimi-CFQ that was developed and refined in Phase 1 was administered to mental health clinicians and its psychometric properties were evaluated. Below I describe the step-by-step procedure for this phase of the study.
**IRB Approval.** Before administration of the CFQ to mental health clinicians across the United States, the Virginia Polytechnic Institute and State University Institutional Review Board (IRB-NUMBER: 14-1227) (See Appendix-J) was approved for the current study on December 22, 2014. There was no monetary incentive for participating in this study. However, participants could receive a summary of the research results if they were interested.

**Sampling technique and sample size.** Convenience sampling method was used to recruit clinical mental health professionals to participate in the second phase of the study. Clinical members of different mental health professional organizations (e.g., American Association for Marriage and Family Therapy, American Psychological Association, American Counseling Association, National Association of Social Work) in the United States were considered the target population in this study. More specifically, the inclusion criteria included having a degree in a mental health discipline, practicing couple and family therapy as a licensed or licensed-eligible mental health practitioner, being legally eligible to practice therapy in the United States privately or under supervision.

Various strategies were used to reach the target population. An email request was sent to clinicians both individually and through organizations who employ clinical members to participate in the study. For this, email requests were sent to directors of accredited MS and Ph.D. MFT programs to distribute the survey’s recruitment email to their current and previous students as well as to the community mental health centers in their area. The list of APA clinical psychology accredited programs was also procured and directors were contacted with the same email invitation letter. In addition, listservs of APA’s Division 5: Evaluation, Measurement, & Statistics, Division 15: Educational Psychology, Division 16: School psychology, Division 29: The Society for the Advancement of Psychotherapy, Division 37: Child and Family Policy and
THE CONTRIBUTION OF COMMON FACTORS

Practice, Division 39: Psychoanalysis, Division 43: Family psychology, Division 56: Trauma Psychology were used to contact eligible participants for the study. If the desired sample size was not reached, then community mental health centers across the country would be contacted.

Sample Size and Power Analysis. Since the questionnaire was developed for the current project there is no estimation of the standard deviation. Therefore, the Rea and Parker (1997) recommendation is used to estimate sample size. They suggested that a sample size that considers 95 percent confidence and an approximately 5 percent margin of error, is acceptable for most types of survey research. Based on Rea and Parker's recommended table, a minimum required sample size would be 385. The expected response rate for the current survey was 20%, based on previous studies using similar methodology with mental health clinicians (Hertlein, 2004; Northey, 2005; Perkins, 2010). In order to gain a sample of 385 at a response rate of 20%, 1925 potential participants needed to be invited to participate in the current study. In addition, it is possible to have returned/unsuccessful emails up to 35% (Vehovar, Batagelj, Manfreda, & Zaletel, 2002), therefore, the researcher considered an ideal number of potential participants to be recruited to be 2600. In the current study a sample of 391 provided a better sample size than the rule-of-thumb most researchers use in factor analysis and structural model which is the subject to item ratios of 10:1 or less (Castello & Osborne, 2005).

Survey content. The research survey is an online survey administered via Virginia Polytechnic Institute and State University's Qualtrics website, which included four sections: In section 1 of the survey six demographic information questions were solicited (i.e., gender, age, years of clinical experience, educational degree, field of study, favorite clinical orientation). Section 2 included the refined self-report instrument, named Karimi-CFQ (See Appendix-D).
Karimi-CFQ included 2-items that captures client’s factors (4 items), therapist’s factors (5 items), relationship factors (4 items), hope factors (4 items), non-theory specific factors (7 items), and systemic factors (4 items) were (See Appendix-D) using a 5-point Likert-type response scale, ranging from 1 to 5. Section 3 included one percentage-based question to compare the contribution of six categories of the Common Factors Model in therapy outcome. Section 4 included a percentage-based question to compare the contribution of total common factors versus model-specific factors in therapy outcomes out of 100%.

**Analyses**

**Reliability.** Instrument reliability refers to the consistency or accuracy and stability of instrument scores over time. It is also a prerequisite of the instrument validity, that is, without good reliability an instrument cannot have sufficient validity (Colton & Covert, 2007; McCoach, Gable, & Madura, 2013). To assess the Karimi-CFQ reliability, two types of reliability were addressed: Cronbach’s Alpha and split half reliability. Also, the item deleted reliability method was used which allowed the researcher to evaluate the reliability of each item in the instrument.

*Cronbach’s Alpha* is a measure of internal consistency which indicates how much a set of items in a questionnaire are related. (Colton & Covert, 2007; Pedhazur, Pedhazur & Schmelkin, 1991). Reliability coefficients of .70 and higher are considered good reliability in social sciences (Pedhazur & Schmelkin, 1991). SPSS software was used to generate Cronbach’s alpha for CFQ to assess the instrument reliability.

*Split-half reliability* is another way to assess the instrument reliability (Colton & Covert, 2007). It is an alternative internal consistency estimate of instrument reliability when the researcher uses a single measurement administered to a sample and test-retest reliability
measurement cannot be run. In other words, this estimation indicates how well the items that are supposed to represent the same construct in an instrument generate similar results (Pedhazur, Pedhazur & Schmelkin, 1991). In this method the instrument items are divided in two equivalent halves and the correlation between the two halves are considered as one indication of the reliability of the total instrument (Colton & Covert, 2007). SPSS uses a special form of the Spearman-Brown Prophecy formula to generate split-half reliability. The 29-items Karimi-CFQ was randomly divided by SPSS in two equivalent sets and generated the split-half reliability score for the instrument.

*Item deleted reliability* was used to check if the reliability of the 29-items in Karimi-CFQ could be increased by deletion of some items. SPSS software provides output which identifies those items that would increase instrument reliability by their deletion. One of these measures is the labeled *corrected item-total correlation* which provides the correlation of an item with the rest of the items on the scale (McCoach, Gable, & Madura, 2013). Item with low inter-item correlation indicate that participants’ performance on that specific item is not correlated with the overall performance of participants on the instrument. In the current study, Items which correlated less than .30 with the respective scale were reviewed. SPSS output also provides other measures such as “*alpha if item deleted*” which shows the estimate of alpha reliability if that particular item were deleted from the scale. When the *alpha if item deleted* for an item is higher than the current estimate of Cronbach’s alpha then the item should be considered for potential deletion (McCoach, Gable, & Madura, 2013).

*Validity.* Validity is the measure which indicates if the instrument measures what it is intended to measure. In order to ensure that CFQ measures the common factors across therapy models, three types of validity were addressed: face, content, and construct:
Face validity indicates a simple type of validity which determines if the instrument seems to measure what it is supposed to measure. In other words, face validity asks if the instrument appears to be a proper measure to capture the desired concepts, and the degree of such appropriateness comes from the potential respondents to the instrument (Calton & Covert, 2007). The title of “Common Factors” and the labels of its six components (client’s factors, therapist’s factors, relationship factors, hope factors, non-theory specific factors, and systemic factors) from the perspective of potential respondents (mental health clinicians) indicate that the instrument is related to processes and mechanisms of change in psychotherapy and family therapy.

Content validity indicates how much the CFQ can represent common factors across therapy models. The content validity of Karimi-CFQ was addressed by including items for each component of common factors from the related literature. The moderate definition of the common factors model (Sprenkle et al., 2009) and its six components was used as reference. Sprenkle et al. (2009) suggested a moderate definition of common factors which emphasizes the role of common factors while accepting the small difference between effective therapeutic models, too. The moderate definition included six components or categories of common factors. All CFQ items were checked with the definition of these components. In addition, the CFQ was reviewed by an expert panel to ensure content validity. A content validity index (CVI) with a 5-point Likert scale was developed in which the expert panel indicated the relevancy of each item to the specific factor/component of the Common Factors Model.

Construct validity. Construct validity refers to the adequacy of inferences which are made based on the observation or measurement scores (Messick, 1995). In other words, construct validity shows the ability of an instrument to adequately measure the intended concept being studied. In order to provide empirical evidence for the hypothetical constructs (client’s factors,
therapist factors, relationship factors, hope factors, non-theory specific factors, and systemic factors) of common factors, 29 variables were operationalized based on the moderate definition of the Common Factors Model. Using SPSS, an exploratory factor analysis (EFA) was used to assess what factors emerged from the data. EFA suggests how many factors can explain the common factors model and what items are the best indicators of each factor. Using Amos software, a confirmatory factor analysis (CFA) provided a model fit, another way to address the construct validity of the Karimi-CFQ. According to the moderate definition of common factors, CFA hypothesizes six components/factors for the model and tests if the model fits with the data. In addition, the CFA determines which indicators/variables have significant relationships with particular factors/components of the model.

Dimensionality. Exploratory Factor Analysis (EFA) is a statistical method used to evaluate the dimensionality of an instrument. EFA is an exploratory method that helps to discover the smallest number of interpretable factors which explain the relationships among a set of variables (McCoach, Gable, & Madura, 2013). EFA does not force a predetermined structure on the relationships between the variables and the factors. In other word, the goal is to find a pattern in which the minimum number of latent factors can explain the possible maximum of variance.

Since the Common Factors Questionnaire (Karimi-CFQ) is the first instrument in the field of common factors, an EFA helps to discover the underlying factor structure of the observed variables collected from clinicians across the United States, without imposing predetermined theoretical structure that comes from the literature. Then the results of EFA can be used to run a confirmatory factor analysis (CFA). EFA proposes a number of latent factors and a pattern of the paths between observed variables and corresponding factors that might be
different than the theoretical model that comes from the literature. In other words, the results of EFA, based on observed data and measurement, could modify the theoretical model.

In order to conduct an EFA the following issues were addressed:

1) Deciding the number of factors: the Bartlett’s test of sphericity and the Kaiser-Meyer-Olkin test were used as criteria to determine if the set of variables are adequately related for factor analysis. In order to decide how many factors would be retained in the model, the eigenvalue greater than 1.0 was used, which is the criterion that most researchers apply to retain the significant factors of a model. The Principal Components Analysis (PCA) produced the eigenvalues that showed the variance accounted by latent factors in the model. Also, the scree test graphically indicated how many factors could be retained in a model to explain the large portion of the variance that co-vary among the factors in the model.

2) Factor extraction method: The Principal Component Analysis (PCA) was used as extraction solution. Maximum Likelihood Method (MLM) was also used because it generates estimates that best represent true factors scores (DiStefano, Zhu, Mindrila, 2009). Item communalities indicated the amount of variance in each item that is explained by the underlying factors in the model.

3) Rotation solutions: The rotation procedure aims to clarify and simplify the factor structure that provides a simple structure and theoretically more acceptable solution. In the current study, the underlying factors of CFQ were assumed theoretically to be correlated. An oblique procedure was used to check if there was any correlation between factors or not. Correlations around .32 and above at the factor correlation matrix indicate that there is at least 10% overlap in variance among factors, which suggests the use of oblique rotation. If there is no such correlation, then the orthogonal method is used. Regarding the cut-offs point of factor
loadings, the path with .30 loadings and higher are considered significant with a sample size of 100 by most statisticians. However, the current study had larger sample (N=391) that allowed smaller loadings also was considered salient (Kline, 2005).

In confirmatory factor analysis (CFA), the researcher assumed a model with a particular structure and then tested whether the data fitted the model. The hypothesized factor model resulted from the literature and the moderate definition of the Common Factors Model (Sprenkle, et al. 2009). The initial CFA model hypothesized six latent factors, each of them with several indicators: client’s factor (7 items), therapist’s factor (10 items), relationship factor (3 items), hope factor (2 items), non-theory specific factor (3 items), and systemic factor (4 items).

The Amos software (version 22) was used to estimate model fit indices such as Chi-square statistic, Root Mean Squared Error of Approximation (RMSEA), and Comparative Fit Index (CFI) that determined the model fit of the hypothetical model with the observed data. The Chi-square statistic shows the degree of difference between expected and the observed covariance matrices. A Chi-square value close to zero indicates a better model fit to the observed data. The Root Mean Square Error Approximation (RMSEA) indicates the residual variance in the model, and its values range from 0 to 1. The smaller values indicate a better model fit. Scholars suggest that values less than 0.05 indicate a good fit, and values between 0.05 to 0.08 or 0.10 indicate an acceptable fit (Hu & Bentler, 1999). The Comparative Fit Index (CFI) indicates a ratio of the discrepancy function of a target model to an independent or null model in which the variables are assumed to be uncorrelated. CFI values close to 1.0 indicate a better model fit. Also, Amos provides R-squared correlation and Standardized Regression Weights. The regression weights indicate the individual correlation of each item to the respective factor. The R-squared values
indicate the amount of variance in each item that is explained by the respective factor. Also, modification indices were used to improve the model fit.

Criterion validity. One of the ways that validity of a new instrument is assessed is to test its correlation with other instruments or criteria that theoretically are related and measure the same construct/phenomenon. Correlation tests were used to evaluate the criterion validity of Karimi-CFQ. The first correlation test was run between the six subscales of Karimi-CFQ and six categories of the Common Factors Model in the second section of survey. The other correlation test was run between the mean of 28-items Karimi-CFQ and total common factors in the third section of the survey.

T-test and ANOVA. A series of statistical analyses were used to test the research hypotheses regarding the contribution of specific components of Karimi-CFQ, specific categories of the Common Factors Model in the section two of the survey, and total common factors versus model-specific factors in therapy outcome in the section three of the survey. Also, the analyses assessed the relationship between clinicians' demographic information (e. g., gender, years of clinical experience, field of study, clinical orientation etc.) and the contribution of common factors to therapy outcomes. These analyses provided information regarding how commonly or differently the common factors contribute to therapy outcomes across different treatment models, therapists, years of clinical experience, and gender.

Independent t-test was used to assess the gender differences regarding the contribution of common factors to therapy outcomes in different sections of the survey. Independent t-test compared the group difference between male and female clinicians regarding their perceived contribution of components of Karimi-CFQ and the sum scores of Karimi-CFQ. An independent t-test was also used to answer which gender attributes a higher contribution of total common
factors to therapy outcomes in the third section of the survey. Also, a one-sample t-test was used to assess the relative degree of contribution of total common factors versus total model specific factors in the survey section three.

Repeated measure analysis of variance was used to compare the contribution of six components of the Karimi-CFQ, and also to compare the six percentage categories of the Common Factors Model in the section two of the survey. Within subjects’ effect ($F$-values) with $p$-value set at 0.05 and the degrees of freedom were reported for each analysis.

Analysis of variance (ANOVA) is a statistical method that looks for significant differences across three or more different groups. ANOVA provides $F$-values with particular degrees of freedom that could be interpreted as significant difference between pairs of groups. In order to determine which pairs of groups show significant difference, a follow-up post-hoc test was used. If the data did not meet the homogeneity of variances assumption either the Games Howell or the Dunnett's C post hoc tests are used.

One Way-ANOVA test was used to assess the relationship between clinicians’ demographic characteristics and their perceived contribution of common factors to therapy outcomes. ANOVA test assessed the group differences between four categories of clinical experience (Low, Medium, Experienced, High experienced), five clinical orientations (Integrative, CBT, Psychodynamic, Humanistic, Postmodern), and three fields of study (MFT, Psychology, Counseling) regarding the contribution of common factors to therapy outcome on Karimi-CFQ.

Also, ANOVA was used to assess if there were significant differences between categories of clinical experience, fields of study, and clinical orientations regarding the contribution of different categories of the Common Factors Model in the section two of the survey. Group differences between the five categories of clinical orientations (Integrative, CBT,
Psychodynamic, Humanistic, Postmodern), four categories of clinical experience (low experienced, medium experienced, experienced, and high experienced), and three fields of study (MFT, counseling, and psychology) regarding the contribution of common factors to therapy outcome on total common factors question in the section three of the survey was also estimated using ANOVA.

**Phase 3. Qualitative Study**

The third phase of the current study included open-ended questions that collected data regarding the therapy process. Using the common factors lens, how would the model guide clinicians’ activities in three stages of therapy: initial, intermediate, and termination. In this study, six experienced therapists who were familiar with the common factors model were asked to report their perception about the application of common factors in the course of therapy, specifically regarding the chronological application of common factors over the course of therapy. They were then asked to recall their observation of their interaction with their clients. This observation included client-therapist interactions, therapist’s introspection of the process, and client’s direct feedback which can clarify the therapeutic processes and application of common factors.

Three open-ended questions triggered the therapists to describe and explain vivid patterns of what has been contributed to therapeutic change in their successful cases, regarding the therapeutic common factors. Wiki, an internet tool created a collaborative space where participants write their opinions in collaboration with one another, and it was used to collect the qualitative data. All participants can edit and modify the documents that have been written by other participants, and the final document indicated a shared knowledge of the topic. Overall, wiki is an excellent tool for qualitative research (Castanos & Piercy, 2010). Three open-ended
questions and the instruction of how to participate in the panel discussions were uploaded on Wikispace website. The qualitative phase provided information to begin to answer the following question:

*Qualitative Q:* When and how do therapists use common factors in the course of therapy to reach the desired therapeutic outcomes?

*Content of Wiki.* The expert panel received an invitation letter with a link to the wiki webpage. The wiki page began with instruction that explain the reason the participants were chosen for the study (which is their expertise in common factors), then it explained the goal of the study and the research gap which the present researcher hoped to address in the wiki discussion. A definition of common factors was provided to make sure that all participants had in mind the same definition during the discussion. Then, the participants read the following paragraphs and questions and shared their therapy experience and commented on others post:

I am interested in how a common factors (client, therapist, relationship, hope, non-theory specific, and systemic factors) conceptualization has guided your work through the course of relational therapy. Please imagine one or more of your previous successful (success defined as 70% improvement) relational therapy cases (e.g., couple, family), and provide your answer for each of the following questions. Thinking of therapeutic change across time, some scholars (Lambert & Olges, 2004; Sprenkle & Blow, 2004) consider three stages of therapy: 1) Initial (a few first sessions); 2) Intermediate (during middle sessions); and 3) Termination (a few last sessions). We would like you to consider an ideal developmental sequence of common factors over the course of therapy and would like you to explain (thinking back on your successful relational therapy cases):
1- What common factors did you use to bring about change in the initial stage of therapy?

2- What common factors did you use to bring about change in the intermediate stage of therapy?

3- What common factors did you use to bring about change in the termination stage of therapy?

Below, you will find a specific section for each of these questions:

Before you start, I would like to remind you that this Wiki space will be open for two weeks and you can get back to it any time you want to complete or change your post. You can also come back to the Wiki space to view and comment on other participants' responses. We appreciate interactive comments because they will allow for a collective understanding of how common factors are used in successful therapy sessions.

Administration of Wiki

Sampling technique and sample size. The purposeful/theoretical sampling method was used to recruit mental health professionals who were experts in the field of common factors and integrative therapy. The goal of purposeful sampling is to focus on specific characteristics of a population that helps the researcher to answer the research question. Purposeful sampling involves intentionally selecting participants who have valuable experience in the field of study (Craswell & Plano Clark, 2011). The researcher recruited six experienced mental health professionals who are knowledgeable in the common factors field.

Exclusion and Inclusion Criteria. Selective sampling for the Wiki discussion was based on criteria guided by research questions (Charmaz, 2006; Echevarria-Doan & Tubbs, 2005).
“Initially, theoretical sampling is selective to the extent that the researcher searches for participants who might contribute to an evolving theory” (Echevarria-Doan & Tubbs, 2005, p.47). Therefore, the researcher needed to recruit participants who were knowledgeable (having publication in the field) of common factors and integrative psychotherapies. In the current study, the experts in the common factors field and integrative psychotherapy were recruited. By reviewing the common factors publications (articles, books, dissertation), the researcher found a list of experts who published in the field and had at least 10 years clinical experience in the field. An invitation letter was sent to a number of experts to recruit at least 6 participants. The qualitative sample consists of 6 participants who were invited to qualitatively explain how they utilize common factors in their effective therapy, emphasizing the chronological process of therapy.

**Analyses**

**Thematic Analysis.** The goal of thematic analysis is to identify those patterns that are relevant to a specific research question (Braun & Clark, 2012). It is a method of analysis that is flexible and provides different ways for the researcher to analyze the data. The researcher can analyze meaning across the whole data set or may focus on one particular dimension of the phenomenon in depth. Also, the researcher can look for the apparent or semantic meanings or can search for latent themes, meanings, ideas, and patterns that are behind the explicit statements (Braun & Clark, 2012).

Thematic Analysis can be conducted either inductively, that is, through a bottom-up approach, or deductively in which that coding is top-down with some predetermined assumptions and concepts. What is happening in reality is a combination of both approaches (Braun & Clark, 2012). In the current study, the qualitative research question is an exploratory experiential one
that needs a bottom-top approach to explore the clinical experience of the experts. However, this study looked for data that might support the theoretical framework of the common factors model. Meaning, the researcher had in mind some predetermined theoretical framework, so a top-down aspect of the analysis occurred, as well. Consequently, in the current study a combination of both approaches were applied to provide rich information regarding the research question.

Braun & Clarke (2006) suggested six phases for thematic analysis that were used by the researcher to analyze the data in relation to the research question:

1) *Familiarizing yourself with the data*: The researcher read and reread the text, highlighted items that are potentially of interest, wrote comments, read analytically and critically, considered what the data means, and noticed the themes that might be relevant to the research question. Also I used my notes during the reading as memory aids for the coding and analysis in the next phase.

2) *Generating Initial codes*: By using codes as building blocks of analysis the systematic analysis starts in which codes are used as labels for a portion of information that is relevant to the research questions. Some codes reflected the expert’s language and terms while other codes drew from the researcher’s theoretical framework. Therefore, codes usually were a mix of description and interpretation. The researcher conducted both coding approaches to provide a thorough story about the phenomenon.

3) *Searching for Themes*: the researcher looks for any overlaps over codes and broad topics that can cover the meanings of some codes together. Themes reflected unifying features and meaningful patterns in the data. Also, in this phase the researcher looked for the relationships between themes which results in a coherent story about the data. Sometimes, a particular theme could underpin other themes. In addition, a miscellaneous theme could include all the codes that
did not match with specific themes. A thematic map which included themes and the relevant excerpt was outlined (See Appendices-G to M for the resulting theme map).

4) Reviewing Potential Themes: The researcher reviewed themes in relation to the coded data and the whole data set was reviewed for the purpose of quality checking. In this phase some themes were combined together or divided in more specific themes, while other themes were discarded or generated.

5) Defining and Naming Themes. To define a theme the researcher asked what was unique and specific about each theme. The researcher considered some criteria to develop good themes and thematic analysis: themes should have a singular focus, should be related to each other and not be overlapped, and address the research question. The researcher asked what was relevant in the data in order to answer the research question. An analytic narrative was told about the data extracts for all themes.

6) Producing the Report: The researcher conducted analysis and wrote the report as interwoven processes in qualitative research. Using first person active tense is the best way to write qualitative report. Such a report makes the analysis process clear and transparent for readers. Like most qualitative research, the reader should be able to understand the conceptual process of analysis that resulted in integration and theorizing. Such a process enhances the results/theory’s “trustworthiness” that provides the credibility and transferability of the findings (Charmaz, 2006; Lincoln & Guba, 1985).

Mixed Method

Using mixed method research, the study applied both positivist and constructivist paradigms. While the reconciliation between paradigms is not complete, some scholars suggest
pragmatism as the best philosophical foundation to be used in mixed method studies (Tashakkori & Teddlie, 2003a). Regarding the novelty of the research problems, as well as the complexity of the research topic, the practical position of mixed methods research provided the researcher with an opportunity to utilize all possible methods and procedures to address the research questions (Creswell & Plano Clark, 2011). It is called the “third methodological movement” (Tashakkori & Teddlie, 2003a), and goes beyond the limitations of quantitative and qualitative methods. There are advantages for using a mixed method study: it provides the most complete analysis of problems, offsets the weaknesses of both qualitative and quantitative research methods, provides more evidence to answer a research problem, and shows flexibility to meet the emerging problems during the course of study (Creswell & Plano Clark, 2011).

In the current study, a mixed method was used as a procedure in which the researcher gathered and analyzed, merged the results, and made inferences by using both qualitative and quantitative methods in a single research or study (Tashakkori & Creswell, 2007b p.4). The quantitative part involved the development of the Common Factors Questionnaire (Karimi-CFQ-See Appendix-B), that was used to assess the contribution of common factors in therapeutic outcomes from the clinicians’ perspective. In the qualitative part a Thematic Analysis (TA) method was used to inductively collect data to explore how and when, the common factors experts utilize common factors over the course of therapy. This resulted in theorizing an integrative common factors framework to guide the therapist in the course of therapy.

Therefore, a mixed method Convergent Parallel Design was used. The researcher used concurrent timing to implement the quantitative and qualitative strands during the research process, considered equal priority for methods, independently analyzed each data set, and then mixed the results during the final interpretation (Craswell & Plano Clark, 2011; Tashakkori &
Teddlie, 2010). Regarding weighting, both the quantitative part and the qualitative part had equal importance in addressing the research problems. In other words, for the current study, it was important to empirically evaluate the contribution of specific common factors in therapy outcome from the clinicians’ perspective. The quantitative part addressed a critical debate between the common factors camp and the model-specific camp in psychotherapy and family therapy. The qualitative part aimed to improve the theorization of the common factors model to the level that can guide clinicians in the process of therapy. The qualitative part addressed the main critique that the advocates of model specific camp point to the common factors model, that is, the common factors model lacks the capacity to guide the therapist over the course of therapy.

“Mixing is the explicit interrelating of the study’s quantitative and qualitative strands and has been referred to as combining and integrating” (Craswell & Plano Clark, 2011). Mixing can occur in terms of when, point of interface, and how, mixing strategies. In the current study, mixing occurred in three points: design, data analysis, and data interpretation. During the design phase, each strand informed the researcher to develop complementary questions and methods in other strand. In addition, during the data analysis of the qualitative phase the quantitative findings were connected, combined and contrasted to the qualitative findings. The emerging categories and processes from the thematic analysis (TA) method were reviewed in comparison to quantitative findings. Such a comparison generated support for the quantitative findings, providing a better explanation for the findings, and/or expanding the scope of the study (Craswell & Plano Clark, 2011; Tashakkori & Teddlie, 2010). Furthermore, in the conclusion and interpretation section, the researcher drew conclusions and inferences that reflect what can be learned from the combining, comparing, and synthesizing of results from two strands—which provided a more complete picture of the phenomenon.
THE CONTRIBUTION OF COMMON FACTORS

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Chapter IV: Results

The current study included three main purposes. The first was to develop a Common Factors Questionnaire (Karimi-CFQ) to measure specific components of the Common Factor Model and to evaluate its reliability and validity. The second purpose was to find the relationship between clinicians’ demographic characteristics and their perceived contribution of common factors in therapeutic change. The third purpose was to enhance the theorization of the Common Factors Model by qualitatively exploring how and when advocates of the Common Factors Model use specific common factors during the course of therapy to bring about desired therapy outcomes. Finally, the results from quantitative and qualitative phases were compared and combined to provide a comprehensive picture of the function of common factors in therapeutic change. The quantitative, qualitative, and mixed methods results are reported below:

Phase 1: Instrument Development

Development of 28-items common factors questionnaire (Karimi-CFQ). The instrument development was conducted through the following steps:

Concept identification. The targeted components of common factors emerged through relevant theories and literature of common factors (DeVillis, 2003; Furr, 2011). The final components were included: Client’s factors, Therapist’s factors, Relationship’s factors, Hope/Expectancy’s factors, Non-theory specific factors, and Systemic factors (See Figure-1). These components were drawn from the moderate definition of common factors by Sprenkle et al. (2009).

Item construction: Based on a review of the literature about 43 items emerged from the literature of common factors (See Appendix- A). Different numbers of items were developed for each of six components of CFQ. The initial items pool was 1.5 time of the final version. The
initial pool items were reviewed by common factors experts, experienced clinicians, and mental health Ph.D students to evaluate for content, relevancy, format, and clarity. Using the experts’ comments and feedback eight items were deleted from the initial pool and a few items were combined. Also, most of the items were reworded and shortened based on the comments by the expert in order to be a good representative of the respective factor/component (See Appendix-B). Based on their comments the pool was revised and shortened to the pilot 34-items CFQ (See Appendix-C). Then, in order to create a face and content validity, the pilot 34-items CFQ version was rated by a panel of experts, who published in the common factors field, to check the clarity, readability, relevance, and dimensionality of each item to respective factors. The experts’ ratings of relevancy for each item were combined to create a content validity index (CVI). An open question asked the experts to add any comment they had about the items. At this stage some items were rephrased based on experts’ comments. The pilot 34-items CFQ received an average relevancy score of 2.4 to 4.5 for different items which indicated a good agreement among the experts (Appendix-C). The researcher decided to keep the items which rated 3.5 (.70% point in a range from 0-5) and the above. Thus, 5 items which received relevancy score less than 3.5 were deleted from the CFQ. The final CFQ contained 29 items (See Appendix-D) which was administered to a large sample of mental health clinicians across the United States in the next phase of the study.

Phase 2: Administration and Evaluation of CFQ

Data collection: Using Virginia Tech Qualtrics website, the survey link was emailed to mental health clinicians across the United States. Also, psychology, counseling, and mental health organizations from the following states were contacted to participate in the study: Alaska,
California, Colorado, DC, Hawaii, Kansas, Massachusetts, Michigan, New Jersey, and New York.

The Qualtrics survey link was opened by 478 participants. Twenty five of them opened the survey but they did not answer or enter any information and were not included in the sample. Also, 62 participants opened the survey and filled the demographic information but for some reasons did not provide any information on the survey (some potential participants emailed the researcher regarding Qualtrics website issues). It is also possible that they might have changed their mind about participation before filling the survey. They were also deleted from the pool and the final sample included 391 participants who continued to take the survey. However, there were a few scattered missing values on some of the variables (2% to 7%). Five multiple imputed data files were estimated using SPSS's Impute command. More specifically, the Fully Conditional Specification Method (FCS/MICE) was selected and the following variables were included in the imputation estimations: age, years of clinical experience, item 1 to item 29 of the CFQ, six percentage categories of CFs, and total CFs and total model-specific factors.

Descriptive Statistics

The sample for the current study included 391 clinicians across the US, 131 male clinicians (33.5%) and 260 female clinicians (66.5%). Participants age ranged from 22 to 86 years ($M=45.75$, $SD=16.8$). Out of 391 participants, 36 participants were in the age group of 22-25 year old, 144 participants were in the 26-40 year old age group, 111 participants were in the 41-60 year age group, and 100 participants were between the ages of 61-86 years. The years of clinical experience ranged from 1 to 60 years, 79 (20.2%) of participants had 1-3 years of clinical experiences; 113 (28.9%) had 4-10 years of clinical experience; 109 (27.9%) had 11-30 years of clinical experience; and 77 (19.7%) had 31-45 years of clinical experience. Participants came
from different fields of mental health, specifically 232 (59.3%) belonged to the psychology field, 83 (21.2%) belonged to the MFT field, 52 (13.3%) belonged to the counseling field, and 24 (6.1%) belonged to social work, psychiatry, divinity, nursing, and others group together.

Participants endorsed their first favorite clinical orientation among nine theoretical models including: psychodynamic, 95 participants (24.3%); integrative, 81 participants (20.7%); cognitive behavior therapy, 79 participants (20.2%); humanistic 78 participants (19.9%); postmodern, 27 participants (6.9%); systemic, 12 participants (3.1%); emotion-focused, 8 participants (2.0%); feminist, 7 participants (1.8%); and structural-strategic, 4 participants (1.0%).

Psychometric Properties of Karimi-CFQ

Reliability of Karimi-CFQ. The internal consistency of Karimi-CFQ was good. Cronbach’s alpha for 28 items was 0.84. Corrected Item-total Correlations ranged from 1.63 to .478. Most of the items showed corrected item-total correlations larger than .30 except items: 2, 4, 5, 6, 7, 8, 10, and 23. Since the contribution of these items in content validity was important, they were kept in the scale. Also, split-half reliability provided support for the Karimi-CFQ reliability. Using SPSS software the 28 items were randomly divided in two halves. The first half included odd items of the instrument and the second half included even items. The split-half reliability was 0.87 (N=391, p<.01) which indicates a good correlation between two halves and an indication of Karimi-CFQ internal consistency.

Item deleted reliability. SPSS output indicated the item deleted reliability measure for all items was lower than current scale Cronbach’s alpha (.842), except item 2 that showed item deleted reliability .843. Because the difference (.001) was not large the researcher decided to
keep the item in the instrument. Item deleted reliability measures indicated all items contributed in the instrument’s reliability.

Table-1
*Item-Total Statistics of 28-items*

<table>
<thead>
<tr>
<th>Item</th>
<th>Total</th>
<th>Mean if Del</th>
<th>Var. if Del</th>
<th>Alpha if Del</th>
</tr>
</thead>
<tbody>
<tr>
<td>1- Client’s motivation</td>
<td>100.90</td>
<td>112.59</td>
<td>.32</td>
<td>.838</td>
</tr>
<tr>
<td>2-Client’s intellectual ability</td>
<td>102.31</td>
<td>114.16</td>
<td>.16</td>
<td>.843</td>
</tr>
<tr>
<td>3- Client’s expectation of therapy success</td>
<td>101.90</td>
<td>110.73</td>
<td>.39</td>
<td>.836</td>
</tr>
<tr>
<td>4-Client’s engagement</td>
<td>100.91</td>
<td>113.70</td>
<td>.28</td>
<td>.839</td>
</tr>
<tr>
<td>5-Client’s persistence</td>
<td>101.36</td>
<td>112.63</td>
<td>.28</td>
<td>.839</td>
</tr>
<tr>
<td>6-Client’s spirituality</td>
<td>103.20</td>
<td>111.33</td>
<td>.24</td>
<td>.842</td>
</tr>
<tr>
<td>7- Client’s factors outside</td>
<td>101.93</td>
<td>111.19</td>
<td>.28</td>
<td>.840</td>
</tr>
<tr>
<td>8-Therapist’s competence</td>
<td>101.46</td>
<td>112.84</td>
<td>.28</td>
<td>.839</td>
</tr>
<tr>
<td>9-Therapist’s support</td>
<td>101.40</td>
<td>109.67</td>
<td>.41</td>
<td>.835</td>
</tr>
<tr>
<td>11-Therapist’s friendliness</td>
<td>101.87</td>
<td>108.56</td>
<td>.45</td>
<td>.834</td>
</tr>
<tr>
<td>12-Therapist’s positive attitude</td>
<td>101.53</td>
<td>108.98</td>
<td>.48</td>
<td>.833</td>
</tr>
<tr>
<td>14- Therapist’s ability to adapt to the client's characteristics</td>
<td>101.48</td>
<td>109.51</td>
<td>.38</td>
<td>.836</td>
</tr>
<tr>
<td>15- Therapist helps the client maintain an appropriate emotional arousal</td>
<td>101.97</td>
<td>109.12</td>
<td>.36</td>
<td>.837</td>
</tr>
<tr>
<td>16-Therapist’s ability to adjust methods to the particular client</td>
<td>101.36</td>
<td>109.36</td>
<td>.42</td>
<td>.835</td>
</tr>
<tr>
<td>17-Therapist’s sensitivity to the client’s cultural values and beliefs</td>
<td>101.43</td>
<td>108.23</td>
<td>.45</td>
<td>.834</td>
</tr>
<tr>
<td>18- R-Affective quality of the client–therapist relationship</td>
<td>101.16</td>
<td>109.59</td>
<td>.46</td>
<td>.834</td>
</tr>
<tr>
<td>19- R-The extent to which the client found therapy activities credible</td>
<td>101.63</td>
<td>110.15</td>
<td>.40</td>
<td>.836</td>
</tr>
<tr>
<td>20- R-The agreement on the goals of therapy</td>
<td>101.64</td>
<td>109.24</td>
<td>.41</td>
<td>.835</td>
</tr>
<tr>
<td>21-Client’s belief that the treatment would help</td>
<td>101.59</td>
<td>108.87</td>
<td>.47</td>
<td>.833</td>
</tr>
<tr>
<td>22-The rationale for how therapy will achieve a positive outcome</td>
<td>102.34</td>
<td>108.95</td>
<td>.41</td>
<td>.835</td>
</tr>
<tr>
<td>23- The client’s new emotional experience</td>
<td>101.52</td>
<td>111.37</td>
<td>.30</td>
<td>.839</td>
</tr>
<tr>
<td>24- The client’s new insight</td>
<td>101.52</td>
<td>110.26</td>
<td>.38</td>
<td>.836</td>
</tr>
<tr>
<td>25- The client’s new behaviors</td>
<td>101.33</td>
<td>110.39</td>
<td>.46</td>
<td>.835</td>
</tr>
<tr>
<td>26- The therapist's relational conceptualization of the problem</td>
<td>101.90</td>
<td>107.61</td>
<td>.43</td>
<td>.835</td>
</tr>
</tbody>
</table>
27- The therapist interrupting the dysfunctional relational cycles | 101.71 | 107.72 | .48 | .833
28- The therapist involving other family members in therapy | 102.62 | 107.13 | .33 | .840
29- The therapist's alliance to all family members | 102.34 | 106.67 | .34 | .840

Note: Item 10 was removed because of low factor loading <.22.

**Content validity of Karimi-CFQ.** In order to demonstrate theoretical content validity, specific items were written for each of six components of the Common Factors Model. Then, each of the items was cross-referenced with particular constructs/factors according to the theoretical framework which is the moderate definition of the Common Factors Model (Sprenkle, et al., 2009; See Figure-1).

In addition, the pilot 34-items CFQ was reviewed by an expert panel for item relevancy that is another way to ensure content validity of the Karimi-CFQ. A content validity index (CVI) with a 5-point Likert scale was conducted in which the expert panel rated the relevancy of each item to the specific factor/component. The scores ranged from 2.4 to 4.5. Those items rated less than 3.5 (0.70% point in the range of 0-5) were deleted. Items 20 with mean 2.4, item 8 with mean 2.9, item 26 with mean 2.9, item 19 with mean 3, and item 27 with mean 3.2 were deleted from the pilot 34-items CFQ. All other 29 items rated 3.5 and the above in the content validity index. Among of 29-items CFQ items 4, 13, 16, 18, 23 received the highest score (M=4.5) in content validity index. Items 5, 6, 9, 10, 28, and 29 received the low score (M=3.5) in the content validity index. These procedures indicated an overall good content validity for Karimi-CFQ.

**Construct validity.** Two techniques were used to evaluate the construct validity of Karimi-CFQ: Exploratory Factor Analysis (EFA) and Confirmatory Factor Analysis (CFA). The results of both methods indicated that Karimi-CFQ has good construct validity.

**Exploratory factor analysis (EFA).** Exploratory factor analysis explores patterns in the data without any stated hypothesis, so there is no substantive constraint on the data. Each latent
factor considered to affect every observed variable. Using SPSS an EFA was run by 29 items of common factors questionnaire (CFQ).

The Kaiser-Meyer-Olkin measure of sampling adequacy and Bartlett’s test of sphericity indicated that the factor analysis provided the minimum standard (Hutcheson & Sofroniou, 1999). According to Kaiser’s (1974) recommendation, values between 0.5 and 0.7 are mediocre, values between 0.7 and 0.8 are good, and values above 0.8 are great or superb. SPSS output indicated KMO measure 0.796 was good, so the factor analysis was appropriate for these data (Table-2).

Table 1

<table>
<thead>
<tr>
<th>KMO and Bartlett's Test</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser-Meyer-Olkin Measure of Sampling Adequacy.</td>
<td>0.796</td>
</tr>
<tr>
<td>Bartlett's Test of Sphericity-Approx. $\chi^2$</td>
<td>3170.372</td>
</tr>
<tr>
<td>df.</td>
<td>406</td>
</tr>
<tr>
<td>Sig.</td>
<td>.00</td>
</tr>
</tbody>
</table>

Bartlett’s measure test claims the null hypothesis that the correlation matrix is an identity matrix, that is, all correlation coefficient would be zero. A significant p-value (less than 0.05) indicates there are some relationships between the variables. SPSS output showed highly significant value ($\chi^2 (406) = 3170.37, p=0.00$), that indicates factor analysis is appropriate with the data.

Rotation optimizes the factor structure and gives equal chance to identified factors in terms of their relative importance (Field, 2005). SPSS output displayed seven factors with their respective factor loadings, and all loading less than .30 was set to be suppressed in the output.

Using Principal Components Analysis (PCA) extraction solution without fixing the number of factors the EFA proposed eight factors with eigenvalues more than 1.0. These eight
factors could explain 58.33% of the variance in the model. However, the scree plot leveled off after the sixth factor, which indicated no significant amount of variance was explained by the next factors. According to this information, the second EFA was run with principal components analysis and with 6 factors similar to the theoretical model of common factors. The pattern matrix results were used to find the optimal pattern which refers to the minimum number of factors that explain the maximum possible variance and with significant item loadings on each factor. The oblimin rotation method was used since the assumption was that all components of the Common Factors Model were correlated, which is the case in most social sciences (Costello, & Osborne, 2005). According to pattern matrix (shown in Table-3), factor one included: items 11-therapist’s friendliness, 12-therapist’s positive attitudes, 9- therapist’s support, 18- affective quality of relationship, and 8-therapist’s competence; factor two included: 28-therapist’s involve family members, 29-therapist’s alliance to family members, 6-client’s spirituality, 7-client’s factors outside of therapy, 2-client’s intellectual ability; factor three included: 21-client’s belief that treatment would help, 3-client’s expectation of therapy success, 1-client’s motivation, 19-the extent to which client found therapy activities credible, 5-client’s persistence, 4-client’s engagement, 22-the rationale therapist gives for how therapy will achieve a positive outcome, 20-the agreement on therapy goals; factor four included: 27- therapist interrupts the client’s dysfunctional sequence of relational cycles, 13- therapist’s efforts to interrupt the client’s dysfunctional patterns, 23-the client’s new emotional experience, 25- the client’s new behaviors, 24- the client’s new insight, 26- the therapist’s relational conceptualization of the problem; factor five included: 10- therapist’s reputation; factors six included: 16-therapist’s ability to adjust methods to the particular client, 14-therapist’s ability to adapt to client’s characteristics, 15- therapist’s ability to help the client maintain an appropriate emotional arousal, 17- therapist’s
THE CONTRIBUTION OF COMMON FACTORS

sensitivity to the client’s cultural values and beliefs. The SPSS output showed good
communalities value for all of the items from 0.373 to 0.672, which indicated each item shared
some common variance with other items and all items had been loaded by the components of the
model.

Table-3

*Exploratory Factor Analysis Pattern Matrix with Six Factors*

<table>
<thead>
<tr>
<th>Components</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1- Client's motivation</td>
<td>.576</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2- Client’s intellectual ability</td>
<td>.401</td>
<td>.370</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3- Client’s expectation of therapy success</td>
<td>.728</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4- Client’s engagement</td>
<td>.525</td>
<td></td>
<td></td>
<td>.387</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5- Client’s persistence</td>
<td>.532</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6- Client’s spirituality</td>
<td></td>
<td></td>
<td></td>
<td>.477</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7- Client’s factors outside</td>
<td></td>
<td></td>
<td></td>
<td>.464</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8- Therapist’s competence</td>
<td>.422</td>
<td>.377</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9- Therapist’s support</td>
<td>.654</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10- Therapist’s reputation</td>
<td></td>
<td></td>
<td></td>
<td>.700</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11- Therapist’s friendliness</td>
<td>.693</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12- Therapist’s positive attitude</td>
<td>.661</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13- Therapist interrupt dysfunctional patterns</td>
<td></td>
<td></td>
<td></td>
<td>.688</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14- Therapist’s ability to adapt to the client's characteristics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.654</td>
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</table>
Confirmatory factor analysis. According to the literature of common factors model six latent variables were hypothesized including: client’s factors, therapist’s factors, relationship factors, hope factors, non-theory specific factors, and systemic factors. Each of the latent factors was
THE CONTRIBUTION OF COMMON FACTORS

linked to several numbers of observed variables/questions. The common factors questionnaire (CFQ) included 29 items. Items 1-7 were loaded on latent client’s factor, items 8-17 were loaded on latent therapist’s factor, items 18-20 were loaded on latent relationship factor, items 21-22 were loaded on latent hope factor, items 23-25 were loaded on latent non-theory specific factor, and items 26-29 were loaded on latent systemic factors.

Using AMOS software version 22, four confirmatory factor analyses were run on the 29 items of the common factors questionnaire. Different model fit indices were used to evaluate the fit of models including: the Chi-square test, root mean square error approximation (RMSEA), and Bentler’s comparative fit index (CFI).

The first confirmatory factor analysis model was run with one general factor in which all 29 items were loaded on one factor. Chi-square value of 1871.25 (df=377), RSMEA value of .101, and CFI value of .476, which indicated a poor model fit. The second model was hypothesized with six factors based on the proposed components and related items in the literature of the Common Factors Model. The model fit indices indicated the model with six components fit better than the first model with one component, Chi-square value of 1434.85 (df=362), CFI value of .624, and RMSEA was .087 which was within the acceptable range (MacCallum, Browne, Sugawara., 1996). In the third step, the information from the exploratory factor analysis (EFA) model and pattern matrix was used to hypothesize the third model. EFA proposed a different paths pattern regarding the indicators to six factors; factor one (items 8, 9, 11, 12, 18), factor two (items 6, 7, 28, 29), factor three (1, 2, 3, 4, 5, 19, 20, 21), factor four (items 13, 23, 24, 25, 26, 27), factor five (10, 22), and factor six (14, 15, 16, 17). The model fit indices improved than the previous model: Chi-square value of 1089.07 (df=362), CFI value of .745, and RMSEA value of .072. To improve the model fit, a fourth model was run with the following changes: the
modification indices for regression weights suggested: a path from the hope factor to item 22 (the rationale the therapist gives for how therapy will achieve a positive outcome); and covariance path between e6 and e7, e7 and e29, e13 and e27, e13 and e26, e25 and e27, e25 and e26, e21 and e22; and item-10 (therapist’s reputation) was removed from the model because it showed the lowest standard regression weight (.22) among the 29-items. An examination of the other modification indices, though suggesting slightly improved fit, were not theoretically justifiable. The fit indices improved for the fourth modified model: Chi-square value decreased to 797.96 (df=326), CFI increased to .83, and RMSEA decreased to .61. Regarding the large sample (n=391) these values of fit indices indicated a good CFA model for Karimi-CFQ.

Table 4

Model Comparisons

<table>
<thead>
<tr>
<th>CFA Models</th>
<th>Chi-Square (df)</th>
<th>RMSEA</th>
<th>CFI</th>
<th>Chi-square Difference Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1 (1 Factor Model)</td>
<td>1871.25 (df=377)</td>
<td>.101</td>
<td>.476</td>
<td></td>
</tr>
<tr>
<td>Model 2 (6 Factor Model based on literature)</td>
<td>1434.85 (df=362)</td>
<td>.087</td>
<td>.624</td>
<td>437.4 (p=.000)</td>
</tr>
<tr>
<td>Model 3 (Based on EFA analysis)</td>
<td>1089.07(df=362)</td>
<td>.072</td>
<td>.745</td>
<td>345.78 (p=.00)</td>
</tr>
<tr>
<td>Model 4 (Modified Model 3)</td>
<td>797.96 (df=326)</td>
<td>.061</td>
<td>.830</td>
<td>291.11 (p=.00)</td>
</tr>
</tbody>
</table>

However, several authors cautioned researchers in using the cutoff points of Chi-Square, RMSEA, and CFI as definite measures (MacCallum et al. 1996; Browne & Cudeck, 1993,
Steiger, 1989; Marsh, Hau, & Wen, 2004). Therefore, other measures were also used to evaluate the measurement model of Karimi-CFQ. Unstandard and standard regression weights are interpreted as the correlation between the observed variables and the corresponding latent factor. All of 28-items showed significant regression weights which is a critical ratio (CR) larger than 1.96 at $p$-value of .05 (See Table-4). Regression weights indicated all 28 CFQ items has significant path coefficients at the $p$-value of .001 to their corresponding latent factors. Standard regression weights ranged from the value of .31 for item-8 to the value of .86 for item-28.

Also, the squared multiple correlations ($R^2$) provide information about how much variance the factors account for in each observed variables/indicators. $R^2$ values for 28 items of CFQ ranged from .742 for item-28 (the therapist involving other family members in therapy) to .094 for item-8 (therapist’s competence) (See Table- 4).

Significant and moderate size estimated correlations were found among latent factors (except between client factor and systemic factor) and error terms, which indicates six factors of the questionnaire measure the same phenomenon.

Table- 5

Unstandard path values, Standardized path values, standard errors, t-values, and squared multiple correlations

<table>
<thead>
<tr>
<th>Unstd. Path</th>
<th>S. E. Path</th>
<th>Std. Path</th>
<th>t-value</th>
<th>SMC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td></td>
<td>Value</td>
<td></td>
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</tr>
</tbody>
</table>
### Client factors

1- Client's motivation  
   1.00  .51  .26

2- Client’s intellectual ability  
   .79  .16  .34  5.10  .12

4- Client’s engagement  
   1.08  .15  .64  7.44  .41

5- Client’s persistence  
   1.36  .18  .63  7.42  .40

### Therapist factors

8- Therapist’s competence  
   1.00  .31  .09

14- Therapist’s ability to adapt to the client's characteristics  
   2.79  .54  .68  5.17  .46

15- Therapist helps the client maintain an appropriate emotional arousal  
   2.14  .45  .47  4.72  .22

16- Therapist’s ability to adjust methods to the particular client  
   2.75  .53  .71  5.21  .51

17- Therapist’s sensitivity to the client’s cultural values and beliefs  
   2.53  .50  .61  5.08  .38

### Relationship

9- Therapist’s support  
   1.00  .56  .31

11- Therapist’s friendliness  
   1.26  .14  .68  8.87  .46

12- Therapist’s positive attitude  
   1.21  .13  .72  9.09  .51

18- R-Affective quality of the client–therapist relationship  
   .86  .11  .53  7.68  .28

### Hope/Motivation

3- Client’s expectation of therapy success  
   1.00  .58  .33
**THE CONTRIBUTION OF COMMON FACTORS**

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<tbody>
<tr>
<td>19-</td>
<td>R-The extent to which the client found therapy activities credible</td>
<td>1.03</td>
<td>.14</td>
<td>.57</td>
</tr>
<tr>
<td>20-</td>
<td>R-The agreement on the goals of therapy</td>
<td>1.14</td>
<td>.16</td>
<td>.57</td>
</tr>
<tr>
<td>21-</td>
<td>Client’s belief that the treatment would help</td>
<td>1.22</td>
<td>.12</td>
<td>.66</td>
</tr>
<tr>
<td>22-</td>
<td>The rationale for how therapy will achieve a positive outcome</td>
<td>1.08</td>
<td>.15</td>
<td>.52</td>
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*Non-theory specific*

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<tbody>
<tr>
<td>13-</td>
<td>Therapist interrupt dysfunctional patterns</td>
<td>1.00</td>
<td>.50</td>
<td>.25</td>
</tr>
<tr>
<td>23-</td>
<td>The client’s new emotional experience</td>
<td>.82</td>
<td>.13</td>
<td>.44</td>
</tr>
<tr>
<td>24-</td>
<td>The client’s new insight</td>
<td>.85</td>
<td>.12</td>
<td>.48</td>
</tr>
<tr>
<td>25-</td>
<td>The client’s new behaviors</td>
<td>1.06</td>
<td>.15</td>
<td>.71</td>
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</table>

*Systemic*

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<tr>
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<tbody>
<tr>
<td>26-</td>
<td>The therapist’s relational conceptualization of the problem</td>
<td>1.44</td>
<td>.20</td>
<td>.66</td>
</tr>
<tr>
<td>27-</td>
<td>The therapist interrupting the dysfunctional relational cycles</td>
<td>1.31</td>
<td>.14</td>
<td>.67</td>
</tr>
</tbody>
</table>

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<tr>
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</thead>
<tbody>
<tr>
<td>28-</td>
<td>The therapist involving other family members in therapy</td>
<td>1.00</td>
<td>.86</td>
<td>.74</td>
</tr>
<tr>
<td>6-</td>
<td>Client’s spirituality</td>
<td>.29</td>
<td>.05</td>
<td>.32</td>
</tr>
<tr>
<td>7-</td>
<td>Client’s factors outside</td>
<td>.29</td>
<td>.05</td>
<td>.35</td>
</tr>
<tr>
<td>29-</td>
<td>The therapist’s alliance to all family members</td>
<td>.90</td>
<td>.09</td>
<td>.75</td>
</tr>
</tbody>
</table>
Figure 2. Hypothesized model of the CFQ
**Concurrent validity.** Predictive validity of the scale was tested through correlation assessment of 28-items Karimi-CFQ with data from the second and third sections of the survey which are independent measures of common factors than 28-items Karimi-CFQ. The six subscales of Karimi-CFQ showed significant correlation with six percentage categories of the Common Factors Model in section two of the survey, which is a concurrent validity indication, including: Client’s subscale \( r = .219, p < .05 \), Therapist’s subscale \( r = .098, p < .05 \), Relationship subscale \( r = .176, p < .05 \), Hope subscale \( r = .132, p < .05 \), Non-theory specific subscale \( r = .048, p < .05 \), and systemic subscale \( r = .250, p < .05 \). Also, SPSS results showed a significant correlation \( r = .10, p < .05 \) between 28-items Karimi-CFQ and total common factors in section three of the survey. In addition, since the participants responded to the CFQ items based on their particular successful client with 70% improvement, it could imply that Karimi-CFQ could predict therapy success.

**Common Factors and Clinicians’ Variables**

Below, the results from three sections of the survey are described:

**Hypothesis 1:** Based on Karimi-CFQ results, there will be a significant difference between specific components of Karimi-CFQ regarding the contribution to therapy outcomes.

Table-7 shows descriptive statistics for six components of Karimi-CFQ. Repeated measure ANOVA was used to compare the mean of six components of Karimi-CFQ. The Mauchly’s test indicated the assumption of sphericity has been violated \( \chi^2 (14) = 222, p = .000 \). The \( p \)-value was 0.00 is less than cut-off point 0.05, which means the variances of the different levels were significantly different. Therefore the Epsilon corrections should be used to correct the \( F \) value. When the estimate of sphericity is more than >.75 it is recommended to use the
Huynh-Feldt correction solution. The results indicate that there are significant mean differences \((F(3.97, 1548.50)=250.61, p=.000)\) between the six components of CFQ. Bonferroni post-hoc tests also indicated significant differences \((p=.00)\) between each pairs of components. Client’s component had larger mean than all other components. In a decreasing order, six components’ mean were client, relationship, therapist, Hope/motivation, Non-theory specific, and systemic (see Figure 3).

![Means of Six components of Karimi-CFQ](image)

**Figure 3. Comparison of Six Components of Karimi-CFQ**

**Hypothesis 2:** Based on survey section 2, there will be significant difference between six categories of Common Factors Model regarding the contribution to therapy outcomes.

Repeated measure ANOVA was used to compare the mean of six percentage categories of Common Factor Model based on data from the section 2 of survey. The Mauchly’s test indicated the assumption of sphericity has been violated \(\chi^2 (14) =339.68, p=.000\). The \(p\)-value was 0.00 is less than cut-off point .05, which means the variances of the different levels were significantly different. Therefore the Epsilon corrections should be used to correct the \(F\) value.
When the estimate of sphericity is less than <.75 it is recommended to use the Greenhouse-Geisser correction solution. The result indicated significant difference between the means of six categories of Common Factors Model, $F(3.69, 1440.31)=182.11, p=.000$.

The results showed that out of 100% contribution to therapeutic change the client category received 25.21%, relationship category received 23.07%, therapist’s category received 20.57%, hope/motivation category received 11.92%, non-theory specific category received 10.08%, and systemic category received 9.13%.

Bonferroni post hoc tests also indicated significant differences ($p=.00$) between each pairs of categories. Client’s category had larger mean than all other categories except relationship category. While the mean of systemic category was significantly smaller than all other categories, its difference from the non-theory specific category was not significant. In a decreasing order, six components’ means were client, relationship, therapist, hope/motivation, non-theory specific, and systemic (see Figure 4).

![Six Percentage Categories of CF- Model](image)

**Figure 4.** *Comparison of Six Categories of the Common Factors Model*
**Hypothesis 3**: Clinicians attribute higher contribution of total common factors to therapy outcomes than total model-specific factors.

In third section of the survey clinicians attributed percentages to common factors versus model-specific factors out of 100% therapeutic change. The average percentage of common factors 68.92 ($SD=15.56$) was larger than the average percentage of model-specific factors 31.02 ($SD=15.45$). Using paired-samples $t$-test, the SPSS output indicated the average percentage of common factors was significantly larger than model-specific factors, $t(390)=24.35$, $p<.01$ (see Figure 5).

![Figure 5. Comparison of CFs versus Model-specific Factors to Therapy Outcomes](image)

**Hypothesis 4**: Female clinicians would attribute higher contribution of common factors in Karimi-CFQ.

The independent-samples $t$-test result indicated that there was a significant difference ($t(389)=3.44$, $p<.001$) on the average score of the Karimi-CFQ between female clinicians ($M=3.81$, $SD=.355$) and male clinicians ($M=3.67$, $SD=.43$) (see Figure 6).
Hypothesis 5: Female clinicians would attribute higher contribution of relationship percentage category and also in total percentage Common Factors than male clinicians.

A series of independent-samples $t$-tests were run to assess if there was any gender difference between six categories of the Common Factors Model. Female clinicians mean ($M=24.07$, $SD=12.74$) in relationship category was larger than male clinicians mean ($M=21.12$, $SD=10.74$) in the section two of survey. The results of the $t$-test analysis indicated a significant difference, $t(389)=2.27$, $p<.02$ (see Figure 7).
In the section three of survey, female clinicians attributed larger contribution of total common factors \((M=70.09, SD=14.16)\) to therapy outcomes than male clinicians \((M=66.60, SD=17.86)\). The independent-samples \(t\)-test indicated significant difference between female and male means in total common factors model in section three, \(t(389)=2.09, p<.05\). However, the both female and male clinicians attributed more percentage to total common factors versus model-specific factors in general (see Figure 8).
Hypothesis 6: Based on survey section 2 and 3, clinicians with higher clinical experience would attribute larger contribution of therapist percentage category and also in total percentage Common Factors than clinicians with low clinical experience.

High experienced clinicians (31-45 years of experience) attributed more therapeutic contribution to therapist category than other three lower experienced groups (Low 0-3, medium 4-10, and experienced 11-30). High experienced group \( (M=24.58, SD=9.79) \) showed larger mean than experienced group \( (M=20.14, SD=9.02) \), medium experienced group \( (M=18.32, SD=7.30) \), and low experienced group \( (M=20.08, SD=6.20) \), \( F(3,374)=9.17, p=.000 \) (see Figure 9).

![Clinical Experience and Contribution of Therapist Factors in Therapy Outcomes](image)

**Figure 9. Clinical Experience and Contribution of Therapist Factors in Therapy Outcomes.**

The three experienced groups of clinicians (high 31-45, experienced 11-30, and medium 4-10 years of experience) attributed more contribution of total common factors to therapy outcome than the low experienced clinicians (with 0-3 years of experience). The high experienced group \( (M=69.22, SD=15.60) \), experienced group \( (M=72.15, SD=15.31) \), and medium experienced group \( (M=71.24, SD=15.20) \) showed significantly larger means than the low experienced group \( (M=62.29, SD=13.92) \), \( F(3, 374)=7.621, p=.000 \) (see Figure 10).
Hypothesis 7: Based on survey section 2 and 3, clinicians with different fields of study would attribute significantly different contribution of total percentage Common Factors to therapy outcome.

The results of the one-way ANOVA indicated that there were no significant differences between clinicians from different fields of study on clinicians’ perceived contribution of CFs to therapy outcomes, $F(2, 364)=.031, p=.970$ (see Figure 11).
Based on the results of section two, MFT clinicians attributed a larger contribution of systemic category to therapy outcomes than clinicians with counseling and psychology degrees, $F(2, 364)=11.67, p=.001$. Clinicians with psychology degrees attributed larger contribution of therapist’s category to therapy outcomes than clinicians with MFT and counseling degrees, $F(2, 364)=7.26, p=.001$. Clinicians with counseling degrees attributed larger contribution of hope/motivation category to therapy outcomes than clinicians with MFT and psychology degrees, $F(2,364)=9.87, p=.000$. Such results may indicate though all fields of mental health attributed almost equal contribution of total CFs to therapy outcomes but each field may attributed more contribution of specific category of CFs.

**Hypothesis 8:** Based on Karimi-CFQ results, clinicians with different clinical orientations would attribute significant different contribution of common factors to therapy outcomes.

The results of one-way ANOVA indicated there was no any significant difference between five clinical orientations regarding the attribution of common factors to therapy outcome, $F(4,355)=1.33, p=.255$ (see Figure 12).

![Clinical Orientations and means on CFQ](image)

**Figure 12.** Clinical Orientations and Means in Karimi-CFQ
**Hypothesis 9:** Based on survey section 3, clinicians with different clinical orientations would attribute significantly different contribution of total percentage Common Factors to therapy outcome.

The results of one-way ANOVA indicated there was not a significant difference between five clinical orientations regarding the contribution of total common factors to therapy outcomes, $F(4,355)=2.46, p=.045$. Integrative therapists showed larger mean ($M=71.72$, $SD=11.96$) than other four clinical orientations including CBT ($M=71.17$, $SD=15.42$), psychodynamic ($M=67.20$, $SD=15.81$), humanistic ($M=66.14$, $SD=17.74$), and postmodern ($M=65.00$, $SD=14.54$). However, post hoc Bonferroni test indicated there was no any significant difference among any pairs of clinical orientations (see Figure 13).

**Figure 13. Clinical Orientations and Contribution of Total CFs**

**Evaluation of Karimi-CFQ**

In the current study different forms of reliability indicated that the Karimi-CFQ has generally good reliability. Cronbach’s Alpha coefficient .842 indicated a high internal reliability for the scale. Also, split-half reliability coefficient 0.87 ($N=391$, $p<.01$) showed that the two
halves of the scale have high correlation. In addition, the item deleted alpha procedure showed that all items of Karimi-CFQ contribute to a good reliability coefficient that means do not increased the reliability if any of the items deleted.

Regarding validity, the different forms of validity assessments indicated that Karimi-CFQ has good validity. In the current study face validity, content validity, and construct validity were evaluated which confirmed the validity of the scale. Content Validity Index (CVI) was administered to experts in the field. The construct validity was assessed by Exploratory Factors Analysis (EFA) and Confirmatory Factors Analysis (CFA) methods. KMO and Bartlett’s test indicated that the questionnaire has the requirements for factor analysis. Exploratory Factors Analysis (EFA) proposed six factors for 29 items of CFs which were drawn from psychotherapy literature. The current theoretical model of CFs also presented six components for the model. The EFA model showed good communalities value for all of the items from 0.373 to 0.672 which indicated all items had been loaded by the components of the model. In addition to EFA, the Confirmatory Factors Analysis (CFA) also provided more support for the construct validity of the questionnaire. Modification indices of covariances and regression weights suggested a few changes in regression paths and covariance of errors path (e. g., item-22 from non-theory specific factor to hope factor) that resulted in better model fit. Also, the results showed item-10 has loading value less than .22 which suggested for deletion. Using Chi-square, RMSEA, and CFI fit indices and modification indices, four models were run to improve the model fit of the questionnaire. The final model with 28 items (excluded item 10 therapist’s reputation) indicted all items has moderate to high standard regression weights from .31 to .86. Also, CFA indicated six components of the questionnaire have medium correlation that indicated they measure different dimensions of the same phenomenon.
Also, predictive validity of the scale was tested through correlation assessment of the Karimi-CFQ with data from the third section of the survey which is an independent measure of common factors than 28-items Karimi-CFQ. SPSS results showed a significant correlation ($r=.10, p<.05$) between 28-items CFQ and total common factors in section three of the survey. In addition, since the participants responded to the CFQ items based on their particular successful client with 70% improvement, it could imply that CFQ could predict therapy success. However, future research needs to include a scale in the study to measure the therapy success.

Subscales/components of Karimi-CFQ showed significant correlation with six percentage categories of the Common Factors Model in section two of the survey, which is another predictive validity indication. Client’s subscale ($r=.219, p<.01$), Therapist’s subscale ($r=.098, p<.01$), Relationship subscale ($r=.176, p<.01$), Hope subscale ($r=.132, p<.01$), Non-theory specific subscale ($r=.048, p<.01$), and systemic subscale ($r=.250, p<.01$).

**Phase 3: Qualitative Results**

*Data Collection*

Six experts in the field of integrative therapy and the CFs model participated in a panel discussion on a WikiSpace website. An invitation letter sent to the potential participants explained the procedure of qualitative study on the Wikispace page. Those experts who agreed to participate were added to the Wiki page through the link. After they signed into the Wiki page they were then a member of the page and could log in whenever they wanted. They posted their responses to each of three qualitative questions. Participants had two weeks open time to revise their own posts or to comments on other participants’ posts.

*Thematic Analysis*
Braun & Clarke’s (2006) framework of conducting thematic analysis was used. The framework suggests six phases to conduct thematic analysis: 1) *Familiarizing yourself with the data*, 2) *Generating Initial codes*, 3) *Searching for Themes*, 4) *Reviewing Potential Themes*, 5) *Defining and Naming Themes*, 6) *Producing the Report*.

**Familiarizing the researcher with the data**: The researcher started the thematic analysis by reading and rereading the whole document which was transferred from the wiki page to a word document. Using a combination of inductive and deductive approaches in the analysis the researcher: highlighted items that were potentially related to the research question which could provide information regarding use of common factors in the process of therapy; wrote comments about how the experts panel experienced the process and how they might think at different stages of therapy regarding the use of common factors. Also, the researcher was aware that the theoretical framework of the common factors model influenced his lens while reading the documents. In addition, the researcher, himself, has been practicing over 20 years as an integrative therapist therefore his personal and professional experience with his own clients also influenced the lens he used to examine the documents.

The researcher also wrote memos during the reading which helped to link the different pieces of the document into a whole picture, such as “*I feel the experts’ theoretical framework is close to my own integrative systemic view in therapy*”, “*the most important process seems to be the linking and integrating different common factors toward the goals*”, “*experts focus on the process of change and what works in the context than solely on the nature of the problem*”, “*experts while describing their experience with particular client they also discussed their theoretical viewpoint*”, “*using a common factors lens gives a flexible contextual view to the therapist to utilize every potential factors in a dynamic process towards therapy goals*”. These
memos developed a whole story about the experts’ opinions of the use of common factors in therapy as well as it helped me to better understand their experience with their successful relational cases.

Generating initial codes. Upon familiarization with the compiled document, initial coding was conducted. In the current study the coding system included a mix of descriptive codes which reflect the experts’ language and words and interpretative codes which reflect the researcher’s theoretical framework. Since the expert panel provided their answers separately for each stage of therapy, the coding system was conducted independently for each of three stages. The emerging codes from three stages of therapy are separately outlined below:

Coding of initial stage of therapy. The process of descriptive coding resulted to 22 descriptive codes (See Appendix-G) that mostly were in experts’ terms and language including: important role of CFs in the early stage, hope in the early stage, work on client’s reluctance and resistance in the early stage, client’s motivation, client’s expectation, client’s persistence, client’s motivation, relationship, affective relationship, family alliance, therapist’s competence, therapist’s confident and security, therapist’s positive attitude, therapist adjusts to client, therapist adjust methods, therapist support, therapist interrupts dysfunctional patterns, relational goal setting, systemic conceptualization, rationale for the client’s perceived problem, treatment rationale.

The interpretive coding procedure resulted in 10 interpretive codes (See Appendix-G) from the initial stage of therapy including, critical time of application, does therapy help?, building hope and motivation through relationship factors, build hope and motivation through therapist’s factors, build hope and motivation through relational conceptualization and goal setting, reframing as a general cognitive non-theory specific procedure (Problem Explanation,
treatment rationale, relational conceptualization, adjustment to client’s expectation/culture/particular characteristics to move towards therapy goals, client’s factors contribute in relationship factors. therapist’s factors boost relationship factors, therapist and relationship factors trigger client’s factors. interaction of therapist, relationship, client’s factors generate hope and motivation.

Coding of the intermediate stage of therapy. The descriptive coding of the intermediate stage resulted in 14 descriptive codes (See Appendix-J) including: therapist’s positive attitudes, therapist’s expertise/competence, client’s engagement, client’s persistence, treatment rationale, interrupting dysfunctional patterns, support goal attainment, therapist revises the assignments, therapist adjusts to clients, clients faces challenges and new experiences, family alliance, new cognitive experience, new emotional experience, new behavioral experience.

In addition, interpretive coding of the intermediate stage resulted in eight interpretive codes (See Appendix-J) including: engagement in new experiences, progress and relapse, maintain treatment rationale, agreement on therapy activities, inoculation of family alliance ruptures, inoculation of relapse, develop idiosyncratic tasks for particular client system, monitoring and guiding the process of change.

Coding of the termination stage of therapy. The descriptive coding of the termination stage of therapy resulted in 12 descriptive codes (See Appendix-L) including: relationship, extratherapeutic factors, therapist’s expertise, therapist’s support, client’s engagement, client’s persistence, client’s factors, client owns the change, treatment rationale, sustain the change, new family patterns, feedback loop is essential in termination.
Also, the interpretive coding of the termination stage resulted in eight interpretive codes (See Appendix-L) including: *attribution of success through new insight and emotional experience at termination, commend and encourage to sustain achieved change, relapse management skills at termination, inoculation for future relapse, feedback loop develops a map of therapeutic change, strengths-based conversation, importance of client’s view on pivotal moments of change, extended therapeutic alliance generates more hope and maintenance of changes.*

**Development of themes.** In order to create themes the researcher looked for any overlaps of descriptive and interpretive codes from previous step of analysis. Each theme was supposed to cover the meanings of some codes together. Based on the research question of chronological application (what, when, and how) of common factors I was looking for processes of decision and action that explained the progress of therapeutic change. This chronological lens helped me to link different processes and pieces of information in a whole picture. In order to emphasize the chronological dimension of the use of common factors, on the Wikipage the expert panel was asked to respond separately to three questions related to each of three stages of therapy (initial, intermediate, termination). Therefore, the researcher developed themes for each stage separately to find what and how specific common factors/processes function in specific time of the therapy course.

*Initial themes from the initial stage of therapy.* The researcher looked for concepts that could reflect unifying features and meaningful patterns in the data from the initial stage of therapy. Seven general themes (*hope and motivation to engage in therapy is the main goal, timing is critical, hope and motivation achieved through different paths, reframing as a general cognitive non-theory procedure, linking common factors in flexible contextual way towards the motivation and treatment goals, process of change, affective relationship generates hope*) were created from
the data and related codes in initial stage of therapy. All experts emphasized on temporal application of CFs in the early stage of therapy specifically regarding the establishment of hope and motivation should precede therapeutic assignments.

**Initial themes from the intermediate stage of therapy.** The researcher looked for concepts that could reflect unifying features and meaningful patterns in the data from the initial stage of therapy. Five general themes were identified (*engagement in therapeutic tasks, facing new cognitive-emotional-behavioral experiences, trend of progress and relapse, intermediate stage is challenging to therapist and client, Split alliance*) from the data and related codes in the intermediate stage of therapy.

The main themes in the intermediate stage of therapy emphasized client’s engagement in therapeutic tasks which includes a series of new cognitive, emotional, behavioral experiences and challenges. Such new experiences are paths towards therapeutic goals that agreed with therapist and client system in previous steps.

**Initial themes from the termination stage of therapy.** The researcher looked for concepts that could reflect unifying features and meaningful patterns in the data from the termination stage of therapy. Five general themes (*maintain the achieved change, attribution of success, inoculation of future relapse, extended therapeutic alliance, feedback loop on therapy process*) were created from the data and related codes in the termination stage of therapy. A thematic map which included themes and their definitions along the relevant excerpts is presented in appendices H, K, and M.

The main goal of the termination stage is to get the client system to sustain and internalize the functional emotional, cognitive, and behavioral patterns which have achieved in previous
stages of therapy. Accessing this ability means the client system can continue the functional patterns without the therapist coaching them.

**Reviewing potential themes.** I reviewed themes in relation to the whole data set and specific coded data were reviewed for the purpose of quality checking. In this phase some themes were combined. From the initial stage of therapy, the theme “Process of change” combined into “Linking CFs in flexible and contextual way towards the motivation and treatment goals” since they covered almost the same content and processes. Other themes also were discarded. For example, the theme “Affective relationship generates hope” was discarded since another theme “Hope and motivation achieved through different paths” was more inclusive and contextually related to the experts’ responses. Also, the researcher reviewed and revised some of the themes’ labels to develop labels which were better representatives of the whole data set. For example, the theme “framing and reframing” was changed to “Reframing as a general cognitive non-theory specific procedure” since the latter theme implied the common cognitive procedure across all therapy models. The theme “intermediate stage is challenging to the therapist and client” was combined with the theme “trend of progress and relapse” to better reflect the experts’ experience regarding the technical dimension of therapeutic change and common factors. The theme “split alliance” was changed to the theme “split family alliance” to emphasize the rupture of systemic and relational alliances for the whole family.

**Themes definitions.** In order to define a theme I asked what is unique and specific about each theme. I considered some criteria to develop good themes: themes should have a singular focus, should be related to each other and not overlap, and address the research question. I asked what is relevant in the data to answering the research question, which is “When and How do therapists use common factors in the course of therapy to reach to the desired therapeutic
outcomes?” I focused on how each theme could explain a feature or piece of therapeutic change over time or stages of therapy. The final goal of the current qualitative study was to improve the theorization of the common factors model to the level that could guide clinicians to “what to do” and “when to do” it in the course of therapy. In other words, two lenses were used while defining and labeling each theme: the process of change, which explains how different common factors interact to generate therapeutic change; and the timing of change, that relates the chronological order or importance of specific common factors in the process of change. In order to develop the final themes and definitions I reread the entire data set to be able to contextualize each of the initial themes in a comprehensive story. The thematic analysis ended in five themes for the initial stage (Appendix-K), four themes for the intermediate stage (Appendix-L), and five themes for the termination stage (Appendix-M). The final themes and related definitions of each stage are discussed here:

Themes and definitions in the initial stage of therapy:

1- Timing is critical. This theme implies that the common factors model has a potential map regarding “what and when” common factors are supposed to be used in the course of therapy. Common factors therapists know the chronological importance of each common factor. In general, some common factors like hope and motivation have critical time in the early stage of therapy. In addition, therapists apply particular common factors at specific moments of therapy to overcome obstacles in the process such as resistance. The following excerpts indicate how experienced therapists intentionally prioritized some common factors to others: “Engagement and development of mutual goals occur during the initial stage of therapy”, or “I think "hope" is another powerful common factor early
on . . . taking a system from "demoralized" to "remoralized" taps into powerful therapist and client common factors”

2- *Hope and motivation are the main goal of the initial stage.* This theme refers to the primary step of therapy in which the client steps into “buy-in” to therapy and includes the credibility of the therapist to solve the perceived problem. Before any task assignment and technique, therapists need to get the client to an agreement that the therapy would help and he/she would agree to a treatment contract and engagement in therapy (“*The client I am thinking about came reluctantly to treatment*”), (‘Early in treatment as we developed a relationship of trust and warmth and as he learned about treatment he begin to have hope that he might benefit from treatment”).

3- *Hope and motivation achieved through different paths.* This theme implies that hope and motivation as the first goal of therapy process can be achieved through different paths. Some therapists use of *relationship factors* such as being warmth and secure (“*This formed a strong relationship; engendered hope*”), other therapists use *treatment rationale and problem explanation* (“*offered a clear rationale for each party of the system*” or “*It was also critical that I honored each party's position on the nature of the problem, their values, language, and their goals*”), that helps client to believe the therapy will help. In other situations the therapist may make use of client’s factors and resources (“*Mother was a hard, resilient woman,...., She sheltered her son and wouldn't let him out on his own, despite the fact that he was very tall and heavy for his age.*”, “*We admired his bravado and strength*”), or therapist’s factors (“*is necessary to show how I gained their trust, engendered hope*”) to engender the optimal hope and motivation.
4- **Reframing as a general cognitive non-theory procedure.** This theme refers to a general cognitive procedure that changes the meaning of the client’s perceived problem in a new context which leads to the client’s motivation and engagement in therapy. Reframing is used in various ways by clinicians from different theories. ("If there is disagreement within the client system on goals, therapists must take an active and unifying stance in reframing the resistance"). Reframing provides a new different conceptualization of the problem that can free the clients from dysfunctional patterns, and helps them to take new views and actions. Relational conceptualization is an important part of relational therapy to get the client system’s cooperation and agreement ("He had an affair to which she responded in part by starting to drink again after many years of sobriety"). Or ("the therapist should obtain the “buy-in” from all parts of the system by skillfully reframing the goal to address the underlying needs of both partners").

5- **Linking Common Factors in flexible contextual way towards the motivation and treatment goals.** This theme implies that common factors are used in a non-static method. In relational therapy, the therapist and the client system creates a context of change that requires the therapist to flexibly monitor the process of change and elastically prioritize specific common factors ("I think of common factors as dynamic processes within the larger context of change"). The therapist monitors how different specific factors interact and activate each other ("this information is necessary to show how I gained their trust and engendered hope", and “taking a system from "demoralized" to "remoralized" taps into powerful therapist and client common factors.”). MEMO my personal clinical experience says that in many situations a new piece of information or change from the client system or therapy system could force a change in the path toward the same
therapeutic goal or to modify the goal itself. One of the experts mentioned the same experience (With this new information, we may decide to modify the goals that we agreed on during the first sessions”) which indicates on contextual and flexible application of common factors.

Final themes and related definitions in the intermediate stage:

1- Engagement in therapeutic tasks. This theme refers to the process in which the client takes action into therapeutic tasks which are developed based on the treatment rationale agreed in the previous stage. Clients believe/buy-in that therapeutic tasks are paths towards agreed therapy goals. The engagement requires therapist’s support and client’s motivation and courage to face new challenges and experiences (“In this stage,…,common factors included client motivation, therapist confidence, expertise, therapeutic alliance, hope,…[to get the client,…]”), or (“they said that the knowledge that I truly cared helped kept them pushing through things when their commitment was weak and they were disillusioned”).

2- Facing new experiences (emotional, cognitive, and behavioral). This theme refers that the vehicle of therapeutic change progresses on the axes of new emotional, cognitive, and behavioral experiences. Common factors therapists use their expertise and support to face the clients with new experiences that generate functional patterns which in turn results in therapeutic goals. They are general main paths from treatment rationale to therapy goals.

Sometime the new experiences happens in the session: (e.g., “allowing clients to explore safely their relational problems with the therapist in the “here and now” context of the therapeutic relationship”), and other times it is a behavioral task experienced out of the session (“Mom brought [her]boyfriend into the relationship and they both set clear limits and expectation ..[for the son]”). Sometime therapists actively interrupt a dysfunctional pattern and
replace it with new functional experiences (e. g., “They were each doing a lot of blaming the other one for their own bad behavior, which I interrupted and processed a lot ala EFT”).

Also, therapists who make a secure therapeutic alliance can push and challenge his or her client to new experiences ("I also adapted to their personalities by pushing and challenging them pretty directly throughout this stage - an approach they liked").

Confronting the problems or challenges is a common process of change across all therapy schools (Weinberger, 1955; Weinberger & Rasco, 2007). Some scholars called them non-theory specific factors in the common factors model which imply all therapeutic interventions across models require some sort of “facing new experiences” by client. (The researcher memos: experienced and integrative therapists can go beyond a specific model and flexibly utilize these three axes depends on the context of change process with specific client system. The same goal can be achieved through these three paths.)

3- Trend of progress and relapse. This theme refers to a challenging process of progressing and relapsing in therapeutic change that is a natural trend in the middle stage of therapy. Clients, to achieve mastery of new functional patterns, usually experience ups and downs and progressively more difficult steps (e. g., “There was a lot of progress, followed by relapse, then progress, then relapse, etc.’). CFs therapists inform and inoculate their clients in advance regarding this trend (“I have learned to offer inoculations during the initial stage of treatment to help with this”,” you may notice early improvement followed by a backslide”). The therapist needs to continuously adjust the relationship and revise the methods to the particular client system to push the progress (“I also adapted to their personalities by pushing and challenging them pretty directly throughout this stage - an approach they liked”). (MEMO: my clinical experience says there is always some degree of resistance against any new change in each client system and their families
which requires flexibility from the therapist and client system in order to install a desired change in a system).

**4- Split family alliance.** This theme specifically refers to a common trend in relational therapy in which therapeutic family alliance may rupture in the middle of therapy in reaction to new changes and challenges they are facing. When a part of the system feels a weaker alliance to the therapist than another part of the system it generates resistance to therapeutic engagement and change (“A split [family] alliance may quickly degenerate into an alliance rupture”). Common factors therapists respect and connect the client subsystems in one unit as couple or family which can prevent split alliance, (“I also relied on the depth of our connection- they knew that I cared about them, and that their marriage mattered to me”). Therapist’s security and expertise in relationship factors may inoculate such a risk.

**Final themes and definitions in termination stage:**

**1- Maintain achieved goals.** This theme implies that the client system needs to sustain and internalize the functional emotional, cognitive, and behavioral patterns which have been achieved in previous stages of therapy. Reaching this ability means the client system can continue the functional patterns without the therapist coaching them (“At termination I am with working clients on sustaining changes that they have made”). Or (Here, I want to make sure that I highlight what the client has done to bring about change. I will often make a list and send it home with the client”). The therapist supports the client to get to this ability through several mechanisms: emphasizing strengths-based conversations with client; empowering the client to own the changes they have made until now; expanding therapeutic alliance available after termination; educating the client regarding future relapse.
2- Attribution of success. This theme refers to a process in which the client system starts to own the therapeutic changes and internalize them as a result of their own efforts and skills (“I commended them for all they had done and gave them a chance to explain how they did it thus having them own the change by attributing it to themselves”). Such an attribution is similar to Bandura (1989) self-efficacy concept, which is negatively associated with relapse (Weinberger, 2014). Therapists use strength-based conversation at termination to help the client own the changes and skills (“A lot of strengths-based conversation and reflection on the progress they'd made”).

3- Inoculation of future relapse. This theme refers to a process in which the therapist educates the client regarding possible future relapse and hurdles and how to manage them (“Upon successful termination, we commended all and inoculated them against inevitable backsliding and future hurdles”). The feedback loop between therapist and client at termination provides the client with new insight regarding the whole process of change. That is another mechanism the client gets cognitive mastery for handling future hurdles (“While important in all stages of therapy, the concept of giving and eliciting client feedback is especially essential in later phases as termination approaches”).

4- Extended therapeutic alliance. This theme refers to the availability of the therapist and the therapeutic system in case the client system needs an additional appointment (“I extend the relationship by reframing termination as variable scheduling- the client calls me for an appointment if a need comes up”). Such an extension generates security and hope which in turn can contribute in better maintenance of achieved goals.

Trustworthiness
In order to enhance the trustworthiness of the data analysis and the results, the researcher considered several strategies:

**Persistent observation/engagement.** I read and re-reviewed the whole document several times before starting coding systems. Over two weeks, every time that each participants added a new post or commented to other participants I re-read the whole document, this process, as persistent observation, helped in credibility and dependability dimensions of trustworthiness, since it gave a general picture and understanding of participants experiences before the researcher starts to develop codes and themes. Such process helped the researcher to consider all different pieces of data in the same context and meaningfully liked them together during analysis.

Thick description is other way to enhance the credibility and transferability of the results. The researcher tried to describe the participants’ characteristics (six experts in the field of integrative therapy and common factors, with Ph.D. degree, minimum of 10 years experience and two publications, etc.) and specific context and time of data collection. The experts provided information about one of their recent successful relational cases. Also, they provided this information on Wikispace during two weeks. Participants could revise their own posts or comment and interact with other participants. Also, the participants provided information for each specific stage of therapy separately. Making clear these conditions, it gives an idea to the readers and researchers to decide how much the results may be transferable to other situations.

Also, in stage four of the analysis, after creating codes and developing themes, I reviewed all the themes in relation to the whole data set and also specific codes. During this process some themes were discarded, modified, or combined. Such a process, as a quality checking, helped the researcher to establish more meaningful and clearer linkage between themes’ labels and
participants experience and intentions. This strategy may be defined as dependability dimension of trustworthiness.

Finally, the researcher by admitting his own predispositions (as an experienced integrative therapist who is advocate of common factors) tried to enhance the confirmability dimension. Also, by addressing shortcomings (e.g., lack of female experts in the panel, and the small number of participants) of the study the researcher tried to increase confirmability and trustworthiness. In addition, the researcher provided tables and thematic map with related codes and direct quotes/excerpts from participants. The researcher wrote memos, as reflective commentary, during the analysis process and reported them in the results to enhance the trustworthiness of the analysis (Lincoln & Guba, 1985).

**Mixed Method Results**

**Merging and Comparing Findings**

Using a mixed methods convergent parallel design, the researcher used concurrent timing to implement the quantitative and qualitative strands during the research process, considered equal priority for methods, and independently analyzed each data set, and then mixed the results during the final interpretation (Creswell & Clark, 2011).

The data sets from quantitative and qualitative strands were merged and compared to assess the convergence and divergence of the results, and to find how each set of data could support the other one. Table-8 shows the comparison between quantitative and qualitative results regarding the most frequent common factors. Qualitative results supported the quantitative data regarding the important role of following common factors: affective relationship, client motivation, client engagement or persistence, non-theory specific procedures, therapist adjusts methods to client, new-insight. The expert panel emphasized the role of the above common
factors to bring about change. Qualitative results supported the quantitative results by providing information on how and when each of the more frequent common factors in quant data works. For example, quantitative data showed therapists attributed high contribution to client’s motivation in therapy outcome and the qualitative results confirmed the importance of the factor as well as explained how and when this important common factor works in therapy.

In contrast, some of the common factors which had low mean in the quantitative results were found to be very important in the qualitative results including: treatment rationale, therapist’s support, goal-agreement, therapist-competence, systemic factors or family alliance. In fact, during the thematic analysis and especially interpretive coding it suggested that this group of common factors may be acting as a mediator mechanisms to develop and activate the first group of common factors (e.g, Client’s motivation or Client’s Engagement). Based on qualitative analysis, a competent supportive therapist by using relationship factors engenders degrees of hope, then provides a fit treatment rationale regarding how therapy works which makes the client more hopeful and motivated. Then by working on a goal agreement the client’s engagement appears to be activated. So it appears that these emerging common factors from qualitative data may function as the main vehicle of change in the therapy processes and/or as the linkage between other common factors. Such a difference between two strands could be due to the different research method questions in each strand that may have guided research participants to a particular aspect of the research topic; or to the level of expertise in qualitative participants who have more experience in general with common factors.

In addition, the qualitative results introduced some new concepts and processes that were not included in the 28-items Karimi-CFQ, including: Client’s Strengths, Attribution of success, Inoculation of relapse, Split family alliance in middle stage, Feedback on therapy process and
termination, Sustain achieved goals. The researcher found this group of common factors mostly as processes rather than static content or items in therapy.

**Quantification of Emerging Factors in Three Stages**

As a part of mixed method study, the emerging codes in thematic analysis were quantified for three stages of therapy. The most frequent codes were: affective relationship, new insight, treatment rationale, therapist support, client motivation, goal agreement, new behavior, therapist competence, therapist adjusts methods to client (See Table-7).

Comparing the first, second, and third stages of therapy regarding the frequency and therapeutic impact of each common factors the results indicated that: in the initial stage of therapy four of the common factors play the main role including: Affective relationship, Treatment rationale, Goal agreement, Client motivation. In the intermediate stage of therapy, the following five factors were important: New-behavior, New-insight, New-emotional, Affective relationship, Client engagement, Therapist support. In the termination stage of therapy, the following factors were important: New-insight, Inoculation of relapse, Client owning the change, Therapist support/competence, Affective relationship.

**Table 6**

*Frequency of Emerging Factors at Three Stages of Therapy from Qualitative Data Analysis*

<table>
<thead>
<tr>
<th>Emerging common factors</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Total number</th>
<th>Therapy Stages: Initial, Intermediate Termination</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Client’s motivation</td>
<td>14</td>
<td>3</td>
<td></td>
<td>17</td>
<td>Initial</td>
</tr>
<tr>
<td>2-Client’s intellectual ability</td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>3-Client’s expectation of therapy success</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>8</td>
<td>Initial</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Value 1</td>
<td>Value 2</td>
<td>Value 3</td>
<td>Stage</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>4</td>
<td>Client’s engagement in therapy process</td>
<td>3</td>
<td>12</td>
<td>15</td>
<td>Intermediate</td>
</tr>
<tr>
<td>5</td>
<td>Client’s persistence</td>
<td>9</td>
<td>2</td>
<td>11</td>
<td>Intermediate</td>
</tr>
<tr>
<td>6</td>
<td>Client’s spirituality or religious faith</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Client’s factors outside of therapy</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>Termination</td>
</tr>
<tr>
<td>8</td>
<td>Therapist’s competence</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>16 Intermediate</td>
</tr>
<tr>
<td>9</td>
<td>Therapist’s support</td>
<td>3</td>
<td>10</td>
<td>7</td>
<td>20 Intermediate</td>
</tr>
<tr>
<td>10</td>
<td>Therapist’s reputation</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Therapist’s friendliness</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>Intermediate</td>
</tr>
<tr>
<td>12</td>
<td>Therapist’s positive attitude</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4 Initial</td>
</tr>
<tr>
<td>13</td>
<td>Therapist’s efforts to interrupt the client’s dysfunctional patterns</td>
<td>6</td>
<td>1</td>
<td>7</td>
<td>Intermediate</td>
</tr>
<tr>
<td>14</td>
<td>Therapist’s ability to adapt to the client’s characteristics</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>Intermediate</td>
</tr>
<tr>
<td>15</td>
<td>Therapist's ability to help the client maintain an appropriate emotional arousal</td>
<td></td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Therapist’s ability to adjust methods to the particular client</td>
<td>8</td>
<td>4</td>
<td>3</td>
<td>15 Initial</td>
</tr>
<tr>
<td>17</td>
<td>Therapist’s sensitivity to the client’s cultural values and beliefs</td>
<td></td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Affective quality of the client–therapist relationship</td>
<td>9</td>
<td>11</td>
<td>5</td>
<td>25 Intermediate</td>
</tr>
<tr>
<td>19</td>
<td>The extent to which the client found therapy activities credible</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>The agreement between the client and therapist on the goals of therapy</td>
<td>16</td>
<td>2</td>
<td>18</td>
<td>Initial</td>
</tr>
<tr>
<td>21</td>
<td>Client’s belief that the treatment would help</td>
<td>6</td>
<td>1</td>
<td>7</td>
<td>Initial</td>
</tr>
<tr>
<td>22</td>
<td>The rationale the therapist gives for how therapy will achieve a positive outcome</td>
<td>15</td>
<td>7</td>
<td>2</td>
<td>24 Initial</td>
</tr>
<tr>
<td>Step</td>
<td>Description</td>
<td>Count 1</td>
<td>Count 2</td>
<td>Count 3</td>
<td>Grade</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------------------------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>23</td>
<td>The client’s new emotional experience</td>
<td>6</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>The client’s new insight</td>
<td>4</td>
<td>11</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>25</td>
<td>The client’s new behaviors</td>
<td>13</td>
<td>5</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>The therapist’s relational conceptualization of the problem</td>
<td>8</td>
<td>1</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>27</td>
<td>The therapist interrupting the dysfunctional sequence of relational cycles</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>28</td>
<td>The therapist involving other family members in therapy</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>29</td>
<td>The therapist's alliance to all family members</td>
<td>5</td>
<td>3</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Client strengths</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Attribution of success</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Therapist educate client for relapse (inoculation)</td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Feedback on therapy process and termination</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Sum</td>
<td></td>
<td>Sum=109</td>
<td>Sum=111</td>
<td>Sum=73</td>
<td></td>
</tr>
</tbody>
</table>
Table 7

Common Factors with High and Low Impact in both Qualitative and Quantitative Strands

<table>
<thead>
<tr>
<th>CF Items</th>
<th>Qualitative Strand</th>
<th>Quantitative Strand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client’s motivation</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Client Engage/Persist</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Non-Theory Specific (New Insight, Behavioral, Emotional Exp.)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Therapist’s ability to adjust methods to the particular client</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Safe-Affective relationship</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Treatment Rationale</td>
<td>✓</td>
<td>O</td>
</tr>
<tr>
<td>Therapist Support</td>
<td>✓</td>
<td>O</td>
</tr>
<tr>
<td>Goal agreement</td>
<td>✓</td>
<td>O</td>
</tr>
<tr>
<td>Therapist Competence</td>
<td>✓</td>
<td>O</td>
</tr>
<tr>
<td>Unique Systemic factors</td>
<td>✓</td>
<td>O</td>
</tr>
<tr>
<td>Attribution of success</td>
<td>✓</td>
<td>O</td>
</tr>
<tr>
<td>Inoculation of future relapse</td>
<td>✓</td>
<td>O</td>
</tr>
</tbody>
</table>

✓ = High therapeutic Impact       O = Low or No Impact
Chapter V: Discussion

Research in psychotherapy and family therapy has shown that different models of therapy are effective but still there are debates in the field regarding the mechanisms that are responsible for therapeutic change (Kazdin, 2007; Prochaska & Norcross, 2007). Psychotherapy models were developed to explain human functioning and the mechanisms that are responsible for therapeutic change. Advocates of model specific camp believe each model has its own unique techniques and interventions which create therapeutic change. On the other hand, advocates of the Common Factors Model believe the shared or common mechanisms of change that work across all therapy models contribute more than model-specific techniques to therapy outcome (Messer, 2004; Sprengle et al. 2009; Wampold, 2010).

Advocates of the model specific camp have criticized the common factors model for several reasons: the common factors model only comes from meta-analyses and the model lacks empirical evidence which should come from direct clinical experience/observation, lack of evidence for the linkage between the function of common factors and therapy outcome, lack of empirical evidence that compares therapeutic impact of common factors versus model-specific factors, and for the lack of ability to guide therapists, as in a manual, over the course of therapy (Chambless & Ollendick, 2001; Sexton et al., 2004). All the criticisms are significant and need particular research methods to be fully answered. The current study was one of the first empirical studies that addressed the above mentioned debates in the field of common factors and integrative therapy.
The current mixed methods study contributes to the field by: gathering direct quantitative information from therapists about their successful therapy sessions/clients that link the perceived contribution of common factors to treatment outcome; testing the therapeutic contribution of common factors across different theoretical orientations and different therapists demographic characteristics; comparing simultaneously the proportional therapeutic contribution of common factors versus model-specific factors to treatment outcome; and using a qualitative method to explore how, when, and what common factors are used by experienced common factors clinicians during the three stages of therapy which improve theorization of the common factors model. Finally, the quantitative and qualitative results were compared and linked, which provided complementary explanations and emerging ideas regarding the contribution of common factors in therapeutic change.

**Quantitative Discussion**

Scholars in the field of common factors recently emphasize scientific/empirical research of common factors in such a way that the results can fit in the lens of evidence-based practice research and be considered scientifically legitimate (Laska, Gurman, & Wampold, 2014; Constantino, & Bernecker, 2014; Weinberger, 2014). Such empirical research will result in the integration of two psychotherapy camps as well as an improvement in our therapy effectiveness in general (Lambert, Ogles, 2014). The current study aimed to develop a valid and reliable Common Factors Questionnaire (Karimi-CFQ) that allows researchers to assess empirically the contribution of common factors to therapeutic change and outcomes. The results indicated Karimi-CFQ has good content and construct validity. The content validity index (CVI) results from an expert panel
supported the assumption that the present questionnaire was indeed measuring the intended content. Exploratory factors analysis (EFA) and confirmatory factor analysis (CFA) provided good beginning support for the scale’s validity. Cronbach’s alph and Split-half reliability coefficients further supported the reliability for the questionnaire. The findings also indicate Karimi-CFQ reflected six components/factors. EFA and CFA statistical methods explored and supported a model with six components (client, therapist, relationship, hope/motivation, non-theory specific, and systemic). The findings support the initial validity and reliability of the CFQ. Future research may provide more support for the questionnaire’s psychometrics and/or its refinement and improvement.

Though convenient sampling was used in the current study, the size and diversity of the sample included in the study it may have helped in generalizing the data. The clinician sample (391 cases) was fairly similar in gender proportions, was drawn from different states in the US and different professional organizations, different clinical orientations, different degrees, wide range of years of clinical experience- and different fields of study.

Regarding the second question of the study: “To what extent do therapists perceive specific components of Karimi-CFQ contributed to therapeutic change?”, the Common Factors Questionnaire (Karimi-CFQ) included six components including: client’s component, therapist’s component, relationship component, hope/motivation component, non-theory specific component, and systemic component. Results showed the six components had significantly different means, that is, specific components of common factors may contribute differently to therapeutic change or outcome. The findings indicated that the client’s component, relationship component, and therapist’s
component had the highest mean contribution. This finding matches with Rogers and humanistic theory that basically emphasizes the characteristics of the healing relationship (healing context: empathy, positive regard, and congruence) between therapist and client that can work across treatment models (Norcross, & Goldfried, 2006; Sprenkle et al, 2009; Wampold, 2010).

Also, the Common Factors Questionnaire (Karimi-CFQ) results indicated that clinicians perceive more therapeutic contribution to the following items: Client’s Motivation, Client’s Engagement, Affective Relationship, Client’s New-Behavior, and Therapist Adjust Methods to Client, which again indicates the important role of client, therapist, and relationship components in therapeutic change. Such findings suggest more empirical research needs to be conducted on client’s factors, therapist’s factors, and relationship factors in evidence-based practice research.

The second section of the survey included a percentage question to compare the proportional therapeutic contribution of six common factors categories out of 100% therapeutic change. Regarding the second research hypothesis (Based on survey section 2, there will be a significant difference among the six percentage categories of the Common Factors Model regarding the contribution to therapy outcome), the findings indicated that the client’s category showed the highest mean, followed by the relationship category, therapist’s category, hope/motivation category, non-theory specific category, and systemic category. The results in section two also provided empirical evidence to support Lambert's (1992) estimated percentage of common factors contribution. The findings of the current study are somewhat different from the estimated percentages proposed by Lambert (1992) based on a narrative review of the literature. Lambert’s
model proposed 40% of change in the client’s extra-therapeutic factors, 30% in relationship factors, 15% in Hope factors, and 15% in technique and theory factors. In the current study the participants attributed 25% to Client factors, 23% to Relationship factors, 20% to Therapist’s factors, 12% to Hope factors, 10% to Non-theory Specific, and 10% to Unique-Systemic factors. However, the reader should note that the use of different categories/terms in the current study compared to previous literature.

The third section of the survey included two percentage questions to compare the proportional therapeutic impact of total common factors versus total model-Specific factors out of 100%. Regarding the third research hypothesis (clinicians attribute higher contribution of total common factors to therapy outcomes than total model-specific factors), results indicated a large difference between the two categories. The clinicians attributed 68.57% of therapeutic change to common factors and 30.86% to model-specific factors. The results also supported Lambert’s model of common factors regarding the larger impact of common factors. However, the current study showed that almost 30% of therapeutic change was attributed to model-specific factors versus the 15% proposed by Lambert (1992). However, some scholars may consider overlap between non-theory specific procedures and systemic factors with model-specific factors (Prochaska & Norcross, 2007). Such an overlap may cause disagreement about the contribution of common factors and specific factors across different studies. The current study was one of the first empirical studies in the field. A more accurate operational definition of common factors will be required in order to provide more empirical evidence of common factors as well as to compare common factors impact to ESTs impact (Lambert & Ogles, 2014; Weinberger, 2014).
The third purpose of the current study was to assess the relationship between clinicians’ demographic characteristics and the contribution of common factors to therapy outcomes. While therapists characteristics are controlled in randomized clinical trials (RCTs), the new research debate in the field suggested including such characteristics in research design as variables that contribute to therapeutic change (Laska & Wampold, 2014; Norcross, 2002). Therapists’ gender, years of clinical experience, field of study, favorite clinical orientation etc. may affect their perceived contribution of common factors to therapy outcomes. Regarding the fourth research hypothesis (Female clinicians would attribute higher contribution of common factors in Karimi-CFQ) the results of Karimi-CFQ indicated that the female clinicians showed a significantly larger mean compared to male clinicians, which indicates the female clinicians were more inclined to attribute more of common factors contribution to therapeutic change. In section two of the survey, which included six percentage categories of common factors, female clinicians attributed more therapeutic impact to Relationship factors and Client factors, while male clinicians attributed more impact to Therapist’s factors, Hope factors, Non-Theory specific factors, and Systemic factors.

In section three, while both male and female clinicians attributed more contribution to common factors than model-specific factors, the female clinicians showed a larger mean than male clinicians to the contribution of common factors to therapy outcomes. On the other hand, the male clinicians showed a larger mean of model-specific factors compared to their female colleagues.

Such results indicated therapist’s gender may affect how clinicians use specific components of common factors to bring about their desired therapeutic change. It is
possible that male and female clinicians reach the same desired therapy goals through different paths by the utilization of different components of common factors. That is, female clinicians compared to male clinicians generally may function better at activating relationship factors and client factors. On the other hand, male clinicians compared to female clinicians, may be able to benefit from other common factors paths (therapist-factors, hope-factors, non-theory-factors, and systemic-factors) to get to the same therapeutic goals. While both male and female therapists can be effective, it may be useful to learn more about the role of gender in the differential use of common factors, particularly those related to the therapeutic relationship (Beutler, Malik, Alimohamed, Harwood, Talebi, Noble, & Wong, 2004; Moreno, Kramer, Scheidegger, & Weitzman, 2005; Robinson, 2009). For example, in some situation a non-directive and empathic stance may be used by a female therapist, while a male therapist may use a challenging and strategic stance. Some scholars concluded that the therapeutic participants (therapist, client) characteristics are much more important determinants of therapeutic change than the treatment model itself (Robinson, 2009; Weinberger, 2014). Gender socialization theory might explain such a gender difference since it explains how the person learns the social expectations and specific attitudes associated with each sex. Such expectations may influence both the therapist and the client during the course of therapy. According to gender socialization, for women a sense of self tends to develop and change in the context of relationship with others versus men that socially are allowed to be more autonomous and problem solvers (Tantillo & Kreipe, 2006).

The results for research hypothesis six (Based on survey section 2 and 3, clinicians with higher clinical experience would attribute higher contribution of therapist
percentage category and also in total common factors than clinicians with low clinical experience) indicated a meaningful relationship between years of clinical experience and the contribution of common factors to therapy. The three experienced groups attributed more contribution of common factors to therapeutic change than the low experience-group. Also, the highest experienced clinicians attributed more contribution to the therapist’s category among the six components of the Common Factors Model than the three less experienced groups. The findings suggest that therapist’s characteristics (e.g., years of experience and/or age) relate to therapeutic change. Interestingly, the lowest experienced group attributed a greater contribution to model-specific factors than the three other more experienced groups. It may be that the less experienced therapist is more dependent on techniques and models than the more experienced clinicians.

One assumption may be that as clinicians grow older they have more life experiences (in addition to clinical experience that can be a correlated factor) and confidence in communication skills, as well as having learned how to effectively use the therapist’s factors to bring about change.

There are some explanations for such findings. Therapists with more clinical experience may possess more life experiences, communication skills, and more confidence that helps them to utilize common factors in more effective ways. Another possible explanation is that clients may invest more trust in highly experienced clinicians. It is only reasonable to assume that as the therapist’s experience and confidence increase, so does the client’s trust. On the other hand, therapists with less experience may need to rely more on specific techniques or theories.
Regarding the degree of education, the results for hypothesis 7 (Based on survey section 2 and 3, clinicians with different fields of study would attribute a significant different contribution of total percentage common factors to therapy outcomes) indicated that there is not a significant relationship between the fields of study and the contribution of common factors. In fact, the three fields of study represented to the participants (MFT, Psychology, and Counseling which included 93% of the sample) has similar findings, which may indicate that a range of clinicians from different fields of study may use the common factors at similar levels in their practices to bring about therapeutic change. Findings further indicate that all clinicians, beyond their fields of education, perceived more contribution of common factors than model-specific factors to therapeutic change. However, it is possible that professionals from each field of study assign more contribution to one of six categories of the Common Factors Model to reach to the same therapeutic goals. For example, MFT clinicians attributed more systemic factors in their practices. Counseling clinicians attributed more hope/motivation factors, and psychology clinicians attributed more therapist’s factors. One explanation could be that the fields of study do not make a change to the general level of utilization of common factors by clinicians but it makes variation in the use of specific components of common factors.

The findings related to hypothesis 8 (Based on Karimi-CFQ results, clinicians with different clinical orientations would attribute significant different contribution of common factors to therapy outcomes) indicated that the clinical orientations do not make a significant difference in the perceived contribution of common factors. In addition, all clinicians from different clinical orientations attributed more contribution to common factors than to model-specific factors in therapeutic change. Though clinicians identify
themselves with different specific clinical orientations and related specific interventions, all appreciate and may use common factors in their practices to reach their desired therapeutic change (Wampold, 2001; Hubble et al, 1999). As Lambert and Bergin (1994) mentioned, a wide range of treatment models can be beneficial as long as they are applied by a “skillful, wise, and stable therapist” (p. 180). So it may be that the therapist’s level of competence in applying common factors as well as competence in conducting a specific treatment model could contribute to therapeutic change more than the treatment model itself (Elkin, et al., 2006; Sprenkle, et al, 2009).

In conclusion, the findings of the current study indicate that the clinicians’ gender and years of clinical experience make a difference to the perceived contribution of common factors in therapy outcome. On the other hand, clinicians’ fields of education and their favorite clinical orientation do not make a difference in their total perceived contribution of common factors to therapy outcomes. However, it possible that some of the therapist’s variables (such as field of study) are associated with larger attribution of specific components of common factors to therapy outcomes. Such findings represent support for the proponents of the common factors model in the debate between common factors camp and the model specific camp, since the results found that most therapists gave more weight to common factors than model-specific factors.

**Qualitative Discussion**

Therapy in general, and specifically relational therapies, always includes fluid processes and several interactional patterns over the course of therapy. Qualitative methods are useful to capture such processes (Sprenkle & Piercy, 2005). The goal of the qualitative portion of this study was to improve the theorization of the common factors
model in a manner that may guide clinicians during the course of therapy. In contrast to quantitative data, qualitative data explain the processes/mechanisms of change which can improve the theoretical level of treatment models and their efficacy (Held, 1991; Kazdin, 2007). The qualitative data collected in this study shed light on the what, when, and how experienced common factors and integrative clinicians use specific common factors during three stages of therapy (initial, intermediate, termination) to bring about change in their successful relational cases. The findings explained that common factors are not a series of fixed and separated factors, but interactive ongoing processes which function in several ways over the course of therapy (Laska & Wampold, 2014). The results suggest that timing is critical and there is a chronological map for the common factors model that can guide therapists over the course of therapy. That is, specific common factors function differently related to different stages of therapy: Initial, Intermediate, and Termination. Also, specific common factors in stage two and three appear to be built on other specific common factors that were used in the preceding stage.

In the first stage of therapy, working on the client’s motivation is the main issue to be achieved through a combination of expressing the therapist’s competence, developing an affective-relationship, discussing the treatment rationale, and working on goal agreement with the client. However, qualitative data indicated that different therapists may use some of these processes more than others to develop the client’s motivation. As discussed in the quantitative part of the study, a female clinician may use more affective-relationship factors as compared to a male clinician who may use more of the therapist’s competence or treatment rationale, though both may be able to increase the client’s motivation. Therapist’s variables and client’s variables may interact which relates
to which specific common factors work more effectively at particular therapy stage.

Research suggested that the client’s preference or characteristics can determine which common factors, as well as what type of techniques, the therapist should use to generate a better therapeutic outcome (Norcross, 2002). Therapy is more than a list of factors from common factors or the model specific traditions, but a combination of interactive and supplementary processes that complement one another to create therapeutic change (Beutler et al, 2012; Beutler, 2014; Laska & Wampold, 2014).

In the intermediate stage of therapy, the participants from the Wiki discussion reported that the main goal of using common factors was to get the client engaged in therapeutic assignments which include a series of new emotional, cognitive, behavioral experiences or challenges in and out of therapy. Some scholars labeled this stage of therapy as skill training or mastery (Weinberger, 2014). The intermediate stage includes a trend of progress and relapse, which is the most challenging period of therapy, and requires both therapists and clients to actively work together (Beutler, Forrester, Holt, & Stein, 2013). The therapist needs to: actively interrupt individual and systemic dysfunctional patterns; monitor and resolve “split family alliance” in relational cases which is a common incidence in the middle stage of relational therapy; monitor and work with clients about “trend of progress and relapse” as a common incidence of therapy process in the middle stage as well as be supportive and actively adjust the methods to particular clients.

Through the identification of themes from the wiki discussion, it appears that the intermediate stage involves the client actively engaging in new challenges and experiences in and out of therapy, utilizing all possible resources in his/her life, providing
the therapist with corrective updated feedback regarding how the methods (including model-specific interventions as well as non-theory specific emotional, cognitive, behavioral tasks/experiences) work and do not work, learning about the progress and relapse process in therapy, and being persistent in therapeutic assignments. Though research indicates that the role of the client’s characteristics and strengths enhances therapeutic change, the field still needs to study the interactive and complementary process of client and therapist with both common factors and model-specific factors (Beutler, 2014).

Findings of the termination stage suggest that the main goal is to help the client internalize and continue the new functional patterns/skills that have been gained in therapy. Such a goal is accomplished through interaction of some processes that allow the therapist to: help clients to own the therapeutic change which they have achieved in therapy; emphasize the clients’ strengths and resources that could be used in the direction of therapy goals, expand the therapeutic alliance for after termination, and educate the client regarding possible relapse after termination.

In the termination stage, the therapist wants to ensure that the client owns the change and has mastered functional patterns and skills at the level that enables him or her to work without the therapist. The process of “owning the change” appears to lead to internal attribution by the client. The internal attribution associated with more self-efficacy which makes the therapeutic outcome last longer and have lower risk of relapse (Bandura, 1989; Weinberger, 2014). Weinberger (2014) criticized the model specific camp for not including the “attribution of change/success” in their study and the common factors camp for referring to it in vague terms. The qualitative results of the current study
would seem to suggest that advocates of the common factors model directly address through future research the notion that the “attribution of success” is a primary goal of the termination stage of therapy.

By combining the three stages of therapy, the qualitative data suggests the following processes are perceived to be the most important common factors in therapy: affective-relationship, new-insight, treatment rationale, therapist support, client motivation, goal agreement, new-behavior, therapist competence, therapist adjusts methods to client, inoculation of relapse, attribution of success.

In addition, the qualitative data generated some new concepts and theoretical themes that can be used by researchers to improve the current Karimi-CFQ or other common factors instruments: working on problem explanation is important at the beginning of therapy as it is important to work on treatment rationale also. Such a shared understanding regarding the problem could contribute to therapeutic alliance and the hope processes (Robinson, 2009). A trend of progress and relapse, if handled well, could lead to an inoculation process that can be a predictor of a better therapeutic outcome. Experienced common factors therapists normally expect a challenging trend in the middle of therapy and work with it as a predictor of good therapy.

Findings from the middle stage of therapy showed an overlap between model-specific factors/techniques and one of the common factors components that is a non-theory specific factors, which includes every general new cognitive, emotional, and behavioral experiences the client faces during therapy. Common factors therapists mentioned that it is hard to exactly distinguish these components of common factors from model-specific techniques. Therefore, more accurate operational definitions are needed
by scholars to distinguish this overlapping area and to bridge the randomized clinical
trials models to the common factors model. Several scholars emphasize more accurate
operational definitions of common factors, which provide the opportunity for the
empirical study of common factors as well as the integration of common factors research
and randomized clinical trials research through the lens of evidenced-based practice
(Laska & Wampold, 2014; Lambert, & Ogles, 2014; Constantino, & Bernecker, 2014;

Mixed Methods Discussion

The quantitative and qualitative results were assessed for divergence and
convergence, and for complementary explanations or new emerging ideas. Quantitative
and qualitative findings supported each other regarding several of the most important
common factors such as client’s motivation, client’s engagement, affective relationship,
new cognitive-emotional-behavioral experiences, therapist adjusts methods to client,
which are emphasized in both strands. In addition, qualitative findings helped in the
interpretation of results from the quantitative data. Qualitative data helped make sense of
the chronological positions of those common factors that were found most important in
the quantitative portion of the study it helping explain why and how some common
factors are important in certain stages of therapy. Further, the qualitative data helped
explain how specific common factors that were found frequently in quantitative data
interacted and complemented each other to achieve stage-related goals as well as
therapeutic outcomes (Laska & Wampold, 2014). Such findings provide beginning
answers to what advocates of randomized clinical trials consider the theoretical gap in
common factors (Chambless & Ollendick, 2001; Sexton et al., 2004). That is, they
criticize the common factors model regarding its ability to guide therapist on what to do and when to do it.

In addition, qualitative data identified several important common factors that were not found with the quantitative data (such as treatment rational, therapist support, goal agreement). The qualitative data also reflected new concept/items of common factors (such as critical time of application, therapist ability to link common factors in the context, trend of progress and relapse, etc.) beyond the list of Karimi-CFQ in the quantitative section of the study. The reason for such different results may be related to the qualitative questions that addressed the function of common factors in the process of “how and when” compared to quantitative questions addressed “what/content” of common factors. Another explanation might be that the expert panel had more knowledge regarding the function of common factors and dynamic processes of therapeutic change than participants in the quantitative study.

**Clinical and Training Implications**

The findings of the study provide knowledge for clinicians who work either by the common factors model or ESTs to enhance therapeutic change in their practices. To summarize: Two thirds (70%) of therapeutic outcomes were attributed to common factors across different clinicians, clinical orientations, fields of study, etc. Experienced therapists with high therapeutic impact (Norcross, 2002; Robinson, 2009) used common factors more frequently. It seems reasonable, then, to assume that clinicians can enhance their treatment efficacy by learning important common factors and how and when they work (Laska, & Wampold, 2014). Working with the common factors model does not necessarily mean leaving specific theory or EST models, but it means that the therapist
can improve the impact of specific theories in the context of the common factors model. Expert clinicians optimize the effectiveness of model-specific interventions by activating specific common factors as a context (Norcross, 2002). To improve clinical impact, clinicians need to look at common factors not as a list of factors (content) but more as a set of change mechanisms (processes) that interact and complement each other. For example, when a therapist is stuck with a reluctant not-motivated client/family, the common factors model provides a road map to get the client motivated through a set of steps and interactions, which precedes the application of any model-specific technique (Weinberger, 2014). Trainers may use the CFQ during practicum and supervision courses to provide feedback to their trainees regarding the implications of common factors in their clinical practice. Such feedback may provide useful information regarding the strengths and weaknesses of therapeutic systems (client, therapist, relationship). Also, trainees and supervisors may benefit from knowing which common factors or models of supervision are frequently used by them, as well as how to integrate these common factors to specific theory or treatment. Lastly, the knowledge and use of common factors may help trainers and trainees to develop a bridge among different therapy models which may increase their theoretical knowledge, technical flexibility, and therapeutic efficacy.

As Weinberger (2014) mentioned, clinicians need to know that neither so called model-specific techniques are purely specific to a model nor are common factors so common across different therapists and clients. There are overlaps in definitions and also in their functioning. For example, there is a significant overlap between emotion validation as an intervention in emotion-focused therapy and affective-relationship and alliance between the therapist and the client. It depends on how they are viewed.
Research indicates that there are shared ingredients or mechanisms of change function behind both sets. Therefore, clinicians should know and keep in mind those shared ingredients in their practices (Kazdin, 2007; Prochaska & Norcross, 2007; Weinberger, 2014).

Finally, psychotherapy and family therapy trainers and supervisors may teach their students regarding the chronological map of the common factors model and critical timing of specific common factors in each stage of therapy, about the contextual process of effective therapy that combines common factors and model specific factors, and how to monitor and link between common factors and therapeutic change/ outcome for each session as well as over the course of therapy.

Research Implications

The findings of the quantitative section indicate that common factors can be operationally defined and quantitatively measured as it is currently done with model-specific factors and RCTs scales. Measuring relative common factors can empirically improve the common factors model and allow efficacy questions to be addressed. Such studies create a shared research language between the common factors camp and the ESTs camp that will enhance psychotherapy knowledge and efficacy. However, compared to the level of empiricism of RCTs or ESTs, the common factors model needs more serious research efforts. To achieve such a goal, several research questions are suggested, and follow:

Researchers need to develop exact operational definitions of common factors to be studied empirically by different researchers across a variety of therapists, clients,
problems, settings, treatment models, etc. The significant variance (almost 70%) of therapeutic change that the participants in this study attributed to the contribution of common factors (e.g., therapist’s variables, client’s variables beyond the diagnostic information, relationship variables, etc.) needs to be examined in clinical settings. The Common Factors Questionnaire (Karimi-CFQ) developed in the current study has more promise in supporting the quantitative study of common factors. However, Karimi-CFQ may receive more psychometrical support and/or refinement by administration to different clinical populations. New emerging concepts/items from qualitative studies may be added to the current questionnaire.

Comparison of the qualitative and quantitative results in the current study indicated that some common factors (e.g., non-theory Specific factors, new emotional, cognitive, and behavior experiences) are vague and can be easily confused by model-specific techniques. More research is needed to define and clarify such factors or processes. Without accurate operational definitions of common factors and model-specific factors, the debate between the two psychotherapy camps will continue, and with no clear explanation of common change mechanisms that are prerequisite of an effective integrative therapy.

The current study provided evidence that the same therapeutic goal can be achieved by a combination of different common factors and specific factors. Future research should focus on the interactive processes among different common factors regarding clients, therapists, problems, situations, etc. For example, in the current study, male and female therapists used common factors in different ways to achieve therapeutic goals. This is one example of how therapist’s variables (such as gender, or years of
clinical experience) may interact with the client’s theory of change, with relationship variables, and other components of common factors.

In the current study, results came from clinicians’ perspectives. This allowed the researcher to collect valuable data regarding the therapy processes. In a future study, a researcher could include clients or clinical observers of research participants. For example, the current study showed more frequency of new-insight factor compared to behavioral and emotional aspects of non-theory-specific factors. Future research may study if the clients’ perspective might show more therapeutic impact for new-behavioral or emotional processes than cognitive processes. In general, the therapist is the person who usually provides insight, education, and knowledge in therapy, and it is the client who goes through emotional experiences and behavioral practices. Such research may provide a more comprehensive picture of the actual change mechanisms in therapy.

**Strengths and Limitations of the Current Study**

This study had several strengths and limitations. It was one of the first studies that empirically provided support for the therapeutic role of common factors in the change process. Common factors were perceived to account for almost 70% of therapeutic change/outcome compared to 30% of specific factors. Also, it provided an initial roadmap regarding how the common factors model can guide the therapists’ activities during the course of therapy. However, the data came from therapists’ perspectives regarding the therapy processes and treatment success. Such data may be different if the source of data comes from the clients’ experience. Though other research has found that therapists’ ratings of therapy success and outcomes are significantly related to clients’ self-reports of improvement (Cline, Jackson, Klein, & Mejia, 1987). A more
comprehensive picture of the change process can be achieved if the therapist’s theory of change is integrated with the client’s theory of change in specific sessions and with particular problems.

Though Karimi-CFQ showed a good face and content validity from experts, good Cronbach’s alpha (.84) and Split-half reliability (.79) coefficients, it is a preliminary version that would benefit from psychometric improvements. From qualitative findings of the study it was found that a few new items could be added to Karimi-CFQ in future studies.

In the quantitative section, participants responded to Karimi-CFQ based on their retrospective recall of their successful cases, which might include memory bias. Other research designs that include clinical observation of therapy sessions or concurrent therapists and clients reporting at the time of the session might bring new and different information. Also, the qualitative participants were six male experts in the field. If the addition of female experts were included in the study, it might have produced richer and different findings regarding the use of specific components of the common factors model in the therapy process. Also, a larger sample size in future studies could provide more reliable evidence.

The broad term “relational therapy” can be both a strength and a limitation of the study. The inclusion of all kinds of possible mental disorders in relational cases could generalize the results of the study. However, for common factors processes to be studied empirically, it would be useful to specify what and how common factors/processes interact with specific clients, disorders, etc. Future research may consider the above-mentioned limitations.
Lack of knowledge regarding the terminology of “non-theory specific” factors and also the overlaps between non-theory specific procedures and model-specific emotional, cognitive, and behavioral techniques probably makes it difficult to respond to several items of the questionnaire (items 13, 22, 23, 24, 25, 26, 27 of Karimi-CFQ) related to non-theory specific factors. In fact, it is hard to accurately distinguish therapy activities as model-specific factors or non-theory specific factors. For example, when the therapist provides insight regarding the relapse or the rationale of therapy to improve hope in the client, it can be seen as either a non-theory specific general cognitive experience or as a specific CBT intervention that challenges an irrational thought like hopelessness. Therefore, the next important step in the field would be the development of operational definitions of common factors as well as model-specific factors in such a way that can study both sets with the same lens, that is, evidence-based practice research (Weinberger, 2014).

**Conclusion**

The current study suggested that common factors are not fixed and separated factors but interactive ongoing processes which function in several ways during the course of therapy (Laska & Wampold, 2014). Also, other research indicates that specific processes could be more effective and critical during specific stages of therapy (Johnson, 2002; Prochaska & Norcross, 2007). Therefore, the common factors model has the capacity for chronological mapping and guiding clinicians over the course of therapy. The current study indicated that common factors are specified at least due to the stages of therapy, client’s preferences, situations, therapist’s variables, etc. Common factors need
to be studied empirically to improve therapeutic impact, especially considering that common factors accounted for 70% of therapy outcomes in the current study.

The findings of the study, especially from qualitative analysis, indicated clinicians achieve therapeutic goals by use of different combinations of common factors. There are possibly shared ingredients/mechanisms of change beneath some common factors as well as model-specific factors that are the main vehicles of change. Such a finding is consistent with emotion regulation theory (Gross, 2007), which indicates all effective treatments promote, in different ways, the emotional regulation process that requires integration of emotion and cognition (Amini et al., 1996; Cozolinio, 2010). These findings support the importance of process-based therapy and conceptualization (Prochaska & Norcross, 2007).
References


of depression collaborative research program. *Journal of Consulting and Clinical Psychology*, 64, 1276–1284.


THE CONTRIBUTION OF COMMON FACTORS


Appendices:

Appendix-A - Initial Items Pool and Reference Literature

<table>
<thead>
<tr>
<th>Ref#</th>
<th>Items</th>
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<td>Therapist’s positivity, friendliness, and ability to build strong relationship</td>
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<td>Bordin et al 1979; Norcross, 2002b; Sprenkle et al, 2009; Wampold, 2010; Rogers, 1957, 1961;</td>
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<td>The extent to which the client was comfortable with therapy activities and found them credible</td>
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<td>Frank, 1961; Sprenkle et al 2009; Lambert and Ogles 2004; Goldfried, &amp; Padaver, 1982;</td>
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<td>The rational of therapy and credibility of related techniques</td>
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## Appendix-B - Initial Item Pool and Experts' Feedback for Deletion or Rewording

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<td>13- Therapist ability to help the client maintain an appropriate emotional arousal</td>
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<td><strong>39</strong> Interventions/ procedures that provide behavioral change and new acts</td>
<td>The client’s new behaviors</td>
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<td>Expanding therapeutic alliance (how much did the expansion of alliance contributed in therapeutic change?)</td>
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### Appendix C- Content Validity Index (CVI) by Expert Panel for 34-items CFQ

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<td>5</td>
<td>4.50</td>
<td>.548</td>
</tr>
<tr>
<td>18</td>
<td>Therapist’s sensitivity to the client’s cultural values and beliefs</td>
<td>3</td>
<td>5</td>
<td>4.00</td>
<td>.632</td>
</tr>
<tr>
<td>19</td>
<td>Therapist creativity to approach problems in new ways</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>.754</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Mean</td>
<td>SD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</td>
<td>------</td>
<td>-----</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>20</td>
<td>Therapist offer level of activity fit with client’s expectation.</td>
<td>1</td>
<td>3</td>
<td>2.4</td>
<td>.655</td>
</tr>
<tr>
<td>21</td>
<td>Affective quality of the client–therapist relationship</td>
<td>4</td>
<td>5</td>
<td>4.50</td>
<td>.548</td>
</tr>
<tr>
<td>22</td>
<td>The extent to which the client found therapy activities credible</td>
<td>3</td>
<td>5</td>
<td>4.00</td>
<td>.632</td>
</tr>
<tr>
<td>23</td>
<td>The agreement between the client and therapist on the goals of therapy</td>
<td>3</td>
<td>5</td>
<td>4.00</td>
<td>.632</td>
</tr>
<tr>
<td>24</td>
<td>Client’s belief that the treatment would help</td>
<td>3</td>
<td>5</td>
<td>4.00</td>
<td>.632</td>
</tr>
<tr>
<td>25</td>
<td>The rationale the therapist gives for how therapy will achieve a positive outcome</td>
<td>3</td>
<td>5</td>
<td>4.00</td>
<td>.632</td>
</tr>
<tr>
<td>26</td>
<td>Client’s self-agency to accomplish the goals</td>
<td>1</td>
<td>4</td>
<td>2.9</td>
<td>.688</td>
</tr>
<tr>
<td>27</td>
<td>Feedback/reality testing</td>
<td>1</td>
<td>4</td>
<td>3.2</td>
<td>.665</td>
</tr>
<tr>
<td>28</td>
<td>The client’s new emotional experience</td>
<td>4</td>
<td>5</td>
<td>4.50</td>
<td>.548</td>
</tr>
<tr>
<td>29</td>
<td>The client’s new insight</td>
<td>3</td>
<td>5</td>
<td>4.00</td>
<td>.632</td>
</tr>
<tr>
<td>30</td>
<td>The client’s new behaviors</td>
<td>3</td>
<td>5</td>
<td>4.00</td>
<td>.632</td>
</tr>
<tr>
<td>31</td>
<td>The therapist’s relational conceptualization of problem</td>
<td>3</td>
<td>5</td>
<td>4.00</td>
<td>.632</td>
</tr>
<tr>
<td>32</td>
<td>The therapist interrupting the dysfunctional sequence of relational cycles</td>
<td>3</td>
<td>5</td>
<td>4.00</td>
<td>.632</td>
</tr>
<tr>
<td>33</td>
<td>The therapist involving other family members</td>
<td>2</td>
<td>5</td>
<td>3.50</td>
<td>1.049</td>
</tr>
<tr>
<td>34</td>
<td>The therapist’s alliance with all family members</td>
<td>2</td>
<td>5</td>
<td>3.50</td>
<td>1.049</td>
</tr>
</tbody>
</table>
Appendix D- Karimi-29-items CFQ

Directions:
Many professionals in the field of psychotherapy claim that certain common factors support change (e.g., client motivation, strength of the client-therapist alliance) across all therapy models. Please consider your most successful case of couple/relational/family therapy (at least 70% improvement). Then rate each item, on average, in terms of how much you believe that item contributed to therapeutic change.

How much you believe the following items contributed to therapeutic change?

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Very Little (1)</th>
<th>Little (2)</th>
<th>Some (3)</th>
<th>Much (4)</th>
<th>Very Much (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client’s factors:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1- Client’s motivation to change</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2- Client’s intellectual ability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3- Client’s expectation of therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4- Client’s engagement in therapy process</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5- Client’s persistence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6- Client’s spirituality or religious faith</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7- Client factors outside of therapy (e.g., client’s social support, serendipitous occurrences)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Therapist’s factors:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8- Therapist’s competence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9- Therapist’s support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10- Therapist’s reputation (This item removed)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11- Therapist’s friendliness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Therapist’s positive attitude</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14- Therapist’s efforts to interrupt the client’s dysfunctional patterns</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15- Therapist’s ability to adapt to the client</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16- Therapist ability to help the client maintain an appropriate emotional arousal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17- Therapist’s ability to adjust methods to the particular client</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18- Therapist’s sensitivity to the client’s cultural values and beliefs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Relationship factors:

19. Affective quality of the client–therapist relationship

20. The extent to which the client found therapy activities credible

21. The agreement between the client and therapist on the goals of therapy

### Hope factors:

22. Client’s belief that the treatment would help

23. The rationale the therapist gives for how therapy will achieve a positive outcome

### Non-theory-specific factors:

24. The client’s new emotional experience

25. The client’s new insight

26. The client’s new behaviors

### Unique systemic factors:

27. The therapist’s relational conceptualization of problem

27. The therapist interrupting the dysfunctional sequence of relational cycles

28. The therapist involving other family members

29. The therapist’s alliance with all family members

*Item-10 was removed from final version of CFQ*
### Appendix- E - Six Total Categories of Common Factors

#### Section 2 of the Survey: Six Categories of Common Factors

Based on your general clinical experience with different clients, please indicate the contribution of the following factors in bringing about meaningful change. What percentage do you give each of the following factors? (The total should equal 100.)

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client’s factors</td>
<td>(e.g., motivation, intellectual abilities, persistence, faith, spirituality, goal-oriented, social support)</td>
</tr>
<tr>
<td>Therapist’s factors</td>
<td>(e.g., competence, positivity and relational skills, reputation, cultural sensitivity).</td>
</tr>
<tr>
<td>Relationship’s factors</td>
<td>(e.g., affective quality of the therapy relationship, agreement on therapy activities and goals)</td>
</tr>
<tr>
<td>Hope/Expectancy factors</td>
<td>(e.g., client’s belief that treatment would help, client’s acceptance of treatment rationale).</td>
</tr>
<tr>
<td>“Non-theory-specific” factors</td>
<td>(new emotional/cognitive/behavioral experience that is not specific to any one particular therapeutic theory).</td>
</tr>
<tr>
<td>Unique family systemic factors</td>
<td>(e.g., relational conceptualization, interruption of relational cycles, involving other family members, expanding alliance).</td>
</tr>
</tbody>
</table>

### Appendix- F - Total Common Factors Versus Total Model-specific Factors

#### Section 3 of the Survey: Common Factors Versus Model-Specific Factors

Compare the contribution of common factors and specific theory/techniques in therapy outcome.

That is, what percentage do you give these two categories? (The total should equal 100.)

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common factors</td>
<td>(client factors, therapist factors, relationship factors, hope factors, Non-theory specific factors, family systemic factors).</td>
</tr>
<tr>
<td>Factors Specific to a particular therapeutic theory</td>
<td>(e.g., psychodynamic, cognitive-behavioral, narrative, structural family therapy/theory).</td>
</tr>
</tbody>
</table>
### Appendix-G: Example of codes and related excerpts for initial stage of therapy

<table>
<thead>
<tr>
<th>Excerpts</th>
<th>Descriptive Codes</th>
<th>Interpretive codes</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I think common factors are MOST applicable early in therapy”</td>
<td>Important role of CFs in early stage, Hope in early stage, Relationship.</td>
<td>Critical time of application.</td>
<td>Timing is critical.</td>
</tr>
<tr>
<td>“In my view, the common factor most evident early in therapy is hope”,</td>
<td>Clients reluctant and resistance in early stage.</td>
<td>Does therapy Help?</td>
<td>Hope and motivation to engage in therapy is the main goal.</td>
</tr>
<tr>
<td>“Early in treatment as we developed a relationship of trust and warmth and as he learned about treatment, he begin to have hope that he might benefit from treatment”</td>
<td>Client motivation.</td>
<td>Building Hope and motivation through relationship factors.</td>
<td></td>
</tr>
<tr>
<td>“Related to this, I think &quot;hope&quot; is another powerful common factor early on”</td>
<td>Relationship Affective R.</td>
<td>Build hope and motivation through therapist’s factors.</td>
<td></td>
</tr>
<tr>
<td>“The client I am thinking about came reluctantly to treatment”</td>
<td>Relationship, Therapist competence, Therapist confident and security.</td>
<td>Build hope and motivation through relational conceptualization and goal setting.</td>
<td></td>
</tr>
<tr>
<td>“Early in treatment as we developed a relationship of trust and warmth”</td>
<td>Relational goal setting, Systemic conceptualization, Family alliance, Rationale for the client’s perceived problem, Treatment rationale.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Establishing an alliance early on especially on the goals dimensions, is a power common factor in early stage therapy”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“I tried hard to maintain a non-reactive presence and validate each of their positions in order to establish safety and increase hope”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Engagement and development of mutual goals occur during the initial stage of therapy”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“as couples or families do not always have the same motivations or goals”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“we gained buy-in and a strong relationship with all members of this family through validating their positions, using their points of view, and aligning with their goals ”</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix-H: Themes and definitions in initial stage of therapy

<table>
<thead>
<tr>
<th>Descriptive Codes</th>
<th>Interpretive codes</th>
<th>Themes and Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Important role of CFs in early stage.</td>
<td>Critical time of application. Does therapy help?</td>
<td>“Timing is critical” This theme implies that the common factors model has a potential map regarding “what and when” CFs are supposed to be used in the course of therapy. Experienced therapists know chronological importance of each common factor. In general some common factors like hope and motivation have critical time in early stage of therapy. In addition, therapist applies particular common factors at specific moment of therapy to overcome obstacles in the process. The following excerpts indicate how experienced therapist intentionally prioritized some CFs to others: “Engagement and development of mutual goals occur during the initial stage of therapy”, or “I think &quot;hope&quot; is another powerful common factor early on . . . taking a system from &quot;demoralized&quot; to &quot;remoralized&quot; taps into powerful therapist and client common factors” “Hope and motivation to engage in therapy is the main goal”: This theme refers to the primary step of therapy in which client steps into “buy-in” stance regarding therapy engagement. Before any task assignment and technique therapist needs to get the client to an agreement that the therapy would help and he/she intends to make a contract for engagement in new experiences.</td>
</tr>
<tr>
<td>Hope in early stage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work on clients reluctant and resistance in early stage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If therapy could help (time sensitive)? Client Motivation.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Relationship Affective R. Family alliance Therapist positive attitudes Therapist competence Therapist confident and security. | Building Hope and motivation through relationship factors. Build hope and motivation through therapist’s factors (competence, | Hope and motivation achieved through different paths. This theme implies that hope and motivation as the first goal of therapy process can be achieved through different paths. Some therapists use of relationship factors such as being warmth and secure (“This formed a strong relationship; engendered hope”), other therapists use Treatment rationale and problem explanation (“offered a clear rationale for each party of the system” or “It was also critical that I honored each party’s position on the nature of the problem, their values, language, and their goals”), that helps client to believe the therapy will help, and in other situation therapist may use of client’s factors and resources (“Mother was a hard, resilient woman,...,
### The Contribution of Common Factors

<table>
<thead>
<tr>
<th>Interrupt Dysfunctional relational patterns</th>
<th>She sheltered her son and wouldn't let him out on his own, despite the fact that he was very tall and heavy for his age. “We admired his bravado and strength”), or therapist’s factors (“is necessary to show how I gained their trust, engendered hope”) to engender the optimal hope and motivation.</th>
</tr>
</thead>
</table>
| Relational goal setting                    | friendliness, trust, etc.).  
  Build hope and motivation through relational conceptualization and goal setting.                                                                                                                                  |
| Systemic conceptualization                 | **Rationale for the client perceived problem**  
  Treatment rationale.                                                                                                                                       |
| Relational conceptualization               | **Reframing as a general cognitive non-theory procedure.**  
  This theme refers to a general cognitive procedure that change the meaning of the client’s perceived problem in a new context which leads to client’s motivation and engagement in therapy. Reframing is used in various ways by clinicians from different theories. (“If there is disagreement within the client system on goals, therapists must take an active and unifying stance in reframing the resistance”). Reframing provide a new different conceptualization of the problem that can free the clients from dysfunctional patterns, and helps them to take new view and actions. Relational conceptualization is an important part of relational therapy to get the client system’s cooperation and agreement (“He had an affair to which she responded in part by starting to drink again after many years of sobriety”). Or (“the therapist should obtain the “buy-in” from all parts of the system by skillfully reframing the goal to address the underlying needs of both partners”). |
| Therapist adjust to client values characteristics | **Adjustment to client’s expectation/culture/particular characteristics to move towards therapy goals.**  
  Client’s factors.  
  Therapist’s factors boost  
  **-Linking CFs in flexible contextual way towards the motivation and treatment goals.**  
  This theme implies that CFs are used in a non-static method. In relational therapy, the therapist and the client system creates a context of change that requires therapist to flexibly monitor the process of change and elastically prioritize specific common factors (“I think of common factors as dynamic processes within the larger context of change”).  
  Therapist monitors how different specific factors interact and activate each other (“this information is necessary to show how I gained their trust and engendered hope”), or (“taking a system from "demoralized" to "remoralized taps into powerful therapist and client common factors.”). |
<table>
<thead>
<tr>
<th>Client motivation</th>
<th>relationship factors</th>
<th>MEMO: my personal clinical experience says that in many situations new piece of information or change from the client system or therapy system forced me to change my path toward the same therapeutic goal or to modify the goal itself. One of the experts mentioned the same experience (With this new information, we may decide to modify the goals that we agreed on during the first sessions”).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist support</td>
<td>Therapist and relationship factors trigger client’s factors.</td>
<td>Interaction of Therapist, relationship, client’s factors generate hope and motivation</td>
</tr>
<tr>
<td>Therapist competence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist reputation helped.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist friendliness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist positive attitudes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist active support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist flexibility</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Appendix-J: Example of Codes and Related Excerpts for Intermediate Stage of Therapy**

<table>
<thead>
<tr>
<th>Excerpts</th>
<th>Descriptive Codes</th>
<th>Interpretive codes</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“they said that the knowledge that I truly cared helped kept them pushing through things when their commitment was weak and they were disillusioned”</td>
<td>Therapist’s positive attitudes, Client’s engagement, Client’s persistence</td>
<td>Client’s motivation and therapist’s factors and alliance interact to get the client engages in tasks.</td>
<td></td>
</tr>
<tr>
<td>“In this stage,…, Common factors included client motivation, therapist confidence, expertise, therapeutic alliance, hope,…[to get the client,..]”.</td>
<td>Therapist’s expertise/competence. Treatment rationale</td>
<td>Use of T. rationale to develop Therapeutic assignments.</td>
<td></td>
</tr>
<tr>
<td>“Ideally, during this phase I am using the treatment rationale to develop task assignments aimed at interrupting patterns and facilitating goal attainment “</td>
<td>Task development, Interrupt dysfunctional patterns, Support goal attainment, Inoculation of relapse.</td>
<td>Therapist interrupts dysfunctional patterns.</td>
<td></td>
</tr>
<tr>
<td>“Relapse is painful, yet an important part of your long term recovery.”</td>
<td>Therapist monitors and supports change.</td>
<td>Therapist Adjusts and revises the method to specific client’s problem.</td>
<td></td>
</tr>
<tr>
<td>“I am also monitoring responses to task assignments tweaking or changing them, and amplifying change”</td>
<td>Therapist Revises the assignments, Client explore new experiences, Progress and relapse.</td>
<td>A process of progress and relapse.</td>
<td></td>
</tr>
<tr>
<td>I believe that a successful “tear and repair” in the intermediate stage of therapy will strengthen the overall therapeutic alliance by allowing clients to explore safely their relational problems with the therapist in the “here and now” context of the therapeutic relationship</td>
<td>Risk for hope and engagement. Therapist adjusts to clients. Clients faces challenges and new experiences,</td>
<td>Therapist actively monitors and supports the change process.</td>
<td></td>
</tr>
<tr>
<td>I also adapted to their personalities by pushing and challenging them pretty directly throughout this stage - an approach they liked</td>
<td>Use of the treatment rationale to develop Therapeutic assignments.</td>
<td>Therapist interrupts dysfunctional patterns.</td>
<td></td>
</tr>
<tr>
<td>“I relied in part on early-phase inoculations similar to asolovey1 above to repair the alliance ruptures”</td>
<td>Therapist adjusts to clients. Clients faces challenges and new experiences,</td>
<td>Trend of progress and relapse.</td>
<td></td>
</tr>
</tbody>
</table>

*Emphasis added for clarity.*
Appendix-K: Themes and definitions and the related codes in intermediate stage of therapy

<table>
<thead>
<tr>
<th>Descriptive Codes</th>
<th>Interpretative codes</th>
<th>Themes and Definitions</th>
</tr>
</thead>
</table>
| Client motivation/hope | Client’s motivation and therapist’s factors interact to get the client engages in tasks. | **Engagement in therapeutic tasks:**
This theme refers to the process in which client takes action into therapeutic tasks which are developed based on treatment rationale agreed in previous stage. Clients believe/ buy-in that therapeutic tasks are paths towards agreed therapy goals. The engagement requires therapist’s support and client’s motivation and courage to face new challenges and experiences. |
| Therapist confidence | Use of T. rationale to develop Therapeutic assignments. | |
| Therapist expertise | Therapist interrupts dysfunctional patterns. |
| Therapeutic alliance | Therapist positive attitudes boost the client’s engagement. |
| Family alliance | |
| Treatment rationale | |
| Develop tasks | |
| Interrupt dysfunctional patterns | |
| Support goal attainment | |
| Therapist positive attitude and support | |
| Client engagement | |
| Client persistence | |
| Therapist support | |
| Affective Relationship | |
| Treatment rationale | |
| Therapist expertise/competence | Loop of feedback and revision of assignments. | **Facing new experiences** (emotional, cognitive, behavioral):
This theme refers that the vehicle of therapeutic change progresses on the axes of new emotional, cognitive, and behavioral experiences. CFs/integrative therapists use their expertise and support to face the clients with new experiences that generate functional patterns which in turn results in therapeutic goals. They are general main paths from treatment rationale to therapy goals. |
| Therapist monitor and support change. | Explore relational problems in new | |
| Therapist revises of assignments. | | |
| Successful tear and repair in the process. | | |
| New Emotional experience | emotional experience. | Sometime the new experience happens in the session such as: (“allowing clients to explore safely their relational problems with the therapist in the “here and now” context of the therapeutic relationship”), and the other time it is a behavioral task experienced out of the session (“Mom brought boyfriend into the relationship and they both set clear limits and expectation ..[for the son]”).

Sometime therapist actively interrupts a dysfunctional pattern and replace it with new functional experiences (“They were each doing a lot of blaming the other one for their own bad behavior, which I interrupted and processed a lot ala EFT”).

Also, therapist who makes a secure therapeutic alliance can push and challenge his clients to new experiences (“I also adapted to their personalities by pushing and challenging them pretty directly throughout this stage - an approach they liked”).

Confronting the problems or challenges is a common process of change across all therapy schools (Weinberger, 1955; Weinberger & Rasco, 2007). Some scholars called them Non-theory specific factors in the model which imply all therapeutic interventions across models require some sort of “facing new experiences” by client. (The researcher memos: experienced and integrative therapists can go beyond a specific model and flexibly utilize these three axes depends on the context of change process with specific client system. The some goal can be achieved through three paths).

| Progress and relapse. | A process of progress and relapse. | Trend of progress and relapse

This theme refers to a challenging process of progressing and relapsing in therapeutic change that is a natural trend in the middle stage of therapy. Clients to achieve mastery on new functional patterns they usually experience up and down and progressively more difficult steps (“There was a lot of progress, followed by relapse, then progress, then relapse, etc.”). CFs therapists inform and inoculate their clients in advance regarding of the trend (“I have learned to offer inoculations during the initial stage of treatment to help with this,” you may notice early improvement followed by a backslide”). Therapist needs to |
The contribution of common factors

Therapist adjusts method to client.  
Family alliance and involvement.  
Client engagement.  
Interrupt dysfunctional relational patterns.  
Therapist support  
Therapist positive attitudes.  
Client’s persistence.  
Therapist interrupts dysfunctional patterns.  
New emotional experience  
Encourage new emotional patterns.  

continuously adjust the relationship and revise the methods to the particular client system to push the progress. ("I also adapted to their personalities by pushing and challenging them pretty directly throughout this stage - an approach they liked").  

(MEMO: my clinical experience says there is always some degree of resistance against any new change in each client system and their families, so in order to install a desired change in a system therapist needs to work on flexibility of methods, relationship, and client system).  

(MEMO: CFs therapist monitors and manages the use of CFs in the context of change process.)

Inoculation to alliance ruptures.  
Therapist adjusts to client’s characteristics.  
New functional patterns  
Clients engagement  
Inoculation of relapse.  

Alliance rupture is part of the middle stage.  

Split Family Alliance
This theme specifically refers to a common trend in relational therapy in which therapeutic family alliance may rupture in the middle of therapy in reaction to new changes and challenges they are facing. When a part of the system feels weaker alliance to therapist than other part of the system generates resistance to therapeutic engagement and change ("A split alliance may quickly degenerate into an alliance rupture"). CFs therapist respects and connects the client subsystems in one unite as couple or family which can prevent Split alliance, ("I also relied on the depth of our connection-they knew that I cared about them, and that their marriage mattered to me").  

Therapist’s security and expertise in relationship factors inoculate such a risk.
Appendix-L: Example of Codes and Related Excerpts for termination Stage of Therapy

<table>
<thead>
<tr>
<th>Excerpts</th>
<th>Descriptive Codes</th>
<th>Interpretive codes</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>At termination I am working clients on sustaining changes that they have made</td>
<td>Sustain changes.</td>
<td>Commend and encouragement to sustain the achieved goals.</td>
<td>Maintain achieved goals.</td>
</tr>
<tr>
<td>I commended them for all they had done and gave them a chance to explain how they did it thus having them own the change by attributing it to themselves.</td>
<td>Therapist support</td>
<td>Attribution of success through new insight and new emotional experience at termination stage.</td>
<td>Attribution of success.</td>
</tr>
<tr>
<td>Upon successful termination, we commended all and inoculated them against inevitable backsliding and future hurdles.</td>
<td>New cognitive experience.</td>
<td>Inoculation of future relapse.</td>
<td>Inoculation of future relapse.</td>
</tr>
<tr>
<td>Here, I want to make sure that I highlight what the client has done to bring about change. I will often make a list and send it home with the client.</td>
<td>Client owns the change</td>
<td>Feedback loop develops a whole picture of change happened over different single sessions</td>
<td>Extended therapeutic alliance.</td>
</tr>
<tr>
<td>“I also, prepare the client for relapse and develop plans for how the manage a relapse”</td>
<td>Inoculation to relapse and future hurdles</td>
<td>Feedback loop on change process.</td>
<td>Feedback loop on change process.</td>
</tr>
</tbody>
</table>
## Appendix-M: Themes and definitions in termination stage of therapy

<table>
<thead>
<tr>
<th>Descriptive Codes</th>
<th>Interpretive codes</th>
<th>Themes and Definitions</th>
</tr>
</thead>
</table>
| Relation          | Attribution of success through new cognitive and emotional experience at termination | **Maintain achieved goals.**  
This theme implies that the client system needs to reach to the ability to sustain and internalize the functional emotional, cognitive, and behavioral patterns which have achieved in previous stages of therapy. Reaching to this ability means client system can continue the functional patterns without therapist coaching them. (“At termination I am working clients on sustaining changes that they have made”). Or (Here, I want to make sure that I highlight what the client has done to bring about change. I will often make a list and send it home with the client”). Therapist supports the client to get to this ability through several mechanisms: emphasizing on strengths-based conversations with client; empowering the client to own the changes have been made until now; expanding therapeutic alliance available after termination; educate client regarding of future relapse. |
|                   | Command and encourage to sustain the achieved goals. | |
|                   | Inoculation against future hurdles and relapses. | |
|                   | Relapse management skills. | |
|                   | !Strengths based-conversation in termination | |
|                   | Feedback loop develops a map of therapeutic change. | |
|                   | Client knows the best regarding the pivotal moments of therapeutic change. | |
|                   | Feedback loop is essential. | |
|                   | Feedback | |
|                   | Extratherapeutic factors. | |
|                   | Treatment rationale. | |
|                   | New emotional family pattern. | |
|                   | Inoculation to future relapse | |
|                   | New insight | |
|                   | Sustain the change | |
|                   | Client’s view of therapeutic change and | |
|                   | Therapist expertise | |
|                   | Therapist competence. | |
|                   | Client engagement | |
|                   | Client persistence | |
|                   | Client owns the change. | |
|                   | New functional patterns | |
|                   | New insight | |
|                   | Sustain the change | |
|                   | Client’s view of therapeutic change and | |
pivotal moments. Feedback loop integrates small changes to an overall process.

| Expand therapeutic alliance to after termination generates more hope and maintenance of the changes | eliciting client feedback is especially essential in later phases as termination approaches”).

**Extended therapeutic alliance.**

This theme refers to the availability of therapist and therapeutic alliance in case the client system needs additional appointment; (“I extend the relationship by reframing termination as variable scheduling- the client calls me for an appointment if a need comes up”). Such an extension generates security and hope which in turn can contribute in better maintenance of achieved goals.
Appendix- N- Survey Invitation Letter

Dear therapist/faculty/colleague,

You, as a mental health professional, are invited to participate in a survey that explores the mechanisms of therapeutic change in psychotherapy and family therapy.

The survey will take approximately about 10-15 minutes of your time, and will provide the researcher and our field with valuable data. At the end of the survey you can indicate whether you would like to receive a report of the research findings.

Informed Consent Information

Your responses will be completely confidential. No response will ever be linked to an individual respondent or that respondent’s email address. You will have the freedom to withdraw from the project at any time.

We anticipate no risk to you from taking part in this study. This study has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University.

If you are interested to participate in this survey, please click the following link:

https://virginiatech.qualtrics.com/SE/?SID=SV_0kTNMZI7kx8JxpX

If that doesn’t work, try cutting and pasting the address into your web browser.

Please feel free to pass this request on to other therapists who might be willing to participate.

Please contact the researchers with questions about the research study and the IRB/Dr. Moore for questions about your rights as human subject research participants.

Hassan Karimi, M.S.
Investigator
Doctoral candidate, MFT, Virginia Tech.
karimias@vt.edu

Faculty Advisors:
Dr. Fred Piercy, Ph.D.
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540-231-9816
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Dr. Tina Savla, Ph.D.
Associate Professor, Virginia Tech
jsavla@vt.edu

David M. Moore, Chair, IRB
540-231-4991
moored@vt.edu
Appendix O- Wiki Invitation Letter

Dear Faculty/therapist,

You have been chosen as a member of a small panel who is knowledgeable about the theory and practice of common factors in psychotherapy. The common factors model is a model that identifies common factors of change that some believe appears in all therapy models. While this model is becoming more popular, it has been criticized by some scholars because it does not function as a guiding model itself that a therapist might use to conduct therapy. That is, some believe that it cannot theoretically guide clinicians on *what to do and when to do it* in the course of therapy (Sexton, Ridley, & Kleiner, 2004). The current study aims to address this criticism.

Through your involvement in a series of Wiki questions, you, along with a small group of experts in the field of integrative therapy, are invited to share your thoughts on a number of questions related to common factors, to comment on and discuss with other participants say, and in the process, to create collective knowledge about this topic.

This Wiki space will be open for two weeks, so you can get back to it any time you want to change your own post or view and comment on other participants’ posts. We really appreciate interactive comments because they create a give and take that helps us understand your thinking and the thinking of other members of the group. This collaborative forum will increase our knowledge of *how and when* the common factors model can guide therapists in the course of therapy.

Informed Consent Information

As a panel of professionals you will share your clinical experience with your colleagues. All of the information you will provide will be kept confidential. We encourage you to use pseudonym for your clients. No response will ever be linked to an individual respondent. You will have the freedom to withdraw from the project at any time.

We anticipate no risk to you from taking part in this study. This study has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University.

If you are interested to participate in this study, please click the following link:

[http://commonfactorsmodel.wikispaces.com/Panel+Discussion+on+How+the+Common+Factors+Model+Guides+Our+Work+Over+the+Course+of+Therapy](http://commonfactorsmodel.wikispaces.com/Panel+Discussion+on+How+the+Common+Factors+Model+Guides+Our+Work+Over+the+Course+of+Therapy)

Thank you very much in advance.

Regards

Hassan Karimi, M.S.

Investigator
Appendix – P- Wiki Instructions for Panel Discussion

**Panel Discussion on How the Common Factors Model Guides Our Work Over the Course of Therapy**

**Dear Participants,**

You have been chosen as a member of a small panel who is knowledgeable about the theory and practice of common factors in the field of psychotherapy and family therapy. While the common factors model is becoming more popular, it has been criticized by some scholars because it does not function as a guiding model itself that a therapist might use to conduct therapy. That is, some believe that it cannot theoretically guide clinicians on *what to do and when to do it* in the course of therapy (Sexton, Ridley, & Kleiner, 2004). The current study aims to address this criticism.

In current discussion the common factors refer to:

- **Client’s Factors** (e.g., motivation, intellectual ability, expectation, persistence, faith, social support, etc.).
- **Therapist’s Factors** (e.g., competence, support, reputation, friendliness, positive attitude, ability to interrupt dysfunctional patterns, ability to adapt to the client’s culture and characteristics, adjust methods to client, etc.).
- **Relationship Factors** (e.g., affective quality of the client-therapist relationship, client finds therapy credible, agreement on therapeutic goals, etc.).
- **Hope Factors** (e.g., client’s belief that therapy would help, the rationale the therapist gives for how therapy will achieve a positive outcome).
- **Non-theory-specific Factors** (client’s new emotional experience, client’s new insight, client’s new behaviors).
- **Unique Systemic Factors** (therapist’s relational conceptualization of the problem, interrupting relational cycles, involving other family members, alliance with all family members).

I am interested in how a common factors (client, therapist, relationship, hope, non-theory specific, and systemic factors) conceptualization has guided your work through the course of relational therapy. Please imagine one or more of your previous successful (success defined as 70% improvement) relational therapy cases (e.g., couple, family), and provide your answer for each of the following questions.

Thinking of therapeutic change across time, some scholars (Lambert & Olges, 2004; Sprenkle & Blow, 2004) consider three stages of therapy: 1) **Initial** (a few first sessions); 2) **Intermediate** (during middle sessions); and 3) **Termination** (a few last sessions). We would like you to consider an ideal developmental sequence of common factors over the course of therapy and explain (thinking back on your successful relational therapy cases):
1- What common factors did you use to bring about change in the initial stage of therapy? (In below, please explain how did you use each of Common factors in initial stage of therapy):

2- What common factors did you use to bring about change in the intermediate stage of therapy? (In below, please explain how did you use each of Common factors in intermediate stage of therapy):

3- What common factors did you use to bring about change in the termination stage of therapy? (In below, please explain how did you use each of Common factors in termination stage of therapy):

In below, you will find specific section for each of these questions:

Before you start, I would like to remind you that this Wiki space will be open for two weeks and you can get back to it any time you want to complete or change your post. You could also come back to the Wiki space to view and comment on other participants' responses. We appreciate interactive comments because they will allow for a collective understanding of how common factors are used in successful therapy sessions.

Thank you so much for your input. Your experience and opinions are valuable!
Appendix-Q: Email Solicitation to Professional Organizations and Mental Health Community Centers

Dear Dr. (name)

Hello! My name is Hassan Karimi. I am working on my Ph.D. dissertation at Virginia Tech and need help finding clinicians who would be willing to participate in a brief online survey on common factors in therapy. I would appreciate your help if you could consider posting the following request on a listserv of current students/alumni/members/therapists.

Thank you very much in advance.

Hassan Karimi

Dear therapist/faculty/colleague,

You are invited to participate in a survey that explores the mechanisms of therapeutic change in psychotherapy and family therapy. We have chosen you because of your role as a mental health professional who serves clients.

The survey will start with several short demographic questions (e.g., age, gender, education etc.) followed by about 29 short-phrase items that you will rate on a 5-point Likert-scale. It will take about 10 minutes of your time, and will provide the researcher and our field with a valuable data related to common factors in therapy. At the end of the survey you can indicate whether you would like to receive a report of the research findings.

**Informed Consent Information**

Your responses will be completely confidential. No response will ever be linked to an individual respondent or that respondent’s email address unless you would like us to contact for a follow-up interview or to receive a brief summary of our results. You will have the freedom to withdraw from the project at any time.

We anticipate no risk to you from taking part in this study. This study has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University. The completion of the web survey is evidence of your voluntary willingness to participate.

If you are interested in participating in this survey, please click the following link:

**Link: web-survey-CFQ:** [https://jfe.qualtrics.com/preview/SV_0kTNMZI7kx8JxpX](https://jfe.qualtrics.com/preview/SV_0kTNMZI7kx8JxpX)

If that doesn’t work, try cutting and pasting the address into your web browser.

Please feel free to pass this request on to other therapists who might be willing to participate.

Should you have any questions or concerns about this research, its conduct, research participants rights, and/or in the event of a research-related injury, please contact:
Hassan Karimi, M.S.  
Investigator  
Doctoral candidate, MFT, Virginia Tech.  
karimias@vt.edu

Faculty Advisors:  
Dr. Fred Piercy, Ph.D.  
Professor, Virginia Tech  
540-231-9816  
piercy@vt.edu

Dr. Tina Savla, Ph.D.  
Associate Professor, Virginia Tech  
jsavla@vt.edu

David M. Moore, Chair, IRB  
Chair, Virginia Tech Institutional Review Board for the Protection of Human Subjects  
Office of Research Compliance  
2000 Kraft Drive, Suite 2000 (0497)  
Blacksburg, VA 24060  
540-231-4991  
moored@vt.edu
MEMORANDUM

DATE: January 16, 2015

TO: Tina Savla, Hassan Karimi, Fred Piercy

FROM: Virginia Tech Institutional Review Board (FWA00000572, expires April 25, 2018)

PROTOCOL TITLE: THE CONTRIBUTION OF COMMON FACTORS IN THERAPEUTIC OUTCOME: A CLINICIANS PERSPECTIVE OF COMMON MECHANISMS OF CHANGE

IRB NUMBER: 14-1227

Effective January 16, 2015, the Virginia Tech Institution Review Board (IRB) Administrator, Carmen T Papenfuss, approved the Amendment request for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report within 5 business days to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

All investigators (listed above) are required to comply with the researcher requirements outlined at:

http://www.irb.vt.edu/pages/responsibilities.htm

(Please review responsibilities before the commencement of your research.)

PROTOCOL INFORMATION:
Approved As: **Exempt, under 45 CFR 46.110 category(ies) 2**

Protocol Approval Date: **December 22, 2014**

Protocol Expiration Date: **N/A**

Continuing Review Due Date*: **N/A**

*Date a Continuing Review application is due to the IRB office if human subject activities covered under this protocol, including data analysis, are to continue beyond the Protocol Expiration Date.

**FEDERALLY FUNDED RESEARCH REQUIREMENTS:**

Per federal regulations, 45 CFR 46.103(f), the IRB is required to compare all federally funded grant proposals/work statements to the IRB protocol(s) which cover the human research activities included in the proposal / work statement before funds are released. Note that this requirement does not apply to Exempt and Interim IRB protocols, or grants for which VT is not the primary awardee.

The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.