

Elements of Motivational Interviewing as Common Factors across Exemplary Marriage and
Family Therapy Demonstrations

Yesim Keskin

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Fred P. Piercy, Chair

Megan Dolbin-MacNab

Erika Grafsky

Robert Stephens

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Abstract

In both individual and relational psychotherapy contexts, it has been argued that the effectiveness of psychotherapy practice is associated with common factors cutting across the models including client factors, therapist factors, hope/expectancy of the clients, allegiance of the therapists, the quality of therapeutic relationship, and the basic counseling skills rather than model specific factors (Davis & Piercy, 2007a, 2007b; Lambert, 1992; Hubble, Duncan, & Miller, 1999; Sprenkle, Davis, & LeBow, 2009; Sprenkle, Davis, & LeBow, 2009; Wampold, 2001, 2008, 2015). However, the common factors perspective has been criticized for not having a theoretical framework, operationalization of its elements, and research support (Sexton, Ridley, & Kleiner, 2004). Despite gradually increasing interest in the literature, the research exploring the common factors of effective psychotherapy practice is still in its baby steps in the context of relational psychotherapy. In this study, motivational interviewing (MI) is presented as a theoretical framework and a practical research tool for exploring common factors in the context of relational psychotherapy. The research questions of to what extent motivational interviewing elements are implemented in the context of relational psychotherapy and to what extent therapist behaviors are associated with client change behaviors were explored by using task analysis and sequential analysis methodologies. Using the AAMFT Masters Series Tapes of MFT Model developers, including Boszmormenyi-Nagy, Minuchin, Satir, Whitaker, and White, the exemplary demonstrations of relational psychotherapy were rated on the Motivational Interviewing Treatment Integrity Scale (MITI 4.2.1., Moyers et al., 2014) for therapist behaviors

and on the Motivational Interviewing Skills Code-Client Behaviors Scale (MISC; Miller, Moyers, Ernst, & Amrhein, 2003) and the Experiencing Scale (EX; Klein, Mathieu, Kiesler, & Gendlin, 1969) for the client change behaviors. The results are discussed in terms of a common factors perspective.

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General Audience Abstract

Since the beginning of psychotherapy as a method of treatment, the answers to the age-old question of how psychotherapy helps people to change has become more sophisticated, elaborated, and diversified. Recent literature focusing on individual psychotherapy processes shows that it might be the common factors cutting across the models including the quality of therapeutic relationship, and the basic counseling skills rather than model specific factors are responsible for change in psychotherapy process. However, there are few studies exploring these factors in the context of relational psychotherapy. By means of in depth analyses of the relational psychotherapy training videos, this study contributes to the understanding of common factors of effective practice in relational psychotherapy. Thanks to this study, the clinicians and researchers can have a better understanding of the effective relational psychotherapy practice. This understanding will allow the clinicians, researchers, and health care providers and educators to provide better clinical service and develop more effective psychotherapy practices.

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Trained and practiced in many theories but family therapy, I discovered and fell in love with Systems Theory while I was writing my Masters Thesis. Then the story went on. The main premise of systems thinking has been fascinating me since then: Every person/thing is a product of the system they are in. This dissertation as well as I am a product of the system I was/am in which I would like to reflect here.

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Chapter I

Introduction

Since the beginning of psychotherapy practice, the answers to the age-old question of how psychotherapy helps people to change has become more sophisticated, elaborated, and diversified. When proposing the “talking cure,” Sigmund Freud (1900) argued that what was healing for individuals is talking in the therapy process freely without having any limitations—as it helps them to release their internal tensions that are suppressed from their conscious minds. Soon after, accepting the argument that talking can cure, various scholars including Carl Jung, Aaron Beck, Carl Rogers, Viktor Frankl, Salvador Minuchin, and Michael White offered different responses regarding the question of how psychotherapy helps people to change.

Since the first wave of psychotherapy effectiveness research, an increasing number of researchers have begun claiming that maybe it is the common elements cutting across the therapy models are creating the change (Blow, 1999; Blow, Davis, & Sprenkle, 2012; Blow, Sprenkle, & Davis, 2007; Davis, Lebow, & Sprenkle, 2012; Davis & Piercy, 2007a, 2007b; Lambert, 1992; Miller et al., 1997; Sprenkle & Blow, 2004b; Sprenkle, Blow, & Dickey, 1999; Sprenkle, Davis, & Lebow, 2009; Wampold, 2012). Based on an extensive meta-analysis of psychotherapy effectiveness studies, Lambert (1992) offers a taxonomy of effective psychotherapy practice. He states that 40% of the treatment outcome is attributed to *client/extra-therapeutic* factors (all aspects of the clients’ environments), 30% is attributed to *interaction/therapeutic* factors (the quality of the relationship among the therapist and the clients), 15% is attributed to *placebo and hope* factors (the extent to which the clients have expectancies for positive psychotherapy outcomes), and lastly, 15% is attributed to the *technical factors/treatment* modality (the specific skills and techniques used by the therapists in the process of psychotherapy). This

groundbreaking study of Lambert (1992) has been referred by various researchers while highlighting the role of the common factors responsible for psychotherapeutic change and gradually became the major framework of the common factors perspective.

The improvements of statistical methods, as well as the standardizations of psychotherapy modalities, gave rise to a psychotherapy process and outcome research aiming to find the factors and mechanisms that are responsible for therapy effectiveness. While the question of how psychotherapy helps people to change remained constant, a century after Freud's invention of talking cure, the field has been occupied with more than 400 treatment modalities with differing assumptions and techniques that have proven to be effective in creating psychotherapeutic change (Karimi, 2015).

One such effective technique is motivational interviewing, which is grounded in fairly standard components. Arkowitz, Miller, and Rollnick (2015) describe this technique as “a brief, opportunistic intervention tool” that gained enormous research support in a short period of time in treating individuals having problems that are considered to be “most difficult to treat” (O'Brien, Childress, Ehrman, & Robbins, 1998). Miller and Rollnick (1991) argue that motivational interviewing is thoroughly *client-centered*, highlights a radically collaborative *relationship* between the therapists and clients, aims to instill *hope* or motivation to the clients to make the change they want in their lives by the use of basic counselling *techniques*. The founders of motivational interviewing argue that by using basic counseling skills (including asking open ended questions, providing affirmations, listening reflectively, and summarizing regarding the principles of rolling with resistance, expressing empathy, developing discrepancy, and highlighting autonomy while keeping a motivational interviewing spirit characterized with

collaboration, evocation, support of autonomy, and compassion), therapists can help people to change (Miller & Rollnick, 2002).

In both common factors perspective and motivational interviewing, the variables of clients, therapeutic interaction, and psychotherapeutic techniques are identified as the necessary elements for an effective treatment process. In both conceptualizations, clients are considered to be the main determinants of the effectiveness of psychotherapy and regarded as people with freedom of choice who are responsible for their actions. In both conceptualizations, a good therapeutic relationship is considered to be a crucial factor in reaching successful therapy outcomes. Moreover, in both conceptualizations, therapeutic techniques are considered as the “tools,” meaning they are less important than the other factors, in creating change during the process of psychotherapy.

The common factors perspective has been criticized for not having a comprehensive set of operational definitions of its elements (Chambless, 2002), for not being able to serve as a roadmap for the clinicians while doing therapy (Sexton & Ridley, 2004), for not having enough research support due to the inability to provide a standardized protocol (Sexton & Ridley, 2002), for being grounded in the meta-analysis findings that are “more than a quarter of a century old” (Sexton & Ridley, 2004) or grounded in individual therapy findings (Sexton & Ridley, 2002), and overall, for being a broad brush oversimplifying the diverse changing mechanisms offered by the various psychotherapy modalities (Sexton & Ridley, 2004).

Based on the resemblances between motivational interviewing and the common factors perspective, I argue that motivational interviewing framework can provide a fertile ground for the common factors research in order to gain a better understanding of how psychotherapy helps people to change. Because the motivational interviewing framework is an evidence based

treatment method (Levensky, Forcehimes, O'Donohue, & Beitz, 2007) with a comprehensive set of operational definitions (Moyers, Martin, Manuel, Hendrickson, & Miller, 2005), a structured manual for treatment process (Miller, Yahne, Moyers, Martinez, & Pirritano, 2004; Söderlund, Madson, Rubak, & Nilsen, 2011), a vast amount of research evidence (Rubak, Sandbæk, Lauritzen, & Christensen, 2005), and continuously-updated evidence of effectiveness (Morton et al., 2015).

In this study, by means of using a task analysis method, I explore to what extent the elements of motivational interviewing are implemented in the exemplary therapy demonstrations of marriage and family therapy (MFT) model developers, including Salvador Minuchin (structural family therapy), Virginia Satir (transformative family therapy), Michael White (narrative family therapy), Ivan Nagy (contextual family therapy), and Carl Whitaker (experiential family therapy). I use the Motivational Interviewing Treatment Integrity Scale (MITI 4.2.1, Moyers, Manuel, & Ernst, 2014), which was developed to assess the proficiency, competency, and behaviors of therapists using motivational interviewing in the psychotherapy sessions.

Considering the criticism of the common factors theory not providing a comprehensive set of operational definitions and conceptual clarity (Sexton & Ridley, 2004; Chambless, 2002), the Motivational Interviewing Treatment Integrity Scale (MITI 4.2.1., Moyers, Manuel, & Ernst, 2014) can serve as a useful tool since all the elements of motivational interviewing are operationally defined, standardized, and exemplified. For instance, in MITI 4.2.1., the motivational interviewing element of “empathy”—that is also considered as a common factor (Sprenkle, Davis, & Lebow, 2009; Davis & Piercy, 2007a, 2007b)—is defined as the extent to which “the clinician understands or makes an effort to grasp the client’s perspective and

experience” on a 5-point Likert Scale ranging from 1 (“Clinician gives little or no attention to the client’s perspective”) to 5 (“Clinician shows evidence of deep understanding of client’s point of view, not just for what has been explicitly stated but what the client means but has not yet said”). Also, these definitions are further elaborated by various examples which makes the operational definitions clearer and more understandable.

With regard to the criticism of common factors theory not providing a roadmap to the clinicians of how to practice (Sexton & Ridley, 2004), the manualized and standardized treatment protocol of motivational interviewing framework can provide a hypothetical model in exploring the mechanism of psychotherapeutic change. Also, the undeniable and drastically improving empirical research support regarding motivational interviewing in the treatment of a variety of psychopathological problems, such as alcohol and substance use disorders (Jensen et al., 2011; Murphy, Dennhardt, Skidmore, Martens, & McDevitt-Murphy, 2010), eating disorders (Macdonald, Hibbs, Corfield, & Treasure, 2012; Rhind, Hibbs, Todd, & Macdonald, 2014), depression (Anderson, 2007; Keeley et al., 2014), obsessive compulsive disorders (Merlo et al., 2010; Simpson et al., 2010), post-traumatic stress disorders (Murphy, Thompson, Murray, Rainey, & Uddo, 2009), chronic disease management (Benzo et al., 2013; Martino, 2011), gambling (Hodgins, Ching, & McEwen, 2009; Yakovenko, Quigley, Hemmelgarn, Hodgins, & Ronksley, 2015), school underachievement (Richer, 2012; Stewart-Donaldson, 2012), and health coaching (Linden, Butterworth, & Prochaska, 2010; Simmons & Wolever, 2013), are providing the empirical evidence that the elements of motivational interviewing is effective in helping people to change. This study, aiming to identify the common elements between motivational interviewing and common factors theory, can help us to better understand the processes and mechanisms of therapeutic change.

With regard to the criticisms against common factors theory stating that the theoretical ground is outdated (Sexton & Ridley, 2004), again, the research and theory support of motivational interviewing can provide more recent and up-to-date evidence regarding the elements and mechanisms of change in therapy session.

Also, considering the individual therapy tradition attached to motivational interviewing, and the relational nature of marriage and family therapy, this study may reveal significant theoretical and empirical differences and/or similarities between individual and relational therapy approaches with regard to the elements and mechanisms of change. Thus, this study can provide a valuable contribution to the field on the criticism against common factors theory arguing that it is based on individual therapy principles, and is irrelevant to the conceptualization of change from a relational perspective (Sexton & Ridley, 2004).

Moreover, this exploratory observational study using scientifically proven, reliable, and valid tools of motivational interviewing in the context of major MFT modalities can provide an extensive and deepened understanding regarding not only the common elements and mechanisms of change, but the motivational interviewing model-specific elements of change. Thus, this study can also provide knowledge for understanding in what ways motivational interviewing is unique in creating change in the psychotherapy session as well.

Overall, this study promises to be a valuable theoretical contribution to the common factors perspective and motivational interviewing framework that may, in turn, lead to major changes in therapeutic structures, educational programs, research practices, mental health policies, and potentially, in our conceptualization of psychotherapy. With regard to therapeutic structures, highlighting the value of common factors can change the delivery of treatment modalities. The effective factors can be consolidated and less-effective factors can be eliminated

(Kraemer, Wilson, Fairborn, & Agras, 2002). Rather than focusing on the uniqueness of treatment styles, the commonalities can be highlighted so that psychotherapy can become more cost-effective. In the educational settings, more attention can be directed towards common factors (Blow & Sprenkle, 2001), so that more effective therapists can be trained and the quality of the MFT profession can be improved. The supervision and education system can highlight the person-of-the-therapist as the meta-model (Fife, Whiting, Bradford, & Davis, 2014), which in turn changes the educational system of MFT from a technique oriented to a personal oriented one. The research practices can shift focus from uniqueness of the models to the commonalities of the models, so that the research results may be more beneficial for the clients, therapists, helping professions, and mental health in general (Laurenceau, Hayes, & Feldman, 2007).

In the following chapter, I will provide a historical overview of the common factors perspective in the contexts of individual and relational psychotherapy. I will present the major statements of the common factors including client/extratherapeutic factors, therapist factors, therapeutic relationship, hope/expectancy of the clients, allegiance of the therapists, and basic counseling skills. Then, I will overview the criticisms against common factors perspective and present the motivational interviewing framework as a theoretical ground and practical tool against the criticisms against common factors perspective. I will present the major elements of motivational interviewing and propose a study exploring the resemblances between the motivational interviewing framework and the common factors perspective. Then, I will present an overview of the task analysis methodology that I used for this study. In the Methodology chapter, I will present the study steps and the findings of the study. Finally, I will discuss the theoretical and practical implications of this study.

Chapter II

Literature Review

In the first section, I will present a historical overview of the common factors perspective. Next, I will provide an overview of the major statements on the common factors including client/extratherapeutic factors, therapist factors, therapeutic relationship, hope/expectancy of the clients, allegiance of the therapists, and basic counseling skills. In the following section, I will present the motivational interviewing framework as well as the proposed perspective and an overview of the task analysis as the methodology of this study.

Common Factors Perspective

The term ‘common factors’ is defined as the techniques and change mechanisms common among all psychotherapy modalities associated with effective psychotherapy practices (Karam, Blow, Sprenkle, & Davis, 2014). Although the relevance of common factors are as old as the psychotherapy practice itself (Hubble, Duncan, & Miller, 1999), the discussion of common factors in the psychotherapy research literature is relatively new. In this section, a brief history is presented of common factors literature in the contexts of individual and relational psychotherapy.

Common factors perspective is rooted in the Rosenberg (1936) study asserting a Dodo Bird Verdict among psychotherapy modalities. With a reference to the Dodo Bird from *Alice in Wonderland* (“All won, all must have prizes”) for the first time in psychotherapy literature, he argues that the effectiveness of psychotherapy modalities is due to the common factors across models, rather than the specifics. Later on, Jerome Frank (1961) argues that not only in psychotherapy but also in all forms of therapeutic contexts including medical and traditional healing practices, there are four components of effective practice: a healing context; a rationale

or a myth providing an explanation for the problem and a method for the solution; a meaningful relationship with the healer; and a ritual or a procedure the client and the healer actively participate.

In the search for the core elements making psychotherapy process effective, perhaps one of the most inspiring and all-encompassing contributions comes from the founder of the person-centered therapy, Carl Rogers (1957, 1961; Raskin & Rogers, 1989; Rogers, Kirschenbaum, & Handerson, 1989). He argues that there are three “necessary and sufficient” conditions for effective psychotherapy: empathy, unconditional positive regard, and congruence. He defines empathy as the therapist’s capacity and willingness to understand the client’s experience. To Rogers (1957), the ability to “put oneself in other’s shoes” is the ultimate necessity for successful treatment. The unconditional positive regard is defined as accepting the other person as a separate, individual human being with highs and lows, and strengths and weaknesses. Rogers (1957) specifically highlights that unconditional positive regard does not mean approving or rewarding the other person; it is respectfully accepting the other person as a whole. And lastly, he defines congruence as the therapist’s capacity and willingness to express oneself genuinely in the therapeutic relationship. Again, Rogers (1957) highlights that congruence does not mean self-disclosing all aspects of life. Rather, it is being honest and present with regard to thoughts and feelings in communication with the clients during the psychotherapy process.

The meta-perspective suggested by Frank and Frank (1961) focusing on the big picture of the healing practices provides a structural-functional framework for the common factors perspective. Orlinsky and Howard (1987) propose a “generic model of psychotherapy” (Appendix A), which consists of five main processes: (a) a therapeutic contract that consists of the mutual agreement between the therapists and the clients on the dynamics of the therapeutic

relationship including logistical details like site, schedule, fee, duration; treatment goals of the clients; and treatment methods the therapist use; (b) therapeutic operations that consist of the cyclical work between the therapists and the clients including the elements of client input or problem statement, therapist reaction or interventions, and the co-operation among the participants; (c) a therapeutic bond including the elements of team-work and rapport; (d) participants' self-relatedness suggesting the level of openness/defensiveness of the clients and the therapists, and (e) in-session impacts that consist of the outcomes attained during the psychotherapy session, like emotional relief or gaining insight. The authors argue that the generic model of psychotherapy not only provides a meta-perspective, but also highlights common elements of effective psychotherapy practice (Orlinsky and Howard, 1987).

In a recent study on updates to the model, Orlinsky (2009) states that: “[The generic model of psychotherapy] serves as a useful framework that can expand to encompass new aspects of therapeutic process that researchers may explore, and that it will also stimulate researchers to take a broader view of the questions that research can ask about the impacts of psychotherapy on the psychological, social, and cultural contexts in which it occurs” (p. 338). In line with the generic model of psychotherapy (Orlinsky & Howard, 1987), based on extensive reviews of psychotherapy outcome research, Lambert (1992, Lambert & Barley, 2002) proposes a taxonomy of effective therapy practice that is consisted of four factors: extratherapeutic/client factors including clients' resources, psychological functioning, and life events (40%); interpersonal relationship between therapists and clients (30%); hope, expectancy, and placebo (15%); and model or technique (15%). Along with Lambert (1992), Wampold (2001) conducts a detailed meta-analysis and argues that 70% of the outcomes of psychotherapy were due to common factors and only 8% were due to model specific elements. He asserts that there is no

particular treatment modality associated with better outcomes than the others, even though regardless of the psychotherapy modality, all clients who attend to therapy show significantly better outcomes compared to individuals who do not attend. Wampold (2001, 2015) then concludes that the therapeutic change is associated with the factors that transcend the specifics of the treatment modalities and suggests a theoretical basis for the common factors perspective named as the contextual model (see also Wampold & Budge, 2012).

Wampold (2015) suggests that the contextual model is composed of three common pathways: Forming a real relationship, fostering expectations, and enacting healthy behaviors. He argues that the therapeutic process is a quite unusual one that consists of a confidentiality principle and extensive focus on working on the negative experiences, which distinguishes the therapeutic relationship from the other social bonds in a significant way. He highlights the role of empathy and collaboration (Rogers, 1957), as well as the role of working alliance (Bordin, 1979) as the essential components of the first pathway. Second, by referring to the research findings stating that people have a tendency to rate the quality of a wine when it was listed with a higher price on the menu (Plassmann, O'Doherty, Shiv, & Rangel, 2008), he highlights the role of expectancy in the process of psychotherapy. As the meta-analyses on the effects of placebos (e.g. Price, Finniss, & Benedetti, 2008) show, clients' expectations of psychotherapy and the outcomes are significantly correlated. Wampold (2012, 2015) points out the role of "agreement" between the therapists and the clients with regard to the explanation of the problem and the pathway of the solution, and the participants of the therapy process working together towards the solution. As the third pathway, Wampold (2012, 2015) highlights the role of specific ingredients that not only strengthen the first and second pathways, but also enact healthy behaviors including promoting functional thinking patterns in cognitive therapies, enhancing social relationships in

interpersonal therapies, increasing the rate of the positive behaviors in behavioral therapies, or processing difficult emotions in emotional therapies.

The rather extreme perspective of Wampold (2001) states that almost no effect of treatments is shared by other researchers. Miller, Duncan, and Hubble (1996) embrace and enhance the taxonomy of common factors proposed by Lambert (1992), and highlight the biggest role of client factors during the psychotherapy process. The authors further argue that the psychotherapy process should include a formal client feedback process to the psychotherapy process, and propose the Outcome Rating Scale and Session Rating Scale, which would allow clinicians as well as the researchers to be able to track the progress of psychotherapy on a session basis (Duncan, Miller, & Sparks, 2004). Also, Pinsof and his colleagues (2009, 2008) developed the Systemic Therapy Inventory of Change (STIC) system, which allows clinicians to receive feedback from their clients and track their progress in a more detailed manner.

In a similar vein, GrenCavage and Norcross (1990) identify five categories of common factors: client characteristics, therapist qualities, change processes, treatment structure, and therapeutic relationship. They further state that the majority of the treatment outcome is due to the therapeutic alliance (56%), followed by catharsis opportunities (38%), practice of new behaviors (32%), expectancies of the clients (26%), therapist qualities (24%), and the rationale providing a roadmap to the change processes (24%).

In the relational psychotherapy field, the common factors perspective is less well-researched and therefore has not faced as much criticism. The current literature consists of the research on identifying the common factors (Blow & Sprenkle, 2001; D'Aniello, 2013; D'Aniello, Nguyen, & Piercy, 2016; Davis & Butler, 2004; Davis & Piercy, 2007a; Davis & Piercy, 2007b; Fife, Whiting, Bradford, & Davis, 2014; Sprenkle & Blow, 2004a; Sprenkle, Blow, & Dickey,

1999; Sprenkle, Davis, & LeBow, 2009), as well as the implications of common factors in training, research, clinical practice, and supervision (D'Aniello, 2015; D'Aniello & Perkins, 2016; D'Aniello, Alvarado, Hulbert, Izaguirre, & Miller, 2016; Karam & Sprenkle, 2010; Karam, 2011; Karam, Blow, Sprenkle, & Davis, 2014).

Sprenkle and Blow (2004b) state that they have a "moderate" position in the context of common factors debate, which seems to have been adopted by almost all the researchers in the relational psychotherapy field (e.g. D'Aniello, 2015; Karam, 2011, Fife, Whiting, Bradford, & Davis, 2014). The authors argue that common factors approach is as important as treatment approaches, which leaves room for the meta-analyses and clinical research trials to posit the superiority of particular treatment modalities over others. According to the moderate common factors proponents, there is no need to take an "either-or position" between common factors and evidence based treatment approaches (Sprenkle, Davis, LeBow, 2009, p. 32). Adrian Blow puts their position nicely: "Like saying the engine is more important than the tire. Can you really say that a car work properly that has one but not the other?" (as cited in Sprenkle, Davis, & Lebow, 2009, p. 124).

The moderate common factors proponents also argue that the moderate model of common factor consists of broad (model independent) and narrow (model dependent) factors that are interacting in a circular manner (Davis & Piercy, 2007a; Davis & Piercy, 2007b; Sprenkle, Davis, & LeBow, 2009). In other words, they insist that during the process of psychotherapy, different common factors are present in one of three stages.

In the earlier stages of psychotherapy, the factors most common across models are: therapists' search and conceptualization of a dysfunction, therapists' allegiance to a model and being perceived as a credible agent by the clients, the fit of the therapists' models to the clients'

expectations, therapists' providing a safe and healing environment, and clients' readiness for change and taking responsibility for their actions. At the second stage (characterized by intervention), the commonalities across models include: slowing down the process, helping clients to step outside of their meaning frameworks, highlighting clients' responsibility for change, and building and maintaining therapeutic alliance. At the outcome stage, the common elements across models include softening negative experiences and creating a space for the other by means of acceptance.

Besides this process based approach, the moderate common factors perspective proponents propose four common factors specific to marriage and family therapy to profession: (1) conceptualizing difficulties in relational terms, (2) disrupting dysfunctional relational patterns, (3) expanding the direct treatment system, and (4) expanding the therapeutic alliance.

Common Factors. Overall, the current state of discussion with regard to these common factors can be grouped into six categories: client specific factors, therapist specific factors, therapeutic relationship, allegiance of therapists, expectancy/hope of clients, and techniques/interventions. In this section, these factors will be discussed in detail in terms of their theoretical precursors and research support.

Client Specific Factors. This term was proposed by Lambert (1992) as the largest portion of variance in outcome, and embraced and enhanced by the proponents of common factors perspective. Miller, Duncan, and Hubble (1997) point out that psychotherapy practice and research dismiss the clients' potential for change and situate the clients to an "incompetent" position. They argue that:

In the clinical literature, clients have long been portrayed as the "unactualized," message bearers of family dysfunction, manufacturers of resistance, and in most therapeutic

traditions, targets for the presumably all-important technical intervention. Indeed, it seems that once people decide to enter treatment they suddenly become something less than they were before. They cease knowing their own mind, are disconnected from their feelings, certainly have "something" wrong with them that requires fixing, and, of course, will do their devilish best to resist the therapist's efforts to help them. It is curious that the very profession that makes helping a virtue has also made a cult out of client incompetence. (p. 24)

Often, this situation is exacerbated by the clients' extratherapeutic factors, which encompass all the factors external to the treatment process that are influencing the outcomes. The proponents of common factors perspective highlight that the client specific variables like developmental status, strengths and the risks, resources and challenges, psychological functioning, social support system, readiness for change, and even the external life events have significant effect on the treatment outcomes (Bohart & Tallman, 1997, 1999; Duncan, Miller, & Hubble, 1997; Duncan, Miller, & Sparks, 2004; Hubble, Duncan, & Miller, 1999; Miller, Duncan, & Hubble, 1997).

Wampold (2001) argues that more than 80% of variance in psychotherapy outcome is explained by extratherapeutic factors. Bohart and Tallman (1999) state that the individuals are more resilient than most professionals in the mental health field are thinking of and they are able to change without receiving psychotherapy. In line with the statements of Bohart and Tallman (1997, 1999), the research shows that people spontaneously recover in time even they do not receive any treatment (Bonnano, 2004; Pennebaker, 1997; Skodol et al., 2007; Willer & Carroll, 2006). For instance, a study exploring the cognitive approach individuals with alcohol use problems who spontaneously recovered, Ludwig (1985) states that individuals report various

reasons for changing their lifestyles, including hitting a personal bottom and experiencing alcohol-induced problems. Moreover, the spontaneously recovered individuals also report numerous factors helping them to maintain their recovery, including changing their perspective and relying on their personal power.

Extensive literature on the dynamics of self-help shows that people have a tendency to search for and find solutions by themselves (Norcross, 2006). In the latest report of Pew Research Center (PWC) Internet & American Life Project (2013), it is reported that 59% of internet users in United States say that they searched for online health information in the past year, and 35% say they have gone online in the past specifically to try to figure out what medical condition they or someone else might have, which equals to approximately to 35% of U.S. adults. The PWC further reports that 35% of the online-diagnosers report that they did not go to a professional after getting the online diagnosis. By the same token, drastically flourishing technology-based mental health treatment methods including mobile applications, self-help websites, and online support groups (e.g. Ambwani, Cardi, & Treasure, 2014; Newman, Szkodny, Llera, & Przeworski, 2011; Yuen et al., 2015), which shows that the individuals can look for and realize the change they want by themselves without having face-to-face contact with psychotherapists.

Prochaska (1999) states that people are capable of finding solutions without receiving psychotherapy service and proposes the transtheoretical model of change with DiClemente (Prochaska & DiClemente, 1983, 1984), offering a psychotherapist- facilitated self-change process for the clients. In the similar vein, the results of a study exploring clients' experience of what was helpful in the psychotherapy process reveal that for the clients, the most helpful aspects of psychotherapy process are feeling understood, being supported while experiencing difficult

times, being encouraged when they try new behaviors, and receiving advice when they need (Levitt, Butler, & Hill, 2006).

The research shows a significant association between client emotional experiencing and positive psychotherapy outcomes (Pos et al., 2009; Watson & Bedard, 2006; Watson & Greenberg, 1996; Yeryomenko, 2012). Emotional experiencing is defined as the quality of cognitive and emotional participation to the psychotherapy process (Klein, Mathieu, Gendlin, & Kiesler, 1969). According to Gendlin (1991), emotional experiencing in depth means not only being in touch with the raw emotional material, but also using this connection in order to achieve a newer sense of understanding the situation and the sense of self. Experiencing refers to the dynamic meaning-making process in which emotional and cognitive content is transformed into a grounded consideration of the information processed in the session.

The research shows that there is a significant association between client emotional experiencing and therapy outcomes in both individual contexts (Watson, McMullen, Prosser, & Bedard, 2011; Watson & Greenberg, 1996) and relational psychotherapy contexts (Johnson & Greenberg, 1988; Greenberg, Ford, Arden, & Johnson, 1993). Similarly, in a follow-up longitudinal research study exploring the trajectories of relationship satisfaction among the couples, Wiebe, Johnson, Burgess Moser, Dalglish, Lafontaine, and Tasca (2016) found that higher levels of emotional experiencing in the sessions predicts higher relationship satisfaction among the couples.

In the context of relational psychotherapy, Sprenkle, Davis, and Lebow (2009) highlight the "match" between clients' needs and therapeutic interventions. They state that when the clients are considered as autonomous human beings who know what works best for them, then, depending on the needs and desires of the clients, therapists may utilize client-appropriated

interventions. The research shows that when people start therapy they usually have an idea about what they need and what works best for them (Philips, Werbart, Wennberg, & Schubert, 2007).

A growing area of research also suggests that for specific populations, some treatment modalities work better (Kazdin, 1997; Rowe & Liddle, 2003; Sexton, Alexander, & Mease, 2004).

Along with the common factors proponents, in motivational interviewing, clients are considered as the core agents of change and accepted with "humane respect" as they are. Supporting clients' autonomy is both one of the core principles and identifying components of motivational interviewing (Miller & Rollnick, 1991). Clients are considered as the active agents of their own processes and their state of mind (and heart) are well respected with understanding and compassion (Miller & Rollnick, 1991). Along with collaboration and evocation, honoring autonomy is defined as acknowledging the other individuals' freedom of choice, and expressing unconditional positive regard towards them as human beings. The clinicians may give advice, or provide information, but always highlight that it is the clients who are responsible for making a change they want for their lives. The authors point out the research suggesting that people generally respond with reactions when they are try to be coerced (i.e. Karno & Longabaugh, 2005a), asserting, "Directly acknowledging a person's freedom of choice typically diminishes defensiveness and can facilitate change" (Miller & Rollnick, 2013, p. 20).

Overall, the proponents of the common factors perspective argue that there is a need for a paradigm shift in the field of psychotherapy in which the clients are considered as active, resilient, competent, creative, and autonomous agents who are able to realize their own-change process rather than the passive recipients of therapeutic interventions and interpretations about their very own realities.

Therapist Specific Factors. Therapist specific factors were introduced by Wampold and Brown (2005) as the source of 8-9% of variance in psychotherapy outcomes. In a more recent meta-analysis of therapist effects based on 45 studies, Baldwin and Imel (2013) report that 5% of the variability in outcomes was explained by differences among therapists—which translates into almost 15% of variance when the effect size is considered.

Because the therapist is the deliverer of the treatment, the sole effects of the therapists are considered to be not easy to be distinguished from technique/intervention related factors (Duncan, Solovey, & Rusk, 1992). However, despite this difficulty, Hubble, Duncan, and Miller (1999) argue that "everybody knows but at the same time is on the building to acknowledge or explore that some therapists are more effective than others" (p. 38). Research shows that despite the standardization movements, the therapist's effects on the treatment outcomes cannot be eliminated (Beutler et al., 2004; Crits-Christoph & Mintz, 1991; Okiishi et al., 2006). However, there is still no solid picture regarding personal characteristics and actions of effective psychotherapists (Beutler et al., 2004).

The research reveals conflicting results with regard to the effectiveness of therapists. There is research supporting the uniformity of a therapist effectiveness hypothesis, suggesting that demographic characteristics including age, gender, race, and ethnicity as well as experience and orientation of the therapists are not associated with treatment outcomes (Beutler, Machado, & Neufeldt, 1994; Beutler et al., 2004; Haga, McCardy, & Lebow, 2006; Horvath, 2001; Okiishi et al., 2006; Stolk & Perlesz, 1990; Wampold & Brown, 2005). For instance, Wampold and Brown (2005) found that the clinicians who are good at treating depression are also good at treating anxiety. Similarly, in a more recent study exploring universality of therapist

effectiveness, Nissen-Lie et al. (2016) found that therapists' effectiveness in one domain is positively correlated with their effectiveness in another.

There is also research suggesting the hypothesis that there are nuances of effectiveness of the therapists. Based on a study including 6,960 patients treated by 696 therapists, Kraus et al. (2011) found that therapists who are skillful in treating individuals with particular problems may not be that skillful in treating individuals having different set of problems. Similarly, it has been found that some therapists are better in the treatment of racial/ethnic minority individuals than their non-minority clients (Hayes, Owen, & Bieschke, 2015).

However, at a deeper level focusing on what the therapists are actually doing in the psychotherapy process, the research shows a more coherent picture. There seems to be a significant correlation between the interpersonal skills of the therapists and treatment outcomes of the clients (Anderson et al., 2016; Holdsworth, Bowen, Brown, & Howat, 2014; Moyers et al., 2016). It has been repeatedly found that the clients' perceived support (Gellatly et al., 2007; Titov et al., 2009), warmth (Farber & Doolin, 2011; Green & Herget, 1991; Thomas, Werner-Wilson, & Murphy, 2005), friendliness and positivity (Lebow, 2006), empathy (Elliott, Bohart, Watson, & Greenberg, 2011), congruence (Klein, Michels, Kolden, & Chisolm-Stockard, 2001), and unconditional positive regard (Faibei & Lane, 2002) from their therapists are significantly associated with positive psychotherapy outcomes.

The research on the qualities and actions of highly effective therapists also shows surprising results. Miller and Hubble (2007) assert that highly effective therapists, whom they call "supershrinks" with a reference to the Ricks (1974) study, engage in deliberate practice. Deliberate practice is defined as "individualized training activities especially designed ... to improve specific aspects of individual performance through repetition and successive

refinement” (Ericsson & Lehmann, 1996, pp. 278-9 as cited in Chow et al., 2015). In a recent study exploring the role of deliberate practice of therapists on treatment outcomes, based on the data from 17 therapists treating 1,632 clients, Chow et al. (2015) found that the time spent on deliberate practice including receiving supervision and attending to professional trainings, is a significant predictor of clients' positive psychotherapy outcomes.

Moreover, it has been found that perceived directiveness (Kamo & Longabaugh, 2005; Miller et al., 1993) of the therapists is significantly associated with negative psychotherapy outcomes. In an exemplary summary of research on what does not work in psychotherapy, Norcross (1999) lists "seven caveats" that should be avoided: confrontation (Miller, Wilbourne, & Hettema, 2003), negative processes (i.e. hostile, blaming, critical, rejecting behaviors and attitudes, listed in Lambert & Barley, 2002), assumptions (Miller, Duncan, Sorrell, & Brown, 2005), therapist centricity (Orlinsky, Ronnestad, & Willutzki, 2004), rigidity (Ackerman & Hilsentoth, 2001), not addressing the alliance ruptures (Safran, Murran, Samstag, & Stephens, 2002), and not responding to the needs of the clients (Norcross, Koochet, & Gaiofalo, 2006).

In the context of relational psychotherapy, along with the individual psychotherapy research findings exploring therapist effects, earlier relational psychotherapy research reflects similar trends with regard to the effects of therapists' gender, race/ethnicity, and experience on treatment outcomes. Bischoff and Sprenkle (1993) state that the gender of the therapist might be associated with the early termination from the relational psychotherapy. Gregory and Leslie (1996) argue that gender and race/ethnicity of therapists might be related to how clients are rating the quality of the relational therapy sessions. They reported that black and female clients rate the quality of the initial relational therapy sessions with black therapists more positively than the white ones. Further, Stolk and Perlesz (1990) argue that there might be a negative

association between years of therapist experience and therapy effectiveness. In a study exploring the relationship between a therapist's experience level and treatment outcomes, the authors found that the clients of the first year MFT therapists reported significantly better treatment outcomes.

The current research focuses more on couples and family therapists (Blow, Sprenkle, & Davis, 2007; Lebow, 2006; Simon, 2006). Blow, Sprenkle, and Davis (2007) argue that being a competent therapist is a common factor of effective relational psychotherapy practice, as the therapeutic change is either initiated or influenced by the therapist. Fife, Whiting, Bradford, and Davis (2013) propose a meta-model of therapy effectiveness in a therapeutic pyramid shape, which is founded on the therapist's way of being. The cultural competency of the relational therapist is found to be an important factor in determining the quality of the relational psychotherapy outcomes (Breuk et al. 2006). Recently, D'Aniello, Nguyen, and Piercy (2016) highlight the role of being culturally sensitive as opposed to doing cultural sensitivity in effective psychotherapy practice.

Overall, common factors proponents suggest that, despite the conflicting research findings with regard to the association between the therapists' demographic qualities and clients' therapy outcomes, there seems to be a coherent picture of therapists' actions helping clients to achieve positive psychotherapy outcomes: empathy, positive regard, congruence, warmth, friendliness, support, and deliberate practice as well as refraining from confrontation, negative processes, assumptions, therapist centrality, ignoring the ruptures, and not responding to the needs of the clients.

Therapeutic Alliance. The term working alliance was defined by Borden (1979) as the agreement on the tasks and the goals of the treatment process and having a personal bond between the therapist and the clients. Lambert (1992) reports the second highest (after client

factors) percentage of variance in psychotherapy outcomes to the quality of relationship between the therapists and the clients. Many other studies and meta-analyses consistently reveal that higher therapeutic alliance is positively associated with successful treatment outcomes (Busseri & Tyler, 2004; Duncan, Miller, & Sparks; 2004; Horvath & Symonds, 1991; Horvath & Bedi, 2002; Messer & Wampold, 2002; Norcross & Wampold, 2011; Safran, & Muran, 2000). Several components of working alliance have been explored, including goal consensus (Mackrill, 2009, 2011; Schnur & Montgomery, 2010) and collaboration (Baldwin et al., 2007; Creed & Kendall, 2005; Schnur & Montgomery, 2010). Tyron and Winogard (2002) state, in a meta-analysis exploring the role of working alliance, that 89% of the studies report significantly positive association between therapist-client collaboration and treatment outcomes.

For example, a study exploring the role of working on alliance among the clients with depression symptoms (in which the researchers tested the alliance and outcome scores at the 5th, 10th, and 15th session review outcome) demonstrates that the working alliance is within the range of 19-32% at the 5th, and within the range of 36-57% at the 15th session (Gaston, Maimai, Gallaghet, & Thompson, 1991). Similarly, various studies exploring the role of early working alliance on the treatment outcomes suggest that higher early working alliance is significantly correlated with positive psychotherapy outcomes (Martin, Garske, & Davis, 2000; Zuroff & Blatt, 2006). Also, weaker early alliances are significantly correlated with early-terminations (Sharf, Primavera, & Diener, 2010).

The research also suggests that the alliance fluctuates during the psychotherapy process (Gaston, 1990; Siefert & Hilsenroth, 2015; Sauer et al., 2003). Siefert and Hilsenroth (2015) report that the working alliance ratings of the clients change in relation to their attachments styles. In other words, securely attached clients build and maintain strong alliances with their

therapists, while the clients with insecure attachments report declines and fluctuations in their alliance reports. Tufekcioglu, Muran, Safran, and Winston (2013) also assert that there is a correlation between personality disorder diagnoses and quality of working alliances. The authors concluded that the individuals who report higher impulsivity and lability scored lower on the working alliances and reported more intense alliance ruptures. This and other studies and meta-analyses show that therapists detecting the ruptures in the working alliances and repairing the ruptures by means of collaborative negotiation is significantly related to positive psychotherapy outcomes (Safran, Muran, & Eubanks-Carter, 2011; Samstag, Muran, & Safran, 2004).

In the context of relational psychotherapy, Sprenkle, Blow, and Davis (2009) highlight that therapeutic alliance is more difficult and more crucial to establish and to maintain in relational psychotherapies. It has been argued that therapists should be mindful about performing a systemic plan to build and maintain multiple (i.e. with each client) and overall (i.e. with the couple/family) working alliances (Shelef, Diamond, Diamond, & Liddle, 2005). Pinsof (1995) points out that the alliances among the family members are also significantly associated with treatment outcomes. Friedlander, Escudero, and Heatherington (2006) report that even when the family members have high individual working alliances with the therapists, when the alliances among the family members are low, there is a high likelihood of early termination.

Overall, as the proponents of the common factors perspective highlight that there seems to be a significant relationship between the quality of the therapeutic alliance and the treatment outcomes. The agreement between therapists and clients on the goals and tasks of the therapeutic process and having a personal bond—as well as therapists' being mindful about the essentiality of alliance building and maintaining, repairing the ruptures, and considering the

client specific characteristics during the process of psychotherapy—are crucial for positive treatment outcomes.

Hope/Expectancy of the Clients. Hubble, Duncan, and Miller (1999) argue that clients' expectancy is the other side of the “therapist allegiance” coin. They suggest that the belief of the therapists in their rationale (or myth, in Frank & Frank's [1991] terms) and the hope of the clients in the rationale of the therapists are pathways to successful psychotherapy outcomes. Lambert (1992) attributes 15% of variance in psychotherapy outcomes to expectancy, hope, or placebo factors. The research on the effects of placebos support the hypothesis that there is a strong correlation between the clients' expectancy and treatment outcomes (Kirsch et al., 2002; Wampold, Minami, Tierney, Baskin, & Bhati, 2005; Wampold, 2015).

In the context of relational psychotherapy, Sprenkle & Blow (2004b) highlight that especially at the beginning of all psychotherapies, instilling hope is considered as an essential component of therapeutic modalities and call for further attention of the researchers regarding the association between clients' expectancy and treatment outcomes.

Therapist Allegiance. Proposed by Frank and Frank (1991) as a rationale or a myth as one of the components of effective healing practices, and embraced and enhanced primarily by the proponents of the common factors perspective. The term allegiance is defined as the belief of the therapists in the treatment method as an effective way to help clients to change (Luborsky, Singer, and Luborsky (1975). The meta-analyses exploring the role of clinician allegiance on the treatment outcomes show significantly positive associations (Hollon, 1999; Leykin & DeRubeis, 2009; Luborsky, 1999; Luborsky et al., 2002).

In a recent meta-meta-analysis including twenty-nine publications from thirty studies exploring the allegiance and outcome relationship, Munder, Brutsch, Leonhart, and Barth (2013)

found that there is a “substantial and robust” association between therapist allegiance and client psychotherapy outcomes. The authors also explored moderator effects, and found no difference across treatment formats, age groups, and presenting-problems of the clients. Similarly, in a recent meta-analysis including findings of a total of 240 randomized controlled trials, Dragioti, Dimoliatis, Fountoulakis, and Evangelou (2015) confirmed that there is a strong effect of researcher/clinician allegiance on the treatment outcomes. The authors further argue that allegiance effect is stronger when the primary investigators of the studies are the founders, developers, or supervisors of the “preferred” treatment modalities.

Leykin and DeRubeis (2009) mention that allegiance creates a significant bias favoring the “preferred” treatments among the evidence based clinical research studies. They suggest that the allegiance bias can be eliminated by strengthening the research designs by means of including research teams favoring each of the treatment conditions. They argue that the allegiance bias can be balanced out by methodological modifications as well. In a recent study, Wampold (2015) highlights the methodological issues related to allegiance, including the fact that in most evidence based clinical trials, both the therapist and clients know that they are in the control (aka less-preferred), groups which could be affecting the performance of the therapists as well as the expectancy of the clients.

Overall, as the proponents of the common factors perspective highlight, it seems like regardless of the therapeutic modality, there is a positive association between the allegiance of therapists and the treatment outcomes of the clients. Because the term allegiance also refers to the therapists’ attributed meaning to their therapeutic performance and, as Wampold (2001) suggests, their attempts to eliminate the allegiance effect would be unethical, the best way to

handle it would be to simply accept the allegiance effect and explore the ways in which it can be utilized within the therapeutic process.

Therapeutic Techniques and Interventions. Therapeutic interventions are considered to contribute 15% of the variance in psychotherapy outcomes (Lambert, 1992). Miller et al. (1997) refer to the common technical procedures as “asking particular questions, listening and reflecting, dispensing reassurance, confronting, providing information, offering special explanations (i.e. reframes, interpretations), making suggestions, self-disclosing, or assigning tasks to be done within or outside the therapy session” (p. 29).

A formulation of techniques was offered by scholars including Prochaska, DiClemente, and Norcross (Prochaska & DiClemente, 1982; Prochaska, DiClemente, and Norcross, 1992) for effective psychotherapy practice. Based on the research findings suggesting no difference between the self-changers and treatment-receivers in terms of treatment of addictions (Pederson & Lefcoe, 1976), the authors conducted extensive studies exploring the dynamics of change, and proposed a Transtheoretical Model of Change transacting across models. The authors propose 10 processes of change that include: consciousness raising, self-liberation, social liberation, self-reevaluation, environmental reevaluation, counterconditioning, stimulus control, reinforcement management, dramatic relief, and helping relationships that can be grouped into five stages of change: pre-contemplation, contemplation, action, maintenance, and relapse (Prochaska & DiClemente, 1982). In a subsequent article, the authors describe the stages in terms of change mechanisms as follows:

Pre-contemplators tend to be defensive and avoid changing their thinking and behavior, they would use the change processes significantly less than subjects in other stages. Because contemplators are seriously thinking about changing their smoking behavior,

they would use consciousness raising the most to gather further information about their smoking. Because self-reevaluation appears to be a process that bridges contemplation and action, self-reevaluation would be used most in the contemplation and action stages. Because subjects in the action stage are most committed to making behavioral changes, they would use self-liberation, counter-conditioning, stimulus control, and reinforcement management the most. No clear predictions had emerged from previous research on which processes would be emphasized during the maintenance and relapse stages. (Prochaska & DiClemente, 1986, p. 390)

The stage specific intervention focused model proposed by Prochaska, DiClemente, and Norcross (Prochaska & DiClemente, 1982; Prochaska, DiClemente, and Norcross, 1992) not only were found to be very effective in the treatment of the problems that are considered to be “most difficult to treat” (O'Brien, Childress, Ehrman, & Robbins, 1998), but also inspired an evidence based intervention, Motivational Interviewing, that was first developed as a “brief opportunistic intervention” and based on its success started to be used as a “stand alone treatment” for a variety of problems (Miller & Rollnick, 1991, 2013).

Similarly, in an extensive study exploring the common factors across emotion-focused couples therapy, cognitive behavioral couple therapy, and internal family systems therapy by means of qualitative analyses of the interviews with model developers, previous students, and clients, Davis and Piercy (2007a, 2007b) report that the common techniques cutting across the models include slowing down the process, helping the client to stand meta to themselves, and encouraging personal responsibility.

Davis and Piercy (2007a, 2007b) argue that the therapists use “slowing down” interventions in order to help the clients to stop their “autopilot” responses, reflect on the process

they are going through, and explore different options. In the context of relational therapy, Sprenkle, Davis, & Lebow (2009) argue, “Slowing down the process helps couples to begin to explore other possibilities for the relational difficulties. The client essentially says, ‘I’m willing to try something different’” (p. 138). Across the models, one common process is argued to be slowing down the process, which helps the clients to be motivated to explore and go through different options to solve their problems.

The second common interventions Davis and Piercy (2007a, 2007b) point out is the therapists’ helping the clients to stand meta to themselves and aiding the clients to see their roles in the problem. In the context of relational psychotherapy, Sprenkle, Davis, & Lebow (2009) state that, thanks to helping the clients to stand meta to themselves process, “Clients are encouraged to step outside themselves in an interaction and look at what they are telling themselves about their partner during an argument” (p. 138).

Across the models, helping clients to think outside of the box and see the context of the problem is considered to be another common intervention across all therapy modalities. The last common technique discussed to be common across all models is helping the clients to be willing to change by means of encouraging their autonomy in their lives throughout the therapy process. Sprenkle, Davis, & Lebow (2009) describe this as, “Lines are encouraged to take personal responsibility more by the language used by the therapist over the course of therapy rather than through interventions aim specifically at encouraging responsibility” (p. 138). The authors argue that despite the different sets of techniques specific to the models, encouraging the clients to feel responsible in their thoughts, feelings, and actions seem to be common across all the therapy modalities (Davis & Piercy, 2007a, 2007b).

In line with the findings of Davis and Piercy (2007a, 2007b), several authors also state that there are common factors specific to all relational psychotherapy modalities which are listed as: “(1) conceptualizing difficulties in relational terms, (2) disrupting dysfunctional relational patterns, (3) expanding the direct treatment system, and (4) expanding the therapeutic alliance” (p. 175). In this regard, it seems like the core techniques/interventions of an effective psychotherapy practice can be summarized with three basic helping skills: helping the clients to reflect on the problem; to gain awareness about their personal, biological, social, and relational roles; and to encourage them to make the change they want for their lives.

Motivational Interviewing

Defined as a client centered and goal oriented therapeutic style aiming to facilitate behavioral change through the exploration of ambivalence (Miller & Rollnick, 1991), motivational interviewing (MI) has gained great success and popularity in the evidence-based research area, in the treatment of a variety of psychopathological problems such as alcohol and substance use disorders (Jensen et al., 2011; Murphy, Dennhardt, Skidmore, Martens, & McDevitt-Murphy, 2010), eating disorders (Macdonald, Hibbs, Corfield, & Treasure, 2012; Rhind, Hibbs, Todd, & Macdonald, 2014), depression (Anderson, 2007; Keeley et al., 2014), obsessive compulsive disorders (Merlo et al., 2010; Simpson et al., 2010), post-traumatic stress disorders (Murphy, Thompson, Murray, Rainey, & Uddo, 2009), chronic disease management (Benzo et al., 2013; Martino, 2011), gambling (Hodgins, Ching, & McEwen, 2009; Yakovenko, Quigley, Hemmelgarn, Hodgins, & Ronksley, 2015), school underachievement (Richer, 2012; Stewart-Donaldson, 2012), and health coaching (Linden, Butterworth, & Prochaska, 2010; Simmons & Wolever, 2013) over a short period of time.

The goal of motivational interviewing is to help clients to feel an intrinsic desire to make a change (Miller & Rollnick, 2013, 2002). Through the use of motivational interviewing, clinicians encourage their clients to come up with their own solutions to their problems. As mentioned above, even though motivational interviewing was developed as a “brief opportunistic intervention” to be used along with other modalities, owing to the research evidence supporting the effectiveness of motivational interviewing, it has been used as a stand-alone intervention and has been developing into a theory (Miller & Rose, 2009).

Motivational Interviewing Elements. Motivational interviewing is composed of three major elements (spirit, principles, and micro skills) and four processes (engaging, focusing, evoking, and planning) (Miller & Rollnick, 1991, 2013). In the following section, the elements and processes of motivational interviewing will be discussed in detail.

Spirit. Since the introduction of the motivational interviewing framework, Miller and Rollnick (1991, 2008, 2011, 2013) have always consistently argued that the spirit of motivational interviewing is its most fundamental aspect, and neither of the “motivational techniques” can be considered as components of motivational interviewing without the “larger mindset and heartset” of the motivational interviewing spirit (Miller & Rollnick, 2013, p. 5).

In the first edition of their book *Motivational Interviewing*, the authors present three components of motivational interviewing spirit: collaboration, evocation, and autonomy (Miller & Rollnick, 1991). Starting from the third edition, they add one more component: compassion. The collaboration component of the motivational interviewing spirit is defined as the “cooperative partnership between the patient and clinician” (Miller & Rollnick, 2013, p. 20). The authors highlight the role of exploration instead of exhortation, supporting the clients rather than persuading or arguing with them, and having an attitude of conducting change instead of

coercion. They say that “instead of an uneven power relationship in which the expert clinician directs the passive patient in what to do, there is an active collaborative conversation and joint decision making process” (Miller & Rollnick, 2013, p. 20).

Evocation is the second component of the motivational interviewing spirit. It is defined as clinicians’ active attempts to motivate the clients to use their own resources for change. Rooted in the strengths focused understanding, the authors highlight that they see the clients as individuals who already have the resources to be able to make a change in their own lives and they do not need “expert-opinions” about their inner realities to be able to make a change. The authors say that “a patient may not be motivated to do what [the clinicians] want him or her to, but each person has personal goals, values, aspirations, and dreams.” (Miller & Rollnick, 2013, p. 20). Thus, in motivational interviewing the clinician instill motivation for the clients to make change.

Autonomy, as stated in the first edition of *Motivational Interviewing*, honoring autonomy is the third component. Along with collaboration and evocation, honoring autonomy is defined as acknowledging the other individual's freedom of choice and expressing unconditional positive regard towards them as human beings. Clinicians may give advice, or provide information, but always highlight that it is the clients who are responsible for making a change they want for their lives. The authors point out the research suggesting that people generally respond negatively when they are trying to be coerced (i.e. Karno & Longabaugh, 2005a). They assert, “Directly acknowledging a person's freedom of choice typically diminishes defensiveness and can facilitate change” (Miller & Rollnick, 2013, p. 20).

And the last component Miller and Rollnick (2013) consider within the element of spirit is compassion. The authors define compassion as “actively promoting the others welfare, to give

priority to others needs” (p. 20). They argue that they chose to include compassion because motivational interviewing can be implemented without compassion, but it doesn't necessarily help the clients to change. Miller and Rollnick (2013) say that “the spirit of compassion is to have your heart in the right place so that the trust you engender will be deserved” (Ibid.).

In the first version of *Motivational Interviewing*, order to make the components of the motivational interviewing spirit clearer, Miller and Rollnick (1991) also provide a comparison chart. The collaboration component is presented as the “mirror-image” of confrontation in which the clinicians expose their clients to an aspect that they are not ready to accept. The contrasting component of evocation is presented as education in which instead of drawing out change, the clients are educated about the change. The mirror image of honoring autonomy is presented as authority in which the clinicians take on an expert role in their interactions with the clients and tell them what to do.

Principles. Motivational interviewing is a practice based on five main clinical principles: expressing empathy, developing discrepancy, avoiding argumentation, rolling with resistance, and supporting self-efficacy.

Expressing Empathy. Miller and Rollnick (1995) propose that the main principle of motivational interviewing is rooted in the Rogerian conceptualization of empathy. They state that expressing empathy through reflective listening techniques and having an accepting attitude are the most essential and characterizing components of motivational interviewing. Empathic clinicians are described as the ones who accept their clients as they are, and show deep understanding of their clients’ perspectives. The principle of expressing empathy is rooted in the spirit of accepting all kinds of feelings the clients may or may not be experiencing, including desiring or resisting to change, or feeling ambivalent to make a change.

Developing Discrepancy. Based on Festinger's (1957) conceptualization of "cognitive dissonance," Miller and Rollnick (1995) argue that the second principle of motivational interviewing is to help the clients to identify and amplify the inconsistencies of thoughts, feelings, attitudes, or behaviors between current behaviors and future goals. The principle of developing discrepancy is rooted in helping the clients to become aware of any disconnects between their current and desired states. The authors state that when the clients develop awareness, they start to consider change.

Avoiding Argumentation. Miller and Rollnick (1995) state that the third principle of motivational interviewing is avoiding argumentation with the clients. The authors state that direct confrontation elicits defensive and reactive responses in clients rather than enhancing the clients' motivation to make a change. Increased amounts of defensive responses from clients are considered as the signals of decreased motivation to change. Based on this principle, therapists should avoid arguing with their clients.

Rolling with Resistance. Rolling with resistance is considered as the "hallmark" of motivational interviewing (Miller and Rollnick, 2002) that is defined as acknowledging the perspectives of the clients, providing new information, and leaving the decision to make a change up to the client. Rather than confronting or challenging the clients, therapists must roll with the resistance of their clients. The authors highlight that in motivational interviewing, the clients are considered as people who are capable of finding solutions themselves and are responsible for creating change in their own lives.

Supporting Autonomy. The last principle of motivational interviewing is supporting the autonomy of the clients. Rooted in Bandura's (1977) conceptualization of self-efficacy, it is stated that the clients' confidence in their abilities to make a change is essential in creating such

a change (Miller & Rollnick, 1995). The authors state that when the clients hope that they can change, it is a lot more likely that they will do so. Therapists who convey hope for their clients to make a change is an essential principle of motivational interviewing.

Microskills. Motivational interviewing is a brief intervention in which the spirit and principles described above are practiced through a variety of “microskills,” including open ended questions, affirmations, reflections, and summarizing (abbreviated as OARS) that are “borrowed from client-centered counseling” (Arkowitz, Miller, & Rollnick, 2015; Miller & Rollnick, 2011, 1991). It has been asserted that OARS skills are primarily used in the early stages of the therapy process. In the following stages, OARS shift into an EARS form—in which E is an abbreviation for elaboration (Arkowitz, Miller, & Rollnick, 2015).

The open-ended questions serve the therapists as a way to engage with the clients, and to build trust with them. They also serve as the ground builders for the therapy process in which the therapists can use other techniques. Affirmations can be implemented in the form of appreciation and acknowledgement, such as “I appreciate your hard work,” which conveys the strength-based approach of motivational interviewing. Reflections are considered as challenging skills to practice, because even though mirroring what the clients say may sound easy, there is a risk of dismissing the clients’ perspectives and telling the clients what they “actually” feel. Summarizing consists of reflecting overarching themes to the clients with the purpose of drawing a bigger picture of what the clients presented so far.

Four Processes. Miller & Rollnick (2011) propose that motivational interviewing is composed of four processes: engaging, focusing, evoking, and planning. Engaging process refers to the first stage of the treatment in which the therapeutic alliance between the therapist and the clients are built. The OARS skills mentioned above are critically important in this stage.

Besides the essentiality of implementing OARS skills, therapists are also encouraged to refrain from behaviors of persuasion and confrontation that are considered to be non-adherent to motivational interviewing. In the second stage, therapists and their clients focus on treatment goals. They work together in order to identify the goals and the direction of the treatment process. In the third stage, therapists specifically focus on evoking the motivation of their clients to make a change in the context of the pre-determined treatment goals. At this stage, three kinds of specific skills are expected from the therapists to be used: recognizing, eliciting, and responding to ‘change talk’. In terms of recognizing, therapists should pay specific attention to the change related content the clients use, which is grouped into themes like desire, ability, reasons, and need for change. Along with identifying the change talk content, therapists are also expected to elicit them by means of using OARS skills. When change talk is heard, therapists are expected to respond to them with EARS skills in order to amplify the change talk, while decreasing the ‘sustain talk’ (which is defined as the talk content not favoring change). Finally, in the last stage, which actually is a recursive process, therapists and their clients work together to develop and implement a strategic plan of change. Overall, motivational interviewing framework offers a minimalistic change directed approach in which basic counseling skills are used strategically in order to recognize, elicit, and amplify the clients’ motivation for change.

Therapist and Client Interactions: Psychotherapy Process Research

Psychotherapy process researchers have argued that identifying the “mechanisms” of change in the psychotherapy process is as important as clarifying the “factors” of effective psychotherapy practice (Knobloch-Fedders, Elkin, & Kiesler, 2015). Since late 1980s, psychotherapy process research focusing on the detection of change mechanisms in psychotherapy process have revealed not only essential findings, but also created room for the

use of several methodologies—including task analysis and sequential analysis (Bakeman & Querra, 1995)—in order to explore how psychotherapy helps people to change.

Several psychotherapy process researchers have made essential contributions to understanding the role of therapist and client interactions with regard to psychotherapeutic change (Greenberg, 1986; Greenberg, James, & Conry, 1988). For instance, it has been found that Rogerian conditions in psychotherapy, including unconditional positive regard, congruence, and empathy, are positively associated with the vocal quality of the clients (Rice, Koke, Greenberg, & Wagstaff, 1979; Rice & Kerr, 1986). These researchers have found that the therapists' use of Rogerian conditions is significantly related to the clients' use of focused and emotional speech, which predicts positive psychotherapy outcomes.

Despite the research on the association between client experiencing and treatment outcomes in the context of various comparative psychotherapy modality studies—including emotion focused therapy, process experiential therapy, cognitive behavioral therapy, and psychodynamic therapy (e.g. Baker et al., 2012; Hilsenroth, Ackerman, & Blagys, 2001; Johnson, 2007; Watson & Bedard, 2006; Wiser & Goldfried, 1998), there is very little research exploring which specific therapist factors might be associated with the quality of client experiencing. The growing research shows that there is a positive correlation between client emotional experiencing and observed therapist empathic attunement and attentiveness (Gordon & Toukmanian, 2002) and perceived therapist congruence and empathy (Van der Veen, 1967). Wiser and Goldfried (1998) found that high client emotional experiencing is associated with therapists providing reflective statements and affirmations as well as collaborative interventions. Similarly, Mackay, Barkham, and Stiles (1998) argue that better client experiencing is associated with therapists' actively encouraging the clients to express their feelings. In a recent study

exploring the relationship between therapist expressed empathy and treatment outcomes in the context of depression treatment, Malin (2016) found that therapist expressed empathy indirectly predicts client experiencing, while directly predicting the working alliance.

However, psychotherapy research in the context of motivational interviewing is only in its first stages (Dobber et al., 2015). Morgerstern et al. (2012) opine, “The active ingredients of motivational interviewing that facilitate positive change” are not yet understood” (p. 860). In a recent article focusing on treatment fidelity, Miller and Rollnick (2014) argue that positive behavior change among clients is associated with a high-quality use of motivational interviewing, which highlights the therapists’ use of theoretical and empirically stated components of motivational interviewing at a high level of proficiency.

Psychotherapy process research in the context of motivational interviewing also states that one client factor that might be associated with positive psychotherapy outcomes is the client’s ‘change talk’ (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003; Glynn & Moyers, 2010; Moyers, Martin, Christopher, Houck, Tonigan, & Amrhein, 2007; Moyers, Martin, Houck, Christopher, & Tonigan, 2009). Change talk is defined as language favoring change (Miller & Rollnick, 2002). Statements implying desire (e.g. “I want to go hiking”), ability (e.g. “I can live healthier”), reasons (e.g. “I should eat more fruits to be healthier”), and need (e.g. “I need to eat more fruits to be healthier”) for change are considered the four main types of change talk (Amrhein et al., 2003). In the context of motivational interviewing, Miller and Rose (2009) state that the behavioral change mechanisms might be composed of two factors: client change talk and the therapeutic relationship. The therapeutic relationship, which also is studied as a working alliance, is well known to be an essential component of successful psychotherapy outcomes

(Moyers, Miller, & Hendrickson, 2005). However, with regard to the client change talk, research shows conflicting results.

Regarding treatment outcomes, and based on an extensive research data which is a part of the ProjectMATCH, Moyers et al. (2007) found that the successful treatment outcomes are associated with higher frequencies of client change talk. However, there is also research showing that there is no association between frequency of change talk and treatment outcomes (Miller, Benefield, & Tonigan, 1993; Miller et al., 2003). Rather, there is a positive association between the strength of change talk, which also is defined as “commitment” language, and successful treatment outcomes (Amrhein et al., 2003; Hodgins, Ching, & McEwen, 2009). So far, there is no agreement on the causality between client change talk and psychotherapy outcomes.

With regard to the therapist factors associated with client change talk, the research shows a more coherent, but still conflicted picture. In a study exploring the differential effects of confrontational and supporting counseling styles, Miller, Banefield, and Tonigan (1993) found that for motivational interviewing, MI-inconsistent behaviors—including when therapists challenge and disagree with their clients—are associated with lower levels of change talk, and higher levels of denial and arguing behaviors of the clients. Similarly, Catley and her colleagues (2006) state that there is a positive relationship between client change talk and MI-consistent therapist behaviors, which are giving advice with permission, affirmation, emphasizing autonomy, asking open ended questions, reflection, reframing, and support. Specifically, they state that reflectional statements of the therapists are significantly correlated with client change talk. Findings of additional research, exploring MI-consistent therapist behavior and client change talk in the context of motivational interviewing with and without feedback, showed that when clients receive feedback, they are more likely to be use change talk and report better

outcomes (Vader, Walters, Prablu, Houck, & Field, 2010). A meta-analysis showed that MI-consistent therapist behaviors are associated with increased frequency of client change talk (but not with a decreased frequency of sustain talk) and with better treatment outcomes (Magill et al., 2014).

A few researchers have stated that there is a significant relationship between MI-consistent therapist behaviors and client change talk (Gaume, Bertholet, Fauzi, Gmel, & Daepfen, 2010; Glynn & Moyers, 2010; Moyers & Martin, 2006; Moyers et al., 2007). In a study exploring the sequential relationship between MI-consistent behaviors and client change talk, Moyers and Martin (2006) found that the clients are more likely to respond with positive change talk when the therapists intervene with motivational interviewing consistent behaviors (e.g. reflections, open questions), as opposed to the motivational interviewing inconsistent behaviors (e.g. confrontation, giving advice without permission). However, in a different study exploring the same phenomena, it was found that although MI-inconsistent therapist behaviors are more likely to be followed by client sustain talk (i.e. talking favoring the status quo), there is no certain link between motivational inconsistent therapist behaviors and client change talk (Gaume & Deappen, 2008).

In terms of relational psychotherapy, there is no known research examining the relationship between therapist specific factors, client experiencing, and client change talk.

Criticisms against Common Factors Perspective

As with almost all the new perspectives raised as an alternative to current ones, the common factors perspective is not free from criticisms. The majority of these criticisms revolve around theoretical and practical issues. Theoretical-level criticisms are principally based on the argument that the common factors perspective is “tautological, unfalsifiable, and thus not subject

to the same scientific rules as empirically supported treatments” (Laska & Wampold, 2014, p. 519). It has been argued that, contrary to the evidence based researchers, common factors proponents have been using inductive and inferential approaches (Baker & McFall, 2014). Asnaai and Foa (2014) argue that the common factors perspective is based on a repudiation of scientific practice because, contrary to the proponents of evidence based treatment proponents, it is based on meta-analyses findings rather than scientific experimentation. Sexton, Ridley, and Kleiner (2004) argue that even though the common factors perspective seems appealing to students, researchers, clinicians, and educators (as it premises a basic foundational framework and a symbiosis of the post-modern values), it oversimplifies the complex and multileveled nature of psychotherapeutic change mechanisms. Along these lines, Constantino and Bernecker (2014) mention that even though the common factors are necessary for effective clinical practice, they are not *sufficient*—as there is a need for a specific rationale of treatment for change to happen. Also, it has been argued that the common factors perspective does not provide responses to the basic theory level questions, including the questions of what components are responsible for change and how these components create a mechanism of change, what are the possible reasons of the problems, what are the short-term and long-term goals therapy goals, and what interventions are used for change to happen (Sexton, Ridley, & Kleiner, 2004).

From a practical viewpoint, the common factors perspective has been criticized for relying on meta-analyses and mega-analyses, which are subject to serious effect size and statistical power issues (Assnai & Foa, 2014; Constantino & Bernecker, 2014; Sexton & Ridley, 2002, 2004; Sexton, Ridley, & Kleiner, 2004); the aforementioned authors state that because of the heterogeneity of the studies included in the meta- and mega- analyses, the results obtained from them do not provide scientific results. Furthermore, the common factors perspective has

been criticized for not providing a tangible road map for the clinicians to point out a specific rationale for change, including clearly defined operational definitions of the common factors and the change mechanisms they create together. Sexton, Ridley, and Kleiner (2004) argue that the common factors are often presented in a free-floating, decontextualized way, which does not help the further development of the field. Conversely, many opponents of the common factors perspective point out the issue of operationalization of the common factors (Carey, 2004; Sexton, Ridley, & Kleiner, 2004). It has been asserted that although there exists a running list of the common factors among a variety of proponents, there is no operationalized definition of what these factors are. The aforementioned authors also argue that the presented common factors are “decontextualized,” which hinders the researchers to conduct falsifiable, and thus scientific, research.

Moreover, it has been argued that the common factors perspective is rooted in basic aspects of counseling and lacks a comprehensive theoretical-conceptual framework explaining the change processes (Sexton, Ridley, & Kleiner, 2004). For instance, Sexton, Ridley, and Kleiner (2004) suggest that the common factors perspective proponents keep highlighting the role of “clients’ hope” in therapy, yet they fail to explain how hope functions in the process of therapeutic change. Hanna (1996) points out that the research suggesting the role of hope in the process of change should explore the key aspects in increasing client motivation for change and decreasing the motivation to stay with current problems. Sexton, Ridley, and Kleiner (2004) further argue that the common factors perspective does not advance theory development or provide a road map with definitions and principles of clinical practice. On the contrary, they state it is an “oversimplification of the complex client change processes, the interactional

dynamics between client and therapist, and the change mechanisms inherent in the common factors perspective” (p. 140).

Besides the well-researched concept of working alliance (Bordin, 1979) and client feedback (Miller, Duncan, & Hubble, 1997), the majority of the common “factors” do not yet seem to be operationalized. The main reason for this operationalization problem is due to the fact that the common factors perspective is a new movement within the psychotherapy field, emerging from and resting on the shoulders of evidence-based research findings.

Considering these critiques, many common factors perspective proponents have provided extensive responses pointing out several methodological issues in evidence based research—including external and internal validity problems (Sprenkle, Davis, & Lebow, 2009), therapist adherence bias (Chambress, 1999; Wampold, 2001), and highlighting the scientific value of meta-analyses as a reliable, scientific method. However, while Wampold (2015, 2001) takes a rather extremist position in this debate, stating almost no value to the effectiveness research exploring the differences among treatments, Sprenkle, Davis, and Lebow (2009) take a “moderate” stance—in their own words—and assert that evidence based research is needed in order to “prove external audiences such as governments, third party payers, and other social scientists that our treatments are efficacious” (p. 129). This statement is particularly striking, not only because the authors state a “both/and” position aiming to embrace and enhance the findings of two “camps,” but also because their argument regarding “approval” (re-)opens the long-running historical discussion regarding the struggle of recognition of psychotherapy as a credible field in the field of psychiatry and other sciences.

In accordance with this criticism, to date, there is no solid theoretical ground for the common factors perspective that can work as a “theory” of common factors (Sexton & Ridley,

2004). However, in line with the arguments described above, I am not sure if the direction of common factors research is currently looking at the biggest picture or building a meta-theory. The common factors perspective invites the researcher to explore elements, grains, nuances, particles, or atoms of effective psychotherapy practice and to investigate microscopic relationships among these tiny little elements of change—rather than building another grand theory. I agree with the arguments above, stating that common factors perspective proponents should explore the functions of the factors within the change process, including how the common factor of hope functions in the process of change. Moreover, despite all these thoroughly elaborated arguments between each “camp,” almost all the researchers state that there is no counter-argument to the statement that there are common ingredients across diverse psychotherapy modalities that are responsible for therapeutic change (Assnai & Foa, 2014; Constantino & Bernecker, 2014).

I argue that both the birth of and the constructive criticisms against the common factors perspective represent a break-point in the evolution process of the practice of psychotherapy as a scientific discipline. Many critics state that the field of psychotherapy began with Sigmund Freud and Freudian psychoanalysis (Freedheim et al., 1992). Today, despite a mass of evidence based research findings providing evidence that psychoanalysis an efficacious treatment tool (e.g. Leichsenring, & Salzer, 2014), neuropsychoanalysis based research exploring the neural correlates of Freudian concepts and psychoanalytic concepts (e.g. Northoff, 2012; Panksepp, 1998; Solms, 2004, 1997) is still considered as vague and scarcely accurate (Blass & Carmeli, 2015)—which might be directly and indirectly influencing the way psychotherapy is approached.

Owing to evidence based research trends, the field of psychotherapy has not only improved tremendously, but has also gained a well-elaborated scientific ground along with other

scientific disciplines. From a Hegelian perspective, highlighting the self-constructive role of being recognized as a way of recognizing one's own self, it is clear that, historically, the field of psychotherapy needed this evidence based research “mania” (Duncan, Miller, Hubble, 1997), proving to others (as a way of proving to one's own self) that psychotherapy is an effective, efficacious, credible, worthy, and among all, “scientific” discipline. In this light, meta-analyses almost unmistakably show that psychotherapy work has experienced a huge developmental step, especially considering the relatively new nature of psychotherapy as a scientific discipline. These meta-analyses are also essential as they remind us that it is the time to move forward towards more nuanced questions other than how psychotherapy (of x, y, or z) works. Common factors perspective proponents argue that the “clients” might be important determinants of the effectiveness of the psychotherapies, instead of the statistical numbers to be controlled in the clinical trials. Not surprisingly, Sexton, Ridley, and Kleiner (2004) also point out as a critique of the common factors perspective that some treatment modalities work better with some populations—and one of the next steps might be exploring these factors as well. However, I believe that their point is a confirmation of the common factors hypothesis.

The critique of “oversimplification” is reminiscent of Ernest Nagel's (1961) basic argument in the *Structure of Science*, with regard to reductionism that the principles of higher levels are derivable from the principles of lower levels. Considering the struggle for recognition that haunts the residents with the field psychotherapy, it is understandable that exploring the very basic, low level processes in the context of complexity of change may sound scary. However, when Salvador Luria and Max Delbruck used reductionistic tooling in biology for the first time, they found that single-celled bacteria could be used in order to understand the complex systems of gene expression and heredity (Luria & Delbruck, 1943). Similarly, when Kenneth Schaffer

(1969) used a reductionistic approach to biology, molecular biology was born—even though that he was harshly criticized (e.g. Kitchner, 1984; Rosengerg, 1985) for oversimplifying the processes and dismissing the complexities of the systems. However, molecular biology not only provides fascinating means to understand complex systems at the micro levels, but also advanced the field of biology tremendously.

In a similar vein, when Jackson Pollock, Willem de Kooning, and Mark Rothko applied a reductionistic approach to their paintings, the school of abstract expressionism was born, which is not only considered as the first American art movement that gained international recognition but also preceded various art movements including pop-art, minimalism, and post-minimalism (Kandel, 2016). Their approach was based on deconstructing the image, and using primary components of painting including form, color, or space to explore effect and richness of these elements. All these “oversimplifying” tools not only provided a universe of new research questions, but also created new fields of study, and advanced the higher-level disciplines to which they belonged. I am wondering if this could be the case for the field of psychotherapy as well.

In sum, I acknowledge that the mass of findings from evidence based research not only advanced and complexified the field incredibly, but also provided a hammer-of-science against the ghosts of psychoanalytic roots, and brought the scientific status to psychotherapy equal to more established fields. The common factors perspective is deeply rooted in and was born from these fascinating findings and thus, has come to be recognized as a scientifically proven, effective practice. Along with the reductionist perspective, discussed by Nagel (1961), I believe we can explore the richness of the complexity in the simple forms, factors, elements, nuances or effective psychotherapy practice.

Proposed Perspective

In the previous sections, I discussed the common elements introduced in the common factors literature, including client specific factors, therapist specific factors, therapeutic alliance, allegiance of therapists, hope/expectancy of the clients, and techniques. In the following section, I discuss the spirit of motivational interviewing, including the foundational attitudes of collaboration, evocation, autonomy, and compassion; motivational interviewing principles including expressing empathy, developing discrepancy, avoiding argumentation, rolling with resistance, and supporting autonomy of the clients; and techniques including open ended questions, affirmations, reflective listening, and summarizing. Then, I review major psychotherapy process research findings in the context of client emotional experiencing and change talk factors, and highlight the need for further research to explore the significance of therapist-client behavior patterns with regard to behavior change.

I propose that the common factors perspective and the motivational interviewing model share many common components. These common elements can not only expand our understanding of the common factors perspective and the motivational interviewing theory, but also can help us to have more gradated and nuanced understanding of how psychotherapy helps people to change.

The client-centered focus of common factors perspective proponents highlights the fact that clients are capable of knowing their self-knowledge (Miller, Duncan, & Hubble, 1997), are more resilient than their conceptualizations in the therapy-models (Bohart & Tallman, 1999), are able to help themselves effectively (Norcross, 2006; Prochaska, 1999), and are equally emphasized by the motivational interviewing model developers. Miller and Rollnick (1991) mention that motivational interviewing is deeply rooted in client-centered psychotherapy. As the

autonomy component of the “necessary” motivational interviewing spirit (as well as the principles of supporting autonomy) clearly highlights, the clients are considered as active agents of their own change processes who are autonomous in, capable of, and responsible for making a change in their own lives. Clients are regarded as the equals to the therapists in the room who interview them, rather than the passive recipients of therapist interventions from both the common factors perspective and in motivational interviewing.

Along with the client factors, the common factors perspective and motivational interviewing share a similar approach to therapist factors. Common factors proponents emphasize therapist factors of interpersonal skills (Anderson et al., 2016; Moyers et al., 2016), warmth (Farber & Doolin, 2011), empathy (Elliott, Bohart, Watson, & Greenberg, 2011), congruence (Klein, Michels, Kolden, & Chisolm-Stockard, 2001), and unconditional positive regard (Faibei & Lane, 2002). Norcross (1999) points out that confrontation (Miller, Wilbourne, & Hettema, 2003) and negative processes including critical and blaming behaviors (Lambert & Barley, 2002) are the attitudes that need to be avoided by therapists. Similarly, in motivational interviewing, the client-centered perspectives including empathy, unconditional positive regard, and congruence are highlighted. The spirit of compassion and the principle of expressing empathy are especially emphasized in motivational interviewing (Miller & Rollnick, 1991). Furthermore, as with common factors perspective proponents, confrontation and persuasion are considered as the two-main motivational interviewing inconsistent therapist behaviors (Moyers et al., 2014).

Therapeutic alliance is considered as one of the strongest common factors of effective psychotherapy practice (Duncan, Miller, Sparks; 2004; Horvath & Symonds, 1991; Horvath & Bedi, 2002; Messer & Wampold, 2002). Similar to the common factors proponents, Miller &

Rollnick (1991) argue that collaboration is one of the necessary components of motivational interviewing spirit, which is communicated through the principles of avoiding argumentation and rolling with resistance.

Common factors proponents argue that hope and expectancy are the common elements of effective psychotherapy practices (Hubble, Duncan, & Miller, 1999; Sprenkle & Blow, 2004b). In motivational interviewing, as the name of the approach implies, motivating the clients to make a change is the “modus operandi” of the model. The evocation component of motivational interviewing spirit and the developing discrepancy principle highlight the importance of instilling hope in the client by means of helping the client to focus on where he or she is at now and where he or she wants to be.

Furthermore, even though it is not mentioned in the original framework, especially thanks to the evidence based research emphasizing the standardization of the treatment delivery, a group of researchers developed various assessment tools including the Motivational Interviewing Treatment Integrity Scale (MITI 4.2.1., Moyers et al., 2016) and the Motivational Interviewing Skills Code (MISC; Miller, Moyers, Ernst, & Amrhein, 2003) in order to assess the adherence and competence of the therapists in using motivational interviewing. Along with proponents of the common factors perspective, these researchers demonstrate that therapists’ use of motivational interviewing at a competent and proficient level is significantly associated with better treatment outcomes (Moyers et al., 2005; Westra, Arkowitz, & Dozois, 2009).

Finally, common factors perspective proponents suggest that basic counseling techniques like asking particular questions, providing information, and reframing are used in all models of psychotherapy (Miller et al., 1997). Similarly, the basic techniques of open ended questions, affirmations, reflective listening, and summarizing are presented as the main microskills of

motivational interviewing (Miller & Rollnick, 1991). In both approaches, the goal of the psychotherapy process is to help clients to slow down their psychological processing, to see the problem they are experiencing from a meta-perspective, and to encourage personal responsibility for change (Davis & Piercy, 2007a, 2007b).

In a nutshell, considering the criticisms of lack of a theoretical framework, operational definitions, and research support for the common factors perspective, I believe motivational interviewing can provide a solid theoretical ground, standardized definitions, and an evidence base—as the spirit, principles, and techniques highlighted in motivational interviewing provide an elegant theory-practice ground for the common factors perspective.

Chapter III

Method

Present Study

In order to explore the two research questions, I picked the AAMFT Masters Series videos of major marriage and family therapy model developers, including Minuchin (the founder of Structural Family Therapy), Nagy (the founder of Contextual Family Therapy), Satir (the founder of Satir Therapy), White (the founder of Narrative Family Therapy), and Whitaker (the founder of Whitaker Therapy) as the sample and explored the research questions listed above in the context of these exemplary demonstrations of marriage and family therapy.

In order to explore the extent to which the elements of motivational interviewing have been implemented by the founders of the major marriage and family therapy models in their exemplary MFT model demonstrations, I use a task analysis methodology that allows researchers to identify the components of therapeutic practice and to describe and analyze the processes of change in the psychotherapeutic context (Rice & Greenberg, 1986). Because of the exploratory nature of this study, I follow the steps recommended by Rice and Greenberg (1996), and examine the motivational interviewing framework in the context of relational psychotherapy using the discovery-oriented phase of task analysis.

In order to explore the extent of the implementation of motivational interviewing elements related to in-session change performances of the clients, I use a sequential analysis methodology that allows researchers to explore the significance of interactions between the therapists and the clients (Bakeman & Querra, 1995). In this study, using the motivational interviewing framework, I examine the extent to which therapists' behaviors are associated with client change talk and emotional experiencing.

Task Analysis

The task analysis method, which is defined by an observational, discovery-oriented, micro-analytic, and multimethod technique that allows researchers to identify the components of therapeutic practice, to describe and analyze the processes of change in the psychotherapeutic context (Diamond, 1992; Greenberg, 1985, 2007; Greenberg & Newman, 1996; Greenberg & Rice, 1984). The method of task analysis allows researchers to conduct qualitative and quantitative analyses based on the nature of their questions (Greenberg & Rice, 1984), which is considered as a “recommended technique” by the American Psychological Association for research to establish empirically derived psychotherapeutic treatment modalities (APA Presidential Task Force on Evidence Based Practice, 2006).

Since Greenberg and his colleagues’ introduction of the task analysis method in the early 1980s, it has been widely used by various researchers to explore a variety of topics regarding psychotherapy process, including the dynamics of the empty chair technique in emotion focused therapy (Greenberg & Foerster, 1996), the dynamics of parent-child impasses in family therapy (Diamond & Liddle, 1996), the process of psychodynamic treatment of depression (Meystre, Pascual-Leone, DeRoten, Despland, & Kramer, 2015), the process of anger resolution in emotion focused therapy (Kannan, Henretty, Piazza-Bonin, Levitt, Coleman, Bickerest-Townsend, & Matthews, 2011), repairing alliance ruptures in the psychotherapeutic process (Cash, Hardy, Kellett, & Parry, 2014; Safran, Murran, & Eubanks-Carter, 2011), and the process of change in structural family therapy (Heatherington, Friedlander, & Liddle, 1990).

Although the task analysis method has been defined as a flexible method that can be shaped based on the questions of the researcher (Greenberg, 1985), and has been constantly evolving with regard to its steps and stages (Pascual-Leone, Greenberg, & Pascual-Leone, 2009),

it is composed of three mainly phases: the discovery-oriented phase, the measurement/validation phase, and the generalization phase.

The discovery-oriented phase starts with constructing a *rational model* based on the researcher's hypotheses rooted in a theoretical framework. Then, the *empirical model* is formed through a process of identifying the sequences of events in the therapy session by referring to the theoretical framework. As the last step of the first phase, the empirical model is compared and contrasted with the rational model, and an ever-finer *synthesis model* of the change task is constructed. The goal of the first phase is to develop a hypothetical-conceptual model regarding the interactions in the psychotherapy session on the basis of the preferred theoretical framework.

According to Rice and Greenberg (1996), the discovery-oriented first phase of the task analysis method is comprised of eight constructive steps: (1) explaining the theoretical framework, (2) description of the task, (3) description of the task environment, (4) assessing the effectiveness of the task environment, (5) the rational task analysis, (6) the empirical task analysis, (7) comparing and contrasting the rational and empirical models, and (8) the construction of the synthesized rational-empirical model. Each of these steps is examined in more detail below.

The first step begins with the researcher's clarification of the theoretical framework on which the study is based. The researcher needs to set the "cognitive map" of the study, which clearly identifies the components and mechanisms of the phenomenon of interest. *The second step* includes a detailed description of the task that is chosen to be explored by the researcher. *The third step* consists of a detailed description of the task environment. *The fourth step* consists of an assessment of change in the identified task environment. *The fifth step* includes the researcher's theoretical-rational map of change regarding the particular task in the identified task

environment, including the researcher's introduction of the theoretical-rational measures to be used to assess the extent to which the “actual-territory” task reflects the theoretical-hypothetical-rational “map” of change. While the rational-hypothetical maps regarding “therapist” behaviors vary across the theoretical approaches of the studies, the most widely used in-session change measures of “client” behaviors are the Experiencing Scale (Klein, Mathieu, Kiesler, & Gendlin, 1969), and the structural analysis of social behavior (Benjamin, 1974). *The sixth step* consists of the application of the rational-hypothetical-theoretical measures in the actual task environments. In this stage, client and therapist performances are observed and explored using the rational model maps/measures to assess the extent to which the actual performances are reflected in the rational model of change. *The seventh stage* includes comparing and contrasting the rational and empirical models by the means of qualitative and/or quantitative data analysis techniques. And at *the eighth step*, based on the findings obtained by the rational-empirical model comparisons in the previous stage, the researcher constructs a synthesized rational model that will be explored in the later studies, as a part of the measurement/validation phase of the task analysis method.

The measurement/validation phase consists of extending the scope of the first phase to a larger sample, identifying the “successful” and “unsuccessful” performances, and conducting statistical analyses to measure the validity of the conceptual model formed at the first phase of the task analysis.

The generalization phase, as its name implies, consists of the processes of constant defining and redefining processes regarding the conceptual model by the means of repeated and extended individual study findings. Because this is a preliminary study, I will only focus on the steps of the first discovery oriented phase (for a detailed description of task analysis procedures, please see Pascual et al., 2009).

Sequential Analysis

Sequential analysis is defined as an observational research methodology that allows researchers to explore the significance of interactions (Bakeman & Gottman, 1986; Gottman & Roy, 1990). It has also been widely used to explore the interactions among couples (Gottman, Markmann, & Noterius, 1977) and mother-child dyads (Blount et al., 1986), as well as the relationship between therapists and clients (Reandeau & Wampold, 1991).

Various research topics have been explored through the use of sequential analysis methodology including the significance of non-emotional behaviors among couples (Aranguren & Tonnelat, 2014), the nature of marital conflict and accord among marital partners (Margolin & Wampold, 1981), and the role of parental behaviors in child distress (Blount et al., 1986), as well as the role of therapist behaviors in client behaviors (Sexton, Hembre, & Kyarme, 1996; Patterson & Forgatch, 1985; Wiseman & Rice, 1989; Moyers & Martin, 2006).

Research exploring how therapist behaviors are related to client behaviors through the use of sequential analyses has revealed several significant results. In a study exploring the role of therapist microskills on working alliance, Sexton, Hembre, and Kvarme (1996) found that therapeutic alliance is influenced by the quality of the content psychotherapists use, such as emotional and verbal content. In another study using a sequential analysis methodology, Patterson and Forgatch (1985) found that the therapists' teaching-focused or confrontational behaviors are significantly followed by noncompliant behaviors of the clients. Wiseman and Rice (1989) state, in a study examining the effect of therapist interventions on client emotional experiencing, that task focused therapist behaviors are associated with a higher level of emotional experiencing among clients. Moyers and Martin (2006) found in a study exploring the significance of relationships between therapist motivational interviewing behaviors and its

impact on client change talk that therapists using motivational interviewing consistent behaviors like reflections, affirmations, open ended questions are more likely to be followed by client talk favoring change.

Research Questions

In this observational, exploratory, and discovery-oriented study, I have two research questions:

- 1- To what extent are the elements of motivational interviewing implemented by the founders of the major marriage and family therapy models in the their exemplary MFT model demonstrations?
- 2- To what extent are the implementation of motivational interviewing elements related to in-session change performances of the clients with regard to change talk and emotional experiencing?

General Hypotheses

Because this is an exploratory study, I do not have specific hypotheses for the research questions described above. However, based on the research findings reviewed in the Literature Review section, I would like to list some hypotheses I developed while conducting this research.

First, even though motivational interviewing and the common factors perspective share various “common” aspects, both models highlight various aspects of psychotherapy that the other one does not. For instance, working alliance is one of the most well-researched and well-accepted common factor, that is also highlighted as one of the foundational factors of motivational interviewing spirit. However, the working alliance factor includes three aspects including task agreement, goal agreement, and bond (Bordin, 1978), which is not elaborated in motivational interviewing. Similarly, the motivational interviewing spirit includes not only

collaboration, but also evocation and support of autonomy—which is not “directly” elaborated in the common factors literature. However, the evocation principle of motivational interviewing shares similarities with the instilling hope principle in the common factors literature, similar to how the support of autonomy principle of motivational interviewing goes along with the client-centered spirit of common factors perspective. In this regard, I do not argue that motivational interviewing is interchangeable with common factors and vice versa.

However, I propose that there is a vast amount of overlap between motivational interviewing and the common factors of effective psychotherapy practice. Thus, regarding the first research question, I expect that in the exemplary practices of marriage and family therapy, the elements of motivational interviewing are implemented at a substantial level, but not at the high proficiency levels of motivational interviewing.

I also expect that, because common factors perspective researchers highlight the role of therapist factors (including Rogerian conditions) over techniques, the relational aspects of motivational interviewing (i.e. empathy and collaboration) will be implemented at a high level, and the technical aspects (i.e. cultivating change talk, and softening sustain talk) as well as behavioral benchmarks (i.e. percentage of complex reflections, and reflections-to-questions ratio) will be implemented at a lower level by marriage and family therapy developers.

Considering the second research question, based on the research literature reviewed above, I expect that the use of motivational interviewing elements is positively associated with positive change talk and high level of emotional experiencing.

Sample

In order to examine the exemplary practices of marriage and family therapy, I used five videotapes from the Master Series collection of American Association for Marriage and Family

Therapy (AAMFT) (<http://aamft.org/iMIS15/AAMFT/Content/store/store.aspx>), representing the consultation sessions of the founders of significant family therapy models, Michael White (1989), Carl Whitaker (1986), Ivan Boszmormenyi-Nagy (1988), Salvador Minuchin (1984), and Virginia Satir (1984)—who are considered as the “Masters” of the narrative, experiential, contextual, structural, and transformative family therapy modalities, respectively. These 1-hour long videotapes are the exemplary sessions with families who gave consent for the sessions to be videotaped for future training and research purposes. In accordance with the purposes of this study, 25-minute long video segments were randomly extracted from each of the five Master Series videos and used for analysis.

Measures

In this study, the therapist behaviors are coded based on the Motivational Interviewing Treatment Integrity Scale (MITI 4.2.1, Moyers, Manuel, & Ernst, 2014), and client change behaviors are coded based on the Experiencing Scale (EX; Klein, Mathieu-Coughlan, & Kiesler, 1986; Klein et al., 1969) with regard to change in emotional experiencing and the Motivational Interviewing Skills Code (MISC; Miller, Moyers, Ernst, & Amrhein, 2003) with regard to change talk in the session.

Therapist Behaviors: The Motivational Interviewing Treatment Integrity Scale.

Therapist behaviors are observed and rated on the Motivational Interviewing Treatment Integrity Scale (MITI 4.2.1, Moyers, Manuel, & Ernst, 2014), which is an observational scale used for the purpose of assessing the extent to which the motivational interviewing elements are used effectively by the clinicians during the session. With psychometric measures ranging from good to excellent (Moyers, Rowell, Manuel, Ernst, & Houck, 2016), MITI is considered to be a powerful treatment fidelity measure. Several 10- to 20-minute long video segments from the videos are

recommended to be picked, observed, and rated in order to reach reliable and valid findings. MITI 4.2.1 is composed of global scores and behavioral counts. However, it has been found that longer session ratings also provide reliable results (Moyers et al., 2015).

Global scores are rated on a 1-5 Likert Scale (1-Low, 5-High) at the end of the observation session, based on the raters' overall impressions on the dimensions including cultivating change talk, softening sustain talk, partnership, and empathy. The behavioral counts dimension is rated on the basis of the raters' counting of the therapists' behaviors during the observation session. The behavioral counts include the elements of giving information, persuasion, persuasion with permission, questions, simple reflection, complex reflection, affirmation, seeking collaboration, emphasizing autonomy, and confrontation. Moyers, Manuel, and Ernst (2014) state that the global scores and behavioral counts are calculated as following:

- Relational Global (Relational) = (Partnership + Empathy) / 2
- Technical Global (Technical) = (Cultivating Change Talk + Softening Sustain Talk) / 2
- (% Complex Reflections) = Complex Reflections / (Simple Reflections + Complex Reflections)
- Reflection-to-Question Ratio (R:Q) = Total reflections/ (Total Questions)
- Total MI-Adherent = Seeking Collaboration + Affirm + Emphasizing Autonomy
- Total MI Non-Adherent = Confront + Persuade

Based on the scoring above, the clinician competency and proficiency benchmarks are calculated in Table 1 below:

Table 1

The Clinician Motivational Interviewing Competency and Proficiency Benchmarks

	Fair	Good
Relational	3.5	4
Technical	3	4
% Complex Reflections	40 %	50 %
Reflections: Questions	1:1	2:1
Total MIA	-	-
Total MINA	-	-

Along with the suggestion of Moyers et al. (2014) stating that Total MIA and Total MINA scores are not found to be informative, they are not included in the proficiency and competency threshold calculations in this study.

Rating of MITI 4.2.1 and Coding Training. With regard to MITI 4.2.1 coding, the standard training procedure recommended by Moyers et al. (2005) was implemented. The weekly coding training meetings were designed as a stepped learning process. The coders and I met on a weekly basis throughout the coding training process. The first four meetings were based on practicing coding materials presented at the MITI 4.2.1 Manual website (<http://casaa.unm.edu/codinglist.html>).

During the first meeting, the coders were assigned to Level I tasks that included very simple information giving and open/closed questions coding. The aim for the first week was to reach at least 90% interrater reliability. As that aim was reached, we transitioned to Level II, which included moderate level tasks like reflections and MI adherence coding. The aim for the second week was to reach at least 85% interrater reliability. Finally, at Level III, the coders were introduced to the segments of a family therapy session—a practice video involving a consultation session by Harry Aponte (1991) from the AAMFT Masters Series tapes. The aim of the Level III training was to reach at least 80% interrater reliability, which was considered to be the lower limit by D’Amico et al. (2012) in a study assessing the treatment integrity of MI for group therapy sessions. It was planned that if 80% of reliability was not achieved by the fourth week, the raters would undergo additional training and practice until this level of reliability was achieved.

Client Behaviors: The Experiencing Scale. The Experiencing Scale (EX; Klein, Mathieu-Coughlan, & Kiesler, 1986; Klein et al., 1969) assesses the clients’ level of experiencing in therapy session. The Experiencing Scale is a 7-point Likert Scale, sensitive to the clients’ engagement level differences within the session (Kiesler, Klein, & Mathieu, 1965). It is considered as a reliable and valid research tool providing an opportunity to investigate the process of change on a microscopic level (Greenberg, 1985). In the Experiencing Scale Training Manual (Klein et al. 1969), it is stated that the scoring process is pretty flexible and adaptable to the purposes of the study. Each therapy session segment can be scored with a “peak” score representing the highest level of experiencing the client has reached, no matter how long the client stayed at that level of experiencing, and/or with a “mode” score representing the rater’s overall perception of client’s experience in the session. Greenberg (1983, 1980) uses the

“utterance-scoring” method while using the Experiencing Scale, in which all the client statements are scored utterance-by-utterance. The interrater reliabilities are found to be acceptable, ranging from .75 to .92 for the peak, and .76 to .91 for the mode ratings (Klein et al., 1969).

During Level 1, the clients talk about external events or ideas without giving any reference to emotions and self-experiencing. At Level 2, the clients talk about themselves but do not refer to their emotions. For Level 3, they talk about their personal reactions to the events and describe their feelings at a limited and/or behavioral level. Level 4 is characterized by self-descriptive speech in which the clients describe their feelings in detail. At Level 5, the clients not only describe but also present an exploratory attitude regarding their feelings. Level 6 is characterized by an elaborative speech regarding feelings and personal experiences. For Level 7, the clients present an ongoing process of experiencing, providing new understandings about the situations the clients are in (Klein et al., 1969).

The Experiencing Scale is used in the analysis of the videos and audios, as well as transcripts (Greenberg, 1985). It has been repeatedly found that the higher scores of experiencing are positively correlated with higher interest in seeking treatment and readiness for therapy (Davis & Hadiks, 1990), higher rapport with the therapist (Davis & Hadiks, 1994), and better therapeutic treatment in session and long term outcomes. It is widely used in a variety of psychotherapy process research studies, including studies on the dynamics of experiencing in the process of group development (Lewis & Beck, 1983), the narrative quality before and after emotion focused therapy (Mundorf & Paivio, 2011), nonverbal aspects of therapist attunement and change of clients’ state (Davis & Hadiks, 1994, 1990), effects of two-chair technique on conflict resolution of clients (Greenberg & Clarke, 1980), client change processes in emotion

focused therapy and cognitive behavioral therapy for depression (Missirlian, 2011), clients' emotional processing in cognitive behavioral and process-experiential therapy (Watson & Bedard, 2006), the relationship between novel figurative language and client experiencing (Stuart, 1997), and operationalizing the change processes in drama therapy (Armstrong, Rozenberg, Powell, Honce, Bronstein, Gingras, & Han, 2016). Also, the Experiencing Scale is one of the most widely used client experiencing assessing scale applied in studies using the task analysis methodology (Greenberg, 2007).

In this study, consistent with the suggestions of Greenberg (1980, 1983), each client statement was rated with the Experiencing Scale (Klein et al., 1969) by two undergraduate coders who were blind to the purposes of the study and trained in accordance with the training procedure described in the Experiencing Scale Training Manual (Klein et al., 1969). Along with the suggestions of Lewis and Beck (1983), who used EX in group settings, each client utterance was coded equally for each of the family members. The authors stated that treating each family member utterance similarly is a disadvantage as it discounts the individual differences in the family regarding the level of experiencing, although it also gives information about the level of experiencing of the individuals in a family context.

Rating of Experiencing Scale and Coding Training. The training in the Experiencing Scale rating is composed of rating eight two-and-a-half-hour long, structured training sessions described in the Training Manual (Klein et al., 1969). These training sessions were divided into 20-minute long practice segments and randomly picked for training purposes. Along with the suggestions of Klein et al. (1969), until the 80% interrater reliability level for peak and mode scores is achieved, the raters were asked to continue rating the client statements on randomly picked training video segments until they reach the reliability level of 80%. When 80% of

reliability was not achieved by the end of the training, the raters went through additional training and practice until this level of reliability is achieved.

Client Behaviors: The Motivational Interviewing Skills Code, Global Client Rating Scale. The Motivational Interviewing Skills Code (MISC- GCR; Miller, Moyers, Ernst, & Amrhein, 2003) was developed to identify motivational interviewing skills and client-therapist interactions. The reliability of the scale is found to be at a reasonable level (de Jonge, Schippers, & Schaap, 2005). Originally it consisted of three consequential “passes” in which the therapist behaviors, client behaviors, and timing were recorded. For the sake of the purposes of this study, I only used the Client Behaviors scale. The Client Behaviors Scale is comprised of three categories which are negative change talk, positive change talk, and follow/neutral statements.

Positive change talk is conceptualized as statements in which the clients show a tendency towards change by the means of stating problem recognition, expressing desire to change, and stating optimism regarding change. Self-reflective statements favoring change, or statements reflecting desire, ability, reason, and need for change are coded as positive change talk. In this study, statements like “It upsets me,” “This is what I want to do,” and “I am trying to find a way for at least to be together” are coded as positive change talk.

Negative change talk is conceptualized as utterances in which the clients show a tendency away from change by means of arguing, blaming, interrupting, negating, and/or ignoring the other people. The statements like “It does not make a difference if I want to see him or not,” “We cannot afford it,” and “You always blame me” are coded as negative change talk. Considering the statements that reflect negative emotions, the decision rule of “favoring change” is used. For instance, “You are irritating” is coded as negative change talk as it sounds like blaming, while

“This makes me irritated” is coded as positive change talk as it sounds like a self-reflective statement.

Follow/neutral talk is conceptualized as the utterances in which the clients show no tendency towards or away from change. Answering therapist questions, talking about other people and situations, and any utterance that is neither positive or negative change talk is coded as follow/neutral talk. During the coding process in this study, the statements like “I am fifty,” “Good morning,” and “People in Sacramento went on a strike” are coded as follow/neutral talk. In adherence to the suggestions stated in the MISC Manual, client questions in which the clients ask questions, request information, and seek the therapist’s advice are also considered as the follow/neutral statements (Miller, Moyers, Ernst, & Amrhein, 2003).

Rating of MISC- GCR and Coding Training. Similar to the MITI 4.2.1 Training process, the two undergraduate trainers who were blind to the purposes of the study were trained for coding client-behaviors with a stepwise method recommended by Moyers and Martin (2006). The undergraduate coders and I met on a weekly basis throughout the coding training process. The first four meetings were dedicated to working on the practice coding materials available on the MISC Manual website (<http://casaa.unm.edu/code/misc.html>). As mentioned in the previous section, the weekly meetings were designed to be a scaffolding learning process.

Procedure

Overall, for this study, two undergraduate coders who were blind to the purposes of the study and trained according to the guidelines described above for MITI 4.2.1, EX and MISC-GCR. Following each scale training process, the undergraduate coders rated five 25-minute long video segments randomly extracted from AAMFT Masters Series videos. Following the final

meeting to calculate interrater agreement and discuss the coding, the coders started the next coding learning process.

The interrater agreement is established through the procedure described by Yoder and Symons (2010). Following the individual coding process for each MITI 4.2.1, EX, and MISC-GCR scales, the coders and I met in order to discuss the ratings and to resolve any discrepancies. First, each coder stated their ratings in turn and the interrater reliability was calculated. Then, the mismatched codes were discussed in light of the coding manuals and the pre-coded training materials, and the coders and authors came up with mutually-decided codes. Specifically, the interrater reliability was calculated as the percentage of matching codes for the overall scores rather than for each subscale (as the sample size relatively small). The coders were asked to finish the coding by themselves first. Then, the coders and the author of this study came together in order to discuss the scores and come to a conclusion. For each tape, one coder listed their codes and the other coder checked it as a match or mismatch. When the coder was done listing their codes, the match percentage was calculated.

The coding criteria proposed by Cicchetti (1994), in which 0-.40 = poor, .40-.59 = fair, .60-.74 = good, and .75-1.0 = excellent, was used for classification. The interrater reliability for MITI 4.2.1 was found to be .80, which is classified as excellent, for EX it was .72, which is considered as good, and for MISC- GCR, it was .86, which is classified as excellent according to the standards proposed by Cicchetti (1994).

Data Analysis

The findings in regard to the two research questions were analyzed through task analysis and sequential analysis methodologies, respectively. Task analysis methodology allows researchers to explore the elements of a process in detail (Rice & Greenberg, 1986). Because the

first research question is about exploring the elements of motivational interviewing in the context of relational psychotherapy, task analysis methodology was used to explore first research question. The second research question aims to explore the significance of interactions between therapists and the clients. Sequential analysis methodology is used to explore the significance of sequential interactions. Thus, sequential analysis methodology was used in order to explore the second research question.

Because the first research question targets the elements of motivational interviewing among exemplary marriage and family therapy demonstrations, the motivational interviewing treatment integrity scale is used. The motivational interviewing treatment integrity scale was developed to assess the proficiency and competency of the therapists in using motivational interviewing. The coding and coding training process was implemented in accordance with the suggestions of Moyers et al. (2016).

For the second research question, because my aim is to explore the significance of interactions between therapist behaviors and client change, I used the motivational interviewing skills code client behavior code and the experiencing scale to assess client change talk and client experiencing. Below, the processes are described in detail for each research question.

Analysis of Research Question 1. The research question of “To what extent are the elements of motivational interviewing implemented by the founders of the major marriage and family therapy models in the their exemplary MFT model demonstrations?” is explored through the eight steps of the discovery phase of the task analysis methodology described above.

Step 1: Explaining the theoretical framework. The common factors perspective and motivational interviewing framework served as the frames of reference in this study. Detailed

information regarding these theoretical frameworks, as well as the proposed perspective, can be found at the Literature Review section.

As the “cognitive map of therapist behaviors” of the study representing the motivational interviewing (in)consistent behaviors, Motivational Interviewing Treatment Integrity Scale (MITI 4.2.1, Moyers, Manuel, & Ernst, 2014)—which was developed to assess the proficiency and competency of the therapists using motivational interviewing in psychotherapy sessions—is used in order to explore the extent to which the elements of motivational interviewing implemented by the founders of the major marriage and family therapy models in the their exemplary MFT model demonstrations.

Step 2: Description of the task. The aim of this study is to explore the extent to which motivational interviewing elements are implemented in the exemplary therapy demonstrations of relational psychotherapy model developers. In this regard, the Motivational Interviewing Treatment Integrity Scale (MITI 4.2.1, Moyers, Manuel, & Ernst, 2014) was used to code therapist behaviors. The proficiency benchmarks were used to assess the motivational interviewing elements use level.

Step 3: Description of the task environment. Each randomly extracted 25-minute long AAMFT Masters Series video segment is described, including information about the constellation, the number of clients per session, and their relationships to each other in order to provide a solid picture of the task environment.

All psychotherapy sessions were conducted in a relational psychotherapy format. In Minuchin’s therapy demonstration, there were nine individuals (Minuchin, co-therapist, mother, father, and five children); in Nagy’s, there were six individuals (Nagy, mom, child, grandmother, grandfather, great grandmother); in Satir’s, there were nine individuals (Satir, mother, father, and

6 children); in Whitaker's, there were five individuals (Whitaker, mother, grandmother, and 2 children); and in White's, there were 5 individuals (White, mother, grandmother, 2 children).

Step 4: Assessing the effectiveness of the task environment. Usually, the fourth step consists of the process of assessing the effectiveness of task environment by using in-session change measures. As the assessment of change is not the primary purpose of this study, this step was excluded.

Step 5: The rational task analysis. For the rational task analysis step, the resemblances between common factors perspective and the motivational interviewing framework was highlighted and presented in the Presented Perspective section.

Step 6: The empirical task analysis. As for the sixth step of task analysis, for each 25-minute long randomly selected video segment from five AAMFT Masters Series videos, coders who are blind to the purposes of this study rated therapist behaviors using the Motivational Interviewing Treatment Integrity Scale 4.2.1. Thus, the actual performance of marriage and family therapists in using the elements of motivational interviewing were mapped during these coding processes.

Step 7: Comparing and contrasting the Rational and Empirical Models. During the seventh step of the task analysis, the obtained data was analyzed, and the rational and the empirical models are compared and contrasted in the Results section. Using the MITI 4.2.1 dimensions—that include relational, technical, % complex reflections, and reflections: questions—were calculated. For each dimension, the score of the marriage and family therapists are compared with the thresholds described above.

Step 8: Synthesis. The results are discussed in the Discussion section.

Analysis of Research Question 2. The research question of “To what extent are implementation of motivational interviewing elements related to in-session change performances of the clients with regard to change talk and emotional experiencing?” is explored through the sequential analysis methodology described above.

In order to explore the significance of the interaction patterns among the therapists and the clients, lag sequential analyses were conducted by using Generalized Sequential Quierier (GSEQ; Bakeman & Querra, 2011) software. The data yielded $n = 2112$ unevenly distributed behavioral units. To ensure the minimum expected frequency of five occurrences of cells in the transitional matrix (Yoder & Symons, 2010), the therapist behavior codes coded with MITI 4.2.1 are grouped into three categories: *neutral behaviors* (e.g. facilitations, giving information, structuring, and fillers), *motivational interviewing consistent behaviors* (e.g. questions, affirmations, simple reflections, complex reflections, seeking collaboration, emphasizing autonomy), and *motivational inconsistent behaviors* (e.g. persuasions, confrontations, and other behaviors that can be classified as neither motivational interviewing consistent nor neutral).

Client behaviors were coded with MISC-Client Behaviors and grouped into three categories: *follow/neutral change talk*, *negative change talk*, and *positive change talk*. The client emotional experiencing levels coded with the Experiencing Scale were labeled as Low (Level 1 and 2), Medium (Level 3, 4, and 5), and High (Level 6 and 7).

In order to explore the associations between therapist behaviors and client change talk, transitional matrices were generated for therapist behavior codes (i.e. lag 0, given behaviors) as the rows and the client change talk codes (i.e. lag 1, target behaviors) as the columns. The similar transitional matrix generation process was applied for the therapist behavior codes and the client experiencing level codes.

Separate chi-square analyses were conducted to explore whether there are significant associations between client change talk, client experiencing, and therapist behaviors. When the chi-square analyses revealed significant results, adjusted residuals were calculated in order to explore the nature of the association in detail (Bakeman & Querra, 2011).

Chapter IV

Results

Results for Research Question 1

In this chapter, the research question of to what extent the motivational interviewing elements are implemented in the context of relational psychotherapy is explored by using the task analysis methodology. Using the Motivational Interviewing Treatment Integrity Scale (MITI 4.2.1., Moyers et al., 2016), therapist behaviors are examined in the exemplary therapy demonstrations of marriage and family therapy model developers including Minuchin, Nagy, Satir, Whitaker, and White. The therapist behavior ratings were compared in terms of motivational interviewing competence and proficiency benchmarks suggested by Moyers and her colleagues (2016). The interrater reliability (ICC) for MITI 4.2.1 was .80, which is considered as excellent according to the classification criteria proposed by Cicchetti (1994).

The therapist behaviors' relevance to the motivational interviewing proficiency and competency are summarized in Table 2 below:

Table 2

MITI 4.2.1 Scores on Video Segments by MFT Model Developers

	Benchmark Score	#1 by Minuchin	#4 by Nagy	#3 by Satir	#2 by Whitene	#5 by Whitaker
Relational	Fair: 3.5 &					
Empathy:	Good: 4	4**	4**	4**	4**	2
Collaboration		4**	4**	3	4**	2
:		4**	4**	3.5*	4**	2
Total:						
Technical	Fair:3 &					
Cultivating	Good: 4	2	2	2	2	2
CT:						
Softening:		2	2	3*	3*	4**
ST:		2	2	2.5	2.5	3*
Total:						
% Complex Reflections	Fair: 40% & Good: 50%	.86**	.86*	.67*	.53**	.24
Reflections: Questions	Fair: 1:1 (100%) &	.33	.62	.12	.63	.12

	Good: 2:1 (200%)					
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*Scores marked * indicate meeting the benchmark values at a fair level, and scores with ** indicate meeting the benchmark values at a good level.*

The results of this study show that, when considering the whole picture as presented at the Table 2 above, overall, motivational interviewing was not implemented at a fair or good level of proficiency in any of the exemplary marriage and family therapy demonstrations. However, in the majority of the exemplary marriage and family therapy demonstrations, some of the elements of motivational interviewing were used at least at the level of fair proficiency.

First of all, regarding the global ratings of motivational interviewing including relational and technical aspects, the results of the study revealed interesting findings. In the majority of the video segments, the use of the relational components of motivational interviewing, including empathy and collaboration sub-components, were rated at a good level of proficiency. On a 5-point Likert Scale, the overall relational component rating was 4 for Minuchin, Nagy, and White, 3.5 for Satir, and 2 for Whitaker. The proficiency level was classified as 3.5 for fair and 4 for good in terms of the relational component of motivational interviewing.

In terms of empathy, the majority of the video segments were rated above 4 at the 5-point Likert Scale. According to the MITI 4.2.1 Manual, Level 4 for empathy includes therapist behaviors like “active and repeated efforts to understand the client’s point of view. Shows evidence of accurate understanding of the client’s worldview, although mostly limited to explicit content” (Moyers, Manuel, & Ernst, 2014, p. 11). Level 4 is further characterized as providing accurate reflections regarding client statements, communicating effectively with the client, and normalizing the concerns of the clients. The video segment ratings for empathy was 4 for Minuchin, Nagy, Satir, and White. The rating was 2 for Whitaker, which has been described as:

“Clinician makes sporadic efforts to explore the client’s perspective. Clinician’s understanding may be inaccurate or may detract from the client’s true meaning” (Ibid.). Level 2 is further characterized as the clinician providing inaccurate reflections and misinterpretations regarding the statements of the clients.

In terms of collaboration, the results of the study revealed similar results to empathy ratings. The majority of the video segments, including the segments of Minuchin, Nagy, and White, were rated as Level 4 in terms of collaboration. Level 4 has been described as: “Clinician fosters collaboration and power sharing so that client’s contributions impact the session in ways that they otherwise would not” (Moyers, Manuel, & Ernst, 2014, p. 9). Further characterizations of Level 4 include some level of structuring of the session, search for collaboration in terms of defining the problems and setting goals, and engagement with the clients in brainstorming, as well as not directing the client toward their own interpretations or agenda. The video segment of Satir was rated as Level 3, which has been defined as: “Clinician incorporates client’s contributions but does so in a lukewarm or erratic fashion” (Ibid.). Level 3 is further characterized with mostly absent righting reflexes, missing some opportunities to engage in power sharing with the clients in terms of problem solving, and seeming to be stand-offish in their interactions with the clients. Similar to the empathy aspect, the video segment of Whitaker was rated as Level 2 in terms of collaboration. Level 2 has been defined as: “Clinician superficially responds to opportunities to collaborate” (Ibid.). It is further characterized as the clinician keeping an expert role in the conversation, not engaging in power sharing with the clients in terms of problem solving, questioning the client’s input at a minimal level, and occasionally correcting the clients and refusing their responses.

With regard to the technical components of motivational interviewing, including cultivating change talk and softening sustain talk sub-components, the majority of the exemplary marriage and family therapy demonstrations were rated below a fair or good level of proficiency. The video segment of Whitaker was rated at the fair level of proficiency with regard to technical component of motivational interviewing. On a 5-point Likert Scale, the overall technical component rating was 3 for Whitaker, 2.5 for Satir and White, and 2 for Minuchin, and Nagy. The proficiency level was classified as 3 for fair and 4 for good in terms of the technical component of motivational interviewing.

In terms of cultivating change talk, the video segments of all marriage and family therapy model developers including Minuchin, Nagy, Satir, White, and Whitaker were rated as Level 2 on the 5-point Likert Scale. Level 2 has been defined as: “Clinician sporadically attends to client language in favor of change – frequently misses opportunities to encourage change talk” (Moyers, Manuel, & Ernst, 2014, p. 5) Level 2 is further characterized as failing to question the benefits of change, not focusing on the change goal, and not exploring the strengths and past successes of the clients regarding the presenting problem.

Considering the component of softening sustain talk, the ratings showed a fairly diverse distribution. The video segment of Whitaker was rated as Level 4 on the 5-point Likert Scale. Level 4 has been described as: “Clinician typically avoids an emphasis on client language favoring the status quo” (Moyers, Manuel, & Ernst, 2014; p. 5). Level 4 is further characterized as showing minimal attention to the talk favoring status quo, not exploring the barriers and difficulties to make a change, and not elaborating further on the reasons to change. The video segments of Satir and White were rated as Level 3 on the 5-point Likert Scale. Level 3 has been described as: “Clinician gives preference to the client’s language in favor of the status quo, but

may show some instances of shifting the focus away from sustain talk” (Ibid.). Level 3 is further characterized as missing some opportunities to avoid sustain talk and focusing on the exploration of status quo instead of focusing on change talk. The video segments of Minuchin and Nagy were rated as Level 2 on the 5-point Likert Scale. Level 2 has been described as: “Clinician usually chooses to explore, focus on, or respond to the client’s language in favor of the status quo” (Ibid.). It is further characterized as reflecting primarily on the benefits of status quo, discussing the problem and the barriers, instead of change.

Overall, considering the global components of motivational interviewing including relational and technical components, none of the video segments by MFT Model Developers were rated at a fair or good level of proficiency in both aspects. In terms of relational components, the video segments by Minuchin, Nagy, and White were rated as good, the video segment by Satir was rated as fair, and the video segment by Whitaker was rated below a fair level. In terms of technical components, none of the video segments besides the one of Whitaker was rated as fair or good in terms of proficiency. Only the video segment of Whitaker was rated at a fair level of proficiency in terms of using technical components of motivational interviewing.

Considering the behavioral counts, Moyers, Martin, and Ernst (2014) state that the fair level of proficiency benchmark in terms of the percentage of complex reflections is 40%, and the good level of proficiency benchmark is 50%. The complex reflections are defined as following:

Complex reflections typically add substantial meaning or emphasis to what the client has said. These reflections serve the purpose of conveying a deeper or more complex picture of what the client has said. Sometimes the clinician may choose to emphasize a particular part of what the client has said to make a point or take the conversation in a different

direction. Clinicians may add subtle or very obvious content to the client's words, or they may combine statements from the client to form summaries that are directional in nature.

(p. 21)

In the majority of the marriage and family therapy demonstrations, the percentage of complex reflections use was incredibly high and above the good level of proficiency. The percentage of complex reflections was 86% in the video segment of Minuchin, 86% at the video segment of Nagy, 67% at the video segment of Satir, and 53% at the video segment of White. In the video segment of Whitaker, the percentage of complex reflections was 24%—which was below the fair level proficiency.

In terms of the reflections and questions ratio, the benchmark was stated as 1:1 (100%) for fair and 2:1 (200%) for good. None of the video segments of the MFT Model developers were rated at least at a fair level of proficiency with regard to reflections to questions ratio. The ratio was 63% in the video segment of White, 62% in the video segment of Nagy, 33% in the video segment of Minuchin, and 12% in the video segments of Satir and Whitaker.

Overall, considering the behavioral count benchmarks of motivational interviewing, none of the video segments of the MFT Model developers were rated at least at a fair level of proficiency. The majority of the video segments were rated above a good level of proficiency in terms of percentage of complex reflections, and none of them was rated at least at a fair level of proficiency in terms of reflections to questions ratio.

Results for Research Question 2

The research question of “To what extent are the implementation of motivational interviewing elements related to in-session change performances of the clients with regard to change talk and emotional experiencing?” is explored through the sequential analysis

methodology described above. In order to explore the significance of the interaction patterns among the therapists and the clients, lag sequential analyses were conducted by using Generalized Sequential Querier (GSEQ; Bakeman & Querra, 2011) software.

The data yielded $n = 2112$ unevenly distributed behavioral units. To ensure the minimum expected frequency of five occurrences of cells in the transitional matrix (Yoder & Symons, 2010), the therapist behavior codes (coded with MITI 4.2.1) were grouped into three categories: *neutral behaviors* (facilitations, giving information, structuring, and fillers), *motivational interviewing consistent behaviors* (questions, affirmations, simple reflections, complex reflections, seeking collaboration, emphasizing autonomy), and *motivational inconsistent behaviors* (persuasions, confrontations, and other behaviors that can be classified as neither motivational interviewing consistent nor neutral).

The client behaviors were coded with MISC-Client Behaviors and grouped into three categories: *follow/neutral change talk*, *negative change talk*, and *positive change talk*. The client emotional experiencing levels coded with the Experiencing Scale were grouped as Low (Level 1 and 2), Medium (Level 3, 4, and 5), and High (Level 6 and 7).

The data analysis revealed that in terms of Experiencing Scale ratings, the groupings of Low, Medium, and High did not help to obtain at least five behavioral units in each cell. So, the Experiencing Scale use data was excluded from the study.

As represented in Table 3 below, in order to have a detailed picture of the extent to which motivational interviewing elements are used in the exemplary demonstrations of marriage and family therapy, actual and detailed relative frequencies for grouped therapist behaviors (i.e. motivational interviewing consistent, motivational interviewing inconsistent, and follow/neutral) were calculated.

Table 3

Actual and Relative Frequencies for Therapist Behaviors

Video Segment	Total Behavioral Units (Client + Therapist)	Actual Frequency (Relative Frequency)	MI Consistent Behavior Frequency (Relative Frequency)	MI Inconsistent Behavior Frequency (Relative Frequency)	Neutral Behavior Frequency (Relative Frequency)
Minuchin	415	94 (.23)	58 (.62)	32 (.34)	4 (.04)
Nagy	420	120 (.29)	78 (.65)	18 (.15)	24 (.2)
Satir	412	251 (.61)	126 (.50)	74 (.29)	51 (.2)
White	507	237 (.47)	149 (.63)	1 (.00)	87 (.37)
Whitaker	358	237 (.66)	109 (.46)	117 (.49)	11 (.05)
	N= 2112				

As the frequencies represented at the Table 3 reveals, in the majority of marriage and family therapy demonstrations, the relative frequencies of therapist behavior units were lower than the relative frequency of client behavior units. In the video segment of Minuchin, the therapist observational behavior units were 23% of the overall behavior units. In the video segment of Nagy, the percentage was 29%. The behavioral units in the video segment of White was 47%. Only in the video segments of Satir and Whitaker were the observed therapist behavior units higher than client behavior units. In the video segment of Satir, the percentage was 61%, while in the video segment of Whitaker, the percentage of therapist behavior units was 66%.

Considering the extent to which motivational interviewing elements were implemented in the exemplary marriage and family therapy demonstrations, the results of the study revealed that in the majority of video segments, more than half of the behaviors were motivational interviewing consistent. In the video segment of Nagy, the motivational interviewing consistent behaviors were 65% of overall therapist behaviors. In the video segment of White, the percentage of motivational interviewing consistent behaviors was 63%, followed by 62% for

Minuchin. In the video segment by Satir, 50% of the overall therapist behaviors were motivational interviewing consistent. Only in the video segment of Whitaker was the percentage of motivational interviewing consistent behaviors lower than inconsistent ones. In the Whitaker's video segment, 46% of all therapist behavior units were rated as motivational interviewing consistent.

As represented in Table 4 below, in order to have a detailed picture of the extent to which motivational interviewing elements are used in the exemplary demonstrations of marriage and family therapy, actual and detailed relative frequencies for grouped client behaviors (i.e. follow/neutral talk, negative talk, and positive talk) were calculated.

Table 4

Actual and Relative Frequencies for Client Change Talk Behaviors

Video Segment	Total Behavioral Units (Client + Therapist)	Actual Frequency (Relative Frequency) of Client Behavior Units	Follow/Neutral Talk Frequency (Relative Frequency)	Negative Talk Frequency (Relative Frequency)	Positive Talk Frequency (Relative Frequency)
Minuchin	415	321 (.77)	229 (.71)	20 (.06)	72 (.22)
Nagy	420	300 (.71)	231 (.77)	27 (.09)	42 (.14)
Satir	412	161 (.39)	75 (.47)	37 (.23)	49 (.3)
White	507	270 (.53)	153 (.57)	56 (.21)	61 (.23)
Whitaker	358	121 (.34)	64 (.53)	51 (.42)	6 (.23)
	N= 2112				

As the frequencies represented in Table 4 show, in the majority of marriage and family therapy demonstrations, the relative frequencies of client change talk behavior units were higher than the relative frequency of therapist behavior units. In the video segment of Minuchin, the client observational behavior units were 77% of the overall behavior units. In the video segment of Nagy, the percentage was 71%. The behavioral units in the video segment of White

represented 53%. Only in the video segments of Satir and Whitaker were the observed client behavior units lower than therapist behavior units. In the video segment of Satir, the percentage was 39%, while in the video segment of Whitaker, the percentage of therapist behavior units was 34%.

Considering the extent to which motivational interviewing elements were implemented in the exemplary marriage and family therapy demonstrations, the results of the study revealed that in the majority of video segments, more than half of the behaviors were follow/neutral talk. In the video segment of Nagy, the percentage of follow/neutral talk was 77%, followed by the percentage of 71% in the video segment of Minuchin. In the video segment of White, the percentage of follow/neutral talk was 57%, followed by 53% for Whitaker, which is followed by 47% for Satir.

Among all video segments, the maximum percentage of positive change talk among all client behavior units was 30%. The highest percentage of positive change talk was rated in the video segment of Satir at the 30% level, which is followed by 23% positive change talk in the video segment of White, and 22% in the segment of Minuchin. In the video segment of Nagy, the positive change talk percentage was 14%. In the video segment of Whitaker, the percentage of positive change talk was lower than 1%.

The maximum percentage of negative change talk was rated for the video segments of Minuchin and Nagy, which were lower than 1%. The highest negative change talk percentage was rated in the video segment of Whitaker, which was 42%. For the video segment of Satir, the percentage of negative change talk was rated as 23%. For the video segment of White, the percentage was 21%.

As Table 5 below shows, in order to deepen our understanding of relative frequencies of therapist and client behaviors in the video segments, an overall relative frequency table is calculated.

Table 5

Relative Frequencies for Therapist and Client Behaviors

Video Segment	MI Consistent Behavior	MI Inconsistent Behavior	Neutral Behavior	Follow/Neutral Talk	Negative Talk	Positive Talk
Minuchin	.14	.08	.01	.55	.05	.17
Nagy	.19	.04	.06	.55	.06	.10
Satir	.31	.18	.12	.18	.09	.12
White	.29	.00	.17	.30	.11	.12
Whitaker	.30	.33	.03	.18	.14	.02

Finally, in order to test the significance of the interaction between therapist behaviors and client change talk, sequential analyses were conducted by using the Generalized Sequential Querier (GSEQ; Bakeman & Querra, 2011) software.

In order to explore the associations between therapist behaviors and the client change talk, transitional matrices were generated for therapist behavior codes (i.e. lag 0, given behaviors) as the rows and the client change talk codes (i.e. lag 1, target behaviors) as the columns. The chi-square analyses were conducted to explore whether there are significant associations between client change talk and therapist behaviors. When the chi-square analyses revealed significant results, adjusted residuals are calculated in order to explore the nature of the association in detail (Bakeman & Querra, 2011).

The results of the chi-square analyses for the therapist behaviors and client change talk interaction are presented in Table 6 below.

Table 6

Adjusted Residuals for Client Change Talk Behavior in Response to Therapist Behaviors at Lag

1

	Client Change Talk (Lag 1)				
Therapist Behaviors (Lag 0)	Follow/Neutral Talk	Negative Talk	Positive Talk	χ^2	p-Value
MI Consistent	4.14**	-4.48**	-.62	39.06 **	$p < .01$
MI Inconsistent	-3.64**	5.75**	-1.36		
Neutral	-1.64	-.16	2.29		

Note. $\chi^2 (4) = 39.06, p < .01$.

**= $p < .01$.

As represented at the Table 6 above, the chi-square tests of independence results show that there is a significant relationship between the therapist behaviors and client change talk, $\chi^2 (4, N=2112) = 39.06, p < .01$. In order to examine the nature of association, the adjusted residuals are calculated.

The adjusted residuals scores for motivational interviewing consistent therapist behaviors and client change talk indicated that it is more likely for therapist motivational interviewing consistent behaviors to be followed by client follow/neutral talk ($ADJR_{MI\ con \rightarrow FollowTalk} = 4.14, p < .01$), and less likely to be followed by client negative talk at a statistically significant level ($ADJR_{MI\ con \rightarrow NegativeTalk} = -4.48, p < .01$). However, no statistically significant association were found with regard to the link between therapist motivational interviewing consistent behaviors and client positive change talk ($ADJR_{MI\ con \rightarrow PositiveTalk} = -.62, p > .01$).

Similarly, the adjusted residuals scores for the motivational interviewing inconsistent therapist behaviors and client change talk indicated that it is more likely for therapist motivational interviewing inconsistent behaviors to be followed by client negative talk

$(ADJR_{(MI\ incon \rightarrow NegativeTalk)} = 5.75, p < .01)$, and less likely to be followed by client follow/neutral talk at a statistically significant level $(ADJR_{(MI\ incon \rightarrow NeutralTalk)} = -3.64, p < .01)$. No statistically significant associations were found with regard to the link between motivational interviewing inconsistent therapist behaviors and client positive change talk $(ADJR_{(MI\ incon \rightarrow PositiveTalk)} = -1.36, p > .01)$. The adjusted residuals for therapist neutral behaviors and client change talk revealed no statistically significant results.

Chapter V

Discussion

In this study, I reviewed the common factors perspective and the motivational interviewing framework, and highlighted the resemblances between these two approaches. I proposed that the basic arguments of the common factors approach—including a client-centered approach (Miller, Duncan, & Hubble, 1997) of therapists highlighting the role of empathy (Elliott, Bohart, Watson, & Greenberg, 2011), congruence (Klein, Michels, Kolden, & Chisolm-Stockard, 2001), and unconditional positive regard (Faibei & Lane, 2002)—are equally valued in the motivational interviewing framework (Miller & Rollnick, 1991).

I also highlighted that working alliance, which is the most widely accepted and researched “common factor” (Duncan, Miller, & Sparks; 2004; Horvath & Symonds, 1991; Horvath & Bedi, 2002; Messer & Wampold, 2002), is equally valued in motivational interviewing. Partnership, along with evocation and autonomy, is considered as one of the foundational principles of motivational interviewing spirit as well (Miller & Rollnick, 1991).

I also drew attention to the hope/expectancy factors pointed out by common factors researchers as one of the essential factors of effective psychotherapy practice practices (Hubble, Duncan, & Miller, 1999; Sprenkle & Blow, 2004b), and to the role of cultivating change talk and softening sustain talk in motivational interviewing (Miller & Rollnick, 1991) as a means of instilling hope and motivating clients to change in psychotherapy process.

Furthermore, I elaborated on the discussion of common factors researchers regarding the role of therapist allegiance to a given model as a common factor of effective psychotherapy practice (Hollon, 1999; Leykin & DeRubeis, 2009; Luborsky, 1999; Luborsky et al., 2002), and pointed out the research findings of motivational interviewing, which state that there is a positive

correlation between therapist allegiance to motivational interviewing and treatment outcomes (Moyers et al., 2005; Westra, Arkowitz, & Dozois, 2009).

Finally, I discussed the argument of common factors researchers that basic counseling techniques—including asking particular questions, providing information, and reframing—are used in all models of psychotherapy (Miller et al., 1997) and highlighted the basic techniques of open-ended questions, affirmations, reflective listening, and summarizing as the main microskills of motivational interviewing (Miller & Rollnick, 1991).

Following the review that both common factors perspective and motivational interviewing have many major arguments in common, I proposed that, thanks to the solid theoretical and practical background, and research support through the standardization of its elements, motivational interviewing elements might provide a better understanding of how common factors can make the psychotherapy process more effective. I highlighted that, besides a few articles (e.g. Davis & Piercy, 2007a, 2007b; Sprenkle, Davis, & LeBow, 2009) and a book (i.e. Sprenkle, Davis, & LeBow, 2009), there is almost nothing in the field of marriage and family therapy with regard to the factors and mechanisms of effective psychotherapy practice. As such, I hypothesized that an exploratory research design examining the motivational interviewing elements in the context of marriage and family therapy could provide not only fruitful results for the distinctive qualities of motivational interviewing, but also the common factors that make psychotherapy effective.

Based on these arguments, I proposed two general research questions: (1) To what extent are the elements of motivational interviewing implemented in the context of marriage and family therapy? (2) To what extent are the implementation of motivational interviewing elements

related to in-session change performances of the clients with regard to change talk and emotional experiencing?

I explored the first research question through a task analysis methodology (Rice & Greenberg, 1986), which allows researchers to identify the components of therapy models. For the second research question, I used a sequential analysis methodology (Bakeman & Quera, 1991), which allows researchers to explore the significance of interactions among therapists and their clients.

The results obtained through the use of a task analysis methodology revealed that, overall, the marriage and family therapy demonstrations analyzed in this research did not meet the proficiency criteria of motivational interviewing use. That is, the results of this study revealed that motivational interviewing is a separate therapy model in which neither of the marriage and family therapy models resemble.

Empathy

In accord with the research reviewed above, it was found that in the majority of the video segments (including the segments by Minuchin, Nagy, Satir, and White), empathy was implemented at a good level of proficiency on the Motivational Interviewing Treatment Integrity Scale. Empathy is considered as one of the most necessary and sufficient conditions of effective psychotherapy practice (Rogers, 1957) and one of the most essential factors of effective psychotherapy practice (Miller & Moyers, 2015; Nolan, 2012; Schmidt & Gelhert, 2017). Elliott, Bohart, Watson, and Greenberg (2011) found that therapist empathy is highly associated with positive psychotherapy outcomes. The findings of this study further support those findings and highlights the fact that therapists who show understanding of the clients' perspectives and actively make an effort to get the experience of the clients is relevant not only in the context of

motivational interviewing, but also in the context of diverse marriage and family therapy modalities.

It is important to note that the video segment of Whitaker was rated at a low level in terms of empathy, along with the low ratings for collaboration. This finding is surprising as empathy typically plays an essential role in the therapy approach of Whitaker. In the past, he has argued, “The family therapist must develop a basic empathy with the family. We hope his/her transference feelings will include an identification, a feeling of pain, and a sense of family’s desperate efforts to self-heal” (as cited in Napier & Whitaker, 2011, p. 210). However, any interpretation of this must be nuanced. Is the therapist’s “feeling” of empathy the same as the “expressing” of empathy? In Whitaker’s case, the response is: probably not. Daniel Bochner (2000) makes a distinctive point with regard to this same question. He argues that in terms of Whitaker’s approach, “empathy becomes important, not as a curative factor in itself, but as an emotional connection that makes it possible for the family to bear the therapist ‘doing whatever (s)he feels right in doing’” (p. 204). In this regard, this study invites further elaboration on the nature and effect of therapist empathy in terms of psychotherapeutic change. How expressed and not-expressed empathy makes a difference in terms of psychotherapeutic change?

Another question arising from the low empathy rating of Whitaker draws attention to the coding tools and coding process. For the Motivational Interviewing Treatment Integrity Scale (MITI 4.2.1., Moyers et al., 2014), empathy is assessed as expressed empathy, rather than a felt one. Moreover, and perhaps because the scale is assessing the expressed empathy rather than felt one, this score was lower than the others, and might reflect what Whitaker was actually doing. Other studies distinguishing between felt and expressed empathy could be a lot more helpful in operationalizing the nature of empathy and understanding how it helps people to change in the

psychotherapy process. It is also important to note that the experiential approach of Whitaker is considered to be the “psychotherapy of the absurd” (Napier & Whitaker, 2011), which might require a more “educated” lens to see his level of empathy behind his so-called “absurd” comments and interventions. In other words, a reason for the lower scores on the empathy scale may be due not only to the scale, but also to the fact that the coders were undergraduate students who were not educated in psychotherapy.

Collaboration

In accordance with previous research findings (Baldwin et al., 2007; Creed & Kendall, 2005; Schnur & Montgomery, 2010), in the videos of Minuchin, Nagy, and Whitaker, the therapists were rated as high on the collaboration subscale. These therapists actively shared power with the clients and let their contributions determine the agenda of the session, which was found to be an essential element of psychotherapy practiced in diverse marriage and marriage and family therapy demonstrations. Although each therapist was practicing a different model of relational psychotherapy, most of them were engaging with the clients when considering their problems, searching for constructing a common ground with regard to definitions of the problems and solutions, and by not attempting to correct them or insist on their thoughts and feelings.

Collaboration is considered as one of the most significant common factors of effective psychotherapy (Lambert, 1992; Grencaage & Norcross, 1990). The empirical research shows that working alliance between therapists and the clients are associated with positive psychotherapy outcomes (Gaston et al., 1991). Lambert (1992) argues that a good relationship between therapists and their clients is responsible for 30% of the change. Similarly, in a meta-analysis, Grenvage and Norcross (1990) argue that therapeutic alliance was responsible for 56% of the

change. The findings of this study support the arguments of these authors, who found that having a collaborative relationship between therapists and the clients is essential for effective psychotherapy practice.

There are two significant issues regarding the collaboration rating. First, in both video segments of Satir and Whitaker, the collaboration was rated as below a fair level of proficiency in terms of motivational interviewing. The reasons for these lower ratings might be that, similar to the empathy ratings, in experiential approaches, the genuine expression of self is highlighted tremendously (Napier & Whitaker, 2011; Satir, 1988) and may be self-expression focus might be manifesting itself as a sacrifice of collaboration in the psychotherapy process. According to the proponents of the common factors perspective, as well as the proponents of motivational interviewing, partnership is one of the most crucial factors of effective psychotherapy practice. This study invites further research exploring the role of collaboration and lack of collaboration in terms of psychotherapeutic change. Another issue is about the role of collaboration in shaping the other ratings. For instance, while discussing the empathy ratings, the coders repeatedly referred to the therapist-client exchanges in the session that could also be considered in the context of collaboration. This indicates that collaboration may be a more salient variable in the psychotherapy process, compared to empathy and other (common) factors. This study calls for more attention to the components of collaboration. For instance, Bordin (1979) describes working alliance as a construct comprised of agreement on tasks and goals and personal bond. Alternatively, collaboration is assessed as an attitude composed of various unspecified variables. A more detailed description of collaboration as well as working alliance may help us to gain a more detailed understanding of what forms collaboration and what specific factors are associated with change.

Relational Component of Psychotherapy

Overall, with regard to empathy and collaboration, the study results also bring up questions about the link between empathy, collaboration, and change. Among the majority of the video segments, the percentage of client follow talk was higher than the percentages of talking patterns favoring change. Also, among the video segments, the majority of the therapists were rated as Level 4 (out of 5) in terms of the level of expressed empathy and collaboration. The previous motivational interviewing research shows that there is a significantly positive association between client positive change talk and therapist empathy and collaboration (Klonek, Wunderlich, Spurk, & Kauffeld, 2016). I am wondering if, in different marriage and family therapy demonstrations in which the therapist empathy or collaboration level was rated as five, the percentage of client positive change talk would be higher. This study certainly opens the gate to explore these nuances further in more detail.

Also, interestingly, in the experiential psychotherapy modalities, empathy and collaboration was rated lower than the demonstrations of other approaches. As mentioned above, in both psychotherapy models of Satir and Whitaker, empathy is considered as an essential factor to understand the perspectives of the clients (Napier & Whitaker, 2011; Satir, 1988) as well as collaboration. Yet, may be these are not an essential “expressional” elements in experiential therapy practice. In this regard, based on the relatively higher percentage of negative client change talk in Whitaker demonstration, one can be quick to say that less expression of empathy is associated to higher percentage of negative client change talk. However, even though the level of collaboration was lower in Satir’s demonstration, the percentage of positive talk was one of the highest among all. In this regard, this study raises the need for further exploration on the

effect of felt versus expressed therapist empathy as well as the role of empathy expression and collaboration on the treatment outcomes.

Instilling Hope (Cultivating Change Talk and Softening Sustain Talk)

Contrary to my expectations, none of the video segments of exemplary marriage and family therapy demonstrations were rated at least at a fair level of proficiency in terms of the technical aspect of motivational interviewing, including cultivating change talk and softening sustain talk. As mentioned above, technical aspects are one of the model-specific aspects of motivational interviewing. However, considering the resemblances between the common factor of instilling hope with regard to effective psychotherapy practice, this study invites further research on the effectiveness of psychotherapy sessions in which the therapists implements low levels of change talk cultivation and sustain talk softening. A reason for these results may be because of the change processes that we should take into consideration while looking at the sessions. In Motivational Interviewing, the change processes are grouped into four stages: engaging, focusing, evoking, and planning (Miller & Rollnick, 1991). In the first stage, the priority is given to engaging with the clients, rather than highlighting change. Considering the fact that these are consultation sessions, rather than real therapy sessions, in which the clients saw the therapists for the first time, it might be that the session is primarily devoted to the processes specific to the engagement stage, rather than instilling hope and evoking change. In this regard, perhaps the proficiency benchmarks of Motivational Interviewing Treatment Integrity Scale could be revised in accordance with each psychotherapy stage. For instance, the proficiency benchmarks may reflect the therapists' prioritizing alliance building in the engagement stage over evoking change.

Interestingly, despite the overall low level of technical component use, in the video segments of Satir, White, and Whitaker, the sustain talk softening was rated at a fair level of proficiency. These findings might be interpreted as the therapists taking more active roles in the session in these segments, and prioritizing change more than other marriage and family therapy model developers. Again, these study results invite further elaboration on the role of change talk in cultivating and sustain talk in softening therapist behaviors in terms of psychotherapeutic change in the relational psychotherapy context.

Overall, in accordance with previous research studies (Hubble, Duncan, & Miller, 1999; Lambert, 1992; Sprenkle & Blow, 2004b), in this study, the therapists showed a decent amount of cultivating change talk, softening sustain talk, and thus instilling hope. Interestingly, even I was not able to test it statistically, as the percentage of positive client change talk was higher in White's and Satir's video segments (in which they were rated as fair on the sustain talk softening element). Interestingly, the Whitaker video segment was rated higher on sustain talk softening as well, even though the percentage of positive change talk was the lowest. Putting all these together, I am wondering if the likelihood of engaging in positive change talk might be due to the combination of relational and technical factors, rather than either of them independently. This study invites further research exploring these dynamics.

Techniques

Percentage of Complex Reflections. Considering the percentage of complex reflections, almost all of video segments of marriage and family therapy model developers performed at a very high level. Interestingly, the video segments of Minuchin and Nagy, the ratings were 86%. The use of complex reflections was significantly higher than the expected highest scores (a good level of proficiency was only 50%). This study invites further research regarding the dynamics of

these high ratings, as well as the low ones. Are these behaviors treatment phase specific, or model-specific? What might be the relationship between complex reflections of the therapists and the change behaviors of the clients?

Reflections to Questions Ratio. In terms of reflections-to-questions ratio, as expected, none of the marriage and family therapy developers were rated at a fair level of proficiency. On the contrary, almost all of the video segments were rated incredibly low, reflecting that the frequency of questions were deliberately higher than the frequency of reflections, which is a non-motivational interviewing model specific factor. The results of this study invite further exploration on the effect of reflections-to-questions ratio in the context of psychotherapeutic change.

Overall, the results showed that, in diverse marriage and family therapy models, the elements of motivational interviewing—including questions, simple and complex reflections, affirmations, seeking collaboration, as well as confrontation and persuasion—are used widely. It has also been found that among the video segments in which the motivational interviewing consistent elements—including where the use percentage of questions, simple and complex reflections, and affirmations is higher, the frequency of client negative change talk was lower. These findings are in accordance with previous research, suggesting that the common elements of psychotherapy are associated with positive client outcomes (Hubble, Duncan, & Miller, 1999; Lambert, 1992; Sprenkle & Blow, 2004b).

Therapist Behaviors and Client Change

One surprising finding is that, by conducting a more detailed analysis of therapist and client behaviors, it has been revealed that in most of the video segments, the percentage of client talk was significantly higher than the percentage of therapist talk. This finding is in accordance

with early research findings obtained through the use of the Motivational Interviewing Skills Code (Miller, Moyers, Ernst, & Amrhein, 2003). The aforementioned researchers argue that significantly more client talk time is associated with better therapeutic practice. Yet, later on they dropped this hypothesis and stopped recording client time as they came to the conclusion that client talk time is not associated with better psychotherapy practice (Miller, Moyers, Ernst, & Amrhein, 2008). A detailed analysis of therapist and client behaviors also revealed that even though none of exemplary demonstrations of the marriage and family therapy model developers were rated at least at the fair level for motivational interviewing adherence and competence, in the majority of the video segments, the percentage of motivational interviewing elements were rated highest.

The results of this study also showed that it is significantly more likely that motivational interviewing consistent behaviors of the therapists were more likely to precede follow/neutral talk, and were less likely to be followed by negative change talk. By the same token, it was revealed in this study that motivational interviewing inconsistent behaviors of the therapists were less likely to precede follow/neutral talk, and more likely to be followed by negative change talk.

However, the results of this study did not reveal any significant relationship between therapist related factors associated with the positive talk patterns of the clients, or the client related dynamics associated with therapist talk. The lack of significant results with regard to therapist behaviors and client positive behavior patterns is in line with the findings of this study on the association between therapist behaviors and client emotional experiencing. Even though the seven levels of experiencing were grouped into three categories as low, medium, and high, unfortunately, there were less than five behavioral units in the group of high emotional experiencing; the positive change talk frequency was lower than the follow/neutral talk

frequency. These results invite further exploration about not only the association between client change talk and the client experiencing relationship, but also the relationship of these two factors to psychotherapeutic change.

This study also provided further evidence that motivational interviewing inconsistent elements (including confrontation and persuasion) are significantly associated with less client neutral change talk and more client negative talk. This might help clinicians to be mindful about factors that are not helping the clients to change, and to increase the percentage of their motivational interviewing consistent elements use in the session, which seems more likely to be associated with client follow talk and less negative change talk.

Overall, as represented in Appendix D below, the results of this study showed that there are various similarities between motivational and the common factors perspective with regard to the highlighted elements and mechanisms of change. The “empathy” component of motivational interviewing is discussed in the context of therapist factors by the proponents of the common factors perspective (Lambert, 1992). The other therapist “spirit” related elements of motivational interviewing (including emphasizing autonomy and seeking collaboration) are discussed as behavioral counts. Further research is needed to clarify the therapist spirit components of effective psychotherapy practice.

The collaboration component of motivational interviewing is discussed by common factors perspective proponents in the light of working alliance (Lambert, 1992). It might be that the common factors literature provides a more detailed and graduated understanding with regard to motivational interviewing research. In this current form, only the collaborative attitude of the therapists was assessed in the sessions. The research literature on working alliance, which is comprised of three sub-constructs of agreements of tasks and goals, and having personal bond,

might provide further understanding of the role of the “collaboration” component in psychotherapeutic practice.

The technical components of motivational interviewing (including cultivating change talk and softening sustain talk) are discussed by common factors proponents in the context of instilling hope (Lambert, 1992). This study added a layer to the common factors perspective in the sense that instilling hope may be psychotherapy-process specific. That is, it may be that instilling hope might not be the priority component of effective psychotherapy practice. Rather, it might be a secondary consideration, a moving force of the process.

Along with the discussions of common factors proponents, this study provided further evidence that techniques and interventions are the “tools” for conveying the message of the therapists. It was found that motivational interviewing consistent techniques (including questions, reflections, and affirmations) were implemented by the relational psychotherapy model developers, in the context of relational psychotherapy, and these basic counseling techniques are not associated with negative change talk. Further research representing positive change talk behaviors might help us to have a better understanding of the therapist related precedents of client change behaviors.

It is important to note that in this study, current motivational interviewing assessment tools were used in order to explore the common factors of effective psychotherapy practice. However, as mentioned above, even though various items are assessed, various other factors remain to be further explored. For instance, we are not sure how much the therapists’ unconditional positive regard is associated with client change. Carl Rogers (1957) argues it as one of the most necessary and sufficient factors, along with therapist empathy. The current scale was not able to capture this dimension, although motivational interviewing is theoretically and

practically client-centered. Similarly, the current scales were unable to capture the role of culture with regard to the process of change. As mentioned above, as a clinician trained in psychoanalytic tradition in Europe, to me, a clinician having an expert role does not seem less collaborative or less empathic, as the therapist is expected to be the expert in the treatment process. However, in United States, where power sharing is highly encouraged, a clinician telling the clients what to do might be perceived as less desirable and less effective. Further research exploring these dynamics would be helpful as well.

In sum, this small-scale, observational, and exploratory study has many clinical, research, and training related implications, as well as a good number of limitations. In the next section, I will discuss these in detail.

Implications

Clinical Implications. Regarding clinical practice, this study primarily highlights the role of empathy expression and collaborative attitude in the context of relational psychotherapy. Regardless of the model that is used, expression of empathy and having a collaborative approach is used, valued, and implemented by the majority of the marriage and family therapy model developers. Even in the MFT model demonstrations, empathy is not expressed saliently, even though the theoretical statements of these scholars indicate that it was inherent to the interventions of the model developers. These findings shed light to the essentiality of the elements of expressing empathy and having a collaborative attitude in the context of psychotherapy. Empathy and collaboration is suggested in the context of motivational interviewing spirit. The findings of this study suggest that these elements are the common elements of therapist spirit, and not specific to motivational interviewing.

Also, this study points out the stage/process based structure of psychotherapy, suggesting that in the first stage of psychotherapy, the priority is given to the engagement process elements, rather than implementing and fostering change. Naturally, it is suggested that clinicians use engagement related elements more in the first stage of psychotherapy—including more dominantly expressing empathy, having a collaborative attitude, and using reflections and questions. However, this study also suggests that even though change is not implemented in the very first session of psychotherapy process, therapist behaviors are significantly associated with the change related talk of clients. The findings should guide clinicians to refrain from motivational interviewing inconsistent behavioral counts—including persuasion and confrontation—and use the motivational interviewing inherent techniques instead—including reflections, affirmations, and questions.

From a larger perspective, these findings suggest that regardless of the model clinicians are using, having an empathic, collaborative “spirit,” and not using challenging techniques (including confrontations and persuasions) is essential, especially at the beginning phase of the psychotherapy process. Clinicians can view the psychotherapy process as a house that they are building together from scratch. The baseline component of this therapeutic change house is an empathic and collaborative approach, which creates a secure base where change can take root. Following the establishment of this alliance, the therapists can go through the following stages in which they evoke, implement, and follow up with change.

Research Implications. Regarding research, this study inspires various future avenues of research and lines of inquiry. First, to my knowledge, this is the first study that empirically explores common factors in the context of relational psychotherapy, and provides research support to counter critics of the common factors perspective, who argue that it is based on vague

conceptualizations and a lack of exploration of change mechanisms (Sexton & Kleiner, 2004, 2002; Sexton, Ridley, & Kleiner, 2004). The research tools that motivational interviewing provide (including MITI 4.2.1 and MISC) serve as the standardized tools to assess some hypotheses of common factors proponents, including hypotheses regarding empathy, collaboration, instilling hope, and basic techniques (e.g. questions, simple and complex reflections, and affirmations).

Also, the results of this study show that individual psychotherapy specific research tools can be used in the context of relational psychotherapy in order to explore the factors and mechanisms associated with effective psychotherapy practice. In this regard, I recommend researchers continue to use these tools while exploring the question of how psychotherapy helps people to change. These tools will help to further understand the elements and mechanisms of change. Similar to the clinical implications, this study highlights the role of the psychotherapy processes in the psychotherapy process. Researchers can further explore what specific elements and mechanisms are specific to the processes of change.

Furthermore, this study inspires researchers to explore certain motivational interviewing related elements and tools further. For instance, in further research, other aspects of motivational interviewing (including the client readiness to change measures) can be used. These tools can help us to further understand the client related factors of change.

I also recommend researchers to elaborate on the motivational interviewing elements while exploring common factors. For instance, in MITI 4.2.1, one of the global factors is collaboration, which may be affecting and being effected by the empathy component. This means that empathy might be a sub-component of collaboration as well as other factors that are not explored in this study. Moreover, in the common factors literature, working alliance is

explored as collaboration, and it is composed of three constructs that are discussed above (Bordin, 1979). Researchers might explore the nature of the collaboration component of motivational interviewing and may divide it into its subcomponents. In that way, the nature of collaboration can be better understood.

Also, in this study, only the MITI 4.2.1 elements of motivational interviewing is explored. The researchers can explore additional elements further and may find other elements and mechanisms that make psychotherapy effective.

Training Implications. This study provides further understanding of psychotherapy training. In current education models, there is a special emphasis on teaching the psychotherapy models (D’Aniello, Alvarado, Hulbert, Izaguirre, & Miller, 2015; D’Aniello & Perkins, 2016; D’Aniello, 2015; Karam, Blow, Sprenkle, & Davis, 2015). In training, therapists are taught a variety of psychotherapy models and are expected to have a gestalt sense of what works in psychotherapy.

This study, along with the suggestions of the proponents of the common factors perspective, invites a change in the training programs to explore and highlight the main components of change, including empathy, and partnership as well as treatment techniques. In a recent process research evaluation study, Knobloch-Fedders, Elkin, and Kiesler (2015) highlight the need for studies to explore the specific ingredients of effective psychotherapy practices by means of exploratory, naturalistic designs and small-N case studies. They argue that these studies will provide us a clearer understanding of the nuances in effective psychotherapy practices. This study encourages training programs to focus on empathy expression skills, collaboration building activities, and hope instilling interventions, as well as gaining the skills to identify which skills work the best in what conditions.

Another training related implication of this study is about the process of coding. While discussing the coding processes with the undergraduate coders, they mentioned that empathy was not sufficient in the therapy demonstration of Whitaker. As a clinician practicing for more than 10 years, it was difficult for me to see how Whitaker's experiential style was considered as low on the empathy scale from the perception of the coders. The coders and I had a fruitful discussion regarding the difference between expressed empathy and felt empathy. To me, Whitaker was expressing high levels of empathy with the client via provocative tools. For instance, when he asked, "How long you have been trying to kill yourself?," his question was deeply caring and/yet provocative to me. The client's response of "for a long time" was a validation of me feeling that actually Whitaker was caring for the client, putting himself in her shoes, and expressing the feelings of her before she mentioned them. However, the exact sentence was considered as a validation of his lack of empathy in the conceptualization of the undergraduate coders. They mentioned that it was not a "right" way of expressing empathy.

There might be various reasons contributing to this issue. First, it may be that the motivational interviewing treatment integrity scale does not perfectly capture this nuance. Second, there may be a generational difference with regard to the perception of empathy. For example, one of the major discussions in the field of psychotherapy is about the role of the therapist and the question of "Truth" in the therapeutic context. Early models of psychotherapy (including psychoanalysis and cognitive behavioral therapy) postionalizes the therapist as the "holder" of truth, who knows what is going on with the client, what the client actually needs, and the truth of the therapeutic process. Thus, the therapist is the holder of expertise and authority in the therapy session and is not expected to express empathy "overtly" or to approach the clients collaboratively. However, in the later models of psychotherapy (including narrative therapy and

solution focused therapy), the therapist is positionalized in a not-knowing stance, who does not know anything about the client, and is eager to learn what the client has to say, think, feel, and experience. In early models, the “Truth” is discovered, while in the later models, it is co-created. In this regard, the later models of psychotherapy highlight a more collaborative attitude in the psychotherapy process. Because each model is a product of the system, it may be that for the undergraduate coders, the “therapist as an expert” is not a relevant role. Regardless of what the therapist feels, the clients and the coders expect them to express what they feel. If it is not expressed, it does not necessarily create a difference in psychotherapy process, in coding, or in training. For training institutions, these findings can be highlighted while covering the psychotherapy modalities. Also, supervision classes can be informed by these findings.

Limitations

This study is not free of limitations. First of all, this is an exploratory study conducted with a very small sample size ($n=5$) representing each of five diverse MFT modalities in 25-minute long video demonstrations. In the future, the same design can be conducted with larger sample sizes with many demonstrations of the same MFT models, which would not only increase the reliability of the findings but also provide more nuanced and refined results.

The same design can also be conducted with multiple videos of psychotherapy processes that are tested and validated to be effective. Exploring the motivational interviewing elements in the videos that represent empirically validated therapeutic change representations may give us more accurate and detailed results about the nature of effective psychotherapy practice elements and mechanisms.

Furthermore, the same design can be repeated in a more detailed context in which the global scores are assessed in shorter and longer treatment processes. For instance, the empathy

scores can be assessed at the 5th, 10th, 15th sessions (where fluctuations might be tested as well). Also, empathy scores can be assessed as 1st, 2nd, 3rd, 4th, and 5th sessions and compared to the scores during the later phases or its relationship to change can be explored. These designs might help us to have a better understanding of the nature of psychotherapeutic change.

Also, future research using this design can include other relational psychotherapy modalities including strategic family therapy and solution-focused therapy, as well as individual psychotherapy modalities including cognitive behavioral therapy and psychodynamic psychotherapy, which could further explore the commonalities among diverse psychotherapy modalities.

It is important to note that these are consultation sessions of relational psychotherapy modalities rather than real psychotherapy sessions. The clients knew that these sessions were consultation sessions which would not repeat again, so the purpose of these videos are to represent how the psychotherapy modalities are conducted, rather than creating a therapeutic change. In this regard, while interpreting the results, it is important to keep in mind this artificial quality of these sessions.

Overall, even though the broad research question aims to explore the common factors of effective psychotherapy practice, in this study, I only investigated the common factors among relational psychotherapy models and motivational interviewing. Neither the study question nor the findings of the study provided information for the question of effectiveness. We still do not know if a psychotherapeutic change has happened in these MFT model demonstration segments or if these use-rates of motivational interviewing are associated with psychotherapeutic change. In future research, the video segments from effective and ineffective therapy sessions can be explored using this research design. These studies would reveal more accurate information about

the common factors of effective psychotherapy practice. Third, even though the motivational interviewing framework and research tools provide tremendous help to conduct scientific research on common factors, there is still a great need for operational definitions, a solidified framework, and research support for the common factors perspective.

In this study, I presented motivational interviewing as a theoretical framework and the Motivational Interviewing Treatment Integrity Scale as a practical research tool for exploring the common factors perspective in the context of relational psychotherapy. I explored the research questions of to what extent motivational interviewing elements are implemented in the context of relational psychotherapy and to what extent therapist behaviors are associated with client change behaviors were explored by using task analysis and sequential analysis methodologies, respectively. My hope is that these findings stimulate further research and ideas with regard to the long-standing question of how psychotherapy helps people to change and expand our understanding of the factors and mechanisms of therapeutic change.

Appendix A

EX (Excerpts)

Tape #: _____ **Coder:** _____ **Date:** _____

“Stage One: The content is not about the speaker. The speaker tells a story, describes other people or events in which he or she is not involved or presents a generalized or detached account of ideas.

Stage Two: Either the speaker is the central character in the narrative or his or her interest is clear. Comments and reactions serve to get the story across but do not refer to the speaker's feelings.

Stage Three: The content is a narrative about the speaker in external or behavioral terms with added comments on feelings or private experiences. These remarks are limited to the situations described, giving the narrative a personal touch without describing the speaker more generally.

Stage Four: Feelings or the experience of events, rather than the events themselves, are the subject of the discourse. The client tries to attend to and hold onto the direct inner reference of experiencing and make it the basic datum of communications.

Stage Five: The content is a purposeful exploration of the speaker's feelings and experiencing. The speaker must pose or define a problem or proposition about self explicitly in terms of feelings. And must explore or work with the problem in a personal way. The client now can focus on the vague, implicitly meaningful aspects of experiencing and struggle to elaborate it.

Stage Six: The subject matter concerns the speaker's present, emergent experience. A sense of active, immediate involvement in an experientially anchored issue is conveyed with evidence of its resolution or acceptance. The feelings themselves change or shift.

Stage Seven: Experiencing at stage seven is expansive, unfolding. The speaker readily uses a fresh way of knowing the self to expand experiencing further. The experiential perspective is now a trusted and reliable source of self-awareness and is steadily carried forward and employed as the primary referent for thought and action.”

Appendix B

MITI 4.2.1¹

Tape #: _____

Coder: _____

Date: _____

Global Scores					
	Score 1 (Low) 5 (High)				
Cultivating Change Talk	1	2	3	4	5
Softening Sustain Talk	1	2	3	4	5
Partnership	1	2	3	4	5
Empathy	1	2	3	4	5

Behavioral Counts		
	Total Counts	
Giving Information		
Persuasion		
Persuasion with Permission		
Questions		
Simple Reflection		
Complex Reflection		
Affirmation		
Seeking Collaboration		
Emphasizing Autonomy		
Confrontation		

¹ Adapted from Moyers et al. (2010)

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Appendix C

MISC-GCR²

Tape #: _____

Coder: _____

Date: _____

	Description	Total Count s	
Questions	Client ask questions, request information		
Follow/ Neutral	Facilitate ('mmh', 'okay') Giving information (explaining, educating, providing feedback) Structure ('We will first talk about this and later ... ') Raise concern with permission ('Can I share some concerns about that with you?') Closed question ('Do you save energy?') Filler ('Nice weather today')		
+ Change Talk	Reason-positive (The benefits of changing or the costs of maintaining) Desire-positive ('I wish ... ') Ability-positive ('I am able to ... ') Need-positive ('I need to ... ') Other-positive (e.g. problem recognition) Taking steps-positive (Specific steps towards change) Commitment-positive (e.g. agreements to change)		
- Change Talk	Reason-negative (The costs of changing or the benefits of maintaining) Desire-negative ('I do not wish ... ')		

² Adapted from Moyers et al. (2003) & Klonek, Lehmann-Willenbrock, & Kauffeld (2014)

	Ability-negative ('I am not able to ...') Need-negative ('I do not need to ...') Other-negative (e.g. verbal resistance.) Taking steps-negative (Specific steps away from change) Commitment-negative (e.g. agreements to maintain)		
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Appendix D

Motivational Interviewing Elements as Common Factors

Motivational Interviewing	Common Factors
Global Scores	
Cultivating Change Talk	Instilling Hope
Softening Sustain Talk	
Partnership	Working Alliance
Empathy	Therapist Factors
Behavioral Counts	Techniques/ Interventions
Giving Information	
Questions	
Simple Reflection	
Complex Reflection	
Affirmations	

Seeking Collaboration	
Emphasizing Autonomy	
Persuasion (MI Inconsistent)	
Persuasion with Permission (MI Inconsistent)	
Confrontation (MI Inconsistent)	

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