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A 20-YEAR REVIEW OF COMMON FACTORS RESEARCH IN MARRIAGE AND FAMILY THERAPY: A MIXED METHODS CONTENT ANALYSIS

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Introduced by Sprenkle, Blow & Dickey (1999), common factors in marriage and family therapy (MFT) have been discussed over the past two decades. Although the MFT common factors literature has grown, there are misconceptions and disagreements about their role in theory, practice, research, and training. This content analysis examined the contributions of the common factors paradigm to MFT theory, practice, research, and training over the past 20 years. We identified 37 scholarly works including peer-reviewed journal articles, books, and chapters. Using mixed methods content analysis, we analyze and synthesize the contributions of this literature in terms of theoretical development about therapeutic effectiveness in MFT, MFT training, research, and practice. We provide commentary on the substantive contributions that the common factors paradigm has made to these areas, and we discuss the implications and limitations of the common factors literature, and provide recommendations for moving common factors research forward.

INTRODUCTION

Since its inception, therapists and researchers have been curious about understanding *how* and *why* psychotherapy helps clients (Davis & Piercy, 2007a, b; Duncan, Miller, Wampold, & Hubble, 2010; Pinsof & Wynne, 2000). Much of the scholarly literature on therapeutic effectiveness strongly suggests that therapy models and techniques are the primary engines of change. For example, randomized controlled trials (RCTs), long considered the gold standard for testing the effectiveness of treatment approaches and interventions (Sprenkle, 2012), rest on the assumption that models and interventions are responsible for change. Likewise, training programs, accrediting bodies, and licensing exams emphasize practitioners' knowledge and proficiency with clinical models. The field of marriage and family therapy (MFT) is no exception. Yet, a number of meta-analyses of psychotherapy outcome studies raise serious questions about the relative influence of models and techniques (Davis & Piercy, 2007a, b; Shadish & Baldwin, 2003; Shadish, Ragsdale, Glaser & Montgomery, 1995). Although models and techniques are important factors in the process and outcome of therapy, these studies provide strong arguments that other factors shared across models account for a greater percentage of therapeutic change. These findings provide indirect empirical support for the common factors paradigm of therapeutic effectiveness.

Common factors are defined as the general mechanisms of change that cut across models, rather than aspects of treatment that are unique to particular models (Lambert, 1992; Sprenkle, Davis, & Lebow, 2009). The common factors paradigm refers to the position that common factors, rather than model-specific factors, are largely responsible for effective therapy (Davis & Piercy, 2007a, b). Outcome studies and meta-analyses of individual, couple, and family therapy effectiveness provide empirical evidence that supports common factors as the primary mechanisms of

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therapeutic change (see Asay & Lambert, 1999; Frank & Frank, 1991; Wampold, 2001). Despite increased theoretical and empirical support for common factors, there has been continued debate about their usefulness in the MFT field. Questions about the role of common factors in the field have been raised (Sexton & Ridley, 2004), and misconceptions and concerns remain (D'Aniello & Fife, 2017; Davis & Hsieh, 2019; Sprenkle et al., 2009).

The purpose of this content analysis is to critically analyze, synthesize, and clarify the contributions of the common factors paradigm to MFT theory, research, training, and practice. As part of the analysis, we highlight the contributions and importance of common factors scholarship in moving forward by offering a holistic understanding of therapeutic effectiveness. Additionally, we present critiques of the existing literature, identify critical gaps, and discuss areas for future research on common factors with the overall aim of furthering understanding of MFT effectiveness. We intend for these findings to be useful to theorists, researchers, supervisors, clinicians, and students.

BACKGROUND: COMMON FACTORS IN MFT

Definition of Common Factors

The term, *common factors* are an umbrella term for the general mechanisms or variables associated with therapeutic change that are common across therapy models (Davis & Hsieh, 2019). Common factors, also called general factors or mechanisms of change, are factors that contribute to change in psychotherapy. They are not the province of a specific model but instead are found in all therapies (Duncan & Miller, 1999; Duncan et al., 2010; Frank, 1976; Garfield, 1992; Hubble, Duncan, & Miller, 1999; Lambert, 1992; Luborsky, Singer, & Luborsky, 1975; Sprenkle & Blow, 2004a; Wampold & Imel, 2015). Common factors are further defined as broad and narrow (Sprenkle & Blow, 2004a; Sprenkle, et al., 2009). Broad common factors include general aspects of treatment such as client and therapist factors, extra-therapeutic variables (e.g., fortuitous events, social support), therapist-client relationship factors, and the client's expectancy of the success of therapy. Empirical support for broad common factors is grounded in outcome studies and meta-analyses of therapeutic effectiveness (Asay & Lambert, 1999; Frank & Frank, 1991; Wampold, 2001). Narrow common factors refer to aspects of treatment found in several models that go by different names. For example, different models of therapy share common processes or goals, otherwise defined as model-dependent common factors. These include shifting each partner's cognition, affect, or behavior; reattribution; reinforcement; desensitization; and psychoeducation and skills training (Davis, Lebow, & Sprenkle, 2012; Davis & Piercy, 2007a). The common factors paradigm is both a paradigm and meta-model (Sprenkle et al., 2009), about the effectiveness of psychotherapy and how therapeutic change occurs.

Common Factors Paradigm in MFT Literature

Aligned with the discipline of psychotherapy in general, the MFT field has traditionally conceptualized and explained therapeutic effectiveness through the lens of models (Fife et al., 2019; Sprenkle, Blow, & Dickey, 1999). Specifically, therapy is effective because of the unique and particular philosophy or intervention of each therapeutic model. However, several meta-analyses of psychotherapy demonstrate this is not the case, finding no model of couple and family therapy consistently yielding better results than others (Shadish & Baldwin, 2003; Shadish et al., 1995; Smith, Glass, & Miller, 1980; Wampold, 2001). Moreover, other meta-analytic studies support the common factors perspective that extra-therapeutic factors and common mechanisms of change are the primary contributors to therapeutic effectiveness (Hubble et al., 1999; Wampold, 2001; Wampold & Imel, 2015).

In 1999, the common factors paradigm was first applied to the MFT field by Sprenkle and colleagues in *The Heart and Soul of Change* (Hubble et al., 1999). Sprenkle and colleagues first reviewed relevant MFT literature supporting broad common factors and then proposed common factors unique to MFT (relational conceptualization, disrupting dysfunctional relational patterns, expanded direct treatment system, and expanded therapeutic alliance). Although their claims were grounded primarily in theoretical arguments, this formative chapter spawned further scholarship related to MFT common factors. In the two decades since this seminal chapter, publications about

MFT common factors comprise theoretical debates, refined arguments, and modest empirical investigation, including two papers awarded the "Best Article of the Year" by the editorial council of the *Journal of Marital and Family Therapy* (see Fife et al., 2014; Karam, Blow, Sprenkle, & Davis, 2015). Given the MFT field's attention to common factors and the clinical implications of the common factors paradigm, it is important to critically examine the impact, strengths and limitations of this paradigm as applied to MFT theory and practice. This critical examination will also include discussion of the future directions of common factors scholarship related to MFT research, training, and practice.

STUDY SCOPE AND PURPOSE

In this mixed methods content analysis, we investigate the influence of the common factors paradigm on the discipline of MFT. This content analysis includes empirical articles, conceptual articles, books, and book chapters that focus on common factors and MFT. We triangulate quantitative and qualitative data to achieve a more robust understanding of the common factors literature than would be possible using one data type alone. We mixed the qualitative and quantitative data strands at the point of the research questions, data analysis, and data interpretation in order to develop a detailed understanding of the common factors literature in the MFT field. To analyze the MFT common factors literature to date, we developed the following research questions to guide our analysis. We developed these research questions from the claims made by common factors scholars; questions, misconceptions, and confusion in the common factors literature; and the current need for a critical analysis of the MFT common factors literature.

Quantitative

1. What are the primary characteristics of the common factors literature in the MFT field?

Qualitative

1. What common factors are identified in the MFT literature?
2. How do common factors researchers draw distinctions between change mechanisms, change process, and common factors?
3. How do common factors contribute to the discussion about the therapeutic effectiveness of MFT?
4. How do MFT scholars explain the relationship between common factors and models?
5. How do common factors inform and enhance MFT practice, research, and training?

Mixed

1. How does the MFT common factors literature answer fundamental questions about therapeutic effectiveness and the process of change in therapy?

METHOD

To answer our research questions, we conducted a simultaneous, exploratory mixed methods content analysis of common factors literature in the MFT field published in the past 20 years. The study followed the design of previous mixed methods content analyses (e.g., Gambrel & Butler, 2013). We first identified scholarly works in the MFT field that primarily focus on common factors. We then developed a quantitative and qualitative coding scheme to guide our data analysis. We used the same sample for the qualitative and quantitative phases of the analysis. Priority was given to the qualitative strand, as we aimed to synthesize the contributions of common factors literature. A detailed description of the method follows.

Mixed Methods Content Analysis

Content analysis is an ideal research methodology for analyzing documents in effort to examine communication and textual patterns (Tashakkori & Teddlie, 2010). In the case of the present study, we aimed to examine a body of published literature, which makes content analysis an ideal method to achieve the study's purpose. Bryman (2006) explains that mixed methods research is

more rigorous than merely grouping together quantitative and qualitative components; rather, these components should be genuinely integrated. Furthermore, Gambrel and Butler (2013) conducted a mixed methods content analysis examining the prevalence and quality of published mixed method studies in the MFT field. These examples illustrate how mixed method content analyses have been used previously to examine a body of literature in a way that integrates quantitative and qualitative components.

Selection Criteria and Selection

Though many of the scholars who write about common factors in MFT frequently draw influence from the greater psychotherapy field, we aimed to understand the common factors literature specific to MFT. Consistent with the paper's aim, works were selected if they focused on common factors of MFT. We used the following criteria to determine whether to include works in our sample: (a) common factors are the primary focus of the work, (b) the authors discuss common factors as applied to the practice of MFT, and (c) the work was published in a peer-reviewed journal or academic outlet between 1999 and early 2019.

Using the inclusion criteria and research questions as a guide, we used EBSCOhost and Wiley Online Library search engines to focus our search of peer-reviewed journal articles, books, and book chapters. The initial search yielded 49 works that met these criteria. We then reviewed each work's bibliographies to identify additional sources that did not emerge through the initial search, resulting in four additional works. Using the inclusion criteria as our guide, we conducted a thorough review of the 53 works to ensure that common factors were the primary conceptual focus, the discussion of common factors included their application to MFT, and they were published in a professional book or peer-reviewed journal. We eliminated 16 works that did not meet these inclusion criteria, leaving us with a final sample of 37 scholarly works including articles, books, and book chapters.

Researcher Reflexivity

The authors have written about common factors extensively. Throughout the data analysis and discussion of the results, we met to discuss our position in relationship to common factors. We engaged in this process to acknowledge our position of support for common factors and our belief in their role as important aspects of therapeutic change; we also recognize there are significant limitations to the existing literature. Our aim was to provide a rigorous, honest, and critical commentary of the common factors literature in MFT, and we continually reminded ourselves of this aim throughout the analysis.

Quantitative, Qualitative, and Mixed Data Analysis

Our analysis followed those used in previous mixed methods content analyses (Gambrel & Butler, 2013). To analyze our sample of scholarly works quantitatively, we developed a coding scheme informed by the existing common factors literature, including strengths, limitations, and questions about the usefulness of the common factors paradigm (D'Aniello & Fife, 2017). Our quantitative coding scheme was intentionally comprised of closed ended responses, as our aim was to provide descriptive data about the scholarly works on common factors. To begin the coding process, the first author developed a table containing the citation of each work, as well as an abbreviation by which to easily identify and label articles in subsequent tables. See Table 1 for a complete description of the coding scheme. We used quantitative methods to track, count, and classify descriptive characteristics of each work in our sample (Gambrel & Butler, 2013). Each author independently coded each work in the sample.

To code for the first question, we each reviewed the work, focusing on whether the work was conceptual (i.e., a nonempirical focus on theoretical development or conceptual ideas) or empirical in nature. Each author then reviewed each work to determine the position of the author: whether the author was a proponent, opponent, or neutral party as it relates to common factors. The coding process for the third question included an additional review of the main contributions and implications of each work as it relates to the field of MFT. In order to enhance reliability, we compared and contrasted our codes and discussed our coding until a consensus was reached.

Table 1
Quantitative Coding Scheme

Question	Possible responses
What types of scholarly works are written?	Conceptual papers Empirical papers
What is the position of the work in relation to common factors?	Common factors proponent Common factors opponent Neutral
What are the main implications of the work for the MFT field?*	Theory development Research Clinical practice Training Supervision

*Implications were counted if the work included significant discussion regarding the topic.

For the qualitative portion of this content analysis, we utilized thematic analysis to address the questions in our qualitative coding scheme (see Table 2) (Braun & Clarke, 2006). We selected thematic analysis for the qualitative analysis because its purpose of organizing and describing data in rich detail is consistent with the aim of the qualitative strand of this content analysis (Braun & Clarke, 2006). Using the qualitative questions as a guide, the first author independently open coded each work in our sample, discussed the coding, and refined the analysis with the second author. We discussed areas of ambiguity or disagreement and developed a consensus about the prominent themes related to each research question.

RESULTS

Quantitative Results

Of the 38 works in our sample, 32 (84%) were published articles in peer-reviewed journals, while six works (n = 6, 16%) were book chapters or whole books. Forty seven percent (n = 18, 47%) of our total sample was obtained from the *Journal of Marital and Family Therapy* (JMFT), four works (n = 4, 11%) were published in *Contemporary Family Therapy* (CFT), two articles (n = 2, 5%) were in *Family Process* (FP), three articles (n = 3, 8%) were published in the *Journal of Family Therapy* (JFT), and one article each (n = 1, 3%) was published in *American Journal of Family Therapy* (AJFT), *Journal of Family Psychotherapy* (n = 1, 3%), *Behavior Therapy* (n = 1, 3%), *New Zealand Journal of Family Therapy* (n = 1, 3%), and *Journal of Child and Adolescent*

Table 2
Qualitative Coding Scheme

Questions

1. What common factors are discussed in MFT scholarly literature?
2. How do common factors researchers draw distinctions between change mechanisms, process variables, and common factors?
3. How do common factors contribute to the discussion about the therapeutic effectiveness of MFT?
4. How do MFT scholars explain the relationship between common factors and models?
5. How do common factors inform and enhance MFT practice, research, and training?

Substance Abuse (n = 1, 3%). These results indicate that *JMFT*, the flagship and top-tier journal of the MFT field (Gambrel & Butler, 2013), has been the primary outlet for common factors scholarship.

The following phase of quantitative analysis focused on the orientation of each work as conceptual or empirical. We classified articles as empirical if there was any original data and empirical analysis presented. Twenty three percent (n = 9) of works involved empirical analysis, while 76% of articles (n = 29) were theoretical or conceptual papers. We then analyzed the position of the authors on common factors. In most cases, the authors did not explicitly state whether the work was intended to support common factors (proponent) or disagree with the usefulness of the common factors paradigm (opponent). Rather, we analyzed the purpose, tone and implications presented for each article. We found that 82% of works in our sample (n = 31) were written by proponents of the common factors paradigm. It makes intuitive sense that authors who support the importance of common factors and purport its usefulness to the MFT field produced the majority of scholarly works on common factors in MFT. There were two works (n = 2, 5%) included in our sample that were part of a debate about the usefulness of the common factors paradigm and included arguments against the importance of common factors' contributions to the MFT field. There were five works in our sample (n = 5, 13%) where the author's position in relation to common factors was unclear, and thus, we coded them as neutral.

The final aspect of our quantitative analysis involved the primary implications of each work in our sample. Although many of the works carried implications for multiple areas, we begin by reporting the area we determined to be the primary area of influence of the specific work. Nineteen (n = 19, 50%) works carried implications for theory development, as their primary intent was to advance how MFTs conceptualize the process of change. Nine (n = 9, 24%) works in our sample primarily emphasized implications for clinical practice, as they offered direct suggestions for changes in treatment based on the common factors paradigm of therapy effectiveness. Eight works (n = 8, 21%) included implications for how MFTs could be clinically trained in common factors, one article (n = 1, 3%) focused on implications for supervision, and one article (n = 1, 3%) focused on implications for research. The most common combination was that articles carried primary implications for theory development and advancement, and secondary implications for clinical practice (n = 16, 42%). These results reflect that common factors literature is being produced primarily to inform theorizing about therapy effectiveness, as well as to inform clinical practice. For example, a central aspect of Davis and Piercy (2007a, b), Sprenkle et al., (2009) and Davis and Hsieh (2019) is the assertion that the common factors paradigm is a meta-model of therapy, rather than a clinical treatment model. This contribution to theoretical advancement is a critical contribution of the common factors paradigm to MFT practice (see Table 3).

Qualitative Results

The presentation of the qualitative results is organized by the five research questions that guided the analysis. Within each section, in addition to presenting the ideas that emerged in the extant literature associated with each research question, we discuss and critique the strengths and limitations of the MFT common factors literature in relation to the research question.

Common factors discussed. The results of the first qualitative research question: *What common factors are discussed in MFT scholarly literature?* showed consistency in the common factors identified in our sample (Table 4). The first prominent theme that emerged is broadly and narrowly conceptualized common factors. The broadly conceptualized common factors, also defined as "model-independent" factors, include general aspects inherent in the structure of therapy that contributes to positive outcomes, such as client factors, therapist factors, therapeutic relationship factors, and expectancy factors (Blow, Morrison, Tamaren, Wright, Schaafsma, & Nadaud, 2009; Blow, Sprenkle, & Davis, 2007; Davis & Hsieh, 2019; Davis, et al., 2012; Davis & Piercy, 2007a, b; Sprenkle et al., 1999). The narrow common factors, also defined as "model dependent" factors, discussed in our sample includes nonspecific aspects of treatment that are common across MFT models (Fraser, 2003; Fraser, Solovey, Grove, Lee & Greene, 2012; Sprenkle & Blow, 2004a). These nonspecific treatment factors may include cognitive mastery, behavioral regulation, and emotional regulation (Blow et al., 2009; Blow et al., 2007; Davis et al., 2012; Davis & Piercy, 2007a, b; Sprenkle et al., 1999; Sprenkle et al., 2009).

Table 3
Quantitative Results

Article code	Empirical (E) Conceptual (C)	Proponent (P) Opponent (O) Neutral (N)	Research (R) Theory (Th) Supervision (S) Training (T) Practice (P)
1. Blow, Davis, & Sprenkle, 2012	C	P	Th, T, P
2. Blow, Morrison, Tamaren, Wright, Schaafsma, & Nadaud, 2009	E	P	Th, P
3. Blow & Sprenkle, 2001	E	P	R, Th, T, P
4. Blow, Sprenkle, & Davis, 2007	C	P	R, Th, T, P
5. D'Aniello, 2015	C	P	Th, T, P
6. D'Aniello, Alvarado, Izaguirre, Hulbert, & Miller, 2016	E	P	T
7. D'Aniello & Fife, 2017	E	P	R, T
8. D'Aniello, Nguyen, & Piercy, 2016	C	P	R, Th, S, T, P
9. D'Aniello & Perkins, 2016	C	P	S, T
10. Davis & Hsieh, 2019	C	P	Th, P
11. Davis, Lebow & Sprenkle, 2012	C	P	R, Th, T, P
12. Davis & Piercy, 2007a	E	P	R, Th, T, P
13. Davis & Piercy, 2007b	E	P	R, Th, T, P
14. Eisler, 2006	C	N	Th, P
15. Fife, 2016	C	P	Th
16. Fife, DAniello, Scott & Sullivan, 2019	E	P	T
17. Holyoak, Fife, & Hertlein, in review	C	P	Th, T, P, R
18. Fife, Whiting, Bradford & Davis, 2014	C	P	Th, T, P
19. Fraser, 2003	C	P	Th, P
20. Fraser et al., 2012	C	P	Th, P
21. Hogue et al., 2017	E	N	R, P
22. Karam, Blow, Sprenkle & Davis, 2015	C	P	S, T
23. Lebow, 2014	C	P	Th, P
24. Morgan & Sprenkle, 2007	C	P	S
25. Sexton & Ridley, 2004	C	O	Th, T, P
26. Sexton, Ridley & Kleiner, 2004	C	O	R, Th, T, P
27. Shamoon, Lappin, & Blow, 2017	C	P	Th, T, P
28. Simon, 2006	C	N	R, Th, T
29. Simon, 2007	C	N	R, Th, P
30. Simon, 2012	C	N	Th, P
31. Sparks & Duncan, 2010	C	P	R, Th, T, P
32. Sprenkle & Blow, 2004a	C	P	Th, P
33. Sprenkle & Blow, 2004b	C	P	Th, P
34. Sprenkle & Blow, 2007	C	P	Th, P
35. Sprenkle, Blow & Dickey, 1999	C	P	Th, P
36. Sprenkle, Davis & Lebow, 2009	C	P	R, Th, S, T, P
37. Thomas, 2006	E	P	P
38. Weeks & Fife, 2014	C	P	Th

Sprenkle and colleagues (Sprenkle & Blow, 2004a, b; Sprenkle et al., 1999; Sprenkle et al., 2009) propose several common factors unique to MFT. The authors assert that although the general common factors of psychotherapy apply to the practice of individual therapy, there are

Table 4
Summary Chart of Emergent Themes

1. Common factors are identified in the MFT literature
   a. Broadly conceptualized common factors/ model-independent
      i. Client factors
      ii. Therapist factors
      iii. Therapeutic alliance factors
      iv. Hope/expectancy factors
   b. Narrowly conceptualized common factors/ model-dependent
      i. Cognitive mastery
      ii. Behavioral regulation
      iii. Emotion regulation
   c. Common factors unique to MFT
      i. Relational conceptualization
      ii. Expanded direct treatment system
      iii. Expanded therapeutic alliance
2. Distinctions between change mechanisms, change process, and common factors
   a. Common factors literature did not discuss this distinction in great depth
   b. Common factors researchers assert that common factors are synonymous with mechanisms of change.
3. Common factors contribution to the discussion about the therapeutic effectiveness of MFT
   a. Offers an alternative explanation to the model specific explanation of therapeutic effectiveness
   b. Factors that span models, rather than model specific ingredients contribute most to effective therapy
4. Relationship between common factors and models
   a. Extreme positions on common factors (i.e., models are unnecessary) gave the common factors perspective an inaccurate reputation
   b. Common factors work with/through models (moderate common factors position)
5. How do common factors inform and enhance MFT practice, research, and training?
   a. Encourage clinicians to consider the impact of factors that span models in practice
   b. Encourage researchers to include model nonspecific factors in research designs
   c. Support the inclusion of common factors in training and supervision
6. How does the MFT common factors literature answer fundamental questions about therapeutic effectiveness and the process of change in therapy?
   a. Provides an alternative perspective from which to conceptualize effectiveness

additional common factors that are specific to couple and family therapy. The first is *relational conceptualization* or understanding clients and symptoms in the context of familial/interpersonal relationships. The second is *disrupting dysfunctional relational patterns* rather than focusing on clients' internal mental processes. *Expanded direct treatment system* refers to the involvement of more than one person in the direct treatment system, and the *expanded therapeutic alliance* refers to the complex task of developing therapeutic relationships with each member of that direct treatment system (Karam, Ko, Pinsof, Mroczek, & Sprenkle, 2015; Sprenkle & Blow, 2004a; Sprenkle et al., 1999; Sprenkle et al., 2009). Research by Hogue et al., (2017) provides useful indirect empirical support for these unique MFT common factors, though they are identified by different terms. Additionally, a recent article by Davis and Hsieh (2019) describes six core principles of a common factors informed therapist. The MFT common factors described in the literature are aspects of couple and family therapy that set it apart from individual therapy, but they lack empirical support in the sample we reviewed.

We also found that therapist factors, also referred to as therapist effects, self of the therapist factors, therapist characteristics, or therapist worldview, were commonly discussed in the MFT common factors literature (Blow et al., 2007; Blow et al., 2009; Fife, 2016; Fraser et al., 2012; Simon, 2006; Simon, 2007; Simon, 2012). There has been considerable attention in the MFT literature to the importance of the therapist's influence on treatment including the therapist's personhood, personality characteristics, worldview, skill level, and model choice (Blow et al., 2009; Blow et al., 2007; Blow, Davis, & Sprenkle, 2012; Fife, 2016; Fraser et al., 2012; Fife et al., 2014; Simon, 2006; Simon, 2007; Simon, 2012; Sprenkle et al., 2009). Therapists vary in their clinical effectiveness; however, therapist factors have been largely controlled for in studies of therapeutic effectiveness (Blow et al., 2007; Davis & Piercy, 2007a, b; Lebow, 2006).

There is a need for a more nuanced understanding of what makes an MFT clinician effective. A recognition of this need spurred additional writing within our sample about the therapist's belief in a treatment model (i.e., allegiance), as scholars argued that doing something that one believes in is likely to yield better results than doing something with half-hearted conviction (Blow et al., 2007; Eisler, 2006). Aligned with the importance of allegiance is the question of what is more important—to match the model used in treatment to the therapist's worldview or to the client's worldview (see Blow et al., 2012; Blow et al., 2007; Simon, 2006, 2007). This research about therapist allegiance to a model and matching the worldview of the model with the worldview of the client or therapist, are a strong start to addressing questions about the role of the therapist in MFT practice. Further inclusion of therapist factors in research studies is paramount to understanding what makes an effective therapist. For example, studies asking clients about their therapists' contributions to effective therapy are useful to understand the influence of therapist factors on clinical outcomes (see D'Aniello, Piercy, Dolbin-MacNab, & Perkins, 2018; Holyoak, Fife, & Hertlein, in review; Christensen, Russell, Miller, & Peterson, 1998).

A number of scholars have emphasized that increased attention should be given to the qualities of effective therapists (Blow et al., 2007; Davis & Hsieh, 2019; Sprenkle et al., 2009; Wampold & Imel, 2015). Although the common factors paradigm of therapeutic effectiveness has contributed to the discussion of the important role that therapists play in delivering effective therapy, further work is needed. We believe that empirical research using unique and diverse methodologies (e.g., quantitative surveys, observational analysis, qualitative and participatory studies) that utilize observer report, client report, and therapist report are necessary to further the understanding of factors associated with successful couple and family therapy.

Common factors, change process, and change mechanisms. In academic discourse, clarity of language is important. It is common for similar terms to be used interchangeably, but that is not always accurate. We chose to investigate the areas of overlap and distinction among the terms, *common factors*, *process variables,* and *change mechanisms*. Doss (2004) differentiates between change processes and mechanisms, offering a framework to explain the relationships among change processes, change mechanisms and outcomes. He proposes that change processes are "aspects of therapy, occurring during the treatment session or as a direct result of therapy homework assignments which subsequently create improvements in the change mechanisms," while change mechanisms are "intermediate changes in client characteristics or skills, not under direct therapist control, that are expected to lead to improvements in the ultimate outcomes of therapy" (Doss, 2004, p. 369). He further divides change processes into therapy change processes ("interventions, directives, or therapist constructed therapy characteristics that are hypothesized as the active ingredients of treatment") and client change processes ("the behaviors or experiences that occur as a direct result of therapy change processes"), and these create improvements in change mechanisms and lead to positive clinical outcomes (Doss, 2004, p. 369). Similarly, Sexton et al. (2004) defines change mechanisms as evidence-based mechanisms (e.g., redefinition of the presenting problem, impasse resolution, and therapeutic alliance, and treatment adherence) that facilitate short-and long-term goals that ultimately lead to therapeutic change. In sum, change mechanisms lead to specific client outcomes, and they can be model-specific or model nonspecific. Although these terms (change process and change mechanism) are often used interchangeably, we argue that greater specificity and consistency in the terminology used in published research would allow studies to be compared and build upon one another.

Authors of MFT common factors literature have yet to reach consensus on distinct definitions for these terms (e.g., Sprenkle & Blow, 2004b). Other times they do not clearly define the differences between concepts or use the terms change processes and change mechanisms as part of the definition of common factors (e.g., D'Aniello & Fife, 2017; Sprenkle et al., 2009). Common factors critics understandably identified the distinctiveness and inconsistent use of related terms as limitations of the common factors paradigm (Sexton & Ridley, 2004; Sexton, Ridley & Kleiner, 2004). They argue that some common factors are broad and lack a specific description (e.g., the relationship), while others (e.g., hope) are the outcomes of other unspecified change mechanisms. They assert that "without clarity, it is very difficult for a clinician, particularly one in training to sort out what he or she might do (mechanisms) from the outcomes sought (common factors)" (Sexton & Ridley, 2004, p. 161). We agree that change processes, change mechanisms, and common factors are not synonymous, and care needs to be taken when utilizing these terms. However, their critique mischaracterizes common factors. Not all change processes or mechanisms are common factors; yet all common factors identified in the MFT literature (both general and MFT-specific) are either processes or mechanisms of change. Furthermore, many factors of change (i.e., processes and mechanisms of change) in effective therapy are likely present in some form within all effective models, thus illustrating the close relationship between change processes, mechanisms, and common factors.

Sexton et al. (2004) argue that the psychotherapy field should explain the nonspecific factors or mechanisms by which common factors (e.g., hope and the therapeutic relationship) are created and developed. They state that the goal should be "to identify the mechanisms by which these factors can be made to occur" (p. 139). Although we agree with this call for continued investigation of mechanisms of change, the mechanism by which one client experiences hope may be different than another. In contrast with a medical model approach, we embrace the contextual model proposed by Wampold and Imel (2015) and Wampold (2001). We feel that empirical research identifying behavioral, observable and measurable in-session events that clients and therapists identify as engendering hope or developing a strong therapeutic relationship is a useful way to continue this discussion. Furthermore, there may be considerable variation in mechanisms needed to facilitate hope (or other common factors) for clients of different constellations, backgrounds, and presenting problems.

Empirical research is needed to understand pathways and mechanisms associated with common factors of change such as hope and alliance. The results of our content analysis highlight the gaps in the MFT theorists' way of understanding how and why therapy works. Currently, the primary ways of understanding these concepts is based on theorizing rather than empirical research, which would serve to strengthen the common factors paradigm.

Common factors and therapeutic effectiveness. The third qualitative research question was *how do common factors contribute to the discussion about therapeutic effectiveness?* A cornerstone of the common factors paradigm is the idea that therapy is effective primarily due to the common factors that span models, rather than the model-specific factors (Asay & Lambert, 1999; Blow et al., 2007; Davis & Hsieh, 2019; Davis & Piercy, 2007a, b; Hubble et al., 1999; Lambert, 1992; Shadish & Baldwin, 2003; Sprenkle & Blow, 2004a, b; Sprenkle et al., 1999; Wampold, 2001). Meta-analytic research provides the strongest empirical support for this assertion. When meta-analyses compare therapy outcomes across models, results repeatedly show no significant differences in therapy effectiveness between models (Shadish & Baldwin, 2003; Shadish et al., 1995; Smith et al., 1980; Wampold, 2001). Additional meta-analytic research demonstrates the positive impact of broad common factors on clinical outcomes (Frank & Frank, 1991; Horvath, 2001; Lambert, 1992). Although these studies provide empirical support for common factors, much of the support is indirect, and our analysis shows that very few studies in the MFT literature focus on common factors directly. In an age of empirically validated treatments and accountability, these results raise the question of whether the indirect support for common factors is sufficient to claim that the common factors theory is empirically supported. Though many models (EFT, FFT, BCT, SFBT, etc.) have a substantive body of empirical effectiveness research, the current MFT literature has not demonstrated the superiority of any model compared to others (Rathgeber, Bürkner, Schiller, & Holling, 2019; Wampold & Imel, 2015). Furthermore, Lebow, Chambers, Christensen and Johnson (2012) found that EFT is effective, however, not superior to other couple therapy approaches. There are

other forces (such as managed care, or fit with the therapist's worldview) that influence therapists' ideas of "What is the best model?" However, these preferences are not based in empirically demonstrated superiority. Because no model has shown superior effectiveness such that it precludes learning other models, therapists have freedom to choose a model(s) among those that demonstrate effectiveness (Davis & Hsieh, 2019). It is noteworthy however, that at this point, it remains unclear as to whether there are statistically and clinically relevant differences between BCT and EFCT, and future research comparing both treatments in a randomized-controlled setting would be useful (Rathgeber et al., 2019).

Despite some empirical support from meta-analytic research, the majority of common factors literature published in MFT journals is conceptual, rather than empirical, as illustrated in our quantitative results. Theorists who question the legitimacy of the common factors paradigm point to the lack of empirical research investigating the common factors paradigm of therapeutic effectiveness in MFT (Sexton & Ridley, 2004). Sexton and Ridley (2004) call on common factors researchers to conduct further original research that is specifically developed and intended to test the common factors approach in couple and family therapy, rather than individual therapy (see also Davis et al., 2012). Several researchers have published studies showing empirical support for the usefulness of common factors in MFT clinical practice and training (Blow et al., 2009; Fife, 2016; D'Aniello et al., 2017; D'Aniello & Fife, 2017; Davis & Piercy, 2007a, b; Fife et al., 2019). In addition to these studies, more research is needed that directly examines common factors and change mechanisms in treatment. Doing so may require scholars to overcome potential barriers such as the lack of funding for common factors research; the research, training, and administrative demands of university faculty; and the difficulty of conducting high-quality randomized clinical trials.

Common factors and MFT models. Our fourth organizing question asks, *What is the relationship between common factors and MFT models*? There have been two primary schools of thought about the relationship between common factors and MFT models. The extreme position of common factors asserts that common factors are exclusively responsible for therapeutic change, and therefore, any treatment approach is as good as another (Hubble et al., 1999). This assertion is consistent with the dodo bird verdict: "Everybody has won and all must have prizes" (Rosenzweig, 1936, p. 412). Common factors opponents took this position to mean that common factors proponents believed a model was unimportant, or worse, unnecessary (Sexton & Ridley, 2004; Sprenkle, et al., 2009). Sprenkle and Blow (2004a) refute the extreme view of common factors in favor of a moderated view. According to the moderate view, models are important to effective practice (Sprenkle et al., 2009). They contribute to the practice of effective psychotherapy because they are the vehicle through which common factors operate (Sprenkle & Blow, 2004a). This paradigm is distinct from the model-driven paradigm of therapeutic change, which assumes the model-specific elements of the treatment model are responsible for bringing about change. Many common factors theorists have adopted and supported the moderate paradigm of common factors in their work (Blow et al., 2009; Blow & Sprenkle, 2001; Blow et al., 2007; Blow et al., 2012; D'Aniello & Fife, 2017; D'Aniello, 2013; Fife, 2016; D'Aniello, 2015; Davis & Hsieh, 2019; Davis & Piercy, 2007a, b; Davis et al., 2012; Sprenkle et al., 2009; Sprenkle & Blow, 2007).

Common factors proponents also acknowledge that common factors and models work through therapists (Blow et al., 2007). Blow et al. (2007) engaged in a spirited debate with Simon (2006) regarding the important role of the therapist, the treatment model and common factors. Simon (2006) holds the position that model effectiveness is largely driven and potentiated by the therapist's allegiance to that model and the fit between the model and the therapists' worldview. Although Model A may be about equally effective as Model B, it may not be so in the hands of a particular therapist (Simon, 2006). Simon (2006) believes that the therapist's ability to select a compatible model "preserves the foundational intuition" of both the common factors paradigm and the model-specific factors paradigm because it shows exactly how both are mutually dependent (Simon, 2006, p. 336). In contrast to this position, Blow et al. (2007) and Davis and Hsieh (2019) encourage therapists to be passionate about theory in general, rather than a specific theory. They advocate for therapists to become well-versed in many therapeutic models and recognize the overlap among theories, so that the therapist can creatively and artfully select and practice the model that works best for a specific client or specific problem. The rationale for this paradigm is

that clients should not be faced with the task of adapting to the particular therapist's model and worldview, but rather, the therapist should adapt to the client's needs and worldview. They unequivocally support the important role of the therapist as a vehicle through which common factors operate (Blow et al., 2007).

Common factors' role in training and research. The final organizing question asks *how common factors inform and enhance MFT training & research*. The question of the relationship between common factors and models carries significant implications for MFT training. MFT programs place model-specific training front and center in their curriculum. Common factors proponents propose that MFTs may be best served by integrating common factors training into the curriculum of graduate programs as part of the training students receive in specific MFT models (D'Aniello & Fife, 2017; Fife, 2016; Fife et al., 2014; D'Aniello et al., 2018; Karam et al., 2015). Author (2017) and Author (2019) conducted two empirical studies focused on the role of common factors in MFT training and found favorable perceptions from faculty and students. Specifically, they found that common factors are frequently included in MFT training programs. Of 31 participants, 28 (90%) directors of accredited MFT/counseling programs indicated that their students receive some form of training in common factors, and they reported overall positive student responses to the training. Karam et al. (2015) highlight specific training in common factors implemented at the University of Louisville where a unique capstone project allows students to specifically assess their theory preference based on common factors, The Family Institute at Northwestern University where students are able to measure their performance in different categories of change using an online computer graph system known as STIC, Purdue University where the science that supports common factors is studied extensively, Alliant International University, Sacramento Campus which requires a common factors course as part of basic core curriculum, and Michigan State University's doctoral program that studies common factors in greater depth. Author (2019) interviewed students about their experience of common factors training and found that students reported overwhelmingly positive experiences of being trained in common factors; developed a more sophisticated understanding of the relationship between common factors, models, and change process; and said it provided increased guidance in how to structure their clinical work. Overall, these results indicate that the majority of MFT students and faculty recognize the value of common factors training as part of MFT graduate education.

Research—The approach of testing therapeutic models using randomized clinical trials continues to be important for demonstrating that MFT treatment produces change, but this research explains little about what happens in therapy sessions that produce that change (Blow et al., 2009; Pinsof & Wynne, 2000; Rice & Greenberg, 1984; Sprenkle & Blow, 2004a). Clinical trials typically control for common factors variables (e.g., therapist or client effects) in effort to attribute the outcome to the model rather than process elements (Blow et al., 2009; Blow et al., 2007; Sprenkle et al., 2009). Process elements include aspects of treatment that are not attributed to the therapy model, including, the client, therapist, client expectations, client motivation, and the therapeutic alliance. The current lack of process-oriented research in MFT has contributed to what is known as the research-practice gap or disconnect between the way MFT is researched and practiced (Dattilio, Piercy & Davis, 2014; Oka & Whiting, 2013; Pinsof & Wynne, 2000).

Although common factors scholars stress the need for empirical research, our analysis of the MFT common factors literature suggests that common factors have played a modest role in MFT research. In the age of evidence-based practice and empirically supported treatments, the common factors paradigm of therapeutic change needs adequate empirical research to be regarded as a legitimate paradigm worthy of attention in training and treatment. In other words, empirical evaluation of the usefulness of common factors informed therapy would be instrumental to ensure that common factors inform MFT theorizing, research, training, and practice. Furthermore, empirical research related to unique MFT common factors is critical. An example of such is a study by Hogue et al. (2017) on core elements of family therapy for adolescent substance use. Researchers used a methodology called a conceptual distillation by which they identified four core practice elements of empirically validated family therapy models for adolescent substance use treatment. This is the type of methodological advancement that is instrumental in moving common factors research forward.

IMPLICATIONS AND AREAS FOR FUTURE SCHOLARSHIP

This content analysis offers a quantitative analysis of the features of the MFT common factors literature and a qualitative analysis and critique of the conceptual and practical contributions the common factors literature provides to MFT. Common factors scholars have continually posed and attempted to answer the question of how common factors move the theory and practice of MFT forward (Sexton & Ridley, 2004; Sprenkle & Blow, 2004a, b). Though no theory is so complete that it precludes further development, the common factors paradigm in MFT is one of the most significant theoretical developments of the past two decades and has made substantive contributions to MFT thinking about models and the change process (Holyoak, Fife, & Hertlein, in review; Fife et al., 2014; Davis et al., 2012). The results of the content analysis strongly suggest that the application of common factors theory has moved MFT theory, research and practice forward in several ways. The common factors paradigm has clearly influenced the ways in which scholars and practitioners think about change and the key elements of effective therapy. Furthermore, common factors scholarship has increased understanding of the relative influence of models and their relationship to clinical outcomes. The overwhelming majority of the articles reviewed embrace a moderate view that models and common factors work hand in hand to facilitate change and positive outcomes.

The common factors paradigm is a useful theory or meta-model for guiding the inclusion of therapeutic process variables in MFT research, training, and treatment (Davis & Piercy, 2007a, b; Fife et al., 2019). MFT researchers recognize the importance of identifying change agents and have made strides in using common factors as a theoretical basis for empirical testing of process elements (Kneer et al., 2011; D'Aniello et al., 2018). MFT training programs have also incorporated common factors in their courses, with positive outcomes reported by faculty and students. Research and theory development should continue to focus on additional factors yet to be identified or accepted as common factors. Examples of such works include Author (2017) who focused on cultural sensitivity as a common factor, client paradigm of therapy productiveness (D'Aniello et al., 2018), and clients' perception of therapist's way of being (Holyoak, Fife, & Hertlein, in review).

Training Implications

Building on the important theoretical and clinical contributions of common factors, research has expanded to include common factors in MFT training (Karam, 2011; Fife, 2016). Our analysis strongly supports the integration of common factors into MFT graduate coursework. Existing empirical research shows that MFT students report positive experiences with common factors training (D'Aniello & Fife, 2017; Fife et al., 2019). A logical place to include common factors is courses where students learn the basic models and techniques of couple and family therapy. In addition to teaching the aspects of MFT models that make them distinct, courses should examine aspects that are similar across models, as well as characteristics of effective therapists and therapeutic relationships (Karam et al., 2015). Ultimately, the effectiveness of the models and techniques used by students will rest upon the quality of the therapeutic alliance as perceived by the client (Fife et al., 2014; Frank & Frank, 1991).

We encourage faculty to introduce common factors early in training programs. Incorporating common factors early can enhance students understanding of models and the processes of effective therapy (Fife et al., 2019). Common factor training can be included in MFT curriculum in order to potentiate and enhance current training models. One way of advancing MFT training in common factors might be to initiate a common factors skills lab, where common factor-based skills are isolated and practiced (Fife, 2016). Additionally, research investigating the ways in which common factors can be infused into MFT training programs alongside model specific training will be important for enhancing student learning.

Research Implications

Perhaps the most obvious and critical finding of this content analysis is the high percentage of works in our sample that was theoretical and clinical in nature rather than empirical. Most of the

empirical support for common factors comes from the individual psychology literature (Davis et al., 2012), and the paucity of empirical studies on common factors is a glaring limitation of the current MFT literature. This disproportionate number of theoretical versus empirical works suggests a few things. There may be confusion or lack of clarity on how to operationalize common factors for empirical testing. Perhaps the common factors paradigm makes intuitive sense and has sparked thought and discussion among scholars, resulting in considerable theorizing about the role of common factors. Yet they may be difficult to test in a randomized clinical trial. Nevertheless, more empirical research on common factors theory can and should be conducted. For example, therapist characteristics, client characteristics, and therapeutic relationship factors can be operationalized and quantified for analysis in research methodologies like observational analysis, video analysis, or client report. Process research methodologies such as perception analysis and interpersonal process recall (Kagan & Kagan, 1991), where clients observe a video of their therapy session, and identify time points in the video where they felt a strong or weakened therapeutic relationship would be useful in understanding client perception of MFT services.

Another possible explanation for the low number of empirical research studies of common factors research may be the lack of grant funding available for such studies (Sprenkle, 2012). Process research studies that examine nonspecific therapeutic factors are not currently highly fundable. Often, grant funding is tied to the needs of a specific population or presenting problem. The majority of research in the MFT field is conducted by faculty and graduate students, and the rising demands on tenure track faculty, particularly at high-level research universities, prioritize numbers of publications and grant writing. Faculty members must balance these requirements with their own research interests. Furthermore, process research is often time consuming, and may make it difficult to publish several papers each year. Though questions about therapeutic effectiveness may be less attractive to federal and other external funders, these questions are of paramount importance to the psychotherapy and MFT field. We encourage professional organizations such as the American Association of MFT, the National Council on Family Relations, and the American Counseling Association to follow in the footsteps of the Family Process Institute and the American Psychological Association and offer research grants to scholars who are investigating therapy process factors.

We offer several topics, studies, methodologies, and research questions as a starting point for family therapy scholars who are interested in addressing existing gaps in the literature and further developing common factors scholarship. Research could focus on the four specific MFT common factors identified by Sprenkle et al. (1999; see also Sprenkle et al., 2009; Davis & Hsieh, 2019). Researchers could analyze actual MFT therapy sessions to find evidence of MFT common factors—to support the claims made in the MFT common factors literature we reviewed. One way to do this, would be to analyze the MFT master session video tapes to find evidence of MFT common factors operating through MFT models.

An additional area of study involves the nonspecific treatment factors in MFT models (also called common pathways of MFT interventions by Davis & Hsieh, 2019; Sprenkle et al., 1999; Sprenkle et al., 2009): behavioral regulation, cognitive mastery, and emotional experiencing/regulation across MFT models. Research could focus on identifying these mechanisms of change manifest in the different MFT models. Researchers could conduct a qualitative content analysis in which they review MFT models in their written form to identify the aspects of each approach that address/focus on these three MFT common factors. Furthermore, investigators could conduct an empirical study in which researchers analyze therapy sessions of MFT models to identify the processes by which the models address or demonstrate these three MFT common factors. Such a study would contribute to scholars' understanding about how common factors operate differently, depending on the therapeutic model. In addition to these specific study ideas, research studies that use the client paradigm of the change process or clinical analyses that focuses on the processes that occur within therapy sessions would contribute to the body of empirical research supporting common factors.

Limitations

Though the present content analysis provides a useful discussion and critique about the contributions and limits of the common factors paradigm in the MFT field, it is not without limitations.

First, content analyses rely on the work of other authors and researchers to comprise their sample of articles. To a degree, the quality of this content analysis is dependent on the quality of the individual works included in the sample. Second, the authors have studied and written about common factors in MFT for several years, and several of our own articles were included in the sample. We acknowledge our position that common factors move the MFT field forward and contribute to the explanation of how change occurs in therapy. In effort to reduce the influence of this limitation, we regularly reflected on and discussed our biases and our position in relation to the phenomenon of interest. Acknowledging our positions allowed these perspectives not to unduly influence the data analysis. We made continual efforts to critically evaluate each work in the sample, which included critiquing our own.

Conclusions

This content analysis has illuminated the strengths and contributions of the common factors paradigm in MFT and also the gaps in this body of research that continue to exist. Future research aimed to continue the conversation about common factors' role in MFT theory development, research, training, and practice should empirically test the contributions of therapy process variables to therapeutic effectiveness in couple and family therapy practice. We proposed several recommendations and calls to researchers, professional organizations, and those who supervise and train MFTs for how they can engage in furthering this body of research.

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* indicates inclusion in the research sample used in the content analysis

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