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Definitional and Research Issues in the Common Factors Approach to Psychotherapy Integration: Misconceptions, Clarifications, and Proposals

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This paper focuses on two common misconceptions of common factors in therapy. The first misconception entails the confusion between common factors and therapeutic factors, and thus the inappropriate and misleading use of the term "therapeutic common factors" in various situations. The second misconception is the mixing of commonalities of different kinds and levels in proposed lists and studies of common factors. These areas are discussed and clarified, and recommendations designed to facilitate conceptual and methodological improvements relative to each misconception are offered. The selection of best levels and kinds of common factors to be studied are further explored (i.e., the study of client change events and antecedent therapist behaviors across different therapies), and specific proposals for their research are outlined.

KEY WORDS: common factors; psychotherapy integration; psychotherapy process; outcome research.

INTRODUCTION

The common factors approach represents one of the three major thrusts in the contemporary movement of psychotherapy integration. The others

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include technical eclecticism and theoretical integration (Norcross & Newman, 1992; for reviews of the movement, see Gold, 1996; Hawkins & Nestoros, 1997; Norcross & Goldfried, 1992; Stricker & Gold, 1993). The common factors approach aims at identifying, defining, and assessing the common elements across all therapies. The idea of common factors has a history of more than 60 years, beginning with Rosenzweig (1936), continuing with the influential work of Frank (1961, 1973, 1982) and others, and flourishing in the 1980s with several proposals of common factors. Notable contributions in this area over the last two decades include, but are not limited to, the work of Garfield (1980, 1986, 1992), Arkowitz (1992a), Beitman (1987, 1992), and Goldfried and colleagues (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Goldfried, 1980, 1991; Goldfried, Castonguay, Hayes, Drozd, & Shapiro, 1997; Goldfried, Raue, & Castonguay, 1998; Wiser, Goldfried, Raue, & Vakoch, 1996).

The existence of common factors that cut across therapies has been supported by comparative outcome studies for more than two decades now, which have consistently demonstrated that all therapies produce equivalent or similar therapeutic outcomes (Elkin *et al.*, 1989; Lambert & Bergin, 1994; Luborsky, Singer, & Luborsky, 1975; Shapiro & Shapiro, 1982; Shapiro, Barkham, Rees, Hardy, Reynolds, & Startup, 1994; Sloane, Staples, Cristol, Yorkston, & Whipple, 1975; Smith, Glass, & Miller, 1980; Stiles, Shapiro, & Elliott, 1986; Wampold, Mondin, Moody, Stich, Benson, & Ahn, 1997). This ''equivalent outcome paradox'' (also known as the ''Dodo bird verdict''; Luborsky *et al.*, 1975) has supported the belief that, despite the theoretical and technical diversity among models of therapy, they share important similarities that are responsible for the equivalent therapeutic outcomes.

It appears in some cases that equivalent outcomes have been attributed largely or solely to these commonalities that are widely known as ''common factors.'' This attribution is responsible for the first misconception in the field, which will be discussed in this paper: The identification and confusion between the concepts and terms of ''common factors'' and ''therapeutic factors.'' Another area of confusion that will be discussed here is the inappropriate mixing of different kinds and levels of commonalities in the study of common factors. Both misconceptions represent sources of confusion in theory, practice, and research, and impede the development of this approach. This paper attempts to provide some clarifications on these issues and provide specific recommendations for further research in the common factors approach.

MISCONCEPTION NO 1: COMMON FACTORS AND THERAPEUTIC FACTORS AS SYNONYMS

The Nature and Sources of the Misconception

The belief that common factors are the only explanation of the nondifferential outcomes has created the first misconception in the literature: the identification of common factors with therapeutic factors. There are two major ways that this identification is expressed in the literature:

1. *The use of the terms ''common'' and ''therapeutic'' interchangeably, or the use of one term* (*e.g.*, *common*) *to describe factors of the other category* (*e.g.*, *therapeutic*). This is obvious in various proposed lists of common factors. For example, Weinberger (1993, 1995) has reviewed five *therapeutic* factors (i.e., relationship, expectations, problem confrontation, mastery, and attribution of change) that have been referred to as *common* factors, even in his 1995 paper where he demonstrated that four of the factors are not so common as is generally believed, and the fifth is not common at all.
2. *The use of a term that combines the concepts of common and therapeutic*. This is evident in the related literature in phrases such as ''common change elements'' (Highlen & Hill, 1984), ''universal healing factors'' (Fischer, Jome, & Atkinson, 1998), ''therapeutic components (with certain common functions) shared by all psychotherapies'' (Frank, 1982), ''therapeutic common factors'' (Grencavage & Norcross, 1990), and ''common therapeutic variables'' (Garfield, 1986). Similarly, additional phrases have been occasionally used to indicate the association of common factors with therapeutic outcome, resulting in the same kind of identification between the two concepts.

Reducing Confusion Resulting from the Misconception

Although it is widely accepted that common factors exist and are somehow contributing somewhat to equivalent outcomes (see Lambert, 1992; Lambert & Bergin, 1994; Luborsky, 1995), it is still unclear (a) what exactly these factors are, and (b) how exactly these factors operate in different therapies; moreover (c) there is no sufficient validation of the therapeutic value of some of these factors. Much work is still needed to define and operationalize these factors, as well as to describe their exact

mechanism of action and the degree and nature of their relation to therapeutic outcome in clients with different diagnoses treated by different therapies. Most of the proposed common factors thus far included in different lists are theoretically derived and not empirically researched (Grenavage & Norcross, 1990; Weinberger, 1993, 1995). In all cases where the combined term is being used, there is no satisfactory empirical evidence that all of the proposed common factors are common and therapeutic. For example, the factor ''provision of a rationale for client's problems and their solution'' has been included in most of the ''common therapeutic factors'' proposals (Grencavage & Norcross, 1990, identified 12 publications that cited that common factor), while its relation to therapeutic outcome has not been sufficiently tested and equally supported (see Ilardi & Craighead, 1994; Weinberger, 1993). In addition, relevant research that supported the differential effectiveness of using specific interpretations (Silberschatz, Fretter, & Curtis, 1986) and specific case formulations (Tishby & Messer, 1995), as well as research showing that it is the plausibility of a rationale *to the client* that matters (see review by Ilardi & Craighead, 1994), suggest that this factor at least should be modified to be ''the provision of *a/the appropriate/ correct/ acceptable* rationale to explain and treat clients' problems and behavior.'' Finally, someone might argue that the ''provision of a rationale for client's problems/behaviors'' is not very common (or relatively neglected) between some solution-focused and action-oriented treatments. Similar conclusions can be reached for other variables appearing in common factors lists, such as ''expectations for cure'' [listed in different forms in 29 common factors publications (Grencavage & Norcross, 1990), but relatively neglected by most schools of psychotherapy (i.e., it is uncommon); Weinberger, 1995].

In order for claims about the common and therapeutic status of a factor to be supported, the following conditions should be met:

1. *Achieve the common factor status*: The existence of a variable/factor would have to be demonstrated in a comparable form in all therapies (or in many of them). ''Deep structure'' similarities regarding therapeutic intents, goals, interventions, variables, etc., should be identified, despite surface differences and varying theoretical terminology that may be used by different models of therapy to describe similar variables and processes. Both Weinberger (1995) and Glass and Arnkoff (1993) have shown how uncommon some therapeutic factors are. They demonstrated that (a) some of the so-called common factors are relatively neglected by most of the schools of psychotherapy (i.e., mastery or control over the problem), and (b) other factors are neglected by all therapies (i.e., the attribution of therapeutic success). In line with this are the *processes of change* described

in the Transtheoretical approach (Prochaska & DiClemente, 1984; Prochaska & Norcross, 1994). These ten processes have been identified as the natural processes used by people in self-change (i.e., consciousness raising, self-liberation, social liberation, counterconditioning, stimulus control, self-reevaluation, environmental reevaluation, contingency management, dramatic relief, and helping relationships). They are necessary and sufficient conditions of change and are spread along a heuristic therapeutic continuum. These processes of change correspond to therapeutic factors in formal therapy. According to the Transtheoretical model, different psychotherapies emphasize only two or three of these processes. Thus, different therapies operate in different stages or phases of change (in a hypothesized therapeutic continuum), depending on the processes of change they emphasize. In agreement with Weinberger (1995), and Glass and Arnkoff (1993), the Transtheoretical model supports the *unique* (but also complementary) nature of therapeutic factors among therapies, rather than their commonality among different orientations. Similar assumptions are shared by the Assimilation model (Barkham, Stiles, Hardy, & Field, 1996; Stiles *et al.*, 1990), which posits that clients respond differentially to treatments according to the level of assimilation of their problematic experiences (i.e., insight-oriented treatments are more effective for less identified/assimilated problems, while action-oriented treatments are more suitable for well stated and clearly identified problems, namely the later levels of problems' assimilation).

2. *Achieve the therapeutic factor status*: The relation of a variable/factor to outcome would have to be validated empirically. Arkowitz (1995) argued that there is not enough evidence at the moment to support that common factors bear a causal relationship to outcome, since most of the relevant data are correlational. The validation of therapeutic causality has been recognized as a difficult task to be accomplished, mainly because of (a) definitional obscurities, (b) difficulties and differences in the operationalization of common factors constructs for research purposes, and (c) the requirement of specific methodological designs (i.e., experimental) to demonstrate causality (see Arkowitz, 1995).

At the correlational level, more empirical research to validate the relationship of many of the proposed common factors with therapeutic outcomes is needed in most of the therapies (see also Grencavage & Norcross, 1990; Weinberger, 1993). However, it should be noted that the value of the process-outcome correlation paradigm in measuring the therapeutic effects of a process variable has been seriously questioned by Stiles (1988, 1994, 1996) with the introduction of the concept of *responsiveness* in psychotherapy. This concept overlaps with the aptitude–treatment interaction

hypothesis, which holds that various interventions can produce differential (i.e., optimal) outcomes if appropriately matched to client variables, and in a close examination actually describes *an ideal*, *multidimensional*, *very detailed prescriptive matching in therapy* (*including the therapeutic relationship*). Stiles and his associates have shown that correlational research might be misleading because (a) it may either indicate that a process component is important (while it is not), or (b) it fail to reveal the importance of a variable that in actuality bears a meaningful relationship to outcome (for a recent full discussion of the responsiveness critique, see Stiles, Honos-Webb, & Surko, 1998).

3. *Achieve the status of both a common and a therapeutic factor*: The existence and the therapeutic value of a variable/factor needs to be validated empirically *in every therapy*, or at least in the major ones. This validation has yet to occur for the great majority of the proposed common factors in various lists, with the possible exception of Orlinsky, Grawe, and Parks' (1994) research. In their comprehensive review of empirical process-outcome research in psychotherapy in the last four decades, support was found for a research-based common factors list in different therapies, along the dimensions of their Generic model of psychotherapy (Orlinsky *et al.*, 1994; Orlinksy & Howard, 1987). Although this work has yielded important findings, their usefulness as a list of therapeutic factors that are common in all therapies is limited by (a) the correlational nature of the research findings reviewed; (b) the inconsistent links of many process variables to the outcome, dependent upon the perspective from which they were measured (i.e., client, therapist, rater); (c) the weak or negative links of some controversial process variables to outcomes in different therapies (e.g., therapist's collaboration vs. directiveness or permissiveness, client's negative affective response, therapist's advice); (d) the somewhat subjective development of the six categories used in the Generic model and somewhat subjective classification of psychotherapy process variables/findings from the reviewed studies into the categories of the Generic model; (e) the underepresentation of some therapeutic models in some of the categories formed (i.e., some therapeutic variables are less "common" than others). Not surprisingly, the 11 process variables most robustly linked to outcome in different therapies (Orlinsky *et al.*, 1994) can be classified as either client characteristics or as variables related to the therapeutic relationship, whereas fewer variables linked to outcome involved specific therapeutic interventions. Overall, the therapeutic alliance is by far the most well-researched common factor in the literature, and this research has shown it to be the common factor most strongly related to outcome (see also Horvath & Greenberg, 1994; Safran & Muran, 1995).

Future Empirical and Conceptual Developments Regarding the Misconception

Over the last decade the Dodo bird verdict has been largely criticized and dispelled on methodological grounds (Beutler, 1991; Kazdin & Bass, 1989; Luborsky, 1995; Norcross, 1995a; Shadish & Sweeney, 1991; Stiles *et al.*, 1986). A total of 15 reasons have been proposed to explain this verdict (see Table I), or as it is also called, ''the outcome uniformity myth'' (Kiesler, 1966) or ''the myth of outcome homogeneity'' (Beutler, 1995). The majority of researchers agree on item one of Table I, the partial contribution of common factors to the equivalent outcomes phenomenon (Lambert, 1992;

Table I. Possible Explanations of the Equivalent Outcome Paradox (Based Mainly on Luborsky, 1995; Norcross, 1988, 1995a; Stiles *et al.*, 1998; Weinberger, 1995)

1. Important common factors with therapeutic value do exist among therapies and partly explain the equivalent outcomes.
2. Different therapies operate in unique ways (i.e., specific factors) but reach the same or equivalent outcomes (i.e., the equifinality principle).
3. An unequal emphasis of therapies on their favorite therapeutic factors that result in unbalanced but equivalent treatments.
4. Different therapies produce equivalent outcomes by appropriately responding and adapting their interventions to their client needs (responsiveness theory).
5. Equivalent outcomes between therapies have been found only in one kind of measure (i.e., symptom change) out of many possible areas of change, and usually from one perspective (self-report; that is, outcome measures are limited and inadequate).
6. Variability in therapist skills and competence, although capable of producing differential results, has been generally disregarded in comparative studies.
7. Comparative outcome research fails to find differences between treatments because they examine the impact of clinically irrelevant and meaningless variables.
8. Half of the published horse-race outcome studies lack adequate statistical power (small samples and small treatment effects) to detect differential effects.
9. The high percentages of improved clients in comparative treatment research make the demonstration of significant differences between therapies more difficult.
10. Researchers' allegiance and bias may favor one treatment vs. the other in different studies, in a way that the biases are finally balanced in a large number of studies and equivalent outcomes appear.
11. Comparative outcome research designs mask subtle differential effects that exist between treatments, and insensitive outcome measures fail to capture them.
12. Aptitude-treatment interaction research shows differential therapeutic outcomes (when aptitude is a meaningful psychological variable).
13. Comparative outcome research supports in general the equivalent effectiveness of therapies. When it comes to clinical practice, therapists continuously make decisions and tailor their interventions to individual clients; they do not use any kind of intervention or approach indiscriminately.
14. From a total of more than 400 therapies, only a very small number has been empirically tested and found to produce equivalent outcomes.
15. Selective attrition in the different therapeutic conditions of randomized controlled trials may also have contributed to the equivalent outcome phenomenon.

Lambert & Bergin, 1994; Luborsky, 1995; Norcross, 1995a; Weinberger, 1995); however, considered cumulatively, the 14 other explanations in Table I decrease the probability that in the future therapeutic commonalities existing across all treatments will be empirically identified to the extent hypothesized by the Dodo bird verdict. Thus, despite the fact that therapies may appear to be equivalent by virtue of lack of differential effectiveness in outcome studies, for a variety of methodological reasons (such as those delineated in Table I) such equivalence is not the case. Differences (in goals, formulations, techniques, etc.) and specific factors possibly exist and account for some demonstrated differential outcomes among therapies.

In view of these considerations, it may be expected that future research would demonstrate (a) *some elements that are both widely common and therapeutic* (e.g., an effective working alliance), (b) additional therapeutic elements that are common only in *some* (*but not all*) *of these therapies*, (e.g., the rehearsal and test of new behaviors), and (c) a few unique elements in some treatments (particularly with specific problems). The last two kinds of therapeutic agents will be responsible for specific effects and should be researched among therapies that have already demonstrated differential outcomes with specific clients and problems (i.e., empirically supported treatments and other prescriptive therapies). Consistent with these expectations is the observation that for some problems certain common factors might be more relevant and important than others (i.e., social support for depression; Arkowitz, 1995; see also Garfield, 1986). Others have suggested the exploration of differential roles and functions of the hypothesized common factors in different therapies and with different clients and problems, as well as their interactions with specific factors and specific contexts they are applied in (Elkin, 1995; Glass & Arnkoff, 1993; Shoham, 1993). The view that common factors may exist and operate in very different forms and ways in various therapies should also be considered in attempts to demonstrate the clear and robust presence of common and therapeutic factors in all therapies.

Additional Recommendations Regarding the Misconception

Following the clarification of these issues, there is a need to adjust the use of the related terms. What has been vaguely identified and implied in the literature needs to be stated clearly. The following suggestions are made: The abandonment of the term ''therapeutic common factors'' and its synonyms, to be replaced with the standard use of more accurate terms such as ''common factors in all therapies,'' ''potential (or hypothesized) common (therapeutic) factors,'' or ''common factors associated with therapeutic outcome.'' Moreover, the terms ''common

factors'' and ''therapeutic factors'' should be used accurately, i.e., in a manner that is isomorphic with the corresponding factors being demonstrated (common or therapeutic, respectively), and not used interchangeably. This suggestion applies also to the term ''change factors,'' in the event that the frame of reference is the broader context of change that includes extratherapeutic change as well. The way the term ''therapeutic common factors'' is currently being used is rather inaccurate, confusing, and misleading, since it applies only in limited cases. Goldfried (1980) has suggested the term ''common clinical strategies'' to be used for the hypothesized common factors, which when empirically validated could be upgraded to ''(common) principles of change.'' An updated, comprehensive, and extended review of the empirical research in common factors might shed further light on the issue and define the appropriate terms to be used in each case or class of common factors.

However, this discussion by no means intends to overlook or understate advances achieved in the field of common factors theory and research. Important work has been conducted by different groups (within the limitations of the existing methodologies), which has effectively established the general value of a common factors approach to the study of psychotherapy integration. Thus, systematic empirical research on common factors is now routinely conducted (e.g., The Stony Brook Psychotherapy Research Program; Wiser *et al.*, 1996), while theoretical explorations are frequently conducted under the auspices of the Society for the Exploration of Psychotherapy Integration (see, for example, the special issue of *Journal of Psychotherapy Integration* on ''support'' in different therapies; Castonguay, 1997). As another example of exploration (methodologically oriented), Castonquay (1993) discussed and clarified the use of the terms ''common factors'' and ''nonspecific variables'' in the literature, and on the basis of his sound analysis recommended retaining the former term and abandoning the latter term in order to better describe the status of developments in the field (i.e., the nonspecifics have been gradually specified). In a similar fashion, this discussion has attempted to clarify distinctions between the terms ''common factors'' and ''therapeutic factors.'' The present author shares Castonguay's optimistic view on the value of studying common factors, while also echoing a note of caution in order to underscore the present limitations of the field and thus the work needing to be done. Rather than having a discouraging effect, these clarifications aim to enhance clinical practice both by preventing premature false conclusions and the negative clinical consequences that may stem therefrom, and by fostering research in the appropriate directions.

Regarding the practice of psychotherapy, an effort to emphasize common qualities of effective models (e.g., support, raising of expectations) in our treatments would definitely be beneficial, but limitations of this ap-

proach should be also clear. The therapeutic denominator proposed by the common factors idea in many cases will be not sufficient to bring the desired outcome. The importance of this discussion for the practitioner is twofold. First, it is designed to serve as a warning to practitioners that an overreliance on common factors at this point of our understanding may limit clinical effectiveness. The misconception caused by the outcome equivalence paradox that common factors are sufficient conditions for cure may misdirect clinicians to ignore and lose potential benefits that specific factors may have to offer. As proponents of the integration movement have suggested, the inclusion of both common and specific factors in our therapies can greatly enhance the probability of optimal results (Beitman, 1992; Lambert, 1992). A second implication of this discussion is to dispel the erroneous conclusion, which can also result from the outcome equivalence paradox, that any kind of therapy would be effective in clinical practice, regardless of the problem or the client. Therefore, a useful suggestion would be that therapists draw from available, theoretically diverse, empirically supported interventions (ESTs) in the treatment of a specific problem (e.g., cognitive or interpersonal therapy for depression). Clinicians may practice either pure-form ESTs or in an assimilative fashion, by integrating effective but missing components (i.e., specific factors) in their therapy (Lampropoulos, in press). Both strategies will increase the probability of an optimum mixture of common and specific factors in therapy, with the latter strategy requiring some additional test of the coherence and the empirical validity of the new assimilated practice (for more on assimilative integration, see Lampropoulos, in press). Regarding research, what is (a) common, (b) therapeutic, (c) common and therapeutic, and (d) specific and therapeutic, needs to be further *specified* and empirically demonstrated before the variables within each of these categories are accepted by the scientific and clinical community as *common* knowledge.

MISCONCEPTION NO 2: CONFUSING THE LEVELS AND KINDS OF COMMON FACTORS

The Nature of the Misconception

Another area of confusion in the common factors literature revolves around the levels and kinds of definitions of common factors that are discussed and researched. On what level should commonalities be measured? Should common theoretical constructs and principles (on an ''upper'' level of theory), or procedures and clinical interventions (on a ''lower'' technical level), be studied? There are a variety of psychotherapeutic constructs, usually described as transtheoretical, pantheoretical, or atheoretical,

that could be investigated as potential common factors, as presented in Table II.

Goldfried (1980) provided critical insight into this issue, and recommended that the most appropriate and fruitful level for studying common factors lies at an intermediate level between theory and technique, which he termed "clinical strategies." Goldfried justified his position by explaining that rapprochement and integration at the theoretical level will be not feasible due to large differences among theories in their respective conceptions of personality and human functioning, while at the technical level efforts for rapprochement will produce only trivial similarities. In arguing for an intermediate level of abstraction between theory and technique as the ideal focus, Goldfried provided a heuristic framework which most theorists and researchers use to propose and empirically study potential common factors.

Sources of the Misconception

Common factor proposals are often limited to one or two of the aforementioned 13 categories. Authors usually choose to focus only on specific

Table II. Therapy Variables as Potential Common Factors

1. Therapist variables (skills, qualities, characteristics and practices; e.g., genuineness, involvement in therapy; see Beutler, Machado, & Neufeldt, 1994),
2. Client variables (e.g., openness, psychological-mindedness; see Garfield, 1994),
3. Therapist–client interaction characteristics (e.g., alliance, relationship, contract; see Sexton & Whiston, 1994),
4. Therapist intentions (e.g., set limits, give information; see 19 categories by Hill & O'Grady, 1985), "purposes" (i.e., nonobservable intentions; Stiles, 1987), or goals,
5. Therapist's verbal response modes (e.g., approval, restatement; see 9 categories by Hill, 1985, 1992; see also Elliott, Hill, Stiles, Friedlander, Mahrer, & Margison, 1987; Stiles, 1986),
6. Therapist specific techniques (e.g., role playing, exposure techniques; see relevant chapters in Bergin & Garfield, 1994),
7. Client verbal modes (e.g., requests, silence; see 9 categories by Hill, 1986; see also Stiles, 1986),
8. Client reactions to therapist interventions (e.g., stuck, understood, supported; 21 categories by Hill, Helms, Spiegel, & Tichenor, 1988),
9. Theories of therapy or parts of them such as theoretical principles and constructs
10. Phases of therapy (e.g., the remoralization phase, the remediation phase; Howard *et al.*, 1993; for similar structures, see Beitman, 1987; Schein, 1973; Strong & Claiborn, 1982),
11. Stages of change and self-change (e.g., precontemplation, preparation; Prochaska & DiClemente, 1984),
12. Levels of problem assimilation (e.g., warded off experience, problem statement; Stiles *et al.*, 1990),
13. Change events or significant/good moments (in-session and intersession; e.g., expression of insight/understanding; see 12 categories by Mahrer, 1988; see also Elliott *et al.*, 1985), processes of change (Prochaska & DiClemente, 1984), or therapeutic realizations (Orlinsky & Howard, 1987).

kinds of commonality, and therefore lists differ from one another (Grencavage & Norcross, 1990; Karasu, 1995). For example, one list may cite patient variables while another therapist operations. Most importantly, although usually within the context of Goldfried's heuristically valuable framework of levels of abstraction, *researchers often have proposed and discussed a mixture of commonalities of different kinds* (and sometimes of different levels). Elkin (1995) briefly commented on the mix of patient processes and therapist interventions in Weinberger's (1995) common factors list, and called for further discussion of the issue. This inconsistency between kinds and/or levels of variables is indeed evident in the literature. Representative examples are a mix of therapist, client, and change variables (e.g., Fadiman, in Brady *et al.*, 1980), therapist qualities and goals (e.g., Raimy, in Brady *et al.*, 1980), and therapy principles and therapist goals, skills, and interventions (e.g., Davison, in Brady *et al.*, 1980). The insufficiency with which theorists and researchers differentiate and clarify relations between these constructs also is reflected in a review by Borders and Byrd (1995) of a recent common factors textbook.

Nevertheless, it is rather important for researchers to acknowledge the differences between these kinds of constructs and discuss commonalities of the same order, in order to conduct valid and meaningful studies. Indeed, in a more sophisticated attempt, Grencavage and Norcross (1990) avoided mixing different kinds of common factors in the same list and reviewed them in five different categories (client characteristics, therapist qualities, change processes, treatment structure, and relationship elements). Examples of other well-known taxonomies that could be used for the categorization and study of common factors (using similar coding schemes and utilizing some of the 13 categories presented in Table II) include those proposed by Stiles *et al.* (1986; three categories: client factors, therapist factors, and the therapeutic alliance) and by Orlinsky and Howard (1987). Orlinsky and Howard (1986, 1987; Orlinsky *et al.*, 1994) developed a generic model of psychotherapy based upon their exhaustive review and organization of findings from psychotherapy process and outcome research. Their generic model describes psychotherapy in terms of transtheoretical (common) components that include a formal aspect (therapeutic contract), a technical aspect (therapeutic operations), an interpersonal aspect (therapeutic bond), an intrapersonal aspect (self-relatedness), a clinical aspect (in-session impacts stemming from therapeutic processes), and a temporal aspect (sequential flow).

Of course, someone might correctly note that the 13 kinds of constructs presented in Table II are more or less closely related (and thus it is difficult to differentiate) and interact with each other, including in nonlinear ways, to affect final outcomes. For example, specific *techniques* that are derived

from specific *theories* and *theoretical constructs* are being used in a specific *time (phase) in therapy* by a *therapist* with specific *qualities* and *characteristics* to achieve specific *goals*. This happens in the frame of an *interactional relationship* of specific *quality* with a *client* who possesses specific *personality characteristics* and *reacts* in specific *ways* to things that happen in therapy. Specific *in-session change events* will occur in therapy that will gradually result in bigger and more *enduring therapeutic outcomes*. This interrelationship among factors, an inherent element of the therapeutic encounter that reflects both its richness and complexity, is both a disadvantage and an advantage in psychotherapy research. It is responsible for the aforementioned confusion between kinds and levels of common factors, but it can also lend more precision to the study of these factors by initially focusing researchers on central constructs of therapy that lie at the same level.

Having described and clarified the confusion that constitutes the second misconception, the next logical question posed is, ''Where does research and analysis of common factors need to focus?'' An attempt to provide some answers and directions *vis-à-vis* this question follows.

Recommendations Regarding the Misconception: Change Events and Therapist Operations in Common Factors Research

Considering the above discussion, the answer regarding the question of focus should definitely be on the *same kind* of constructs, while the selected kind should be somewhere at the intermediate level of clinical strategies, as recommended by Goldfried (1980). However, the concept of ''clinical strategies,'' while very useful as a heuristic, unfortunately does not provide adequate guidance by itself for identifying what specifically needs to be studied. It is argued that, to enhance the capacity of the clinical strategies concept to serve this guidance function, it should be complemented with some other kind of construct that can provide a systematic and meaningful way to research and compare commonalities among therapies. The most appropriate construct for this purpose are the in-session ''change events'' (which will be considered for the purpose of this discussion more as a process variable, in line with the conception of other researchers, e.g. Orlinsky *et al.*, 1994).

Change Events

These minioutcomes that build the subsequent bigger outcomes of therapy are real and continuous reflections of clients' experience in therapy

that demonstrate how therapy achieves its effects. Research data supporting the robust link of change events to the final outcome in therapy are reviewed by Orlinsky *et al.* (1994) under the category "therapeutic realizations." Researchers agree that the future exploration of common factors should include clients' perceptions about their change (Glass & Arnkoff, 1993), their construction of therapeutic events (Hill, 1995a), and what actually does happen in therapy between client and therapist to effect change (Arkowitz, 1995). Change events, as they are measured by *client self-report* measures (e.g., the Session Impacts Scale; Elliott & Wexler, 1994; the Helpful Aspects of Therapy Form; Llewelyn, Elliott, Shapiro, Hardy, & Firth-Cozens, 1988; the Therapeutic Realizations Scale; Kolden, 1991; the Therapy Session Topic Review; Barkham *et al.*, 1996), as well as *trained observers*, using rating systems such as the Category System of Good Moments (Mahrer, 1988) or the Rutgers Psychotherapy Progress Scale (Holland, Roberts, & Messer, 1998; Messer, Tishby, & Spillman, 1992), can satisfy these conditions, utilizing the two most promising perspectives in process and outcome methodology (i.e., client and observers' reports). In addition, qualitative narrative approaches such as task analysis (Greenberg, 1986), comprehensive process analysis (Elliott, 1989), and assimilation analysis (Stiles, Meshot, Anderson, & Sloan, 1992) can be used to further unfold and explain clients' constructions of these change events in relation to both participants' behaviors.

Therapist Operations

The value of change events methodology needs to be complemented by the concurrent measurement of therapists operations. The term "therapist operations" will be used here to describe an ideal, combined level of measurement that includes both therapist intentions/goals and interventions used to facilitate change. The construct of therapist operations falls in the general area of clinical strategies described by Goldfried (1980); specifically, therapist intentions are closer and represent theory (i.e., derive from theory-based case formulations) and therapist interventions are closer to the lower level of techniques. The rationale for proposing therapist operations lies in the cumulative evidence that the widely used construct of verbal response modes (VRMs) alone, without information about the context in which it is applied, is rather inadequate for purposes of describing or measuring meaningful units of therapist behaviors. It has failed to differentiate therapists' specific underlying goals for specific interventions, to correlate with change events and other process variables, and failed to predict change (e.g., Stalikas & Fitzpatrick, 1995, 1996; see also Elliott, Stiles, Shiffman,

Barker, Burstein, & Goodman, 1982, and Hill, 1995b, on the limitations of VRMs). After two decades of research with rather poor results, VRMs measures should be replaced or complemented with more global and meaningful measures of therapist behavior.

Research Agenda

Based upon the aforementioned recommendation that change events and therapist operations constitute two primary constructs for research investigating commonalities among therapies, three specific research recommendations are proposed: one regarding change events, one regarding therapist operations, and one regarding a combination of both.

1. *Further development of the existing change events lists* (Boulet, Souliere, Sterner, & Nadler, 1992; Elliott, James, Reimschuessel, Cislo, & Sack, 1985; Mahrer, 1988) through exploratory research (discovery oriented; Mahrer, 1996) to steadily expand the array of identified change events in different therapies. The use of discovery-oriented research to explore any important change events that have not yet been identified is a prerequisite for studying their relationship with therapist operations in various modes of therapy.

2. *Research to identify therapist operations* and measurement development to assess them at a sufficient level to describe meaningful therapist behaviors. This includes two specific considerations: First, the level of measurement needs to move from the relatively fruitless molecular level (i.e., speaking turns) to the level of the entire session. Second, therapist interventions should be measured as specifically and comprehensively as possible, including their underlying goals/intentions as well as their specific content and object. Thus, measures of therapist VRMs should be complemented by measures of therapist intentions or replaced by measures that assess both. Recently, more global, richer constructs and measures of therapist behavior than the VRMs have appeared. Such examples of global (session-based) and therapy-specific measures of the therapist behavior are the Sheffield Psychotherapy Rating Scale (Shapiro & Startup, 1990) and the Collaborative Study Psychotherapy Rating Scale (see Hill, O'Grady, & Elkin, 1992). Being developed as measures of therapist adherence to manualized interventions and scored by observers, these measures incorporate theory-based therapist intentions since most of their items are therapy specific. Other global measures such as the Therapeutic Procedures Inventory (McNeilly & Howard, 1991; Orlinsky, Lundy, Howard, Davison, & Mahoney, 1987) have separate scales for therapist goals and therapist interventions, or simultaneously consider therapist intention, and content and

object of his/her behavior (i.e., the Inventory of Therapeutic Strategies; Gaston & Ring, 1992). Similarly important is the work of Stiles *et al.* (1996), who validated empirically the Therapist Session Intentions (TSI) form, which describes conceptually coherent clusters of therapist intentions or in-session therapeutic foci from theoretically different therapies. Designed to focus on whole sessions rather than speaking turns, the TSI is a much more global measure of therapeutic intentions than Hill and O'Grady's (1985) therapist intentions list; it also correlates with measures of therapist actual behavior, namely the SPRS. Overall, the closer and more completely and objectively any of these kinds of measures can describe *what the therapist actually does in session that facilitates a change event*, the greater its usefulness in meaningful process research. This may require the inclusion of more than one perspective (i.e., therapist, client, and observers) to complement and to ensure accuracy in the description of therapist's behavior.

3. *Comparative search across therapies for change events* (including their patterns, combinations, and sequences) as a meaningful and systematic way to identify common factors, following the examples of Mahrer, Boulet, and Stalikas (1987), Mahrer, Nadler, Stalikas, Schachter, and Sterner (1988), Mahrer, Lawson, Stalikas, and Schachter (1990), Stalikas (1990), and Llewelyn *et al.* (1988). At the same time, the investigation of therapists' related operations that facilitate these events should be measured. This exploration will take place ideally in sessions of equally effective, empirically supported manualized therapies. The reasons behind this preference include (a) the need to secure that the therapists operations and change events under study are related to demonstrated robust final therapeutic outcomes; (b) the need to explain the equivalent outcomes of two or more equally effective treatments for the same disorder; and (c) the standard and replicable "language" of therapist operations provided by treatment manuals. Given the complexity and the variability of the therapeutic endeavor, it would be advisable to start implementing the aforementioned research recommendations in an environment that is as controlled as possible, like the one provided in manualized ESTs. Further, manualized interventions may provide an ideally documented condition of theory-informed therapy (i.e., they are measured for adherence to treatment manuals, while even master therapists may occasionally or systematically and severely depart from their theories in everyday clinical practice). An example of one such study would be the concurrent research of specific change events and the associated therapist operations in cognitive-behavioral and psychodynamic-interpersonal therapies in the Second Sheffield Psychotherapy Project, as they already have been separately measured in different studies by the Session Impacts Scale and the Helpful Aspects of Therapy measure (see Reynolds *et al.*, 1996), and by the Coding System of Therapeutic Focus (Goldfried

et al., 1997) and the TSI forms (Stiles *et al.*, 1996), respectively. Alternatively, from another perspective ratings from observers can be used to identify the change events in recorded sessions (e.g., Mahrer, 1988).

The heuristic value of research guided by these three recommendations is further underscored by the fact that, in studying these kinds and levels of variables in the search for common factors, other variables are involved as well. For example, change events usually appear in a certain sequence in therapy; therefore phases of therapy and time are also being considered. Finally, these proposals allow the investigation of common and specific factors by studying both the therapist (intentional and actual in session input) and the client (session by session effects of that input), in short, distinct, and manageable meaningful units. The latter advantage is very important, because it ensures a context-sensitive approach that does not inappropriately try to separate the study of common factors from their specific elements (see Butler & Strupp, 1986; Omer & London, 1989; Shoham, 1993). The necessity for studying common factors in the specific contexts in which they take place has achieved unanimous agreement in the field, yet remains a difficult task. Thus, it is proposed that these units of measurement (i.e., change events and therapist operations) are the best possible ones, an ideal compromise between the existing methodological limitations and the quality demands for clinically useful psychotherapy research. Starting with change events as the guiding construct for research and studying their relationship with therapist operations, the schism between the traditional correlational paradigm and the responsiveness critique also can be partly reconciled, by adopting a process-process correlational paradigm (that can also be complemented by qualitative research). Last, measures of the therapeutic relationship, client behavior (in session input), and other more static or changing client and therapist variables also could be included to add to the knowledge of therapeutic change. This is likely to be important, considering that the client's degree of formal disorder—as denoted by the client's diagnosis—and intimately related psychological condition are continuously changing throughout therapy (see also Beutler, 1991; Safran & Messer, 1997).

CONCLUDING COMMENTS

In this paper I have attempted to identify two misconceptions and the significant confusion they have created in the study of common factors, and have provided clarification and specific recommendations in order to correct these misconceptions and to reduce the confusion they have produced. In addition, stemming directly from these recommendations, I have

proposed a number of specific directions for research. However, a variety of complex issues remain to be solved regarding what, where, and how common factors should be defined, operationalized, measured, researched, and analyzed. For more discussion on common factors and their research, the interested reader is referred to recent roundtables (Norcross, 1993, 1995b), a monograph by Weinberger (1995), followed by nine reactions, and other related publications (e.g., Arkowitz, 1992a,b; Butler & Strupp, 1986; Carroll, Nich, & Rounsaville, 1997; Castonguay, 1993; Castonguay *et al.*, 1996; Crits-Cristoph, 1996; Garfield, 1996; Goldfried, 1980, 1991; Goldfried *et al.*, 1997, 1998; Grencavage & Norcross, 1990; Henry & Strupp, 1994; Henry, 1998; Karasu, 1986; Omer & London, 1989; Wiser *et al.*, 1996). It is the author's hope that the conceptual and methodological ideas presented in this paper will foster greater precision and specificity in the investigation and understanding of key common factors in psychotherapy, which in turn can generate truly meaningful findings that yield direct clinical benefits for the practicing clinician.

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