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Chapter

A Chronological Map of Common Factors across Three Stages of Marriage and Family Therapy

Hassan Karimi, Fred Piercy and Jyoti Savla

Abstract

Meta-analysis research supports the notion that common factors are at work across theoretically different therapies. However, some advocates of empirically supported treatments (ESTs) criticize that there is no common factor chronological map to guide clinicians across different stages of therapy (initial, intermediate, termination). In this chapter, supported by recent research, we propose a preliminary chronological map which has the potential to guide clinicians as they use common factors across all three stages of couple and family therapy. The common factors approach is an overarching therapeutic model within which the therapist can determine and use well-timed common mechanisms of change to support therapy's success. This is consistent with the AAMFT Core Competencies to provide safe and effective therapy.

Keywords: common factors, chronological map, process-research, systemic therapy, family therapy

1. Introduction

Outcome research has supported the therapy effectiveness in psychotherapy and Marriage and Family Therapy (MFT) fields [1]. The findings, over decades of comparative studies, indicate therapy is effective. It can be as effective as medical treatment, and its outcome can last longer than medical treatment [2, 3]. However, the therapy field still deals with controversial debates regarding how therapy provides change and thorough what mechanisms? [4, 5].

In reaction to Hans Eysenck's [6] claim that psychotherapy is ineffective, a series of outcome research studies were conducted that itself caused the emergence of competitive treatment models. Such a trend led in the movement of Empirically Supported Treatments (ESTs) to find the most effective treatments for specific problems [3, 7, 8]. That is, the advocates of ESTs assumed their model-specific factors/techniques were the mechanisms responsible for therapy effectiveness [9]. Therefore, these researchers support outcome research and more controlled comparative studies to establish a specific treatment manual for each specific clinical problem [10]. On the other hand, the advocates of the common factors (CFs) approach believe that shared factors/change mechanisms are responsible for therapeutic outcome across all successful treatment models [3, 8]. They assume that there is not one significant model that achieves higher efficacy than others. For a

few decades, we have seen a loop of research between the two camps. The advocates of model specificity piled supportive findings for their models' efficacy, which provided more raw data for advocates of CFs to run meta-analysis that shows equal efficacy across different treatment models [3, 11]. Breaking such a loop toward a better understanding of therapeutic change mechanisms requires more process research and multiple research methods [4, 5, 11]. Process research, by focusing on specific "whats," "whys," "whens," and "hows," can contribute to more clinically relevant and theoretically integrative models.

In this chapter, we provide an overview of the common factors approach and its development. We also discuss the critiques that ESTs advocates posit on CFs approach. Then, we propose a chronological map of when certain common factors are most relevant, which is supported by our qualitative research, as well as other MFT literature. Finally, we discuss the research, clinical, and training implications of the chronological map.

2. Development of common factors approach

Rosenzweig [12] was the first to discuss common factors in the literature. He suggested therapy effectiveness is due to a therapeutic relationship and a treatment rationale that justifies therapeutic tasks. Frank's [13] work prepared the field to move toward integrative therapies. Frank proposed four key dimensions of healing process: (1) an emotionally charged confiding relationship, (2) a therapeutic context, (3) a credible rational that provides a convincing explanation for the client's problem and how to resolve it, and (4) a procedure or task that requires active participation of the client. Then, the research of Luborsky et al. [14] found equivalency of effectiveness across active treatments, which indicated three of every four clients improved, regardless of treatment type.

Lambert [15], based on a review of outcome studies, proposed a four-factors model of what factors contribute to effectiveness, with estimated percentages, including extra-therapeutic change factors 40%, common factors 30%, technique factors 15%, and expectancy factors 15%. Though these percentages were mostly interpreted or cited as factual, empirical evidence, a recent study by Karimi [16] indicates that the percentage of each CFs category can vary due to specific characteristics of therapist, client, problem, etc. That is, the CFs are not a set of static factors, but are dynamic and interactive factors. Another significant contribution by Lambert [15] is a developmental conceptualization of therapy as a process that contains three sequencing stages: support factors, learning factors, and action factors.

A few other insightful theories of integration [17–20] have been introduced in the field, which emphasized mostly common mechanisms/processes of change across treatment models. For example, Goldfried and Padawer [18] conceptualized therapy at three differentiated levels that include: *theories, strategies, and interventions*. At the highest level of abstraction, theories intend to explain human functioning and pathology. At the lowest level of abstraction, techniques which are linked to specific theories intend to generate change. And strategies are within the middle level of abstraction which can be activated by different techniques. It seems that experienced therapists consider these strategies or change processes as a heuristic guide in their practice [21]. For example, the therapists deliberately can choose from seemingly different techniques (e.g., cognitive restructuring, empty chair, family sculpting, paradoxical homework, etc.) when they target a particular change process (e.g., detriangling from parents), which meets the therapy goal (improvement of depression).

Though, the advocates of ESTs insist on manualizing specific protocols for specific problems/disorders [9]. The integrative and CFs scholars [11, 22] challenge the uniformity myths in ESTs, which assumes therapy is consistently applied across therapists and clients. In theory, the therapist may start with a specific model, but in actual practice, the therapist's behavior is mostly guided by the client's responses/characteristics, so the process turns into a progressively individualized one [23, 24]. In addition, the most comprehensive evidence-based study to date (American Psychological Association Task Force, 1993) indicated that there were no differences among all forms of treatment (cognitive behavioral therapy, interpersonal therapy, medication with management, and placebo plus clinical management) on the client's level of depression, but there was a difference in the level of the therapeutic efficacy of the therapists; while the treatment models, the settings, and even the therapist experience were controlled [25].

Sprenkle and Blow [11] proposed a moderate definition of CFs in the marriage and family therapy field; they consider CFs as the main mechanisms of change, though specific models play a role in therapeutic change too. In fact, they consider models as vehicles that delineate a temporal sequence indicating when each CFs should be punctuated during the therapy process. They proposed six categories of common factors: client, therapist, relationship, expectancy/hope, Non-specific mechanisms, unique MFT common factors. Since therapy inherently is a multilevel interactional process [21, 22], such a distinction between the components is more artificial than factual. For the purpose of this chapter, we use this moderate definition of common factors. However, we believe future research may well modify these common factors or introduce new items to improve the conceptualization of CFs.

2.1 Client factors

Client factors include a set of characteristics (e.g., motivation, spirituality and religious faith, cognitive ability, self-agency, cooperation on therapeutic tasks, perseverance, expectations) that are potential resources that relate to clients' movement toward their therapy goal. Unfortunately, professional centrism caused the field to overlook the invaluable therapeutic potency of client factors [8, 26]. Clients usually edit and reconstruct therapeutic interventions and the therapist's style to individualize them to their values and goals. According to Miller and associates [27], "The research literature makes it clear that the client is actually the single most potent contributor to outcome in psychotherapy."

2.2 Therapist factors

Researchers proposed a set of characteristics for therapists (e.g., therapist positivity and friendliness, level of activity in the session, providing structure to face clients with cognitive, emotional, and behavioral experiences, therapist openness, therapist's ability to adapt to client's preferences, therapist's cultural sensitivity) that contribute in therapy outcome [3, 8]. Researchers using Randomized Clinical Trials (RCTs) studies usually try to control the therapist's variables. However, reanalysis of the most comprehensive evidence-based study on depression (American Psychological Association, Task Force, 1993) identified therapist effectiveness as the main treatment factor; while the treatment models, settings, and even the experience level of therapists were controlled [25]. Also, a meta-analysis of psychotherapy outcome studies [3] has found that clinicians' differences contributed more effect size (0.65) to outcome variance than the treatment models themselves (0.20). Therefore, the therapist's role in therapy outcome is sometimes referred to as a "neglected variable" [28]. Consequently, more research on therapist's competency

is critically needed, both for research and training purposes. More specifically, research can explore the core competencies that a systemic therapist needs in working with couple and family systems.

2.3 Relationship factors

Relationship factors are associated with the therapeutic alliance, which involves three components: Bonds, Tasks, and Goals. Bordin [29] defined these components as follows: Bonds refer to the nature of affection in the therapeutic relationship, such as caring, warmth, etc.; Tasks refer to the client and therapist's agreement on therapeutic activities and their credibility; Goals refer to the client and therapist's agreement and cooperation toward what they hope to achieve in therapy. The link between therapeutic alliance and outcome has been well-studied in both psychotherapy and family therapy, though the nature of alliance is more complicated in relational therapy [30, 31].

2.4 Hope factors

Being in therapy, a perceived healing process, itself generates hope in the client; which then contributes to the client's motivation and engagement [15]. However, the presence in therapy itself is not the determinant factor of the client's hope. This is because we assume therapeutic hope is a multifactorial dynamic phenomenon and a product of the interaction between therapist, client, their relationship, and contextual factors, plus the therapeutic rationale. Though the clients enter with different levels of hope and motivation, therapists apply different strategies to increase hope [32, 33]. Sprenkle and Blow [22] suggest that the field needs more research to explore the relationship between hope and change process, and how best to enhance client hope. This is potentially a more challenging theme in relational therapy; since a part of the client's system often becomes hopeless or reluctant while the other part is pushing for change.

2.5 Non-specific mechanisms

Though specific theories use different theoretical concepts and terminology and apply their own specific techniques, all those techniques can be defined in three general categories: Behavioral regulation, Cognitive mastery, and Affective experiencing [20]. That is, two different theory-specific techniques (e.g., family sculpting, empty chair) could activate the same emotional processing/regulation in the client system. Prochaska and Norcross [21] refer to such events as change processes that function between theory level and technique level; which are heuristic strategies used by experienced therapists.

2.6 Common MFT/systemic factors

Family therapists generally identify the field of MFT as a distinct profession because of the systemic epistemology that shifts the focus from the individual to relationship patterns. That is, we live in relational systems in which problems develop and solutions can be created [34]. Accordingly, interviewing a youth without the family makes it more difficult to understand and change his/her problem, and identifying one family member as the entire problem is both wrong from a relational lens and also less helpful [35]. So, the systemic epistemology guides problem definition, treatment rationale, and therapy goals in a manner that is different from those typically associated with individual therapy. All MFT therapies, to varying

extents, share these common mechanisms: (1) relational conceptualization of problems, (2) disrupting dysfunctional relational patterns, (3) expanding the direct therapeutic system, and (4) expanding the therapeutic alliance [22].

3. Debate on common factors and model specificity

Advocates of the model specificity have mentioned a few critiques of the common factors model, including: (a) the support for a common factors model mostly comes from meta-analyses that indicated the equivalency of outcomes across treatment models, so it might not scrutinize some potential differentiating variables between models; (b) the common factors need better operational definitions to be researched and understood; (c) there is lack of evidence to show a specific link between the function of particular common factors and therapy outcome; (d) there is a lack of research that compares therapeutic impact of common factors versus model-specific factors; and (e) finally the CFs model is lacking a temporal and conceptual framework to guide therapists over the course of therapy [9, 10].

We believe these critiques are reasonable and should be addressed by multiple research methods to improve the CFs model as an integrative or metatheoretical approach. The results of meta-analyses on outcome equivalency can be interpreted in at least three ways: first, different models may generate the same efficacy but through different mechanisms of change; second, there might be significant differences between therapies' outcome, but we have not used the right research questions/measures/methods to find them; and third, the common change mechanisms can explain the equivalency of outcomes and possible minimal differences [11].

Since the focus of model specificity research is on efficacy and therapy outcome, the advocates of RCTs/ESTs "incorrectly presumed that therapy was consistently applied across therapists and within each case" ([11], p. 3). That is, most RCTs neglected the therapist and client's factors and their phenomenological experiences, which is a significant source of therapeutic variance [7, 15]. As Kazdin [36] mentioned, "many researchers lament that the manuals, including their own, are incomplete and do not reflect the complexity of treatment and scope of the exchanges between therapist and patient" (p. 293).

Meta-analysis research also cannot adequately explain the therapy process, since its results are built on the RCTs data with little attention to the specific therapeutic mechanisms at work. Likewise, the advocates of model specificity camp believe the current CFs approach overlooks the convolution of therapeutic change and the multilevel reality of practice. More specifically, Sexton et al., [10] concluded that "Two reasons lead us to this conclusion. First, common factors are not conceptually clear, operationally defined, or contextualized within a clinical process enough to make them either researchable or understandable. Second, as currently described, common factors are independent factors that are decontextualized from the complex process of therapy" (p. 137).

Neither manualized ESTs nor huge meta-analysis studies can unfold the mechanisms of change in therapy [11, 23]. The core phenomenon in clinical/MFT theories is to explain the process (when and how) of change, and a key reason for the development of integrative models is to maximize the therapeutic change by making use of multiple therapeutic skills. Similarly, the common factors model can play an integrative role in training, practice, and research. It would certainly help, though, if there were clearer definitions of the factors and their interactions; the context and mechanisms through which the factors are activated; and the temporal order they should be used to achieve both proximal and distal outcomes [5, 11]. Such process-progress research can help to capture the therapist and client's

phenomenological experiences, which can shed light on the change mechanisms at different stages of therapy [11, 37]. Any research to this end, can contribute to the development of more effective integrative and clinically relevant theories, and overcome a research-practice gap in the MFT field [5, 8, 11]. Process-progress research can be conducted in different forms and based on a variety of measures. For this chapter, we focus primarily on an exploratory qualitative study that examines the therapist's phenomenological experience of using common factors at three stages of therapy. In the next section, we briefly discuss the research procedures and the findings that suggest a chronological map of using CFs.

4. Research design

Qualitative research is appropriate when theory about a phenomenon is lacking or needs improvement [38]. We used a qualitative research design to address our research goal to improve the theorization of the common factors approach. We considered our project as process research or discovery-oriented research; which is concerned with what is happening in the course of therapy [37]. One assumption of such a research method is that the therapist and client behaviors occur differently at various stages of therapy. That is, even the same act/intervention (e.g., alliance, therapist competence) can be used in different contexts and for different purposes. Based on literature [22, 39, 40] we considered three stages of therapy (initial, intermediate, termination), with the assumption that each stage requires a particular set of CFs, specific interaction between the factors, and different phase-based functions/purposes. Since we aimed to get an in-depth understanding of the phenomenon, we used open-ended questions with a focus on participants' phenomenological experience. We used validation strategies such as having other researchers review our procedures, and eliciting feedback from our participants through member checks [38].

4.1 Sampling and participants

A purposeful/theoretical sampling method was used to recruit an expert panel. The goal of theoretical sampling is to find participants who are the most knowledgeable people in the field of study [38]. Our panel consisted of six experts who were willing to provide in-depth and interactional discussion on a Wiki site designed for this purpose. (As is typical of studies of expert opinion, such as Delphi studies, the backgrounds of the participants are more important than the number of participants.). The inclusion criteria for the expert panel included: Ph.D. degree in a mental health field, publication (peer-reviewed articles, book, dissertation) in common factors/integrative therapy, and more than 10 years of teaching and training experience. Our participants' fields of study included clinical psychology, marriage, and family therapy, and counseling. As for clinical orientation, the participants identified themselves as eclectic CBT, integrative psychodynamic, and integrative family systems therapy.

4.2 Data collection

A Wiki page including instruction and three open-ended questions was created. The Wiki allows participants to discuss their own experiences and interactively comment on others. The participants were not told the identity of the other participants to keep the influence of particularly well-known participants to a minimum. The data was considered the results of the participant's opinions and the results of their shared Wiki conversations [41]. The Wiki webpage began with an explanation

that included: the research goal and current research gap in common factors; a brief definition of common factors to make sure all participants had similar definitions of common factors; and three open-ended questions related to a successful (70% improvement) relational (couple/family) therapy case that they previously worked with. The questions posed were:

1. How and what common factors did you use to bring about change in the initial stage of therapy?

2. How and what common factors did you use to bring about change in the intermediate stage of therapy?

3. How and what common factors did you use to bring about change in the termination stage of therapy?

The Wiki space was available for 2 weeks, which allowed the participants to come back and complete/edit their work or comment on others' posts. We assigned separate questions for each stage of therapy to collect information related to differential common factors they may have used at different therapy stages.

4.3 Data analysis

Thematic analysis (TA) was used to identify those patterns that were relevant to the specific research question [42]. That is, when and how do expert therapists use common factors in the course of therapy to reach their desired therapeutic outcomes? We conducted thematic analysis both inductively (bottom-up approach) and deductively (top-down approach). The inductive approach created opportunity for development of new themes of common factors (therapy principles) as well as provided explanation that how and when therapist uses particular common factors at specific points of time in therapy (therapeutic procedures). On the other hand, we employed a deductive analysis, as well, because we had predetermined assumptions and definitions of CFs components [22]. In order to increase the rigor of our data, we employed multiple levels of data analysis, from the narrow codes to more abstract dimensions and interpretations. We used Braun & Clarke's [42] framework of thematic analysis, including: (1) Familiarizing yourself with the data, (2) Generating initial codes, (3) Searching for themes, (4) Reviewing potential themes, (5) Defining and naming themes, (6) Producing the report.

5. Research findings

Using thematic analysis, several codes emerged, and specific themes were developed for the initial, intermediate, and termination stages of therapy, including five themes for the initial stage, five themes for the intermediate stage, and four themes for the termination stage (see **Table 1**). The final themes and their definitions for each stage are discussed here:

5.1 Initial stage

5.1.1 Time planning

Though this theme emerged initially in the first stage of therapy, it continued over the intermediate and termination stage too. This theme refers to the therapists' general

Stage	Mechanisms of change	Goal
1	Time planning Hope and motivation are primary goals Family Alliance in early stage Reframing as a general cognitive-systemic mechanism Hope and motivation achieved through different paths	Hope and motivation
2	Engagement in therapeutic tasks Expanding the direct therapeutic system Facing new experiences Trend of progress and relapse Feedback loop Split Family Alliance	Engagement in new functional patterns
3	Attribution of success Inoculation of future relapse Extended therapeutic alliance Maintain achieved goals through different paths	Maintaining the goal

Table 1.
A chronological map of common factors.

strategy in prioritizing particular common factors at each moment throughout the course of therapy. The experts believed that such planning worked as a heuristic strategy that helps them map the sequence of actions in the course of therapy. That is, the expert panel explained they would not jump into task/homework assignments before they built a strong alliance with each client and facilitated hope, motivation, problem rationale, and treatment rationale. For example, during the early sessions, the therapist initially works on therapeutic hope and persuasiveness. For example, one expert stated: *"I think common factors are MOST applicable early in therapy,"* specifically this expert would focus on supporting the client's decision to come to therapy and explaining how therapy might be helpful if the client system *"came reluctantly to treatment because he was embarrassed that he needed help. His expectations were low and he had misgivings about whether psychological interventions could help."*

5.1.2 Hope and motivation are primary goals

This theme indicates that the experts intentionally prioritize the client's hope and motivation in early sessions of therapy, rather than just listening to the client's problem narrative. Though, the expert panel identified with different theoretical backgrounds, all emphasized the development of hope and motivation as their proximal goal in early stage ("*I gained their trust, engendered hope,…*"). Previous research also indicates that both the common factors approach and the model specific treatments approach emphasize the important role of hope and motivation in the early stage of therapy [23, 33]. For example, Functional Family Therapy (FFT) [43] specifically focuses on hope in the first phase of FFT (labeled induction-motivation). That is, the therapist actively works to get the client to believe that the problem can change and that the therapist and therapy would promote the change ("*taking a system from 'demoralized' to 'remoralized' taps into a powerful therapist and client common factors*.").

5.1.3 Systemic alliance in early stage

This theme refers to specific points: First, building an alliance with all family members is a unique challenge in relational therapies *("I believe the difficulty in working with a system initially, is that different members of system come in with*

different goals"). Second, such alliance in early sessions is accomplished through specific mechanisms: (a) an affective bonds with all members by empathy and validation of their positions *("we gained buy-in and a strong relationship with all members of this family through validating their positions, using their points of view, and aligning with their goals"..."and bonds with all involved (empathy, validation and support)"*); (b) a goal agreement ("*Establishing an alliance early on, especially on the goals dimensions, is a power common factor in early stage therapy*"). Based on our data, we assume the third component (tasks agreement) of alliance usually occurs in the intermediate stage of therapy.

5.1.4 Reframing as a general cognitive-systemic mechanism

This theme, in relational therapies, refers to a general cognitive-systemic procedure that alters the meaning of the client's perceived problem and its relational context. The therapist challenges the definition of the client's presenting problem and creates a new contextual lens; in which the blaming of self and others faded away and so the possibility of transition from stuck position seems doable *("He had an affair to which she responded in part by starting to drink again after many years of sobriety" or "I offered a clear rationale for each party of the system"*). Therefore, it implies that change is doable and so hope is engendered.

Our data indicate the relational conceptualization of the problem (systemic reframing) not only generates a new systemic lens but also unites the members toward the benefit of the whole system, so contributes both in hope and the within-family alliance [35, 44–46]. Systemic reframing function across all MFT models. For example, Bowen challenges the most "subjective face" of the problem. Haley and the Mental Research Institute (MRI) group challenge "the more of the same," and White challenges the "social dominant systems." Despite the widespread use of reframing in therapy, there is a lack of empirical evidence to explain the impact of this mechanism on family interaction and therapy outcome [33]. Alexander et al. [47] showed lower defensive behaviors following reframe intervention than other types of therapist's interventions (reflection, restructuring statements).

5.1.5 Hope and motivation achieved through different paths

This theme refers to the fact that the hope and motivation as the primary goal of the early stage can be developed via multiple pathways; which are due to a variety of factors (the therapist and client's characteristics, clinical settings, clinical problem, session formats, etc.). Some of the experts achieved the goal through relationship factors and the therapist's presence (e. g., "*I tried hard to maintain a non-reactive presence and validate each of their positions in order to establish safety and increase hope"..."this formed a strong relationship, ..., and engendered hope" or "I also want to emphasize that the most important common factors are reflected more in who the therapist 'is' rather than what the therapist 'does'.*"), which is consistent with some theories (Attachment, Bowenian, Experiential, Emotion-focused). That is, people will be hopeful and explorative when they find themselves in a safe and secure relationship [37]. Other expert used his own expertise/competency (therapist factors) to build trust and, in turn, hope in the client system *("... to let them know that even though they are freaking out and do not see a way out of it all, it is something that I have seen often, understand, and know how to handle"*), this could be consistent with the Structural-Strategic model [44, 45].

The other mechanisms were problem explanation, goal setting, and treatment rationale that fitted with client's worldview to develop hope and motivation (*e.g., "offered a clear rationale for each party of the system" or "It was also critical that I*

honored each party's position on the nature of the problem, their values, language, and their goals"). Also, some of the experts used "breaking dysfunctional patterns" which contributed to hope and motivation through reduction of negativity and blaming in the client's system [33, 45]. The following excerpts illustrate that CFs are not just a list of static factors, but they are prioritized and interactively used to create a context of change *("I think of common factors as dynamic processes within the larger context of change," or, "Early in treatment as we developed a relationship of trust and warmth and as he learned about treatment, he begins to have hope that he might benefit from treatment. As you can see from this, some therapist, relationship, and hope components were evident. I was using a CBT approach to treatment"*). So, we assume that these hope-generating mechanisms function beyond a specific theory or model, but within the therapeutic participants.

5.2 Intermediate stage

5.2.1 Engagement in therapeutic tasks

This theme refers to the process in which the therapist works with the client system on the assumption that change requires action and responsibility. This process is based on previously activated client's factors (such as hope and motivation, etc.), therapist's factors (support, expertise, etc.), relationship factors (bonds, trust, etc.), and the problem explanation and treatment rationale *("During the middle phase of treatment, I maintained my treatment rationale (chosen to fit with these clients and the way they viewed their problems)"*). Our participants' experiences indicate some clients easily engage in therapeutic tasks while others are reluctant; which demands the therapist to actively work on this process to get the client system engaged *("The case I'm thinking about was unique.....they were all seen as resistant or reactive to treatment"..."I gained their trust, engendered hope, and offered a clear rationale for each party of the system"*). Our findings suggest that this mechanism is used by all models. However, the client characteristics and the type of problem determine to what extent a therapist should work on this mechanism *("I also adapted to their personalities by pushing and challenging them pretty directly throughout this stage – an approach they liked"*). For example, the therapy dropout rates for youth with behavioral and drug problems are estimated from 50–75% [48], which can explain why FFT specifically emphasizes on engagement and motivation of youth and families in early stage of therapy [47].

5.2.2 Expanding the direct therapeutic system

This theme refers to the therapist intention to expand the therapeutic contact to other family members or systems who can facilitate therapeutic change. *("Mom brought boyfriend into the relationship and they both set clear limits and expectations {for the son}"*). This is another unique systemic CFs that function across MFT therapies, specifically integrative models. For example, multisystemic family therapy (MSFT) expands therapeutic interventions to the wider school and interagency network [49]. The degree of such expansion is based on the relational conceptualization of the problem at stage one as well as the ongoing feedback from the client system to therapy interventions.

5.2.3 Facing new experiences (emotional, cognitive, behavioral)

This theme refers to any new cognitive, behavioral, and emotional experience that helps the client to achieve therapeutic goals. They are new functional patterns

that are challenging pathways to achieve therapeutic goals. Some experts used cognitive strategies *("his insights were also related to the CBT intervention"*) versus others that used emotional strategies ("*processed a lot ala EFT*"), and others used behavioral strategies ("*I develop task assignments aimed at interrupting patterns"…"son began doing his homework and was rewarded by going to work in doing some construction jobs with [the mom's]boyfriend"*). The critical point is the overlap between these apparently content-distinct interventions which all finally result in the same functional pattern (process) in the client system. That is, from an experiential lens there is a concurrent experience of emotional, behavioral, and cognitive aspects in real life. For example, the "blamer softening" technique in EFT is considered primarily an emotional processing intervention but in fact it is associated with promotion in both intrapersonal awareness and interpersonal restructuring of interactions [37]. That is, an emotional schema of self and others changes which, in turn, triggers new behaviors from the partner. However, we assume the therapist's style and client's characteristics and feedback could guide which type of these three mechanisms would be more desirable and applicable. *("I was calm (that's my overall style/personality anyway*," or "*My position with her son was to commiserate with his distress over Dad and to empathize with him over how his mother was treating him like a child"*). Even within an evidence-based treatment like Emotion-Focused Therapy (EFT), the therapist's emotional presence (e.g., manner of emotional responsiveness and softened vocal quality) predicts heightened levels of client emotional experience in successful "Blamer Softening," which is a unique indicator of successful therapy [50]. As Lebow [5] noted "therapists vary enormously," so the same cognitive technique, for example, can function unevenly in the change process due to such an enormous variety.

In addition, these new experiences can be done either in the session *("allowing clients to explore safely their relational problems with the therapist in the 'here and now' context of the therapeutic relationship"*), or out-of-therapy session ("*Son was allowed more freedom and complied by returning home early and pitching in with home chores*."). This distinction between in-session and out-of-session tasks itself is an important research topic in the MFT field.

5.2.4 Trend of progress and relapse

This theme refers to a natural trend of progress and relapse in an intermediate stage of therapy. The experts described it as a process in which the client system normally experiences ups and downs to achieve a new functional pattern, though progressively toward more competence ("*There was a lot of progress, followed by relapse, then progress, then relapse, etc.," or, "'I believe that a successful' 'tear and repair' in the intermediate stage of therapy will strengthen the overall therapeutic alliance by allowing clients to explore safely their relational problems"*). Expert therapists anticipated such a trend, so they inform and inoculate their clients in advance regarding of the trend ("*I have learned to offer inoculations….. to help with this", "you may notice early improvement followed by a backslide"*). By doing precedent inoculation, the therapist prevents hopelessness and alliance rupture as well as inspires more client's persistence and engagement.

Also, it seems the conceptualization of this trend goes beyond individual therapy and contains a wider contextual lens. Our findings indicate a reaction by the client's family of origins and their work following therapeutic change during the intermediate stage *("there were extratherapeutic factors happened in each of their families as well as their work lives that essentially forced them to either turn towards or away from each other. Therapy helped guide that change"*).

Another sub-theme related to the "trend of progress and relapse" was "ongoing mutual feedback"; which helped the experts to continuously adjust

the relationship, their conceptualization, and methods due to improvisational nature of the process ("*I also adapted to their personalities by pushing and challenging them pretty directly throughout this stage - an approach they liked," or, "the concept of giving and eliciting client feedback, is especially essential in later phases," or, "I try to balance being real and authentic about my hopes for them while at the same time creating space for them to chart the course they feel is best*"). Recently, the mutual feedback has received more attention as a critical change mechanism in therapy [5, 11].

5.2.5 Split systemic alliance

This theme refers to a common phenomenon in the intermediate stage of relational therapy in which a part of the client system experiences weaker alliance to the therapist than another part of the system [31]. It causes resistance to engage in therapeutic tasks while the therapist is aiming to unite them toward their therapy goal *("A split alliance may quickly degenerate into an alliance rupture,"...., "I continued to be open to flex as needed if their alliance was faltering in any ways"*).

To repair a split systemic alliance, the experts approached the client subsystems in one unite as a couple or family system *("I also relied on the depth of our connection- they knew that I cared about them and that their marriage mattered to me" or "she said that she knew that I really wanted them to succeed as a couple, which kept her going"*). They used a few systemic change mechanisms, including relational conceptualization of the problem which takes away the blame from all members; presenting relational patterns as therapeutic target; disrupting conflicted family interactions to reduce negativity [7, 33]; prioritizing the wellbeing of the whole system than any individual member of the system; and presenting emotional neutrality to all members [7, 35].

5.3 Termination stage

5.3.1 Attribution of success

This theme refers to a process that helps the client system to own the therapeutic changes that have been made. That is, the client system internalizes them as a result of their efforts and skills *("I commended them for all they had done and gave them a chance to explain how they did it thus having them own the change by attributing it to themselves"*). This mechanism is consistent with the self-efficacy concept [51] that is negatively correlated with relapse [52] ("*Here, I want to make sure that I highlight what the client has done to bring about change. I will often make a list and send it home with the client").*

5.3.2 Inoculation of future relapse

This theme refers to a process in which the therapist educates the client system about the possible relapse after termination, and the strategies can be used to handle a possible relapse *("Upon successful termination, we commended all and inoculated them against inevitable backsliding and future hurdles"*). Our findings show that the experts used a feedback loop with the client system to help them gain insight about the change process, which itself is a pathway for clients to be able to handle possible future hurdles *("While important in all stages of therapy, the concept of giving and eliciting client feedback is especially essential in later phases as termination approaches"*).

5.3.3 Extended therapeutic alliance

This theme refers to the availability of the therapist after termination in case the client system needed help or support (*"I extend the relationship by reframing termination as variable scheduling- the client calls me for an appointment if a need comes up"*). By doing this, the therapist intentionally expands the therapeutic alliance beyond the therapy course; which generates security and hope that can contribute to better maintenance of achieved goals.

5.3.4 Maintain achieved goals

This theme refers to the mechanism that helps the client to sustain new functional patterns that they have developed in the course of therapy. That is, the client system earns a capacity to continue the therapy outcomes without depending on the therapist ("*At termination I am working clients on sustaining changes that they have made*"). To this end, the experts utilized several mechanisms: using strengths-based conversations with client; empowering the client to own the changes have been made in therapy; expanding therapeutic alliance available after termination; educating client regarding of future relapse *("A lot of strengths-based conversation and reflection on the progress they'd made, as well as inoculation against future relapse as has been mentioned by others...." "I also, prepare the client for relapse and develop plans for how to manage a relapse",.., "specific interventions ongoing to help create a situation where changes could be maintained")*.

6. Discussion

Despite disagreements between advocates of the model-specificity approach and CFs approach on outcome equivalency, they agree that the process and progress research can shed light on the mechanisms of change; which can bridge the two approaches and contribute to the field's integration [4, 5, 8]. To this end, we presented a primarily chronological map of common factors at three stages of relational therapy, which is supported by the findings of our qualitative process research and existing MFT literature.

Our findings show that the experts, regardless of their theoretical lens, focused on generating hope and motivation as the primary goal of the initial stage, though they achieved it through different combinations of these CFs (using therapist presence and safe relationship, family alliance, therapist expertise/competency, relational conceptualization of problem, interrupting dysfunctional pattern, and goal agreement). It is consistent with the phased-based goals and challenges in most evidence-based treatments. For example, Functional Family Therapy [43] labels the first stage as "Induction-Motivation," or Structural Therapy [45] labels it as "Joining and Accommodation," though they may use different combinations of the above-mentioned change mechanisms/CFs to achieve the same proximal goal.

The priority goal in the intermediate stage was the engagement in therapeutic tasks, which calls for the client system's responsibility and action toward therapy goals. To this end, the experts utilized the therapist's presence, relationship factors, and the client's hope as a context. However, the main mechanisms were: the relational conceptualization of the problem, systemic goal agreement, and treatment rationale. By doing so, they enhance the credibility of therapy which itself is a mechanism of therapeutic change [13, 53]. As opposed to blaming clients for being uninterested or unmotivated, the experts contextualize the problem explanation and treatment rationale within the client's system and culture to enhance their engagement in therapy [54, 55].

Another important finding was a "trend of progress and relapse" in the second phase of therapy, which was considered to be a natural phenomenon and a systemic reaction to the client's initial change. [47]. We propose the trend of progress and relapse as another unique systemic CFs that should be researched within a systemic perspective. That is, a change in one part/member of the system followed with changes in other parts as well as with support or reaction from neighboring systems [34, 45]. Systemic terminology (such as "symptom exchange," "change back," "social dominant narratives," "ecological model," etc.) can explain the trend of progress and relapse within a relational-contextual lens, which provides more therapeutic options and resources [56, 57]. We believe this common factor represents a unique systemic theme that could contribute to the understanding of change in relational therapy.

As a result of the therapist's effort to get the client system engaged in a task (functional pattern), the client system may react by "split systemic alliance" in which a part of the system experiences weaker alliance and so lower cooperation and engagement in the therapeutic task. Previous research [22, 48] indicates that the nature of alliance in family therapy is different than in individual therapy, due to the complex multiple relationships and competitive demands between the participants [35, 44]. We assume a systemic task asks for redefinition of relationships, power, and positions within the client system, which requires degrees of flexibility and responsibility by the members [47]. Also, it is consistent with the basic systemic assumption of triangulation. This is when a dyad that is not ready to take responsibility in a challenging situation drags the third person into their argument. This third person is often asked to "take sides" [35, 45]. Considering the critical role of systemic alliance in relational therapy outcome and dropout, it is important to explore what mechanisms are used by clinicians across treatment models to handle this challenge and which ones are more effective.

The main goal in the termination stage was to enable the client system to "maintain the achieved goals." The experts applied a few mechanisms to accomplish this goal: first, they used "attribution of success" in which the therapist uses a feedback loop and strengths-based conversation by which the client system explains how they made therapeutic changes. We assume this is consistent mostly with narrative and solution-focused questioning. Telling and re-telling the change a story of success enhances "self-efficacy" and "resiliency" in the client system [52, 58]. Second, they used "inoculation of future relapse" to educate the client system on useful strategies for handling any possible relapses following termination, which is mostly consistent with cognitive theory; third, they "expanded therapeutic alliance" and therapist availability for after termination in case the client system needed help, which generates hope, safety, and resiliency. This mechanism is most closely associated with attachment theory. We assume that integrative therapists apply a combination of these mechanisms that go beyond a specific theoretical model [5, 21].
Previous research [8] indicates that the therapy structure/plan itself contributes to therapy outcome. However, it is specifically important to explore when (if at all) and how clinicians address the termination process with their clients in daily practice. Moreover, what is its impact on therapy length and outcome? We assume this is an important component in the development of a temporal protocol for the use of common factors.

Consistent with other phased-based therapy proposals (e.g., [39, 40]), our findings indicate that common factors function within a phased-based framework. That is, the CFs are used as change mechanisms/strategies with specific proximal process goals at each stage of therapy, not as a list of distinct factors. This primarily temporal protocol of CFs can be used by trainers and trainees as a guide to map the sequence of actions in the course of therapy. Though, there are differences at the theoretical level (e.g., assumption of pathology, importance of relationships versus

meaning, etc.) between traditional and post-modern MFT models, both emphasize the same phase-based goals and challenges; which are addressed through almost the same change mechanisms. For example, let aside that it is inconsistent with its collaborative philosophy, Solution-Focused Therapy (SFT) concerns with the clients' motivation level, and labeled them as visitors, complainants, and customers [59]. To solve such a cognitive dissonance at theoretical level, the SFT theorists intended that "the labels were not included; and the descriptions were more nuanced in later years," however, it did not change their actual practice in which they are applying almost the same strategies "normalizations, reframes, new information; and acknowledgment of clients' feelings" to improve the client's motivation level ([32], p. 69, 70). We believe that the field needs to redirect the focus of research and training on these phased-based change mechanisms, which can lead to better clinically relevant and theoretically integrative models [4, 5, 8]. As Kazdin [4] notes, "after decades of psychotherapy research, we cannot provide an evidence-based explanation for how or why even our most well-studied interventions produce change, that is, the mechanism(s) through which treatments operate" (p 1).

Also, our findings indicate that each change mechanism may have a different function at different points of time in therapy process [37]. For example, a relational definition of the problem and/or the therapist's expertise initially are utilized to build hope and motivation, while the same mechanisms are utilized to repair split systemic alliance in the intermediate stage. So, we assume a cyclical/recurring pattern of presence for these change mechanisms, not necessarily a linear one. For example, research [23] indicates that the client's engagement is the single best predictor of outcome. However, the therapeutic relationship may be the most important mediating factor between engagement and outcome.

Based on systemic epistemology that is the core theoretical belief in all MFT models, our findings support the notion that CFs function differently in systemic/relational therapy than individual therapy. As Bateson [34] mentioned "When you separate mind from the structure in which it is immanent, such as human relationships… you embark on a fundamental error," (p. 493). It seems, the pioneers (Bowen, Haley, Whitaker, Fisch, etc.) focused much more on shared underlying family/systemic processes and the relevant systemic change mechanisms than the specific models. This may have contributed in the field to be naturally short-term and integrative, specifically in actual practice [5]. Research supports the notion that CFs should be understood based on systemic concepts and interactional processes when it comes to relational therapies [7, 8, 10]. For example, Functional Family Therapy researchers found that high individual alliance by the adolescent is a predictor of dropout if there is unbalance in adolescent and parents' alliances with therapist [48]. On the other hand, postmodern theories also gradually admitted the power and complexity of dysfunctional patterns in some systems. Lipchik [32], as one of the pioneers of SFT, mentioned that the SFT team gradually modified their theoretical belief that the solution-focused process works, regardless of the type of problem or situation, and so recognized the complexities of some problems and the surrounding systems.

Therefore, it is reasonable to assume that all effective MFT models (including traditional, postmodern, or integrative) deal with the same underlying systemic/interactional processes in actual practice, regardless of their level of theoretical congruency and technical terminology. That is, the clinical research should focus on those change mechanisms (e.g., inoculation, systemic alliance, relational conceptualization, etc.) that can alter such systemic processes (e.g., split systemic alliance, lack of boundaries, etc.) which are common, in some degree, within all clinical problems. So, we need mechanism-based change theories and research that guide us regarding what mechanism to use, when to use it, and how it should be used during the change process.

To that end, process-progress research [37] can help, since it explains the therapist and the client's actions at each point of the change process. Therefore, we can link in-session improvements on critical factors and treatment outcomes [11]. Accordingly, the "practice-based evidence" that is based on client's feedback can inform us about the client's theory of change [23]. Finally, the convergence of the therapist and the client's theories of change will provide useful evidence-based explanations for why and how therapy works, and through what mechanisms. We believe that the chronology of common factors that we present in this paper represents one important step in this direction.

Author details

Hassan Karimi[1*], Fred Piercy[2] and Jyoti Savla[2]

1 Johns Hopkins University, Baltimore, USA

2 Virginia Tech, Blacksburg, VA, USA

*Address all correspondence to: hassan.karimi@jhu.edu

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