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ORIGINAL PAPER

Refining the Meta-Theory of Common Factors in Couple and Family Therapy: a Deductive Qualitative Analysis Study

Stephen T. Fife[1] · Carissa D'Aniello[1] · Dane Eggleston[2] · Jesse Smith[3] · Daniel Sanders[4]

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Abstract

Common factors in couple and family therapy (CFT) have been discussed theoretically and clinically, with limited direct empirical support for CFT-specific common factors. The purpose of this study was to empirically examine the meta-theory of common factors unique to CFT. To do so, we used deductive qualitative analysis (DQA), a methodology suited for research that aims to evaluate, refine, and expand existing theory. Our sample consisted of fourteen ($n = 14$) video-recorded therapy sessions (videos and transcripts) conducted by therapists with expertise in seven CFT models: Bowenian family therapy, emotionally focused therapy, experiential therapy, narrative therapy, solution-focused brief therapy, strategic therapy, and structural family therapy. Following the procedures of DQA, we conducted an in-depth analysis of the data using CFT common factors as sensitizing constructs (deductive), along with open (inductive), focused, and theoretical coding. Results show (a) strong support for certain previously identified CFT common factors (expanded direct treatment system, expanded therapeutic alliance), and (b) partial support for and refinement of other CFT common factors (conceptualizing and reframing difficulties in relational terms, facilitating constructive interactions, and valuing clients' perspectives). Results also support the moderate view of CFT common factors – that they work through therapy models. This paper offers an empirical examination of common factors in couple and family therapy that clarifies, deepens, and refines previous iterations of CFT common factors. We conclude with a discussion of the results in the context of CFT literature and provide implications for clinical practice, training, and research.

Keywords Common factors · Couple therapy · Family therapy · Qualitative research

A Deductive Qualitative Analysis Study

Beginning with the seminal chapter by Sprenkle et al., (1999), therapists and scholars over the past two decades have given increased attention to common factors in couple and family therapy (CFT) (e.g., D'Aniello & Fife 2017, 2020; Davis et al., 2012; Davis & Piercy, 2007a, b; Fife et al., 2014; Karam & Blow, 2020; Karam et al., 2015; Sprenkle et al., 2009; Sprenkle & Blow, 2004a, b). Common factors are general mechanisms or variables associated with therapeutic change that are common across treatment approaches. Broadly conceived, the common factors perspective can be understood as a meta-theory about the fundamental aspects and processes of therapeutic change that can be applied to diverse therapy models (Davis et al., 2021; Davis & Hsieh, 2019; Karam & Blow, 2020; Sprenkle et al., 2009). Although there is general enthusiasm for the common factors perspective of change in CFT (D'Aniello & Fife, 2017; Fife et al., 2019), the body of scholarship on CFT-specific common factors is largely conceptual and theoretical in nature, with limited direct empirical support for the theory as a whole (D'Aniello & Fife, 2020; Davis et al., 2012; Sprenkle et al., 2009). If the assertion is correct that common factors are shared across and work through models (Sprenkle & Blow, 2004a, b; Wampold & Imel, 2015), CFT common factors will be evident in model-specific

✉ Stephen T. Fife
stephen.fife@ttu.edu

1 Department of Community, Family, and Addiction Sciences, Texas Tech University, 1301 Akron Ave., MS 41250, 79409-1250 Lubbock, TX, USA

2 Lubbock Christian University, Lubbock, TX, USA

3 Department of Counseling and Family Therapy, Drexel University, Philadelphia, PA, USA

4 Department of Human Development and Family Studies, Utah State University, Logan, UT, USA

sessions. The purpose of this study is to present the results of an empirical examination of CFT common factors using deductive qualitative analysis, a research method intended for evaluation and refinement of existing theory and conceptual models (Gilgun, 2019).

Background: CFT Common Factors

In its early development, the CFT field focused on systemic models that differentiated it from other mental health professions (Davis et al., 2021). This initial focus on model distinctions was perpetuated as model developers and clinical training emphasized the unique aspects of CFT models instead of their commonalities. This model-specific focus has resulted in theoretical and clinical myopia in CFT, with therapeutic change and positive clinical outcomes attributed primarily to the unique or distinctive aspects of therapy models and techniques, rather than the common factors and processes inherent in psychotherapy and shared across CFT models.

Though CFT models are effective for resolving a variety of problems (Shadish & Baldwin, 2003; Wittenborn & Holtrop, 2022), the primary contributors to their effectiveness are not yet well understood (Blow et al., 2009; Karam & Blow, 2020; Sprenkle & Blow, 2004a). Common factors meta-theory is an alternative to model-specific explanations of change, expanding understanding of the process of change and positive clinical outcomes by illuminating critical principles underlying effective therapy and their relationship with CFT models (Davis et al., 2021; Davis & Hsieh, 2019). The meta-theory is a framework that incorporates principles of therapeutic change shared by therapy approaches that can be superimposed over any model of therapy (Fife et al., 2014). With a meta-theory, the emphasis is on principles underlying effective therapy, rather than model-specific aspects or techniques. CFT common factors meta-theory unifies aspects of diverse treatment approaches, which facilitates its application with different models (Davis et al., 2021).

Common Factors Unique to CFT

Common factors meta-theory originated in psychotherapy (Rosenzweig, 1936) and was later applied to CFT. In the seminal chapter and later volume on common factors in CFT, Sprenkle and colleagues (1999, 2009) discussed common factors applicable to couple and family therapy. In addition to general common factors of psychotherapy that are found in CFT (e.g., client factors, therapist effects, expectancy effects), they also described common factors that are unique to therapy with couples and families: conceptualizing client difficulties in relational terms, expanding the direct treatment system, expanding the therapeutic alliance, disrupting dysfunctional relational patterns, and privileging client experiences (see also Davis et al., 2012; Karam & Blow, 2020). *Relational conceptualization*[1] involves therapists and clients understanding problems in interpersonal, rather than individual, terms. *Expanding the direct treatment system* is described as involving more than the "identified patient" in therapy by including other family members in treatment and considering the important role of family members and significant parties who are not present in the treatment. The *expanded therapeutic alliance* refers to the working alliance that is formed between the therapist and each member of the treatment system. *Disrupting dysfunctional relational patterns* refers to the ways systemic therapists interrupt or break up clients' dysfunctional or pathological interaction cycles. In their original chapter, Sprenkle et al., (1999) also included *privileging clients' experience* but suggested this applied primarily to social constructionist models. This common factor was omitted by Sprenkle and colleagues in subsequent publications about CFT common factors (Davis et al., 2012; Sprenkle & Blow 2004a; Sprenkle et al., 2009). These unique CFT common factors are core constructs of the meta-theory being examined in this study.

Gaps in Empirical Support for CFT Common Factors

The common factors paradigm is one of the most significant theoretical developments in systemic family therapy in the past 20 years (Fife, 2020; Weeks & Fife, 2014). Yet empirical support for CFT common factors has consistently lagged behind conceptual and theoretical arguments (D'Aniello & Fife, 2020; Karam & Blow, 2020). In a content analysis of CFT common factors literature, D'Aniello & Fife (2020) found that out of 38 works, only nine (23%) were empirical in nature. Currently, the most compelling empirical support for common factors in CFT comes from outcome studies of therapeutic process variables and meta-analyses of therapeutic effectiveness across therapy models and modalities (Ahn & Wampold, 2001; Shadish & Baldwin, 2003; Shadish et al., 1995; Wampold & Imel, 2015). Although some research has investigated the expanded therapeutic alliance (e.g., Friedlander et al., 2011; 2018) and enactments (e.g., Andersson et al., 2006; Zuccarini et al., 2012), CFT-specific common factors remain largely unexamined.

[1] Please note that throughout the remainder of the paper we use italics when referencing the primary CFT common factors proposed by Sprenkle and colleagues (1999, 2009).

The existing theoretical and empirical arguments provide direct and indirect support for common factors' contributions to therapeutic change, suggesting that CFT is effective because of common change processes that cut across all effective therapies, more so than the unique contributions of therapeutic models (Davis et al., 2012; Sprenkle & Blow, 2004a, b; Sprenkle et al., 2009). However, the five unique CFT common factors proposed by Sprenkle et al., (1999, 2009) have not been subjected to systematic empirical examination across CFT models. Although the meta-theory of CFT common factors has expanded the field's view of change, it, too, is at risk of myopia and stagnation without further examination and refinement. Additional theoretical development and empirical support is needed to further solidify the position of common factors in CFT training, research, and practice (D'Aniello & Fife, 2020; Davis et al., 2012; Karam & Blow, 2020).

Study Purpose and Research Questions

Despite strong theoretical scholarship and modest empirical support for unique CFT common factors, in-depth research on common factors in CFT is lacking (Karam & Blow, 2020), and direct empirical testing of the meta-theory is in its infancy (Davis et al., 2012; Davis & Piercy, 2007a, b). While we recognize the importance of common factors that are general to psychotherapy, we focus on CFT-specific common factors. This study is a response to calls for further reflection and research on common factors in CFT (D'Aniello & Fife, 2020; Karam & Blow, 2020; Sprenkle et al., 2009), including studies using qualitative methodologies to enhance understanding of the current common factors paradigm (Davis et al., 2012). This paper presents the results of a study designed to empirically examine the meta-theory of common factors within CFT using deductive qualitative analysis (DQA). The research questions that guided the study are: What common factors are exemplified in CFT sessions conducted by model developers and experienced therapists? What evidence in therapy sessions supports or contradicts the meta-theory of CFT common factors? How can the existing meta-theory of CFT common factors be improved?

Method

Deductive Qualitative Analysis

DQA is an approach to qualitative research designed to advance theory development by empirically examining existing theory using specific cases to test, refine, and expand the theory (Gilgun, 2015, 2019). DQA involves identifying evidence that supports the theory being examined, disconfirming evidence or cases where the theory is refuted, and new information that refines or adds to existing knowledge. The purpose of this approach is to empirically test existing theory and develop an improved and inclusive theory that more closely reflects the data being analyzed and accounts for increased diversity in the phenomena being studied (Gilgun, 2005). Similar to other empirical approaches, theoretical constructs are tested through the analysis of empirical data – although with DQA studies, the data is qualitative rather than quantitative.

DQA combines deductive and inductive analysis, using sensitizing constructs from current theory (deductive) and actively examining evidence in the data for new concepts (inductive) (Gilgun, 2005, 2013, 2019). It also includes negative case analysis, which involves purposefully attending to evidence that refutes, adds to, or reformulates the existing theory being examined (Gilgun, 2019). This helps restrain researchers from imposing prior concepts onto the data or identifying only evidence that confirms previous conceptualizations and missing other phenomena that may contribute to an enhanced theory (Gilgun, 2019). Analytic procedures parallel those of grounded theory (open, focused, and theoretical coding; see Charmaz 2014; Corbin & Strauss, 2015; Gilgun, 2014) and include attending to supporting, contradicting, refining, and expanding evidence (Gossner et al., 2022). Like grounded theory, all findings (including sensitizing constructs from the original theory) must earn their place in the results by being grounded in the data (Charmaz, 2014; Glaser & Strauss, 1967). Despite these parallels to grounded theory, DQA is distinct from grounded theory in that it includes a deductive component and is designed to test existing theory. The analysis is complete once categories are well-developed and theoretical saturation is reached (Gilgun, 2014).

DQA studies involve four key processes: (1) generating sensitizing constructs, (2) collecting a purposive sample, (3) coding and analysis, and (4) theorizing (Gossner, 2022). The intended result of DQA is an improved theory that is more refined and nuanced than the original theory. For further description of DQA methodology, see Gilgun (2013, 2015, & 2019).

Generating Sensitizing Constructs

In DQA, researchers begin by generating sensitizing constructs from the theory being examined in the study (Gilgun, 2014, 2019). We included the CFT common factors proposed by Sprenkle et al., (1999, 2009) as sensitizing constructs: *expanding the therapeutic alliance*, *conceptualizing client difficulties in relational terms*, *disrupting dysfunctional*

Table 1 *CFT videos and therapists**

Model	Therapist 1	Video 1 Name	Therapist 2	Video 2 Name
Bowenian Family Therapy	Monica McGoldrick	The Legacy of Unresolved Loss	Philip Guerin	Bowenian Family Therapy with Philip Guerin
Emotionally-Focused Therapy	Sue Johnson	EFT in Action	Leslie Greenberg	EFT with Couples
Experiential Therapy	Carl Whitaker	Experiential Family Therapy with Carl Whitaker	Virginia Satir	A Step Along the Way
Narrative Therapy	Michael White	Escape from Bickering	Stephen Madigan	Narrative Family Therapy with Stephen Madigan
Solution-Focused Brief Therapy	Insoo Kim Berg	Irreconcilable Differences	Bill O'Hanlon	Solution-Oriented Family Therapy
Strategic Therapy	Cloe Madanes	Strategic Therapy with a Couple	James Coyne	Strategic Couples Therapy with James Coyne
Structural Therapy	Salvador Minuchin	Unfolding the Laundry	Harry Aponte	A House Divided

* See Supplemental File (Video References) for complete video references

relational patterns, and *privileging client experiences*. These constructs provided a preliminary deductive focus to our coding. We also analyzed the data inductively through open coding, negative case analysis, and research team discussions (Gilgun, 2014).

Sampling

DQA researchers utilize purposeful sampling, intentionally selecting cases that represent many types or variations of the phenomenon being studied (Gilgun, 2005). For the purposes of our study, we included sessions of family therapy model developers and therapists who were invited to demonstrate seven CFT models: Bowenian family therapy, emotionally focused therapy (EFT), experiential therapy, narrative therapy, solution-focused brief therapy (SFBT), strategic therapy, and structural family therapy (see Table 1; see supplemental file "Video References" for complete references). Clients in one video were actors (McGoldrick), and all others were actual clients who agreed to participate in a filmed therapy session for training and demonstration purposes. Apart from the video of McGoldrick, therapists in the videos met with the clients for a one or two session consultation. Videos were selected based on several criteria. First, the sessions were with either couples or families. Second, videos were purposefully sampled to include a wide range of CFT models. Third, the videos were intended to provide sound representations of specific CFT models. Fourth, to have variation within the CFT models, videos of two different therapists for each of the seven models were included in the study ($n = 14$). Data included both the video and the transcript of each session.

Coding and Analysis Procedures

Analysis of the videos and transcripts was conducted by a team of seven researchers and followed the procedures of DQA (Gilgun, 2005, 2013, 2014). The analysis of each therapy session took place in three steps. First, at least two members of the research team watched each video recorded therapy session together, taking notes on initial reflections related to our research questions. We then discussed our observations and recorded these in memos. Next, research team members independently coded the transcript of the therapy session using the sensitizing concepts described above (deductive) and open coding procedures (inductive) (Gilgun, 2019). Examples of inductively derived codes include gathering systemic information, facilitating enactments, and valuing clients' perspectives. During this coding process, researchers identified evidence consistent with CFT common factors, instances in the data not accounted for by CFT common factors, as well as negative cases or concepts that contradicted aspects of the meta-theory. An example of negative case analysis is the repeated occurrence of therapists' efforts to facilitate positive interactions among family members, in comparison to the relatively few instances of *disrupting dysfunctional interactions* (a sensitizing construct derived from the meta-theory). Following separate coding of the session transcript, research team members met again to discuss their analysis of the session, compare the analysis with previously coded videos, and refine the coding process for the next video. This process was repeated for each therapy video analyzed in the study.

Our research team applied this analysis process in two phases. In phase one, we divided into two coding teams (with three and four members respectively), each analyzing one of the videos and transcripts of four CFT models (Bowenian, EFT, SFBT, Structural; $n = 8$). After coding this initial subset of the data, the two teams met together, compared similarities and differences in our coding, resolved discrepancies, and defined significant categories. During this phase of the analysis, we developed a preliminary codebook that included the codes that were derived from the CFT meta-theory (i.e., sensitizing constructs) and those developed

inductively through our initial analysis. In phase two, each team used the codebook as a guide to analyze sessions of the remaining three therapy models (Experiential, Narrative, Strategic; $n = 6$), with each team analyzing one of the videos and transcripts of each model and comparing these to previously analyzed sessions and our provisional findings. Researchers remained open to evidence that was new or divergent from the earlier analysis, continually refining the deductively and inductively derived codes and categories.

Theorizing

Throughout the analysis, we engaged individually and as a group in an iterative process of constant comparison of data, codes, and categories (Charmaz, 2014). Data were reanalyzed as the analysis progressed, which refined our conceptualization of CFT common factors and processes evident in the sessions and ensured our findings were grounded in the data. Regular research team meetings facilitated advanced theorizing about prominent categories, close examination of supporting evidence, and careful consideration of negative cases that suggested refinement or expansion of CFT common factors meta-theory. The result is an enhanced conceptual framework of CFT common factors that supports, refines, and expands the meta-theory proposed by Sprenkle et al., (1999, 2009).

Reflexivity and Trustworthiness

Researcher reflexivity is particularly relevant to DQA, as the analysis draws from existing ideas related to the concept(s) or theory being studied. Within the interpretive qualitative tradition, researchers are not considered objective observers or independent from the subject of study (Charmaz, 2014; Daly, 2007). Throughout the study, we endeavored to remain cognizant of our positions regarding common factors and their influence on the research. Each member of the research team had prior engagement with common factors. The two lead authors (CFT faculty) have experience publishing and teaching about common factors, while the other five team members received common factors training in graduate school. We discussed at length our views of common factors and CFT models, and team members engaged in reflexive memo writing and discussions throughout the research process (Gilgun, 2015). We believe common factors have an important role in the practice of CFT and have a positive influence on treatment outcomes. We hold the view that common factors work through models and that therapeutic change is facilitated by what is shared across models more than what is unique or different about them (Sprenkle et al., 2009). Although there is a growing body of supporting literature, we believe the current meta-theory of CFT common factors deserves more empirical scrutiny.

In addition to engaging in reflexivity, we undertook several steps to enhance the trustworthiness and fidelity of our analysis and results. First, the use of a research team allowed each team member to test their conceptualizations and interpretations of the data against those of others who had different perspectives, life experiences, training, and preconceptions (Gilgun, 2005). This included the opportunity to question one another's conceptualizations. When disagreements or differing interpretations arose, we examined these carefully, with the discussion remaining open until we resolved discrepancies and reached a consensus. Multiple perspectives helped us avoid premature conclusions about the meaning of the data. Negative case analysis also helped us guard against imposing preconceived ideas on the data or merely finding what common factors meta-theory suggested we would find (Gilgun, 2013, 2019). Additionally, an external auditor with experience using DQA reviewed our analysis and results in light of DQA purposes and procedures. Through reflexive memos, multiple coding teams, team meetings, and careful comparison of our findings with the data, we maintained an awareness of our perspectives on common factors, challenged our assumptions, and faithfully represented the content of the therapy sessions we studied.

Results

Key Overarching Findings

Consistent with the unique CFT common factors identified by Sprenkle and colleagues (1999, 2009), all therapists in this sample, regardless of the model used, worked with an *expanded direct treatment system*, developed an *expanded therapeutic alliance*, and *conceptualized difficulties in relational terms*. Although the results generally support previously identified CFT common factors, our analysis also identified disconfirming and refining evidence that suggest revisions to CFT common factors meta-theory related to *conceptualizing difficulties in relational terms, disrupting dysfunctional relational patterns*, and *privileging clients' experience* (see Table 2). While the factors described below were common across therapists, some transcripts gave better representations of these factors, leading to a higher number of quotations from some therapists than others.

Table 2 *Sensitizing constructs and DQA results*

CFT Common Factors – Sensitizing Constructs	Supported and Refined CFT Common Factors
Expanded Direct Treatment System	Expanded Direct Treatment System*
Expanded Therapeutic Alliance	Expanded Therapeutic Alliance*
Conceptualizing Difficulties in Relational Terms	Conceptualizing and Reframing Difficulties in Relational Terms+
Disrupting Dysfunctional Relational Patterns	Facilitating Constructive Interactions+
Privileging Client's Experience	Valuing Clients' Perspectives+

Note: * Supported CFT Common Factor; + Expanded/Refined CFT Common Factor.

Expanded Therapeutic Alliance

Through our examination of the data, we found that therapists across models develop a *therapeutic alliance* with each member of the client system. Therapists make deliberate efforts to connect with family members, understand their motivation for seeking treatment, and increase their comfort. For example, Harry Aponte intentionally connects with each member of the family at the beginning of the session, "I'm Harry Aponte. Maybe we can re-introduce ourselves because, I think I got your names; I don't have your ages." Building an alliance also includes helping clients feel comfortable with the therapist. Susan Johnson (speaking to a couple in which the husband was in the military) uses clients' language throughout the session to connect with them, "I'm parachuting into your lives here. I want to help you feel as safe and comfortable with me as possible. Is there anything you want to ask me that would help you know about me?"

Developing an alliance with the client system also involves efforts to understand clients' perspective on the challenges that brought them to therapy and what they hope to gain from their treatment. Michael White asks the family if they could share "the thing that is on your mind at the moment that would be most helpful for us to talk about." After one member responds, White follow up with the others, "Okay, we've got one idea of what we should talk about. Do we have other ideas as well?" In similar fashion, Monica McGoldrick says, "I'd like to hear a little from each of you what you see as the problem, and then I'm going to ask you some questions." Carl Whitaker specifically asks the opinion of a daughter who had not spoken in the session, "What do you think is going on, Darcy, in your family? You got a sense of it?" This question then led Darcy to provide her perspective of the family's interpersonal patterns.

Therapists also use aspects of their personhood, such as personal warmth, touch, and sense of humor, to facilitate joining with clients. For example, when an adolescent says he is good at manipulating his parents, Salvador Minuchin teases, "You're a master manipulator? Are you doing a job on me right now?" Furthermore, certain behaviors support a strong therapeutic alliance, such as validating each client's perspective, expressing empathy, complimenting them, and acknowledging positive aspects of the client system. In one instance, Insoo Kim Berg compassionately notes, "It sounds like you're both feeling very frustrated about what's going on or what's not going on with the two of you." Later she remarks, "I really am very impressed, Bill, that you responded to Leslie's initiating this meeting and your willingness to take time from your very busy schedule, and obviously, this relationship is very important to you."

Conceptualizing and Reframing Difficulties in Relational Terms

Therapists' sessions illustrate two distinct yet related parts comprise this common factor: (1) the conceptualization of client problems in relational terms, and (2) reframing interventions that arise from this systemic conceptualization. While therapists using modern CFT models tended to show more overt evidence of conceptualizing and reframing difficulties in relational terms, postmodern therapists also offered relational conceptualizations and reframes.

Our analysis indicates strong support for the frequency and utility of *conceptualizing difficulties in relational terms*. Evidence of therapists' relational conceptualization of family problems is manifest in their questions and interventions emphasizing interpersonal patterns and interactions within client systems. For example, when one partner describes the couple's repeated communication struggles, James Coyne asks, "Can you think of an example of [when] this pattern, this process gets to be the issue?" Later in the session his questions invite the couple to further see the interpersonal dimension of their struggles, "Are there things he could say so that you wouldn't have to take it so personal or feel you had to fix it?" Similarly, Berg asks the wife in her session, "What do you need so that you feel that Bill understands how hard you are working to make this marriage work, to make this family go? What do you need from Bill?" In the session with Carl Whitaker, he asks one of the children about how she gets along with the others, "How's it with you and your brother and sister? Do you guys really have it out or do you just play nicey nicey?" Further evidence of the therapists' relational conceptualization is evident in Cloe Madanes' session. She asks the husband his interactions with his wife, "What advantage do you get from that?

How does it work for you? It must have some advantage, or you wouldn't do it." After he responds, Madanes asks the wife, "Have you found any way to break his pattern when he goes into that?" Johnson also asks her couple client, "How do you see what is happening between the two of you right now?"

The second part of this common factor, *reframing difficulties in relational terms*, reflects reframing interventions that arise from therapists' systemic and relational conceptualization. When therapists held an overarching relational conceptualization of the client problem, they asked questions or offered reflections and reframes to increase clients' awareness of their interactional patterns and facilitate a shift in the clients' view of the problem from an individual to a relational view. An example of such a reframe occurs in the EFT session with Johnson. Each partner reports the other is the problem (i.e., too demanding or too withdrawn); however, Johnson asserts that the problem is "the dance," or the partners' interaction/relational pattern, which keeps them from connecting. She invites them to consider this perspective through questions such as, "Does it seem like you guys are waiting for this tension to come up and take you over and get you caught in this dance?" In another video depicting structural family therapy, the parents in a family session report that the problem is their child's behavior. Aponte reframes this understanding of a child's behavior problem into the need for increased alignment among the two parents. Aponte states, "The two of you are very sensible people. I'm still trying to figure out, how do you two talk? How do you two work this thing out between you?" He continues, "What I'm feeling from you two is that you each figure, 'How am I going to solve it?' but you don't really sitdown face to face and say, 'Well, let's work this thing out.'" Additionally, Berg offers a couple the following reframe, "It seems like what you want is you want to be understood, you want to be involved in Bill's life. You want him to involve you in his life. You want to involve him into your life." She continues, "And the other side of it for you, from your side, Bill, is like you want to make things easy for Leslie. You want to take care of things on your own. You want to be responsible. You want to make her life easier."

Through therapists' questions and observations, clients are invited to reconceptualize problems and solutions in more systemic terms. McGoldrick offered a relational reframe with a client who reported that her father was absent in her life. McGoldrick framed this as a relational difficulty, stating, "Maybe you and [your father] just need to get connected in a way that has been missing for you." In White's session, the family is discussing positive changes they have noticed, and he asks, "What difference do you think that [change] could make in your relationship with Debbie?" After a client describes a positive interaction in which his partner did not get defensive, Coyne invites the couple to take a relational perspective on solving their communication struggles, "Any sense of contribution that you might make when he is successfully able to negotiate these situations? Anything that you might do that aids him in doing that?" Michael White also offers a useful reframe to a family describing their struggles. White asks the family about how these have affected their relationships. He asks Mom, "So this problem has problem has really interfered in your relationship with Mike (the teenage son)?" After she agrees, he asks Mike, "Would say this problem has interfered in your relationship with Debbie (younger sister)?" He then asks Mom, "And what effects has that had in your relationship? What has this problem been doing to your relationship, this conflict that you've had? These disagreements that you have? What has happened with your relationship with Mike, Debbie? Since this conflict has been here?"

Facilitating Constructive Interactions

Therapists' efforts related to client interactions focused primarily on *facilitating constructive interactions* between family members. Therapists across models structured enactments, facilitated positive interactions, or coached conversations between partners and family members. The focus of facilitating constructive interactions is typically to promote new, constructive experiences of client communication and relationships. For example, Johnson asks one partner to turn to the other and re-state a positive observation he made about his partner. Johnson capitalizes on such a moment by asking the partner to turn and deliver that positive message directly to their partner rather than looking at the therapist. In the same session, Johnson clearly states why she wants the couple to express feelings to each other when she says, "So can you tell her? Because it is different coming from me. Can you tell *her*?" Through this effort to facilitate direct interaction between clients, Johnson encourages them to form more productive communication patterns. Leslie Greenberg meets with a couple who are struggling with how their frustration with extended family members influences their relationship. Greenberg asks a series of questions, and ultimately encourages the couple to have a constructive discussion about their needs. He asks, "When you are spilling over with frustration, what do you need from him? It seems there is something you need."

Other therapists use direct and indirect invitations to facilitate constructive interactions between family members. For example, Minuchin structures an enactment between parents in a family session by inviting the wife to speak with her husband, "Talk with him and tell him how you would like him to change and what will you do to change him." In a family

session depicting narrative therapy, after the son shares his opinion Madigan asks him, "Do you ever have talks with your mom about why things happen that way sometimes?" When he answers, "Not really," Madigan encourages him to talk about this, "Do you think that might be important to talk with your mom or your dad or your brothers about this?" In a similar manner, after the husband states he loves his wife, Berg encourages him to share this with her, "Does she know how much you love her?" When he hesitates, she nudges him further, "What do you think? Does she know?" Aponte also facilitates constructive interaction when he suggests that the parents talk about parenting outside of their sessions, "The biggest work that has to be done here is between you two. You love each other, and you're both very dedicated and committed people, but I don't think you two talk enough." Aponte focuses on encouraging productive interactions to align the parental subsystem and develop greater consistency in their parenting.

In her session with a married couple, Madanes encourages them to describe to each other how they are feeling. She asks, "What has to happen, Joanne, for you to feel that you are getting enough love and connection? Or giving enough love?" Turning to the husband, "What do you suggest to Joanne, Tom, that she can do to improve her grade in giving love? Could you acknowledge more frequently that she loves you and that you like her love? What can you do to help her?" He says there are times his wife does not know how much she is loved; Madanes encourages, "So, go over and give her a hug and tell her." Later she asks the wife a similar question, "How can you help him to accept himself better when he makes a mistake?" After she responds, Madanes prods, "So, show me how you do that."

Valuing Clients' Perspectives

In our analysis of the therapy sessions, we found therapists across models consistently *valuing clients' perspectives.* This includes soliciting input from each member of the client system and incorporating their perspectives, experiences, and desires into therapy. Although therapists did not necessarily privilege clients' perspectives over their own ideas of treatment or healthy family functioning, they each valued the clients' perspective in various ways and solicited client input.

Valuing clients' perspectives involves focusing on what is important to clients and seeking their input on the direction and outcome of the session. White illustrates this by asking the family, "What if I could understand the most immediate concern to you?" Based on their response, White suggests a direction for the session and asks, "Would that be agreeable to you?" Similarly, Minuchin asks members of a blended family how they see the family challenges and what they hope to get from therapy. In McGoldrick's session with a father and daughter, the father questions the direction McGoldrick is taking the session. Her affirming response is a turning point that serves to increase the father's engagement in treatment. McGoldrick also asks the daughter, "So is there anything that you think would be good for us to change about the way things are going, from your point of view?" Berg also solicits the couple's input by asking, "What do you suppose needs to happen as a result of you being here today so that six months from now you can say to yourselves, 'That was a good idea that we went and talk to Insoo.'".

In addition to seeking input on the focus of sessions, therapists asked clients' permission to discuss a topic or initiate an intervention. An interesting element of Satir's session is the combination of giving directives and valuing clients' perspective. She directs family members to move around the room and engage in specific interactions. However, she does this affirmatively by regularly asking clients for permission to proceed, "Does that feel all right to you?" Philip Guerin demonstrates similar respect when, sensing client discomfort with the topic, he asks, "Do you want me to stop talking about this? Am I upsetting you now?" After the client responds "No," Guerin confirms, "So I can keep asking questions?" This type of regard is evident throughout sessions; for example, after proposing homework for the couple at the end of the session, Coyne asks, "Is this a comfortable way to proceed?"

Therapists also value clients' perspectives by seeking clarification or confirmation about the meaning clients give to their experience. Seeking such clarifications contributes to a tone of respect toward clients. For example, Madigan clarifies that it was not his client but the court (the referral source) that defined anger as the presenting problem. Madigan then asks, "What word would you use [to describe the presenting problem]?" In a session with Bill O'Handon, parents describe the difficulty they have with their young adult daughter. He then turns to the daughter, "Okay, but tell me your view of it. Same thing? You don't want him to get mad at you." He continues, "What happens when they start talking to you and you're walking away? What's going on?" After one partner describes the couple's struggles, Madanes asked the other partner, "How do you perceive this? Is this the way it is? Is his description accurate?" In another case, Johnson invites her clients to provide their input, "Sometimes I put together what you say in a particular way. If I don't have it exactly right, if I am making assumptions or am I slightly off, I want you to correct me. I want you to say, 'No Sue, it's not like that, it's more like this.'".

Discussion and Implications

The aim of the present study was to empirically examine CFT common factors meta-theory by analyzing therapy sessions with experienced therapists and model developers across seven CFT models. Previously identified CFT common factors served as sensitizing constructs for our deductive and inductive analysis of the sessions. Results include support for the current CFT common factors meta-theory, disconfirming evidence, and refinements to the meta-theory. In this section, we discuss our findings in the context of the extant literature and provide clinical, training, and research implications of the results.

Refining CFT Common Factors Meta-Theory

CFT common factors meta-theory maintains that common mechanisms of change cut across models; however, the meta-theory has lacked direct empirical examination. Overall, our results suggest the existing meta-theory of CFT common factors is sound, although incomplete. Common factors were manifest in model-specific CFT sessions, providing empirical support for the current meta-theory of common factors in CFT, as well as ways in which it can be refined. Specifically, the results support the expanded therapeutic alliance, incorporate valuing clients' perspectives as an integral part of developing and maintaining the alliance, broaden relational conceptualization to include reframing difficulties in relational terms, and suggest facilitating constructive interactions as a refinement to disrupting dysfunctional interactions. The findings support the notion that CFT models have much in common, and therapists who use different models often employ similar common factors (Davis et al., 2012; Karam & Blow, 2020; Sprenkle et al., 1999, 2009). Findings also provide strong support for the moderate view of common factors, namely that common factors work through models (Sprenkle & Blow, 2004a, b). Given the presence of common factors in model-specific sessions, therapists would be well served to consider the influence of common factors in their work with couples and families. Attending to CFT common factors may enhance therapists' ability to connect with clients, strengthen their therapeutic skills, and increase their effectiveness.

Expanded Therapeutic Alliance

Research on individual and relational therapy indicates that the therapeutic alliance is the therapist-influenced factor that has the greatest impact on clinical outcomes (Friedlander et al., 2018; Knobloch-Fedders et al., 2004, 2007; Quick et al., 2021; Sparks & Duncan, 2010; Wampold & Imel, 2015). Each therapist in the study worked with an *expanded direct treatment system* and demonstrated deliberate efforts to develop a *therapeutic alliance* with each member of the client system, providing strong support across models for these two CFT common factors.

Establishing a therapeutic alliance is a critical task for successful therapy, one which becomes increasingly complex as the number of people participating in therapy increases (Davis et al., 2012; Karam & Blow, 2020). Our results align well with the three elements of an alliance proposed by Bordin (1979): establishment of a bond between the therapist and client(s), collaboration on the tasks of therapy, and agreement on the goals for treatment. Further, our results align with Friedlander and colleagues (2006) work which asserts that a client's sense of safety is related to the emotional connection between client and therapist. When working with couples and families, therapists should develop and maintain a therapeutic alliance with each member of the client system. This includes building rapport with each person, attending to their comfort with therapy, seeking clients' input, and understanding their reasons for seeking treatment and what they hope to gain from therapy. The therapeutic relationship is nourished by therapist characteristics, such as personal warmth and genuine regard, and behaviors, such as validating, expressing empathy, and complimenting. Engaging in therapeutic tasks that are meaningful to each member of the couple or family couple system is also an important way to build and maintain the alliance (Karam & Blow, 2020). Therapists' efforts to maintain a balanced alliance and make repairs, if necessary, may include seeking client feedback through direct questions or alliance measures (see Friedlander et al., 2018).

Valuing Clients' Perspectives

The results of the study support *valuing clients' perspectives* as a common process in CFT. We conceptualize valuing multiple clients' perspective as an important aspect of the expanded therapeutic alliance (see also Friedlander et al., 2006). While individual therapists may also value their clients' perspectives, CFT therapists face the unique challenge of valuing the perspective of multiple clients simultaneously and communicating this in ways that are meaningful to each member of the client system. Previously, Sprenkle et al., (1999) proposed *privileging clients' experiences* as a common factor primarily in postmodern models, but it was not included in subsequent publications (Sprenkle et al., 2009; Davis et al., 2012). *Valuing clients' perspectives* is analogous to Sprenkle's concept but fits more closely with the data and reflects its common utilization of across CFT

models. Therapists in the study did not abandon their own knowledge and experience; yet they consistently valued the clients' perspective in the dialogic process of therapy and incorporated their input into the sessions.

There is little previous research on valuing clients' experiences in CFT. Nevertheless, others have examined the importance of valuing clients' ideas in therapy. Duncan & Miller (2000) make a case for privileging the client's ideas about change over the therapist's to best facilitate progress in treatment. Similarly, Blow et al., (2012) assert that clinical outcomes in CFT are enhanced when therapists take client input seriously and match their approach with clients' interests, motivation, culture, and worldview. Furthermore, Carlson & Erickson (2001) argue convincingly that clients' freedom and creativity are enhanced when their personal experiences, knowledge, desires, motivations, and skills are valued. Valuing clients' perspectives may also enhance client engagement in therapy (Friedlander et al., 2006). Therapists across CFT models can communicate their appreciation of clients' reasons for seeking therapy and their desired outcomes, include clients in the focus and plan for treatment, and incorporate their input in sessions. Further, family members witnessing a therapist valuing others' perspectives can be a powerful intervention, inviting them to consider the perspectives of others more openly. Therapists may also obtain client perspectives by collecting feedback from clients on a regular basis (e.g., ORS/SRS, Duncan & Sparks 2016; PPI, D'Aniello & Tambling 2016; D'Aniello et al., 2018). These measures can inform treatment and identify areas where correction is needed.

Conceptualizing and Reframing Difficulties in Relational Terms

Conceptualizing and reframing difficulties in relational terms emerged as a multidimensional common factor in our analysis. As proposed by Sprenkle et al., (1999, 2009), therapists in the study conceptualized client problems in relational, rather than individual, terms. Additionally, the therapists used reframing to help clients change their view of the problem. The inclusion of *reframing difficulties in relational terms* marks a refinement to CFT common factors meta-theory and adds empirical support to previous proposals that changing the way clients think is a common aspect of change in CFT (Sprenkle et al., 1999, 2009, 2012; Sprenkle & Blow, 2004a). Framing and re-framing a problem in relational terms (also known as systemic reframe) is a therapeutic intervention that spans CFT models (Weeks & D'Aniello, 2017; Weeks & Fife, 2014). Clients often describe or conceptualize problems in linear terms and as residing in one member of the family. To invite clients to view the problem systemically, therapists in the study asked questions and reframed problems in ways that highlighted the interpersonal nature of clients' problems and solutions. Crafting and offering systemic reframes of client issues is a central clinical skill that couple and family therapists must develop. As therapists listen to the clients' descriptions of the problem, they can attune to the clients' view of the problem, typically an individual view, and offer a relational reframe of the problem that includes the couple or family. This may help therapists and clients develop a shared understanding of the problem.

Facilitating Constructive Interactions

Previous iterations of CFT common factors meta-theory propose that disrupting dysfunctional interactions is a common factor that follows logically from conceptualizing problems in relational terms (Davis et al., 2012; Sprenkle et al., 2009). Although there were a few instances when therapists in the study interrupted unproductive interactions to maintain the structure of the session, there was very little direct evidence for this common factor. When therapists focused on client interactions, the vast majority of their efforts were directed toward *facilitating constructive interactions* and communication between family members. This included interventions such as structured enactments, coaching communication, and instructing clients to speak directly to each other. Constructive in-session interactions often served as an opportunity for clients to interact in new and more positive ways.

Helping clients experience new, productive interactions with each other can be understood as one way of intervening in a family's interaction patterns. Although facilitating constructive interactions is a known intervention in CFT, the findings of the study clarify, deepen, and refine the previously proposed common factor disrupting dysfunctional interaction patterns (Davis et al., 2012; Sprenkle et al., 2009). The results also align with previous research showing the positive impact of therapists' efforts to facilitate constructive interactions through enactments (Andersson et al., 2006; Zuccarini et al., 2013; Woolley et al., 2012). Additionally, a recent observational analysis of couple session interactions showed that the absence of positive in-session interaction was linked to therapy discontinuation (D'Aniello et al., 2021). This study illustrates that engaging in positive in-session interactions was critical to therapy persistence, suggesting that positive in-session interactions are desirable and productive. Taken together, the findings of the present study and existing literature suggest that therapists should strive to create opportunities for positive client interactions

to help family members interact in new and more productive ways.

Training Implications

In addition to supporting and expanding upon previous CFT common factors literature, the results of our study reinforce recent calls for increased common factors training in CFT programs (D'Aniello & Fife, 2017; D'Aniello & Perkins, 2016; Fife et al., 2019; Karam & Blow, 2020; Karam et al., 2015). In their survey of MFT program directors, D'Aniello & Fife (2017) found that common factors are regularly included in CFT training, though not in a consistent or standardized way. CFT practicum students who participated in a semester-long training in common factors reported experiencing increased understanding of CFT models, conceptual abilities, confidence, and clinical skills (Fife et al., 2019). The evidence of common factors within sessions illustrating various CFT models supports the view that common factors operate across and through models (Sprenkle et al., 2009; Wampold & Imel, 2015). The findings also support the inclusion of common factors training for couple and family therapists in clinical training so they can best potentiate common factors to enhance clinical effectiveness.

Textbooks and courses in many CFT training programs typically align with the historical practice of emphasizing the unique aspects of CFT models. This may be related to the necessity of preparing students for the national licensing exam that requires students to differentiate among models. The present findings suggest that therapists would also benefit from training designed to help them apply common factors in treatment. Previous research suggests that introducing common factors early in students' training enhances students' understanding of models (Fife et al., 2019). Along with strong training in CFT models, instructors and supervisors can integrate training on creating a strong expanded therapeutic alliance, framing client problems in relational terms, and facilitating positive client interactions, helping them become common factors informed emotionally focused therapists, structural therapists, narrative therapists, or any other CFT model (Davis & Hsieh, 2019).

Research Implications & Future Directions

The present study suggests the importance of continued research into the common factors perspective of change in CFT. While there has been some empirical research on specific CFT common factors (Andersson et al., 2006; Davis & Piercy, 2007a, b; Friedlander et al., 2011, 2018; Knobloch-Fedders et al., 2007), there continues to be a need for further empirical examination of and support for the common factors perspective of change in CFT. The minimal number of empirical studies may relate to a lack of funding for such research (Karam & Blow, 2020), the time consuming and costly nature of clinical research, as well as a reliance on previous meta-analyses and common factors research from individual psychotherapy. Nevertheless, additional empirical and theoretical study, evaluation, and critiques are necessary to continue refining the CFT field's understanding of common factors. Additional analyses of therapy sessions with a larger and more diverse sample would be useful to confirm, refute, or further expand the present findings and current understanding of CFT common factors. Researchers could replicate the methodology presented in this paper to analyze therapy in naturalistic settings to better understand how common factors manifest in couple and family therapy sessions across CFT models. Researchers could also conduct future studies aimed to investigate the role of common factors in sessions based on therapist characteristics, such as clinical experience, practice setting, and model orientation. Furthermore, research on the different ways CFT models facilitate behavioral, cognitive, and affective change will also expand understanding of CFT common factors (Sprenkle et al., 1999, 2009; Davis et al., 2012). Finally, few scholars have articulated the interrelationship between CFT common factors. Additional work on understanding how various common factors relate to each other and how they work together with CFT models to facilitate change is critical to advancing research on therapeutic effectiveness and understanding of common factors meta-theory.

Limitations

Though the present study provides empirical support for CFT common factors meta-theory and application, it is not without limitations. We consider our findings provisional, as they are specific to our sample and may not be transferable to therapists who practice in naturalistic settings. Additional limitations include the nature and size of the sample. The data are comprised of videos depicting model developers and experienced therapists conducting therapy with clients who consented to participate in therapy for demonstration purposes. It is possible there was a performance aspect in the therapists' effort to demonstrate the hallmarks of the model quickly and succinctly that does not apply to treatment as usual. Likewise, clients' participation may have been influenced by these circumstances. Additionally, nearly all the videos depicted only an initial session. Thus, the results may be particular to early phases of treatment and have limited application to later phases. Furthermore, the therapy in these videos may have limited ecological

validity, as in most cases the therapist knew they would only have one session with the clients, and in one case the model was demonstrated with actors and edited videos based on an actual case. While the videos were developed to exemplify CFT models, there is no measure of fidelity for the models that were demonstrated. Although these videos vary from a natural therapy environment, all showcase an actual therapist demonstrating the model.

Conclusion

Theory is at the heart of the CFT discipline (Fife, 2020), and systemic theory and clinical models are central to distinguishing it from other mental health disciplines (Davis et al., 2021). Nevertheless, the field must avoid theoretical myopia and stagnation. Theory development, testing, and improvement are essential to the vitality of the field of CFT. The common factors conceptualization of therapeutic effectiveness is one of the most important theoretical developments in the 21st Century, yet additional empirical evaluation is necessary to further establish its place in CFT research, training, and practice (D'Aniello & Fife, 2020; Davis et al., 2012; Karam & Blow, 2020). This paper offers an empirically based examination and refinement of the meta-theory of common factors in couple and family therapy. Our findings are provisional and, like previous conceptualizations of CFT common factors, are subject to analysis and revision. We encourage additional empirical study of common factors and further development of this perspective on therapeutic change.

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Data Availability The data that support the findings of this study are available from the corresponding author upon request.

Declarations

Disclosures The authors have no relevant financial or other conflict of interests to disclose.

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