The framework for integrating common and specific factors in therapy: A resolution

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Received 2 March, 2016; Accepted 19 August 2016

A framework for integrating common and specific factors in therapy is provided in this study. The key to integration is employing the common factors as fundamental principles; meanwhile, incorporating a specific model and unique techniques carefully to respond to the client's needs, demographic variables, and ethnic/cultural characteristics. The four major constructs of common factors (that is, client characteristics, therapist characteristics, process of change, and therapeutic context) are discussed. The four important therapy paradigms (analytic-dynamic, cognitive-behavioral, humanistic-experiential, and systemic therapies), in which the important specific factors are derived from, are also delineated. The author revised and extended the generic model and the process-based model to provide a better framework in understanding both types of factors. The main features of these two models have been integrated within the three phases: pre-therapy, process of therapy and post-therapy. In order to enhance the optimal effectiveness of therapy, the integration should follow three principles: using the findings of empirical studies, matching the client's variables, and responding to the notion of multicultural counseling. Implications for therapy research, training/education and clinical practice are highlighted.

Key words: Common factor, specific factor, counseling, psychotherapy.

INTRODUCTION

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Psychotherapy typically comprises of specific ingredients, and each of these ingredients requires many related therapeutic actions. Therapists usually adhere to and rely on a specific approach and unique techniques in conducting interventions (Parsons and Zhang, 2014; Prochaska and Norcross, 1999). They consider some of the approaches more effective than others. The adopted specific theoretical approach and techniques are often argued to be responsible for therapeutic gains. Despite the provision of diverse therapeutic approaches, literature noted a few differences in treatment efficacy among them (Sexton et al., 1997; Wampold, 2001). If differences do exist, they appear to be extremely small at best (Wampold et al., 1997). Any degree of client change may be attributed to a common process shared by all approaches, instead of specific ingredients utilized by only a few (Lambert, 1991; Sexton et al., 1997; Wampold, 2015). There is evidence that common factors across various therapeutic schools...
contributed much more than specific ingredients to the therapy outcome variation. Common factors could account for 30% of variation among clients’ improvement while only 15% by specific psychological techniques (Lambert and Cattani-Thompson, 1996; Sexton et al., 1997). Their findings highlighted the importance of focusing on common factors in all therapies. The debate on specific technical factors vs. common/non-specific factors has been gaining attention (Garfield, 1992; Stiles et al., 1986; Parsons and Zhang, 2014). Some scholars emphasized and advocated the importance of common factors that therapists should discard the traditional single therapy approach and rely on a common instead of specific factors in conducting therapeutic interventions (Lambert et al., 2004; Patterson, 1984). They have considered common factors to be necessary and sufficient in the therapeutic process.

Berman and Norton (1985) emphasized the importance of identifying factors common to all forms of treatment rather than from examining features specific to particular therapies. Messer and Wampold (2002) pointed out the widespread operation of common factors in therapy. Young (1992) proposed a REPLAN model focusing on the utilization of common factors in therapeutic treatment. This model is based on curative factors—the dimensions underlying all approaches: relationship, efficacy and self-esteem, practicing new behaviors, lowering or raising emotional arousal, activating expectations of help, motivation and providing new learning experiences, and changing perceptions (Frank and Frank, 1991). However, some other scholars have acknowledged common factors as an important component of change but have not ruled out the possible role of the unique techniques (Wampold, 2001, 2015). Both common and unique factors are important and necessary in the therapeutic process (Goldfried, 1991; Wampold, 2015; Warwar and Greenberg, 2000), especially the interrelationships between both types of factor (Arkowitz, 2003).

Should therapists follow the traditional style of adopting one specific approach to conduct interventions? Or should they employ common factors instead of specific techniques in therapeutic interventions? How should they handle both common factors and specific components during the process of therapy? The purpose of this study is to provide a resolution in the debate between common and specific factors through an integration of the two. Common and specific factors are elaborated in the next two sections respectively, followed by a delineation on the integrative conceptual framework of both. The term of “therapy” in this article refers to a broad scope of different styles of counseling and psychotherapy. Similarly, the term “therapist” refers to various professionals in counseling and psychotherapy fields.

**COMMON FACTORS**

Common factors are the similarities between different theoretical models. They are the active elements or essential ingredients across all counseling and psychotherapy approaches (Frank and Frank, 1991; Leibert et al., 2011; Weinberger and Rasco, 2007). Strupp (2001) identified that the outcome of a counseling and/or therapeutic process was frequently affected by the personal characteristics of the counselor/therapist and the client’s positive feelings—non-specific (common) factors—which can elicit the positive therapeutic emotional and interpersonal interactions.

In organizing these common factors, the three dimensions a client’s characteristics, a therapist’s characteristics, and the process of change (Lambert and Ogles, 2004) can serve as a reference. These dimensions corresponded to the three major sets of variables (that is, client’s, therapists and process) in counseling intervention. Lin (2005) proposed a process-based conceptual framework which included an additional construct—a therapeutic context or healing setting.

The therapeutic process and its outcomes are first influenced by various preexisting characteristics (input variables) from both the client and therapist. Subsequently, when both parties get involved in the process of change, the major constructs—therapeutic relationship, therapeutic techniques, placebo, expectancy, hope and rituals—interacted closely within a holistic frame of the therapeutic context.

**Client’s characteristics**

The client is the chief agent of change in therapy (Duncan, 2002). He/she is the most potent contributor to the outcome in therapy (Lambert and Cattani-Thompson, 1996; Miller et al., 1997; Sexton et al., 1997). Among a client’s various characteristics (for example, inner strengths, religious faith, goal directedness, personal agency, motivation, persistence, and capacity for change), his/her expectation is an active ingredient and has been confirmed as an important common factor (Sexton et al., 1997; Walborn, 1996). A positive expectation hope or faith is conceptualized as a critical precondition and is the most cited common factor for therapy to continue (Grencavage and Norcross, 1990; Prochaska and Norcross, 1999). Therapy can be viewed as a process in which the therapists induce an expectation in the client that treatments will heal him/her. Any positive change is a function of the client’s expectation to improve (Prochaska and Norcross, 1999). Therefore, the client’s willingness to change is viewed as an extra-therapeutic factor (Wampold, 2015). Furthermore, a client’s experience and/or emotional involvement in therapy, as a means for him/her to engage in an affective problem-solving process (Greenberg et al., 1993), is a common factor related to change in many therapeutic approaches (Bohart and Wugar, 1991; Castonguay et al., 1996).
Therapist’s characteristics

The common factors concerning the therapists are their characteristics, such as warmth and empathy (Brown, 2015; Moss and Glowiak, 2013), and unconditional positive regard in therapy (Brown, 2015; Gencavag and Norcross, 1990; Lambert and Cattani-Thompson, 1996; Moss and Glowiak, 2013; Patterson and Watkins, 1996; Prochaska and Norcross, 1999). These therapist-facilitative qualities (for example, honesty, support, empathy, genuineness, caring, acceptance, openness and respect) exert their effects by enhancing the therapist’s role as a benevolent agent of influence (Beutler et al., 1995; Brown, 2015; Moss and Glowiak, 2013).

Moreover, Whitbourne (2011) organized positive and common qualities of therapists into three categories: possession of a sophisticated set of interpersonal skills, the ability to help the client build trust in the therapist, and have a willingness to establish an alliance with the client. Other characteristics played active roles in the client’s improvement are therapist’s expectation for improvement, ability in persuasion, demonstration of warmth, attention, understanding and encouragement, and central to psychological interventions (Lambert and Cattani-Thompson, 1996; Moss and Glowiak, 2013). The therapist’s professional status or reputation and competences (for example, communication ability, caring, understanding, encouragement, persuasion, and integration) have also been identified as important factors (Frank and Frank, 1991).

Process of change

What is common to successful therapies is the process conducted by a skilled therapist who helps the client get involved (Nelson-Jones, 2013; Sexton et al., 1997). Lin (2005) proposed the process of change as a common dimension with five aspects:

1. The therapeutic relationship
2. Therapeutic techniques
3. Placebo, hope, and expectancy; and
4. Rituals.

In addition, a therapeutic context as a healing setting is crucial for clients’ making changes.

Therapeutic relationship

The therapeutic relationship is common and essential to all approaches (Bordin, 1994; Castonguay et al., 1996; Carr and Szymanski, 2011; Gross and Capuzzi, 2001; Moss and Glowiak, 2013; Nelson-Jones, 2013). The development of a strong therapeutic alliance between the two parties is important in therapy (Ardito and Rabellino, 2011; Gencavag and Norcross, 1990; Norcross et al., 1990; Prochaska and Norcross, 1999). It has also been identified as a major ingredient for behavioral change (Beutler et al., 1986; Frank and Frank, 1991; Sangganganavanich and Reynolds, 2015). A good therapeutic alliance is related to positive outcomes across various therapeutic modalities (Ardito and Rabellino, 2011; Horvath and Greenberg, 1994; Luborsky, 1994; Moss and Glowiak, 2013; Safran and Muran, 1996).

Therapeutic techniques

Combinations of affective, experiential, cognitive and behavioral regulations are common techniques in therapy. Lambert and Bergin (1994) identified three categories of common techniques: supportive (for example, reassurance, trust, empathy and catharsis), learning (for example, cognitive learning, advice, affective experiencing, and feedback), and action (for example, behavioral regulations, cognitive mastery, and practicing new behaviors). Other common techniques consist of therapists’ feedback for promoting awareness, corrective experience, and continued reality testing. Major therapeutic techniques common across schools share certain effects on outcome variance, such as corrective emotional experiences (Arkowitz, 2003; Frank and Frank, 1991), self-understanding (Brown, 2015; Luborsky, 1984), feedback (Brown, 2015; Lambert and Bergin, 1994), cognitive insight (Frank and Frank, 1991), emotional catharsis (Applebaum, 1982; Gencavag and Norcross, 1990), emotional arousal (Frank and Frank, 1991; Luborsky, 1984), reality testing (Goldfried, 1982), and communication, action, problem-solving, coaching, thinking and reflecting feelings (Brown, 2015; Culley and Bond, 2011; MacCluskie, 2010; Nelson-Jones, 2013).

Placebo, hope, and expectancy

“Placebo, hope, and expectancy” could contribute as much as 15% of the therapy outcome variation (Assay and Lambert, 1999). The placebo effect is an important component, and perhaps the entire basis for the existence, popularity, and effectiveness of therapy (Snyder et al., 1999). The curative effects come from the positive and hopeful expectations that accompany the use and implementation of methods and techniques (Frank and Frank, 1991; Sangganganavanich and Reynolds, 2015; Wampold, 2015; Weinberger, 1995). The power of expectation evokes from the therapist’s beliefs in therapy and human being’s capacity for change. The therapist expects the client to change as a result of the particular interventions and active participation in the process. Meanwhile, the client must be able to engage in
the process of self-exploration and be motivated to change.

Rituals

Rituals are a shared characteristic of healing procedures in many cultures (Frank and Frank, 1991). The therapist and client both need a structured, concrete method of ritual for mobilizing therapeutic factors. The use of rituals in a therapeutic context inspires hope and a positive expectation for change by conveying that the user possesses a special set of skills for healing (Hubble et al., 1999). In successful therapies, both parties must believe in the restorative power of the treatment’s procedures (that is, rituals) (Frank, 1973). A rational, conceptual schema offers a plausible explanation for the client’s symptoms and prescribes a ritual or procedures for resolving problems (Frank, 1982; Tinsley, 2000).

Therapeutic context

The healing context and its meaning attributed by the therapist and the client are critical contextual phenomena (Frank and Frank, 1991). A healing setting—a safe environment—heightens the client’s expectation from a healer (Frank, 1982). A provision of new learning experiences is not therapeutic unless the client perceives that the therapy is taking place in a healing context. Beutler et al. (1995) proposed four basic aspects of treatment context: the treatment location or setting (where), the intensity of treatment (how much), the modality through which treatment is delivered (what kind), and the format in which this modality is transmitted (with whom). Wampold (2015) proposed a common factor model (contextual model) which contains three pathways: the real relationship, the creation of expectations through explanation of disorder and the treatment involved, and the enactment of health promoting actions. Before these pathways can be activated, an initial therapeutic relationship must be established.

SPECIFIC FACTORS

The proliferation of therapeutic schools has reached as many as 400 (Bergin and Garfield, 1994; Karasu, 1986; Prochaska and Norcross, 1999). Each treatment model/approach utilizes specific ingredients targeted to remediate a particular psychological deficiency (Wampold, 2015). Every therapeutic approach has its own uniqueness, such as philosophical stance, problem conceptualization, theoretical constructs, therapeutic procedures and techniques. Often, the therapist would induce a client to:

1. Enact some healthy actions
2. Think about the world in less maladaptive ways
3. Rely less on dysfunctional schemas (cognitive-behavioral treatments)
4. Improve interpersonal relations (interpersonal therapy and some dynamic therapies)
5. Accept one’s self (self-compassion therapies, acceptance and commitment therapy)
6. Express difficult emotions (emotion-focused and dynamic therapies), and/or
7. Take the perspective of others (Wampold, 2015).

Based on therapeutic orientations, they can be categorized into four broad systems:

1. Psychodynamics
2. Cognitive-behavioral or behavioral
3. Humanistic-experiential, and
4. Systemic (family) approaches (Casas, 1995; Orlinsky and Howard, 1995; Wachtel and Messer, 2003).

Psychodynamic approach

The psychodynamic therapies include classical psychoanalysis and its early variants, as well as various analytically oriented treatments. This approach emphasizes the client’s early life experiences, early motivations which client is unaware of, situations of conflict between motives, the salience of motivational forces, and the role of unconscious forces on determining and directing his/her mental life (Orlinsky and Howard, 1995).

Psychopathology arises from unconscious pathogenic ideas of false beliefs that are usually based on traumatic childhood experience (Deveaux, 2014; Warwar and Greenberg, 2000). A therapist typically aim to provide the client with insight on their unconscious motivations as a means toward resolving conflicts and redirecting energies toward current life tasks (Corey, 2012; Orlinsky and Howard, 1995; Prochaska and Norcross, 1999). The therapeutic conceptualization and actions (for example, free association, interpretation of dreams, transference) are responsible for the therapy outcomes (Orlinsky and Howard, 1995). The client must uncover, process, work through unconscious mental forces and early life experiences that could be the basis for problematic thoughts and behaviors (Casas, 1995; Wachtel and Messer, 2003). Psychodynamic therapy focused on the notions of the unconscious mind, libido, transference and defense mechanisms; and psychoanalysis is a method for treating mental illness via dialogues between the client and psychoanalyst (Wright, 2013).

The key change process is to provide the client with insights on his/her problem through interpretation (Deveaux, 2014; Warwar and Greenberg, 2000). The investigation of the interpretation of transference to extract a client’s underlying pattern of conflictual themes can guide the therapist in determining a treatment focus,
as well as, in making interpretations of the client's wishes toward other people, expected responses of others and responses of the self (Luborsky, 1994). The therapist must develop:

1. A complex collaboration between himself/herself and the client, and
2. A working response to an interpretation through the results of precondition, interpretation and response operation.

**Cognitive-behavioral approach**

A cognitive-behavioral therapy (CBT), integrates both behavioral and cognitive treatments, aim to correct maladaptive patterns of behavior and thought by weakening or suppressing old habits and reeducating the client with more effective cognitive and interpersonal skills (Corey, 2012; Kalodner, 2011; MacCluskie, 2010; Orlinsky and Howard, 1995; Porter, 2014; Prochaska and Norcross, 1999). The ingredients of any treatment are grounded on the scientific understanding of behaviors (Fishman and Franks, 1992). There are three general classes of specific ingredients:

1. Behavioral activation
2. Activation and modification of dysfunctional thoughts; and
3. Identification and modification of more stable patterns of thought (Jacobson et al., 1996; Meichenbaum, 1997).

Research supports the effectiveness of CBT. Through reviewing a representative sample of 106 meta-analyses examining CBT for various problems, the strongest support exists for the CBT of anxiety disorders, somatoform disorders, bulimia, anger control problems, and general stress (Hofmann et al., 2012). After retrospectively examining the outcomes of patients who received group CBT for depression at a psychiatric outpatient clinic between 2003 and 2013, Thimm and Antonsen (2014) supported that group CBT for depression has shown effectiveness can be delivered in routine care settings. CBT is effective for treating insomnia when compared with medications, and its effects may be more durable than medications (Mitchell et al., 2012).

A behavioral therapy incorporates operant and classical learning paradigms to modify maladaptive behavior and thought patterns (Casas, 1995; Trolley and Siuta, 2014). A therapist facilitates a client’s therapeutic changes by challenging his/her beliefs with behavioral experiments for hypothesis testing. Specific ingredients, such as counterconditioning, stimulus control, contingency management, relaxation training, psychoeducation, and stress management, will be included in therapies (Casas, 1995; MacCluskie, 2010; Porter, 2014; Prochaska and Norcross, 1999).

Cognitive therapists regard that an individual's emotional and behavioral responses to a situation are largely determined by how he/she perceives, interprets and assigns meanings to that event (Kalodner, 2011; Porter, 2014; Warwar and Greenberg, 2000). They viewed psychopathology as systematic information-processing biases (Beck, 1997). A cognitive therapy is usually a structured, time-limited approach in which the therapist takes an active role in collaborating with the client to change his/her dysfunctional beliefs. Therapeutic interventions are tailored to a particular client’s difficulties with a new emphasis on the role of specific types of dysfunctional beliefs for the problems presented (Beck, 1997; Beck, 2011). The primary mechanism of change is to alter core cognitive schemas targeted by specific techniques, such as the identification of distorted and dysfunctional cognitions, correction of faulty conceptions and self-signals, and modifications of dysfunctional thoughts and beliefs (Corey, 2012).

**Humanistic-experiential approach**

The humanistic-experiential therapies focus on concrete, nonrational or prerational, symbolic aspects of experiences—emotion, bodily sensation and feeling, imagery, and imaginative fantasy—and the failure to give adequate expression in consciousness and behavior (Orlinsky and Howard, 1995). This type of therapies emphasizes in empowering individuals to act on the world and to determine their own destiny (Casas, 1995; Witty and Adomaitis, 2014). Major features consist of:

1. A focus on present as opposed to past experiences.
2. The importance of a therapeutic relationship in which the therapist is empathic, caring, genuine, and nonjudgmental; and
3. Central goals of therapy that include increased individual autonomy, independence, and self-actualization (Casas, 1995).

Through creative self-expression, the reattunement or centering of consciousness in the flow of immediate sensory and affective experience, and the rebalancing or harmonizing of personal energies, the client can attain psychological well-being (Orlinsky and Howard, 1995). The humanistic approach—focus on the process in the here and now—see people as basically healthy (Corey, 2012; MacCluskie, 2010; Warwar and Greenberg, 2000), emphasize the importance of the client-therapist relationship in promoting therapeutic changes (MacCluskie, 2010; Watson and Greenberg, 1994), put therapeutic goals as establishing congruence and acceptance of client’s responsibility (MacCluskie, 2010), and value the therapist’s presence as being highly therapeutic (Watson et al., 1998). The primary task in humanistic therapies is to facilitate the client’s experiences, particularly in those
to problematic areas that he/she shows concerns (Corey, 2012; Greenberg et al., 1993).

Systemic therapy

Systemic therapy is primarily about understanding ideas in the wider social context. The client’s improvement is viewed as modifications on the functional properties of the system rather than on his/her own characteristics. A psychological symptom is considered to be maintained by a particular repetitive patterns of behavior organized within a troubled social system. The therapist often looks into the family system for indications of the problem and targets interventions on the relationship system; any symptom can thus be redefined as indicators for an entire ecology of relationships (Goldberg et al., 2014; Keeney, 1994). An alternative account of recurrent patterns of behavior, which focuses on behavioral maintenance in the present by feedbacks within the system, can be offered. The social context of the behavior is highlighted rather than the characteristics of the individual displaying that behavior.

Systemic family therapies—emphasize the exchange and processing of information, conflict and the flow of influence among intimates—are an active but indirect approach to resolving problems (Goldberg et al., 2014; Orlinsky and Howard, 1995). This family system perspective holds that symptoms are an expression of a dysfunction within a family; these dysfunctional patterns could be passed down from several generations (Corey, 2012; Goldberg et al., 2014). Systemic theorists believe that families are self-regulating and self-maintaining (Stevens, 2001), and many inner disturbances developed in a family or another relational context (Casas, 1995). The family play an important role in the development and maintenance of pathology and dysfunction, thus, it is more effective to work with a family or a relational system than with an isolated individual.

INTEGRATING COMMON AND SPECIFIC FACTORS

Several proposed models have attempted to draw a relationship between common and specific factors in the therapeutic process. Two representative models are the Generic Model (GM) by Orlinsky et al. (2004) and the Process-based Model (PM) by Sexton et al. (1997). Brief introductions of these two models are delineated below, followed by a description of the proposed framework of integrating important components of these two models to synthesize common and specific factors effectively.

The GM distinguishes therapeutic process as a system of action from other larger surrounding systems which served as functional environment. It emphasizes on treatment specificity and the matching of technique to the client and problem, as well as on using empirical data to determine choice of therapy. This model also concentrates on the matching of a broad array of client variables, treatment variables, and outcome. Monitoring variables, such as therapist characteristics (for example, experience, attitudes and beliefs), client characteristics (for example, symptom complexity, coping style and resistance to influence), technique variables (for example, muscle relaxation skills, empty chair, role and play) and interactions among these variables are essential. Each form of therapy, as stated by this model, involves a particular configuration of these process facets. There are always some therapeutic contracts which entail specific therapeutic operations. In the course of therapy, the client and the therapist form a therapeutic bond and experience specific modes of self-relatedness, through which they attain some in-session impacts. Furthermore, these facets interact with each other as a temporal pattern of events.

PM proposes that the therapeutic process and its outcomes are influenced by various preexisting characteristics of the client and the therapist (input variables). Some of these characteristics are stable (for example, demographic, personality style and personal history), whereas others are subject to change during the course of therapy (for example, beliefs, attitudes and expectations). Once therapy begins, the three primary factors—therapeutic contract, therapeutic relationship, and specific techniques—will impact the outcome. The combination of these three factors is responsible for certain in-session experiences for both parties.

Both GM and PM emphasize to facilitate client’s change through integrating both common and specific factors in therapy. Therapy is viewed as a process conducted by a skilled therapist who helps the client get involved in the process. The therapist can emphasize the crucial process of change and highlight therapeutic relationship and techniques in the therapy. Common factors (for example, therapy relationship, client’s and therapist’s characteristics) can served as fundamentals, while specific factors can be incorporated to match with a client’s characteristics, needs and problem types. Both models stress the importance of prescriptive matching among variables to achieve the optimal effect of therapeutic interventions.

With an attempt to combine the strengths of both models, the author employed the process-based concept (input, process, and output) (Sexton et al., 1997), key variables (for example, therapeutic relationship, contract, operations), and the context of therapy (Beutler et al., 1995) as important constructs during the process of change. The main features of these two models were integrated into a framework within the three phases: pre-therapy, process of therapy, and post-therapy. These elements of therapeutic process influence one another reciprocally and are embedded within a holistic framework. This conceptual framework is presented in Figure 1.
Pre-therapy phase

Two major inputs in the pre-therapy phase are the client’s specific factors (for example, sociodemographic status, personal style, developmental status, self-system, adaptation to current life situation, range and severity of problems, developmental history, interpersonal skills, intellectual acumen, state of pain, and desire for change) and those of the therapist (for example, sociodemographic status, personal style, life situation, and professional status and expertise). During the therapeutic process, the therapist accommodates the client’s specific traits (for example, age, gender, ethnicity, and education level) in order to work with him/her effectively. Certainly, the client's personality traits may react with the therapist's characteristics to produce specific interaction effects that will influence the outcome (Beutler et al., 1995); therefore, a carefully matched pair on their attributes will be beneficial (Sexton et al., 1997). In this phase, an assessment of the client’s predisposing qualities (for example, personal traits, stressors, resources, problem type, problem severity, distress level, client personality, etiology, etc.) will be conducted by an intake therapist. With the input data, the intaker could select a therapist best matched to the client’s presenting problems, levels of distress, and relational style. Two principles of matching—ethnic and language—have been addressed in literature.

Ethnic matching

A preference for a therapist of the same race may be a salient variable in therapy (Zane et al., 2004). Client often prefers an ethnically similar therapist (Kenney, 1994; Okonji et al., 1996; Sue and Sue, 2012). Therapist-client ethnic match is associated with the increased use of mental health services, a lower likelihood of dropout, and more positive treatment outcomes (Sue and Sue, 2012; Yeh et al., 1994; Zane et al., 2004).

Language matching

Language matching is a particularly important factor in the treatment of monolingual minorities; it is a starting point for culturally competent mental health services (Zane et al., 2004). Spanish-speaking Mexican American clients who used interpreters during therapy sessions reported that they felt more helped and understood than their bilingual counterparts who spoke to the therapists in English (Kline et al., 1980). Non-English speaking Asian Americans demonstrated better therapeutic outcomes when matched with a therapist of similar ethnicity and
spoken language (Zane et al., 2004).

**PROCESS OF THERAPY**

Both GM and PM highlighted three main constructs in the process of therapy: therapeutic bond (or relationship), therapeutic contract, and therapeutic operations (application of specific techniques and interventions). The therapeutic bond and contract are considered as common factors across therapies; therapeutic techniques and interventions are specific factors. The establishment of therapeutic relationship and contract should be solidified in conjunction with specific therapeutic operations. As both parties have involved in the process of therapy, the combination of these factors could lead to certain in-session experiences for them (Sexton et al., 1997).

**Therapist’s facilitative qualities assist the development of the therapeutic relationship**

Common factors, such as the therapist’s support, empathy, caring, acceptance and respect, are the foundation for establishing a therapeutic relationship with a client. These facilitative qualities could aid the therapist in empathic understanding and involvement with the client (Brown, 2015; Gaston, 1990). His/her contributions to the client’s successful outcomes are made mainly through empathic, affirmative, collaborative, and self-congruent engagement. Personal connections with the client must be made in order to develop interactive, dynamic, therapeutic relationships. This client-therapist relationship is important for significant progress in therapy and provides the foundation for forming a working cooperative effort (Ardito and Rabellino, 2011; Sangganjanavanich, 2015; Wampold, 2015). Through this relationship, the therapist can express his/her faiths, hopes, and positive expectancies on improving the client’s condition. The therapeutic relationship built with collaborations has been identified as the most important common factor (Ardito and Rabellino, 2011; Bordin, 1994; Castonguay et al., 1996; Gelso and Hayes, 1998; Pinsof, 1994; Raue and Goldfried, 1994).

**Therapeutic relationship serves as a basis to build up a therapeutic contract**

Same as the therapeutic relationship, the therapist and the client must build up a therapeutic contract. They engage in the social roles of a therapist and a client, respectively. Therefore, their actions and experiences are often shaped by and reflecting the normative expectations associated with these roles. They learn and implement the norms in the process. Norms delineating in the therapeutic contract define the optimal interaction between a client and a therapist that are presumed to promote favorable outcomes. A successful therapy occurs in the context of a therapeutic relationship in which the two parties have mutual feelings of empathy and affiliation; goals are achieved in collaborative ways. Contractual provisions stipulate:

1. Where and when the treatment is to take place (treatment context)
2. Whether it is to be individual therapy or a form of therapy including more than one client, for example, group or family therapy (treatment modality).
3. How and how much the therapist is to be paid (compensation); and
4. How long each session should last, how frequently they should occur, and whether there should be a limited or unlimited number of sessions (timing) (Lambert and Ogles, 2004).

**Therapeutic rituals facilitate client’s involvement with therapy**

Therapeutic rituals serve as a set of shared characteristics of healing procedures in most cultures (Frank and Frank, 1991). The therapist and client need a structured, concrete method of ritual for mobilizing therapeutic factors. The use of rituals in a therapeutic context inspires hope and a positive expectation for change by conveying that the user possesses a special set of skills for healing (Hubble et al., 1999). Frank (1973) supported the idea that, in successful therapies, both client and therapist must believe in the restorative power of the treatment’s rituals. The client’s change and improvement happen in a context that mobilizes growth through rituals. A rational, conceptual schema not only provides a plausible explanation for the client’s symptoms, but also prescribes a ritual or procedure for resolving problems (Frank, 1982).

**COMMON FACTORS TO PROMOTE CLIENT’S INVOLVEMENT WITH THERAPEUTIC OPERATIONS**

Combinations of affective, experiential, cognitive, and behavioral regulations have been recognized as common techniques in therapy. Lambert and Bergin (1994) identified three categories of common factors: support factors (for example, reassurance, trust, empathy and catharsis), learning factors (for example, cognitive learning, advice, affective experiencing, and feedback), and action factors (for example, behavioral regulations, cognitive mastery, reality testing, and practicing new behaviors). Other common techniques consist of the therapist’s feedback for promoting awareness, corrective experience, and continued reality testing. Major
therapeutic techniques common across schools share certain effects on outcome variance, such as corrective emotional experiences (Arkowitz, 2003; Frank and Frank, 1991), cognitive insight (Frank and Frank, 1991), self-understanding (Luborsky, 1984), feedback (Lambert and Bergin, 1994), emotional catharsis (Applebaum, 1982; Grencavage and Norcross, 1990), emotional arousal (Frank and Frank, 1991), reality testing (Goldfried, 1982), and communication, action, problem-solving, coaching, thinking and reflecting feelings (Nelson-Jones, 2013).

EMPIRICALLY-VALIDATED AND CULTURALLY RESPONSIVE TREATMENT SPECIFICALLY PRESCRIBING FOR CLIENT’S CHARACTERISTICS

After building a trustful relationship and a reasonable contract with a client, the therapist have to empirically identify the client’s qualities that will hold the most promise for enhancing the fit of possible treatments (Beutler and Clarkin, 1990). Specific interventions, derived from psychodynamic, humanistic-experiential, cognitive-behavioral, systemic (family) systems and other approaches, should be tailored for the client’s specific problems (Garfield, 1992). Any interaction of client’s personality traits and the selected therapeutic techniques could lead to a desirable or undesirable outcome (Beutler et al., 1995). This notion of matching provides a guideline on incorporating common and specific factors in a therapy. The search for unique effects of specific interventions goes on in a context due to the interaction between the client’s characteristics and these particular interventions. The therapist has to follow a sequence in carrying out a treatment plan and choose the therapeutic strategies and techniques primarily based on the client’s predisposing qualities; he/she decides the focal target(s) of change and the strategies to be used. Specific techniques based on the following principles could be incorporated to promote client change.

Empirical evidence matching

In order to enhance the effect of therapeutic interventions, empirically-validated (or supported) treatments should be carefully considered (Chambless and Ollendick, 2001). The focus on developing or identifying this type of treatments clearly will be relied on the therapeutic effectiveness of the techniques based on their theories. With the rise of managed health care over the last decade, attentions have been placed increasingly on developing specific protocols or practice guidelines for behavioral healthcare. Both movements were evolved out of the possibility in creating a better standardized delivery of mental health services through the use of treatment manuals (Lambert et al., 2004). Empirical evidence was delineated to support the effectiveness of specific guidelines and/or treatment for certain types of problems/symptoms.

First, cognitive and behavioral therapy (CBT) appears to be effective in the treatment of adult psychiatric populations (DeRubeis and Crits-Christoph, 1998) and children/adolescents (Kazdin and Weisz, 1998) with a variety of disorders, such as panic, GAD, social phobia, bulimia nervosa, and depression (Lin, 2003). This type of interventions is effective in helping clients tolerate noxious medical procedures, prevent high-risk behaviors, preserve immune system functioning, and reduce chronic pain (Hollon and Beck, 2004). It also shows a great promise in the treatment of internalizing disorders in children and adolescents, as well as can be used to reduce belief in delusions and speed up the course of recovery.

Second, depressed clients who are resistance prone appeared to do better with a less directive technique. A nondirective skill may be a good match for certain resistant (for example, defensive and reactive) clients (Beutler et al., 1995). Cognitive interventions are more effective than insight-oriented treatment for clients with externalizing problems (Beutler and Consoli, 1992).

Third, experiential-humanistic therapy in general achieved clinically meaningful, stable gains than the psychoeducational group for most clients with significantly greater improvement (Paivio and Greenberg, 1995). Psychodrama-based interventions (a branch of experiential approaches) demonstrated significant improvements for PTSD clients with inpatient treatment (Cox et al., 1999).

Fourth, Nelson and Allstetter-Neufeldt (1996) pointed out that when the clients’ problems arise from situational difficulties caused by external factors are best to be addressed by teaching, learning, and problem-solving methods; meanwhile, complex problems that involve enduring personal and interpersonal patterns should require more in-depth examinations and treatments for changing behavioral, cognitive, and/or systemic pattern(s).

Fifth, clients respond better to the influence of common factors that facilitate change when their symptoms are not too severe. Some behavioral and cognitive methods appear to have superior effects on some otherwise difficult problems, such as severe phobia, compulsions, bulimia nervosa, tension headaches, insomnia, and other health-related dysfunctions (Lambert et al., 2004).

Last but not least, four important observations of client/treatment matching highlighted by Lambert et al. (2004) are clients with severe and chronic disorders, such as schizophrenia and bipolar disorder, seem to respond well to specific medications, while their responses to therapy are less dramatic; family-based interventions have been shown to be especially effective in slowing relapse in schizophrenia and in treating conduct disorder in adolescents; behavioral therapy has been shown to be more effective than other treatments.
with disturbed children; and psychoeducational interventions that do not depend on theoretical positions or relationship factors often result in substantial improvement.

**Culturally responsive matching**

Culturally responsive matching is another key principle for pairing client with therapy. This incorporation of various specific factors in therapy is based on the philosophy of multicultural counseling. Clients often considered culturally trained therapists are greater in expertise, trustworthiness, attractiveness, empathy, and unconditional positive regards (Wade and Bernstein, 1998). Culturally responsive therapies provided by indigenous healers have shown as effective for ethnically and/or culturally different clients (Atkinson et al., 1998; Sue and Sue, 2012). A culturally competent therapist should assist the client to function effectively in his/her own culture, as well as in the mainstream (McFadden, 1996; Nelson-Jones, 2013).

The client’s ethnic/cultural characteristics must be considered during the process of therapy in order to select the interventions that are responsive to his/her culture. For example, Asians often:

1. Present more somatic complaints than non-Asian clients; this has been interpreted as evidence of somatization in which physical symptoms are expressed in place of psychological symptoms (Sue and Sue, 2012).
2. Tend not to make a strong distinction between emotional and physical problems and attribute both to bodily imbalances (Flaskerud and Soldevilla, 1986).
3. Are prone to believe that mental health can be restored by avoiding negative thoughts and/or using self-discipline (Lum, 1982).

Therefore, they may find the initial stage of a therapy which relies heavily on painful or negative thoughts, emotional catharsis, and de-emphasis of somatic interventions contradicted with their conceptualization of positive mental health benefits (Sue and Sue, 2012). Culture-specific therapeutic methods could be most useful for many Asian clients as they are less verbal and refrain from expressing their feelings in public (Sue and Sue, 2012). They are also not custom to discuss psychological problems with professions, family, or friends; their communication styles may influence the therapeutic relationship and the development of rapport. Differences in family structures, value orientations, and beliefs about mental health and illness between Asian and White American cultures can be illustrated in another example. Western culture typically focuses on the nuclear family unit that involves more egalitarian relationships and emphasizes the values of individualism, competition, self-worth, and direct expression of emotions. However, many Asian cultures have traditions from non-egalitarian societies that center on extended family in structured, hierarchical relationships stressed the values of collectivism, group achievement, face, and emotional restraint (Sue and Sue, 2012). A culturally responsive therapy with an Asian client may emphasize on family and societal structure; the therapist will avoid completely to rely on verbal expression and open self-disclosure as the primary means for resolving psychological problems. Culturally responsive therapies could result in a greater client return rate, satisfaction with therapy, and depth of self-disclosure (Atkinson and Lowe, 1995; Ratts and Wayman, 2015). Their effectiveness has been supported by empirical evidence (Atkinson et al., 1998; MacCluskie, 2010; Sue and Sue, 2012; Zane et al., 2004). Cultural matching between therapist and client, and between therapy style and the client’s ethnic/cultural characteristics, are important in initiating a positive interaction in therapy.

**A THERAPEUTIC CONTEXT INTEGRATING BOTH COMMON AND SPECIFIC FACTORS**

A therapeutic context consists of:

1. The immediate treatment setting (for example, university counseling center, community mental health clinic, inpatient psychiatric ward, or private practice office) and personnel who interact regularly with clients and therapists (for example, receptionists, supervisors).
2. The wider service delivery system in which the treatment setting is located (for example, managed care systems and health maintenance organizations).
3. Other social institutions located within or outside the service delivery system (for example, welfare agencies, law courts, clients’ families); and
4. Social, economic, and/or political climates (for example, holiday seasons, business recessions, national crises) (Orlinsky et al., 2004).

A context or functional environment in which a therapy takes place is constituted by the social institutions and cultural patterns of community the client and therapist belong to. In addition, these social institutions and organizations impose their influences on all the therapeutic practices and cases. Responding to the notions by scholars (Orlinsky et al., 2004), the community’s cultural beliefs and values on normality, the appropriate forms of emotional experience and expression, communicative norms, the nature and causes of deviance (pathology), and the appropriate modes of helping, will exert guiding influences on the therapeutic process, just as those beliefs and values in turn are affected over time by what articulate and influential members of the community experience in therapy.
Post-therapy

Therapy, as a system of actions, can be viewed as having both individual and collective contexts that the therapeutic process (as input) is recursively influenced by its own outputs including the outcome. Those individuals directly involved in the process will experience the most immediate impacts. Every therapist should pay attention to how the current events of therapy could influence the future events that may affect the client’s well-being.

DISCUSSION

Literature have supported that the matching of therapist and client, therapeutic style and client’s characteristics, and therapeutic technique and problem type could enhance the effectiveness of therapy (Lambert et al., 2004; Sexton et al., 1997). The incorporation of therapist’s characteristics in both promoting a therapeutic relationship and formulating a mutual, collaborative therapeutic contract is fundamental to therapeutic operations. Moreover, all these common factors mutually interact to induce the client’s hope, faith, expectancy, and involvement in therapy.

The selection of specific techniques should reflect the client’s needs, problem types, and demographic characteristics. These specific factors from a certain therapeutic approach should be based on the therapeutic relationship, contract, and other common elements (for example, hope, expectancy, placebo, faith, hope, rituals) in a holistic context to facilitate the client in developing insight, gaining awareness, expressing emotion, learning behaviors, and developing a sense of mastery during the process of therapy.

This article supports that common factors across therapies do not eliminate the need of considering variables that are unique to therapeutic approaches. Even though common factors may contribute more to the success of therapy, the value of specific factors in a therapy cannot be neglected when the therapist prescribes a treatment or a combination of treatments customized to a client’s problems. The integration of both common and specific factors can improve the effectiveness of the process of therapy.

Individual differences should be highlighted in any therapy and the type of interventions should match the client’s characteristics. The suitability of a therapeutic intervention to the client’s particular needs is more important than the intervention itself (Silberschatz and Curtis, 1986). The assessment of how well-suited interventions is in relation to the client’s problems and treatment goals. The type of technique and its appropriateness for the client may predict client’s immediate response and the outcome (Piper et al., 1993). When a client with specific problems or symptoms, the therapist should not only adopt the common factors but also incorporate specific techniques to maximize the effectiveness.

There is an on-going movement on matching client type with treatment style and matching client-therapist characteristics. Studies on matching are based on the belief that therapy is generally effective, but not all clients benefit equally from a specific treatment (Bergin and Garfield, 1994). By matching a client with certain characteristics and/or problems to a particular treatment or process variable, researchers could identify the most suitable and productive therapeutic method. Matching the three elements—clients, therapists, and treatments—is a crucial step in enhancing the effectiveness of therapy (Beutler, 1989; Beutler and Mitchell, 1981; Luborsky et al., 1986; the importance of carefully selecting and incorporating specific factors in treatment should be emphasized (Sexton et al., 1997; Wampold, 2015).

The movement of multicultural therapy highlighted the importance of developing approaches and practices that may be more effective with various racial/ethnic groups (Casas, 1995; Ratts and Wayman, 2015; Sue and Sue, 2012). Multicultural therapists adopt the best therapeutic style for a specific type of clients with certain type of problems (Sharf, 2000) by addressing theories, concepts and techniques targeted clients from different ethnic-cultural backgrounds (Sue and Sue, 2012; Wampold, 2015). When incorporating both common and specific factors in therapy, the therapist not only should employ the fundamental similarities across therapeutic approaches, but also utilize the specific factors sensitive to the psychosocial, cultural attributes and constructs (for example, worldviews, cultural assumptions, historical/life experiences, and acculturation level) of the client. The interactions of race, culture, biology, gender, class, sexual orientation, religion, and other variables must be considered in selecting the therapeutic techniques.

Certainly, the common factors will provide a cooperative working endeavor. It is the client’s increased sense of trust, security, and safety, along with decreases in tension, threat, and anxiety that lead to changes in conceptualizing his/her problems and, ultimately, in acting differently by reframing fears, taking risks, and working through problems in interpersonal relationships (Lambert and Ogles, 2004). The emphasis on studying common factors along with specific techniques will encourage a harmony and more extensive cooperation between the various competing approaches; consequently, the effectiveness of therapy will be further improved. Treatment manuals are developed to standardize treatments in psychotherapy efficacy studies (Wade et al., 1998). They contain a definitive description of the principles and techniques of the therapy, as well as a clear statement of the operations the therapist is supposed to perform (Kiesler, 1994). Treatments typically contain many specific ingredients; each specific ingredient requires many related therapeutic actions. Descriptions of the specific ingredients and the rationale for their
inclusion can also be found in a treatment manual. Utilizing treatment manuals have several advantages on implications for therapy, research, training, and practice:

1. Enhancing the internal validity of comparative outcome studies.
2. Providing a precise and organized way of training and supervising therapists, facilitating the development of rating scales for treatment integrity (adherence or conformance) and therapist competence.
3. Speeding up the process of training
4. Enhancing the possibility of replication; and
5. Helping to sort out the active ingredients of therapy by facilitating the comparison of the common components of treatments. Some research findings supported that manualized treatments used in efficacy studies can be transported into clinical settings (Wade et al., 1998).

CONCLUSIONS

The proposed model can serve as an effective reference framework for clinicians to integrate both common and specific factors in practice to achieve an optimal therapeutic outcome. Education programs for therapists should emphasize the common factors across various schools and build up their trainees’ abilities to employ common factors as the fundamental elements. Meanwhile, trainees must learn to incorporate the specific techniques, methods, and strategies appropriately to formulate their own therapeutic style with various types of clients. Researchers should focus on the implementation of this model and examine the outcome quality of therapy. Future research could investigate the parameters of the common and general factors across the various therapeutic schools and explore the effectiveness of various common and specific techniques.

The debate between common and specific factors in therapy may able to be resolved through an integration of the two. The proposed process-based model responds to the consensus that the field of therapy can be gradually unified by combining the fundamental similarities and the useful differences across schools. Three principles useful for integrate both types of factors are:

1. Conducting ethnic/language matching in pre-therapy.
2. Using empirically supported interventions; and
3. Responding to the notion of multicultural counseling.

A therapist can maximize the therapeutic effectiveness by employing those common factors highlighted in literature while capitalizing on the contributions of specific techniques proven to be successful for certain clients. The movement toward identifying the common factors evident in all successful therapies should be continued. These common factors are those captured a significant amount of the variance in treatment outcome.

Researchers are increasingly focusing on the study of client-treatment protocol matching. Clients with certain problems could be treated with various packaged interventions that have a behavioral, cognitive, and/or dynamic focus. Studies on therapeutic outcome can provide a useful guideline for determining the choice of treatment for certain well-defined concerns. With the changing economic, social, and political forces shaping the boundaries of therapy, therapists must create and apply more responsive models to deliver mental health services that fit into, not fight against, the rapidly changing cultural conditions. The goal of integrating both types of factors is to respond to the needs of diverse clients, from diverse situational contexts, with diverse psychological difficulties.

Conflict of interests

The authors have not declared any conflict of interests.

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