2022

GRADUATE STUDENTS' PERCEPTIONS OF PSYCHOTHERAPISTS' ENGAGEMENT IN COMMON FACTORS

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A thesis submitted in partial fulfillment

of the requirements for the degree of

MASTER OF ARTS

to the faculty of

DEPARTMENT OF PSYCHOLOGY

of

ST. JOHN'S COLLEGE OF LIBERAL ARTS AND SCIENCES

at

ST. JOHN'S UNIVERSITY

New York

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ABSTRACT

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Manuel Jose Orellana

The study investigated the extent to which common factors (CF) interventions are found within the training recording of cognitive behavior therapies. Some scholars have proposed that effective psychotherapy can be accounted for by Common Factors that exist across all psychotherapies that work. This study aims to see if CF interventions are found within cognitive behavior therapies. To discover the extent to which CF interventions are found within cognitive behavior therapies, we asked graduate students in a psychotherapy course who were assigned to watch training sessions of CBT sessions and instructed to rate the therapists' behaviors using the Multi-Theoretical List Psychotherapeutic Interventions (MULTI) scale. The MULTI includes subscales that include the therapists' behaviors identified with Common Factors, Psychodynamic, Interpersonal therapy, Person-Centered (PC) Therapy, Behavior Therapy, Cognitive Behavior Therapy, and Dialectic Behavior Therapy. Because the students' ratings on the MULTI were nested with therapists, within sessions, and within raters, a mixed models' analysis was used to determine if the CF MULTI subscale were significant across student scores across tapes, therapists, and type of therapy. Before MULTI subscales were loaded, estimates of covariance parameters were checked. It was found that Beck's Cognitive Therapy (CT), Motivational Enhancement (ME), Rational Emotive Behavioral

Therapy (REBT), Schema-Focused Cognitive Therapy (SFCT), and General Cognitive Behavioral therapy (GCBT) all had significant ratings of CF MULTI scores. Social Problem Solving Therapy (SPS) and SFCT had significant differences in PD MULTI scores.

Moreover, finally, CT, ME, REBT, and GCBT had significant differences in PC MULTI scores. Overall, CF interventions were highly rated and agreed upon in CT, ME, REBT, SFCT, GCBT orientations. The results of this study support the fact that there are common factors that therapists in training can observe in all types of CBT and that CBT therapies engage in behaviors characterized by other theoretical orientations.

Keywords: Training, Psychotherapy, Common Factors, Rational Emotive Behavioral Therapy, Multitheoretical List of Therapeutic Intervention, Cognitive Therapy, Cognitive Behavioral therapy.

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Chapter 1: Introduction

Statement of the problem

Psychotherapy research has yielded significant findings that treatments work (APA proclamation). Researchers have attempted to study what works within a therapy session or theoretical orientation. This study attempted to examine whether therapists following a Cognitive Behavior model engage in the Common Factor interventions and bring into light problems that have plagued that field of psychotherapy. Cognitive therapies are some of the best researched and have yielded evidence for their effectiveness. What attributes to their success? Within the many theoretical schools of cognitive therapy, are some more effective than others? What factors are responsible for effective treatment? As has been the case, the field of psychotherapy has tested many therapies empirically and has produced a list of treatments that have robust empirical findings. Cognitive therapies provide an excellent starting point for research and study. Over the years, different theoretical orientations have developed theories of psychotherapy and how successful treatment is produced. One of the models is the Common Factors model. What is the extent that the common factors are found within cognitive therapies? A great starting point will be is discuss some of the problems within the field of psychotherapy that led to pursuing this study. This section reviews a description of the common factors model of psychotherapy and why cognitive behavior therapies have already been identified as the gold standard of effective psychotherapies.

Proliferation of Psychotherapies

There has been a proliferation in the number of psychotherapies over the last 40 years. From 1959 to 1986, there was a count of 400 different schools of psychotherapies.

(Beitman, Goldfried & Norcross 1989). About 20 years ago, the count of brand-name psychotherapies reached 500 (Aveline 2001). This number makes it impossible for a clinician to learn them all. Which of the 500 therapies should be studied, taught, or promoted? This number of psychotherapies also makes it impossible for researchers to determine the comparative efficacies of all these therapies. For most of this time, no school of psychotherapy could establish itself as superior in efficacy or effectiveness to the others, nor could one corner the market on validity or utility (Beitman, Goldfried & Norcross 1989). This problem of the proliferation of psychotherapies motivated researchers to search for unifying and comprehensive models (Beitman, Goldfried & Norcross 1989). Because of the difficulty in the time needed to investigate all of them, researchers have focused their efforts on the most frequently used schools of psychotherapy (Lilienfeld & Arkowitz 2012). The best-known schools are behavior therapy (altering unhealthy behaviors), cognitive-behavior therapy (altering maladaptive ways of thinking), psychodynamic therapy (resolving unconscious conflicts and adverse childhood experiences), interpersonal therapy (remedying unhealthy ways of interacting with others), and person-centered therapy (helping clients to find their solutions to life problems) (Lilienfeld & Arkowitz 2012).

Pressure towards evidence-based psychotherapies

Within today's scientific settings, professional standards demand that clinical practice draws heavily upon empirical evidence (Desai 2006). This situation has been the case in medicine, which has solid scientific foundations (Desai 2006). In the practice of medicine (and mental health), the science base or the evidence was expected to yield to the wise and considered, even if intuitive, opinion of the treating clinician (Desai 2006).

This situation has been the case in the field of psychotherapy. A founder of a psychotherapy school would provide theories of personality, psychopathology, and therapeutic methodology (process, content, and relationship) (Prochaska & Norcross 2018). In the Twentieth Century, this classical approach has been transformed in various ways and from many directions and forces (Desi 2006). One of the directions has been the influential movement of evidence-based medicine and evidence-based practice (Desi 2006). This approach takes a strong position against the traditional model of practice (Desi 2006). In this approach, the clinician is expected to consider the updated and current scientific evidence instead of their own or a founders' opinion (Desi 2006). The four fundamental principles of evidence-based medicine which are influencing the field of psychotherapy are: a) the usage of the best available scientific evidence, b) individualizing the evidence, c) incorporating patient preferences for interventions, and d) expanding clinical expertise (Desi 2006).

With this background, there has been strong pressure brought on the mental health field by the government, insurance companies, and consumers to use evidence-based interventions. Evidence-based practice of psychology is being brought in line with the past 20 years of work in evidence-based medicine, which advocates for improved patient outcomes by informing clinical practice with relevant research (Sox & Woolf, 1993; Woolf & Atkins, 2001). The pressure was put on the mental health field to utilize the therapies that were tested empirically. In 1998, The Institute of Medicine (IOM) pushed for the improvement in the quality of health care in the healthcare system (Institute of Medicine (US) Committee on Quality of Health Care in America, 2001). The IOM's National Roundtable on Health Care Quality documented three types of quality problems:

overuse, underuse, and misuse (Institute of Medicine (US) Committee on Quality of Health Care in America, 2001). They realized the harm due to the collective impact of all the health care quality problems on patients (The US Institute of Medicine Committee on Quality of Health Care in America, 2001). Health care professionals, health care policymakers, consumer advocates, and purchasers of care began to address these problems in delivering healthcare services and closing the quality gap (Institute of Medicine (US) Committee on Quality of Health Care in America, 2001). The challenge was set to bring the full potential benefit of effective health care to all Americans while avoiding unnecessary and harmful interventions and eliminating preventable care complications (Institute of Medicine (US) Committee on Quality of Health Care in America, 2001). The Advisory Commission on Consumer Protection and Quality also released a report on quality (Institute of Medicine (US) Committee on Quality of Health Care in America, 2001). That report called for a national commitment to improve quality (Institute of Medicine (US) Committee on Quality of Health Care in America, 2001). The advisory commission concluded that the health care industry was plagued with overutilization of services, underutilization of services, and errors in health care practice (Institute of Medicine (US) Committee on Quality of Health Care in America, 2001). One way to improve the quality of the health care system, the IOM Identified, was to support evidence-based practice (Institute of Medicine (US) Committee on Quality of Health Care in America, 2001). The goal is to make the evidence more useful and accessible to support clinicians and patients' clinical decisions and construct quality measures for improvement and accountability (Institute of Medicine (US) Committee on Quality of Health Care in America, 2001). Keeping in line with the field of medicine, a

stronger and more organized evidence base should facilitate the development of valid and reliable quality measures for priority conditions that can be used for both internal quality improvement and external accountability (Institute of Medicine (US) Committee on Quality of Health Care in America, 2001).

The IOM called for an effective infrastructure that was much needed to apply evidence to health care delivery (Institute of Medicine (US) Committee on Quality of Health Care in America, 2001). They place great emphasis on systematic approaches to analyzing and synthesizing medical evidence for both clinicians and patients (US Institute of Medicine US Committee on Quality of Health Care in America, 2001). The research on evidence-based psychotherapies has shown their effectiveness and are cost-effective for treatment on a wide range of psychiatric conditions (Cook, Schwartz & Kaslow 2017). Psychiatric disorders are prevalent worldwide and are linked with high rates of disease burden, as well as elevated rates of co-morbidity with other medical disorders (Cook, Schwartz & Kaslow 2017). This has led to an increased focus on the need for evidence-based psychotherapies. Psychiatry is now becoming reliant on evidence-based psychotherapies. This furthers the need for stronger psychotherapy research on evidence-based psychotherapies.

The evidence-based practice movement has become an essential feature of health care systems and health care policy (American Psychological Association, Presidential Task Force on Evidence-Based Practice, 2006). Within this context, the American Psychological Association (APA) 2005 Presidential Task Force on Evidence-Based Practice defined and discussed evidence-based practice in psychology (EBPP) (American Psychological Association, Presidential Task Force on Evidence-Based Practice, 2006).

In an integration of science and practice, the Task Force's report describes psychology's fundamental commitment to sophisticated EBPP and considers the full range of evidence psychologists and policymakers must consider (American Psychological Association, Presidential Task Force on Evidence-Based Practice, 2006). This resulted in the definition of evidence-based medicine (EBM) put forth by Sackett et al. (Sackett, Rosenberg, Gray, Haynes & Richardson 1996). They described evidence-based medicine as integrating individual clinical expertise with the best available external clinical evidence from systematic research (Sackett, Rosenberg, Gray, Haynes & Richardson 1996). The best available external clinical evidence is clinically relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (which includes clinical examinations), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens (Sackett, Rosenberg, Gray, Haynes & Richardson 1996). External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer (Sackett, Rosenberg, Gray, Haynes & Richardson 1996). The APA was also influenced by the IOM.

These efforts to increase the use of evidence-based psychotherapy in the United States led task forces to define, identify, and disseminate information about empirically supported psychological interventions (Chambless & Ollendick 2001). Evidence-based practice in psychology is, therefore, consistent with the past 20 years of work in evidence-based medicine, which advocates for improved patient outcomes by informing clinical practice with relevant research (Sox & Woolf 1993). In 1995, the Task Force on

Promotion and Dissemination of Psychological Procedures (henceforth, referred to as Task Force) of Division 12 (Clinical Psychology) of the American Psychological Association (APA) issued the first of three reports in which it identified many psychological interventions as empirically validated treatments that were later called empirically supported treatments (ESTs) (Chambless & Ollendick 2001). In subsequent reports, the Task Force expanded the list of ESTs and collected and published information concerning training opportunities and materials for therapists (Chambless & Ollendick 2001). As of 1998, the list included 71 treatments (Chambless & Ollendick 2001). The Committee on Accreditation (American Psychological Association 1996) decision to include some training in ESTs as part of the guidelines for accreditation of doctoral- and internship-training programs in applied psychology no doubt heightened the already intense interest in the definition of ESTs (Chambless & Ollendick 2001). As it became clear that APA

would not itself pick up the work of the EST list, Division 12 committed itself to continue these efforts by transforming the Task Force into a standing committee charged with evaluating the efficacy and effectiveness of psychological interventions (Chambless & Ollendick 2001).

This effort to define the evidence-based practice profession has had a schism. One group of professionals led by members of the APA Division of clinical psychology and the division of child and adolescent clinical psychology set criteria for what degree of scientific evidence would be necessary to define empirically-based psychotherapies of specific disorders and clinical problems. Reviews of the research that found such support

would result in these divisions adding the treatment for the problem to the list of scientifically support psychotherapy to their respective websites.

On the APA Division 12 of clinical psychology website (https://div12.org/treatments/), a list of empirically tested psychological treatments is provided under the web page tab, *treatments*. The treatments have been evaluated to determine the strength of their evidence base (Society of Clinical Psychology APA Division 12, 2016). The treatments have evidence ratings ranging from strong to insufficient evidence (Society of Clinical Psychology APA Division 12, 2016). On the APA Division 53 of the clinical child and adolescent psychology website (https://effectivechildtherapy.org/therapies/), a list of evidence-based therapies is also provided. The list of therapies provided has been proven to work (Society of Clinical Child & Adolescent APA Psychology Division 53, 2020). All the treatments listed use techniques that are based on scientific evidence to understand and treat various behavioral and mental health issues in young people (Society of Clinical Child & Adolescent APA Psychology Division 53, 2020).

The evidence base criteria that the Society of Clinical Child and Adolescent Psychology uses to determine if treatments work for a variety of child and adolescent mental health problems ranges from "Level One" (most support) through "Level Five" (lowest support) (Society of Clinical Child & Adolescent APA Psychology Division 53, 2020). The review criteria used are based on evidence-based updates in the Journal of Clinical Child and Adolescent Psychology that was started in 2013 (Southam-Gerow & Prinstein, 2014). This current research supporting each treatment listed on the website has been evaluated to determine how effective it is in addressing each behavioral issue or

mental disorder (Society of Clinical Child & Adolescent APA Psychology Division 53, 2020). The methods criteria include group design, (studies that involve a randomized controlled design), independent variables defined (treatment manuals or logical equivalent that were used for the treatment), population clarified (studies conducted with a population, treated for specific problems, where inclusion criteria have been clearly defined), outcomes assessed (reliable and valid outcome assessment measures utilize when gauging the problems targeted), and analysis adequacy (appropriate data analyses was utilized and the sample size was sufficient to detect expected effects) (Southam-Gerow & Prinstein, 2014). The five levels are then outlined for the evidence-based criteria. For a treatment to get level one: treatments have strong evidence base criteria (Efficacy of treatment is statistically significantly superior to pill or psychological placebo or another active treatment or equivalent, but not significantly different, to an already well-established treatment in experiments), treatment was in at least two independent research settings and by two independent investigative teams demonstrating efficacy, and treatment meets all five of the methods criteria (Southam-Gerow & Prinstein, 2014).

On the Division 12 website, the evidence-based criteria is based on Chambless' and Hollon's 1998 criteria for defining empirically supported treatments. In evaluating the benefits of a given treatment, the greatest weight should be given to efficacy trials and then followed by research on clinical effectiveness and with various populations and by cost-effectiveness research (Chambless & Hollon, 1998). The treatments are also going under new evaluation criteria. The new evaluation aims to begin to evaluate treatments in a manner that parallels and will support the methods proposed by the APA, but in a

manner that lends itself to the more rapid dissemination of scientific findings to those who would benefit most from them (Tolin, McKay, Forman, Klonsky & Thombs, 2015). Tolin et al. (2015) proposed that the process of identifying one or two positive studies for a treatment stop, and that instead researchers begin evaluating systematic reviews of the treatment outcome literature, weighting them according to the risk of bias in the studies contributing the review (Tolin, McKay, Forman, Klonsky & Thombs, 2015). They further recommend that instead of labeling treatments as "well established" or "probably efficacious," as is currently done under the current system, researchers translate the research findings into clear recommendations of very strong, strong, or weak, using well-established, widely accepted, and transparent grading guidelines (Tolin,, McKay, Forman, Klonsky & Thombs, 2015). These steps, which can be implemented immediately, will significantly improve the quality of information that is disseminated (Tolin, McKay, Forman, Klonsky & Thombs, 2015).

This movement also leads to the development of comparisons of the relative effectiveness of the different psychotherapies. This research led David et al. (2018) to conclude that CBT was the gold standard in Psychotherapy because it had the most scientific evidence supporting its efficacy and effectiveness.

Two sources challenged the notion that CBT represented the most effective form of psychotherapy. First, Wampold and Imel (2015) reviewed the literature and concluded that although there have been more studies to support the efficacy and effectiveness of CBT, there is no direct evidence that CBT from studies that directly compare CBT to other major forms of psychotherapy. Thus, they concluded that all psychotherapies are equally effective. Wampold and Imel (2015) review the evidence that psychotherapies are

effective for common factors that are present in all major forms of psychotherapy. Comparisons of different forms of psychotherapy most often result in relatively nonsignificant differences, and contextual and relationship factors often mediate or moderate outcomes. These findings suggest that (1) most valid and structured psychotherapies are roughly equivalent in effectiveness and (2) patient and therapist characteristics, which are not usually captured by a patient's diagnosis or by the therapist's use of a specific psychotherapy, affect the results."

Second, the American Psychological Association (2013) passed a resolution that said, "Comparisons of different forms of psychotherapy most often result in relatively nonsignificant difference, and contextual and relationship factors often mediate or moderate outcomes. These findings suggest that (1) most valid and structured psychotherapies are roughly equivalent in effectiveness and (2) patient and therapist characteristics, which are not usually captured by a patient's diagnosis or by the therapist's use of a specific psychotherapy, can affect the results.

Thus, the psychotherapy research community is divided by those who believe that CBT has demonstrated itself to be the most supported type of psychotherapy and those who believe that Common Factors account for the positive results of effective psychotherapies.

To date, we do not have data on where the common factors are represented in the practice of CBT. This study attempts to answer this question by having psychology graduate students rate the degree of senior CBT therapists' activities on training recordings designed to teach CBT skills. This method was chosen because these

recorded training sessions were designed to demonstrate what the therapists' thought were important skills to model and teach.

The Common factors

The field of research and application in psychotherapy has been profoundly influenced by two different approaches: (1) the empirically supported treatments (ESTs) movement (just mentioned previously), which is linked with the evidence-based medicine (EBM) perspective and (2) the "Common Factors" approach, also known as the Dodo Bird Verdict (Castelnuovo, 2010).

The pressure from the IOM and the quest for a solution in response to the proliferation of psychotherapies has led to an attempt to compare various psychotherapies. The goal is to see which psychotherapies are supported by evidence and provide the best treatments. This has led to a debate that all psychotherapies might be equally effective and that the common factors (CF) account for the success of effective therapies. In psychotherapy research, researchers are now trying to determine if there are certain common factors that account for the effectiveness of so many therapies.

The common factors (CF) have had a long history in psychotherapy theory, research, and practice (Wampold 2015). This is not a new idea, and it was fits introduced by Rosenzweig in the 1930s. Also, it was discussed by Frank and Frank in their book originally published in 1961, *Persuasion and Healing*. Even the very partisan Albert Ellis, who advocated his form of psychotherapy, noted the existence of common factors Ellis wrote (1964), "There is a common factor in all kinds of effective therapy that the adherents of the "different" schools simply fail to recognize (p 87)." Usually, when looking at which are the best EST, there is a focus on showing how psychotherapies

work, but little is known about the mechanisms of change of these therapies (Cuijpers, Reijnders & Huibers, 2019). Although there are many therapies, and most therapies were developed with a clear theoretical explanation of how the therapy is supposed to bring about change in the patient, the scientific knowledge about these mechanisms is limited (Cuijpers, Reijnders & Huibers, 2019). There is another model that says that the effects of therapies are not or not only realized by these specific effects but instead are realized predominantly through common factors (Cuijpers, Reijnders & Huibers, 2019). These common factors, which are sometimes are called nonspecific or universal factors, are factors that all therapies have in common, such as the alliance between the patient and the therapist, expectations, and a rationale that helps patients understand why they have problems and what can be done about them (Cuijpers, Reijnders & Huibers, 2019).

The common factors, or characteristics present across psychotherapies, have long been considered crucial to fostering positive psychotherapy outcomes (Browne, Cather, & Mueser 2021). However, some researchers have posited that these factors are more than a set of therapeutic elements that are common to all or most psychotherapies (Wampold 2015). The common factors shape a theoretical model about the mechanisms of change in psychotherapy (Wampold 2015). In other words, the contextual model offers an overarching theoretical framework for how common factors facilitate therapeutic change outcomes (Browne, Cather, & Mueser 2021). The contextual model theorizes that improvements occur through three primary pathways: The real relationship, expectations, and specific ingredients outcomes (Browne, Cather, & Mueser 2021). The mechanisms underlying the three pathways involve evolved characteristics of humans as the ultimate social species, and so, psychotherapy is a special case of a social healing

practice (Wampold 2015). The contextual model offers an alternate explanation for the benefits of psychotherapy against ones that emphasize specific ingredients that are supposedly beneficial for particular disorders due to the remedy of an identifiable deficit (Wampold 2015). The most well-studied common factors, which also are described within the contextual model, include the therapeutic alliance, therapist empathy, positive regard, genuineness, and client expectations outcomes (Browne, Cather, & Mueser 2021).

Frank & Frank (1991) proposed a classification scheme where psychotherapy is considered a cultural healing practice, like religious and indigenous people's healing practices and not a medical treatment. Frank & Frank (1961) theorized that healing practices involve: a rationale or conceptual scheme, procedures that the healer and patient believe in, and involve active participation, positive expectations for change, an emotionally charged confiding relationship with a helper, a healing setting with the expectation of professional assistance, and a plausible explanation for symptoms, and treatment. This last element was found to be the variable that was necessary as the effective component of placebo effects in the 1970s and 1980s: a ritual that requires the active participation of therapist and client.

The contextual model proposes that there are three pathways through which psychotherapy produces benefits, and it works through various mechanisms (Wampold, 2015). The mechanisms underlying the three pathways entail evolved characteristics of humans as a social species, and so psychotherapy is a special case of a social healing practice (Wampold, 2015). The contextual model is proposed to be an alternative to the medical model in which therapies are supposed to work through specific ingredients that

are “purportedly beneficial for particular disorders due to remediation of an identifiable deficit (Wampold, 2015).

Of all the common factors that have been proposed, the therapeutic alliance or therapeutic relationship is labeled by many as an important common factor (Cuijpers, Reijnders & Huibers, 2019). The alliance is composed of three components: the bond, the agreement about the goals of therapy, and the agreement about the tasks of therapy, and alliance is the most researched common factor (Wampold, 2015). The research evidence does support the importance of the alliance as an important aspect of psychotherapy, as predicted by the contextual model (Wampold, 2015). The association between alliance and outcome in psychotherapy has been widely examined in treatment studies, and the most recent meta-analysis, based on more than 200 studies, has found that stronger alliances are indeed associated with better outcomes (Cuijpers, Reijnders & Huibers, 2019).

Empirical studies have shown that a solid therapeutic alliance, higher ratings of therapist empathy, positive regard, genuineness, and more favorable outcome expectations are related to improved treatment outcomes (Browne, Cather, & Mueser 2021). However, debates continue about whether psychotherapy outcomes are most heavily determined by these common factors or by factors specific to the type of therapy used (Browne, Cather, & Mueser 2021). The common factors are valuable in treatment delivery and could focus on psychotherapy practice (Browne, Cather, & Mueser 2021). The evidence has shown that the common factors must be considered therapeutic, and attention must be given to them in theory, research, and practice (Wampold & Imel, 2015).

The common factors approach have also noted that considerable research exists to support that the persona of the therapist accounts for a considerable variation in psychotherapy outcome (Wampold & Imel, 2015) Research suggests that specific psychotherapist characteristics are key to successful treatment (Wampold & Imel, 2015). In psychotherapy research, the advantages of the nested design is that one can compare treatments administered by therapists who are skilled in and have allegiance to each of the therapies being compared (Wampold & Imel, 2015). Research suggests that allegiance is so important to successful outcome, the nested design allows a comparison of treatments conducted by therapists who have allegiance to those treatments, provided of course that researchers appropriately balance the allegiance of the therapists. (Wampold & Imel, 2015). The essence of therapy is embodied in the therapist (Wampold & Imel, 2015). The particular treatment that the therapist delivers does not affect outcomes to a significant degree but that allegiance to the therapy is an important factor (Wampold & Imel, 2015). There is evidence that supports the notion that some therapists consistently achieve better outcomes than others, despite the treatment provided which raises an important question: What are the characteristics and actions of effective therapists (Wampold & Imel, 2015)?

Wampold predicts that based on meta-analytic reviews, the variance in psychotherapy outcome is determined it is 30% by Common Factors, 15% by the person of the therapies, 15% by the theoretical orientation of the therapy (Wampold & Imel, 2015).

Some researchers noted that the research supporting the common factors model is far from conclusive. Cuijpers, Reijnders, & Huibers (2019) point out that the common

factors model often points to meta-analyses of comparative outcome studies that show all therapies have comparable effects. However, not all meta-analyses support the common factors model; the included studies often have several methodological problems, and there are alternative explanations for finding comparable outcomes.

To date, research on the working mechanisms and mediators of therapies has always been correlational, and to establish that a mediator is indeed a causal factor in the recovery process of a patient, studies must show: a temporal relationship between the mediator and an outcome, a dose–response association, evidence that no third variable causes changes in the mediator and the outcome, supportive experimental research, and have a strong theoretical framework.

Currently, no common or specific factor meets these criteria and can be considered an empirically validated working mechanism. Therefore, it is still unknown whether therapies work through common or specific factors or both. For now, the best developed and most modern common factors model is the contextual model (Wampold, 2015).

CBT: Most effective Evidence-Based psychotherapy?

There are strong voices in CBT that claim that this model represents the most effective psychotherapy. Considering the number of publications/studies, academic programs, and/or practicing professionals, cognitive behavioral therapy (CBT) has been argued to be the gold standard of the psychotherapy field (David, Cristea, & Hofmann 2018). Several reasons are provided: CBT is the most researched form of psychotherapy, No other form of psychotherapy has been shown to be systematically superior to CBT (and if there are systematic differences between psychotherapies, they typically favor

CBT), and the CBT theoretical models/mechanisms of change have been the most researched and are in line with the current mainstream paradigms of human mind and behavior (for example, information processing theories) (David, Cristea, & Hofmann 2018). Modern CBT is an umbrella term of empirically supported treatments for clearly defined psychopathologies that are targeted with specific treatment strategies (David, Cristea, & Hofmann 2018). In line with the medical model of psychiatry, CBT establishes the general goal of treatment in symptom reduction, improvement in functioning, and remission of the disorder (Hofmann, Asnaani, Vonk, Sawyer & Fang 2012). In order to achieve this goal, the patient becomes an active participant in a collaborative problem-solving process to test and challenge the validity of maladaptive cognitions and to modify maladaptive behavioral patterns (Hofmann, Asnaani, Vonk, Sawyer & Fang 2012). Modern CBT refers to a family of interventions that combine various cognitive, behavioral, and emotion-focused techniques (Hofmann, Asnaani, Vonk, Sawyer & Fang 2012). Due to clear research support, CBT leads international guidelines for psychosocial treatments and is the first-line treatment for many disorders, as noted by the National Institute for Health and Care Excellence's guidelines and American Psychological Association (David, Cristea, & Hofmann 2018).

The Therapist-Client Relationship in CBT, PD, and PC therapies

Does CBT stress the therapeutic relationship less than psychodynamic (PD) therapies or person-centered therapies (PC)? Due to the sometimes highly structured nature of CBT, it can give way to a manualized approach, if used rigidly, or with a central focus on predetermined interventions, there is a risk of neglecting the dynamic

relationship that develops between the clinician and clients (Okamoto, Dattilio, Dobson & Kazantzis, 2019). However, the dynamic relationship is a necessary condition for the effective practice of CBT (Okamoto, Dattilio, Dobson & Kazantzis, 2019). Psychodynamic therapy focuses on the psychological roots of emotional suffering (American Psychological Association, 2010). Psychodynamic therapy focuses on self-reflection and self-examination, and the use of the relationship between therapist and patient as a window into problematic relationship patterns in the patient's life is an important component (American Psychological Association, 2010). In person-centered approaches, it is the therapist's empathy, acceptance, and genuineness that allow many clients to feel safe enough to enter into a real relationship with the therapist and be willing to develop an implicit or explicit agreement, understanding, or "contract" to engage in therapy (Kirschenbaum & Jourdan, 2005). Rogers's core conditions may or may not be necessary or sufficient for effective psychotherapy (the debate is ongoing), but whether considered among the common factors of effective therapy or a means to achieve a therapeutic alliance, the value of empathy, unconditional positive regard, and congruence is supported by the latest generation of psychotherapy process-outcome research (Kirschenbaum & Jourdan, 2005). The person-centered approach, which holds the therapeutic relationship as central and essential to effective counseling and psychotherapy, is still one of the models that has relevance (Kirschenbaum & Jourdan, 2005). Although relatively few therapists describe themselves as primarily client-centered in their orientation, client-centered principles pervade the practice of many, if not most, therapists (Kirschenbaum & Jourdan, 2005). Various schools of psychotherapy already have recognized the importance of the therapeutic relationship as a means to, if

not a core aspect of, therapeutic change (Kirschenbaum & Jourdan, 2005). It seems that person-centered approaches are usually the gold standard of therapeutic alliance that is essential for effective psychotherapy. The therapeutic relationship is the context within which interventions occur and is a critical aspect of treatment (Kirschenbaum & Jourdan, 2005). From that basic understanding, the unique nature of the client–therapist relationship within CBT is an important component, and these include concepts of collaboration, empiricism, and Socratic dialogue (Okamoto, Dattilio, Dobson & Kazantzis, 2019). The question becomes, to what extent do CBT therapists utilize PC interventions. And do CBT therapists utilize PD approaches in sessions? This is especially important to know considering the CF model. If CBT interventions do, in fact, utilize PC approaches and exhibit many of the CF criteria for effective psychotherapy, CBT therapies might be strong candidates for some of the strongest effective therapies among them all.

Psychotherapy Integration

Within the field of psychotherapy, there have been advocates for a move towards psychotherapy integration. In theoretical integration, therapists will blend two or more psychotherapy systems with the goal that integrated therapy will be more effective than each therapy system alone (Prochaska & Norcross, 2018). The focus is on integrating the underlying theories of psychotherapy along with the techniques (Prochaska & Norcross, 2018). Starting in the early 2000s, cognitive therapy combinations dominated the list of psychotherapy integration (Prochaska & Norcross, 2018). It does seem that the most different systems of psychotherapy appear to be PC and CBT approaches. If the field is moving towards integration, do CBT practitioners also display PC interventions that

highlight possible integration between the two systems? There is a notable absence of consensus in psychotherapy, characterized not only by the specific theory and techniques associated with each theoretical orientation but also by its unique language (Goldfried, 2019). There has always been difficulty in obtaining an agreed-upon consensus within psychotherapy which might be caused by shifts in research methodology and its therapeutic focus (Goldfried, 2019). Psychotherapy research efforts over the years appear not to have had a clearly thought-out and programmatic strategy and have been determined by the changing views of the DSM and the research proprieties on the part of the NIMH (Goldfried, 2019). Something that might integrate the different theories of psychotherapy at the midlevel of abstraction (somewhere between theory and technique) is the idea that it is possible to consider principles of change that are common to most forms of therapy (Goldfried, 2019). In spite of the quite different theoretical foundations across behavioral/cognitive-behavioral, and experiential/humanistic orientations, some similarities might be found (Goldfried, 2019). This is especially relevant because the CF model reveals some common aspects that many effective therapies, if not all, may showcase. CF may reveal the commonalities across many different theoretical orientations that are obscured by their unique theoretical language. Something to also note is that there has also been an ever-increasing movement within biological psychiatry to look for medical treatments for psychological problems (Goldfried, 2019). This presents a pressing need to strengthen the field of psychotherapy by developing a solid evidence-based and clinically agreed-upon core (Goldfried, 2019). CBT and PC therapies seem to be regarded as some of the strongest cases for EST. If the field of

psychotherapy is beginning to move towards integration, then to what extent do CBT therapies integrate PC approaches?

Rationale for the study

With the problems caused by the proliferation of psychotherapies, pressure from the IOM, and the research of the common factors in all psychotherapeutic orientations, and the CBT being a strong candidate for a definitive evidence-based therapy, this study will aim to find if there are common factors in several evidence-based orientations. This will allow researchers to find these common factors in other therapies.

If CBT is the most successful model of psychotherapy, this issue becomes does CBT represents a unique type of intervention that is identified by its theory of procedures or do CBT therapists do an excellent job at including the common factors into their treatments. One way to examine that issue is to look at the public face of CBT and see how much the leaders in that field display the Common factors in the public presentation of the various CBT approaches.

It is common in psychotherapy for a founder or leader of a therapy school to produce video demonstrations of the therapist performing their respective therapies. This allows professionals to see the representative of a field of psychotherapy perform the intervention and provides a teaching model so that graduate students and professionals can learn how to do psychotherapy. There are at least two repositories for such demonstration tapes. The psychotherapy recordings produced and marketed to psychotherapists by the American Psychological Association and the Psychotherapy.net organization provide access to many psychotherapy demonstration films produced by the developers and advocates of the various models of psychotherapy.

This study explores the degree to which CBT therapists who represent the primary forms of CBT exhibit Common Factor activities by measures of a psychotherapy rating form. We believe that CBT therapists will display a significant number of Common factors activities in their demonstration sessions while they do the activities associated with their specific orientation to CBT. If this is true, it might be challenging to account for the effectiveness of comparing CBT therapies due to the Common factors interventions and the CBT interventions being confounded in the same sessions. If the CBT therapist does indeed do many Common Factor interventions, then the Common factors model does indeed provide factors that perhaps all therapists and therapies utilize. This would challenge therapists who advocate for unique specific factors or a unique school of psychotherapy. However, if a CBT therapist does indeed do many common factors, what does that mean for the uniqueness of CBT? If the students identify more common factors in one particular brand of cognitive therapy, is it the theoretical orientation of the therapists' that is influencing the students to rate these high on common factors? This study provides an opportunity to gauge students' perceptions of common factors within cognitive therapies.

Chapter 2: Method

Participants

The participants in the study were graduate students at St. John's University enrolled in the Ph.D. program in Clinical psychology or a Psy.D. program in school psychology. Both sets of students completed the ratings while they were enrolled in a summer course in Cognitive Behavior Therapies. All the students had completed a course in Behavior Therapy and with an intake seminar or a course in counseling skills. The course was offered during the summers' of 2017, 2018, and 2019. There were ninety-five raters. Eighty-five of them were female, and ten were male. The Clinical psychology students were in the summer between their first and second years in the program, and the School Psychology students were between the second and third year of their programs. These participants are a nice middle of the way between naïve and expert, as these students are still learning clinical interventions.

Measures

The MULTI. The measuring tool that was utilized in the study is the Multi-theoretical list of therapeutic interventions (The MULTI) designed by McCarthy & Barber (2009). The MULTI allows lay and experts from various backgrounds to measure what therapists do in a typical session. The initial MULTI was developed by consulting treatment manuals, therapy books, adherence measures, theoretical and review articles, and experts from a wide range of therapeutic orientations and generating a list of the most prominent interventions from each orientation (McCarthy & Barber 2009). To be easily usable by all individuals and to require no training to use, items were initially worded at a

Flesch-Kincaid fifth-grade reading level (McCarthy & Barber 2009). All these aspects that involved the development of the scale allow it to be utilized by academicians or experienced psychotherapists and a wide range of people. The current MULTI consists of 60 items and eight subscales: Behavioral Therapy (BT), Cognitive Therapy (CT), DBT, IPT, Person-Centered (PC), Psychodynamic (PD), Process-Experiential (PE), and Common Factors (CF) (McCarthy & Barber 2009). To evaluate the content validity of these subscales, the researchers contacted 36 experts from the six theoretical orientations to review the items in the subscale representing their orientation. At least one expert in five of the orientations replied (They could not contact any ‘‘common factors’’ experts) (McCarthy & Barber 2009). Something to note about Common Factors is that no matter how unimportant they may be from the point of view of a particular theory, they are central to nearly all psychological interventions in practice, if not theory (Lambert 2005).

Psychotherapy Recordings

Thirty-nine instructional psychotherapy tapes were utilized in this study. All the tapes demonstrate different cognitive therapies performed by theoretical experts. The therapy types among the tapes include Cognitive therapy (CT), Social Problem Solving, Motivational Enhancement, Dialectical Behavioral Therapy (DBT), Rational Emotive Behavioral Therapy (REBT), Acceptance and Commitment Therapy (ACT), Schema Focused Cognitive Therapy, Generic Cognitive Behavioral Therapy (GCBT), and Non-Cognitive Behavioral Therapy. Table 1 lists the tapes, therapists, and theoretical orientation that’s demonstrated.

Table 1.

List of Therapy Tapes with Therapist, theoretical orientation

Therapy Recording	**Therapist**	**Theoretical Orientation**
Cognitive Behavioral Therapy	Donald Meichenbaum	CBT
Problem Solving Therapy With a Woman Coping With Binge Eating	Arthur M. Nezu	Problem Solving Therapy
Mixed anxiety and Depression: A Cognitive-Behavioral Approach	Donald Meichenbaum	CBT
Constructivist Therapy for the Loss of a Spouse	Robert A. Niemeyer	Constructivist Therapy
Cognitive Behavior Therapy for Anxiety Disorders	Michelle Craske	GCBT

Multimodal Therapy	Arnold Lazarus	CBT/MMT
Cognitive Behavioral Therapy for Anxiety and Depression (Session 4 of 6)	Amy Wenzel	CBT
Cognitive Behavioral Therapy for Anxiety and Depression (Session 6 of 6)	Amy Wenzel	CBT
Learning to Overcome Automatic Negative Thoughts	Ann Marie Albano	CBT
Treating Social Anxiety with Cognitive Behavior Therapy	Ann Marie Albano	CBT

Cognitive Therapy to Control Compulsions (Session 2 of 6)	Keith Dobson	CT
Cognitive Therapy to Control Compulsions (Session 3 of 6)	Keith Dobson	CT
Cognitive Therapy for a Client With Depression	Judy Beck	CT
Cognitive Behavioral Therapy With a Single Parent	Gail Iwamasa	CBT
Cognitive Behavioral Therapy for a Woman With Social Phobia	Bunmi Olatunji	CBT

Cognitive Therapy (Session 3 of 5)	Keith Dobson	CT
Schema Therapy With a Client Suffering from Anxiety	Jeff Young	Schema Focused CT
My Kids Don't Appreciate Me: REBT with a Single Mother	Janet Wolfe	REBT
REBT for Anger Management	Janet Wolfe	REBT
3 Approaches to Personality Disorders Dialectical Behavior Therapy with Marsha Linehan	Marsha Linehan	DBT

Dialectical Behavior Therapy With a Female Military Veteran	Alexander L. Chapman	DBT
Exploring Relapse Prevention Admits Parental Loss	G. Alan Marlatt	Relapse Prevention
Bob Leahy with patient	Bob Leahy	CT
Steve Hayes with same patient	Steve Hayes	ACT
Depression and Anxiety With Acceptance and Commitment Therapy	Steve Hayes	ACT
Coping with the suicide of a loved one	Albert Ellis	REBT
Cognitive Therapy for Depression	Art Freeman	CT

REBT	Raymond DiGiuseppe	REBT
ACT: Acceptance and Self-Control	Steve Hayes	ACT
ACT: DEFUSION	Steve Hayes	ACT
Assessing Alcohol Drinking Attitudes With Motivational Interviewing	Linda Sobel	MI
Art Freeman with Edward	Art Freeman	CT
Culturally Responsive Cognitive Behavioral Therapy (Session 2 of 6)	Pamela Hays	GCBT
REBT Couples Therapy	Raymond DiGiuseppe	REBT
REBT for anger	Raymond DiGiuseppe	REBT
REBT With Siblings	Raymond DiGiuseppe	REBT

REBT	Raymond DiGiuseppe	REBT
3 Approaches to Personality Disorders- CBT with Arthur Freeman	Arthur Freeman	CBT
Homosexual Couples Counseling	Raymond DiGiuseppe	REBT

Note: Most of the recordings are available and published by Psychotherapy.net

Procedures

Students were required to observe the psychotherapy recordings sessions as part of a required course in cognitive behavior therapy that was offered in the summer sessions. The students were enrolled in the Ph.D. program in Clinical Psychology or a Psy.D. program in School Psychology. Throughout three summers of enrollment in the doctoral program, students in the class, Cognitive Therapies, rated instructional therapy tapes utilizing the MULTI as a part of a graded assignment. The students watched tapes of skilled therapists demonstrating unique psychotherapy. After watching each recording , the students rated the recording using the MULTI,. They were instructed to observe the videos and rate the recordings on the MULTI to identify which therapeutic activities the therapists performed. The professor did not score the ratings, but the

students did need to complete the assignment or get an incomplete grade until all the recordings were watched and rated. Students entered an eight-digit ID number that was used in the course to identify the students and ensure they got credits. These ID numbers were removed from the data file before any research was performed on the data. There was no place for the students to reveal their names. This assignment was given for three summer semesters in 2017, 2018, 2019. The researcher asked for the IRB approval to analyze this data as an archival data file after the ID numbers were removed and there was no way for the students to be identified. This study was approved by the University's IRB – IRB-FY2020-529.

Throughout three summers of enrollment in the doctoral program, students in the class, Cognitive Therapies, rated instructional therapy tapes utilizing the MULTI as a part of a graded assignment. The students watched tapes of skilled therapists demonstrating individual psychotherapy.

The ratings were collected on Qualtrics, and the data was downloaded from the platform to an SPSS data file. After ratings of the MULTI scores were collected, the data was cleaned up for any errors. A mixed model analysis on SPSS was run on Therapy recording measures, Therapy type, and Common factor scores in three psychotherapeutic interventions that the MULTI total score measures: Cognitive Behavioral Therapy (CBT), Psychodynamic, and Person-Centered. Before the factors were loaded, a covariance parameter was examined to see if the data were nested. Visual representations of the ratings of the MULTI scale were also provided for the three subscales that were run.

The idea behind the study is to see if there are any significant differences in the ratings of the tapes by the students among three variables: therapists, therapy type, and Common Factor scores. The MULTI provides the study to provide empirical evidence of a specific therapy type being utilized. Furthermore, Raters could utilize the scale with ease and provide evidence if they are observing what a therapist, of a certain theoretical disposition is doing what they claim is their theoretical orientation. This study has a good size of raters that will shed light on consensual agreement of Common Factor scores among these therapy tapes (which are from a cognitive orientation). Common Factors allows an opportunity to identify possible common patterns that are seen in a unique therapy session. The results from the mixed models' analysis show the level of agreement among three variables: student raters, recorings , and the therapists.

Chapter 3: Results

Before this study moved forward with the mixed models' analysis, covariance parameters' estimates were run to see if the data was nested within the study's variables. Table two demonstrates that our data is indeed nested, and this allows the study to move forward and load the subscales. This also means that the effect of Raters was significant.

Table 2.
Estimates of Covariance Parameters

Parameter	Estimate	Std. Error	Wald Z	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Residual	0.078	0.019403	4.044	.000	0.048	0.127
Intercept [subject Treatment # * RECORDING_# * Number] = Variance	0.326	0.023	13.934	.000	0.283	0.375

a. Dependent Variable: Common Factors MULTI Subscale.

Common factor scores were loaded, and the mixed model analysis revealed significant differences for Beck's Cognitive Therapy, Motivational enhancement, Rational Emotive Behavioral Therapy, Schema Focused Cognitive Therapy, and generic Cognitive Behavioral therapy. Table 3 demonstrates the significant differences. Figure 1 shows a visual representation of the mixed models results. The students had a high level

of agreement that the tapes that had therapists demonstrating Beck's cognitive therapy demonstrated common factors, *a lot of the session*. The students had a high level of agreement that motivational enhancement demonstrated common factor interventions between *several times in the session* and *a lot of the session*. Rational emotive behavioral therapy interventions demonstrated common factor interventions between *a lot of the session* and *most of the session.* Schema-focused cognitive therapy interventions demonstrated common factors between *a lot of the session* and *most of the session.*

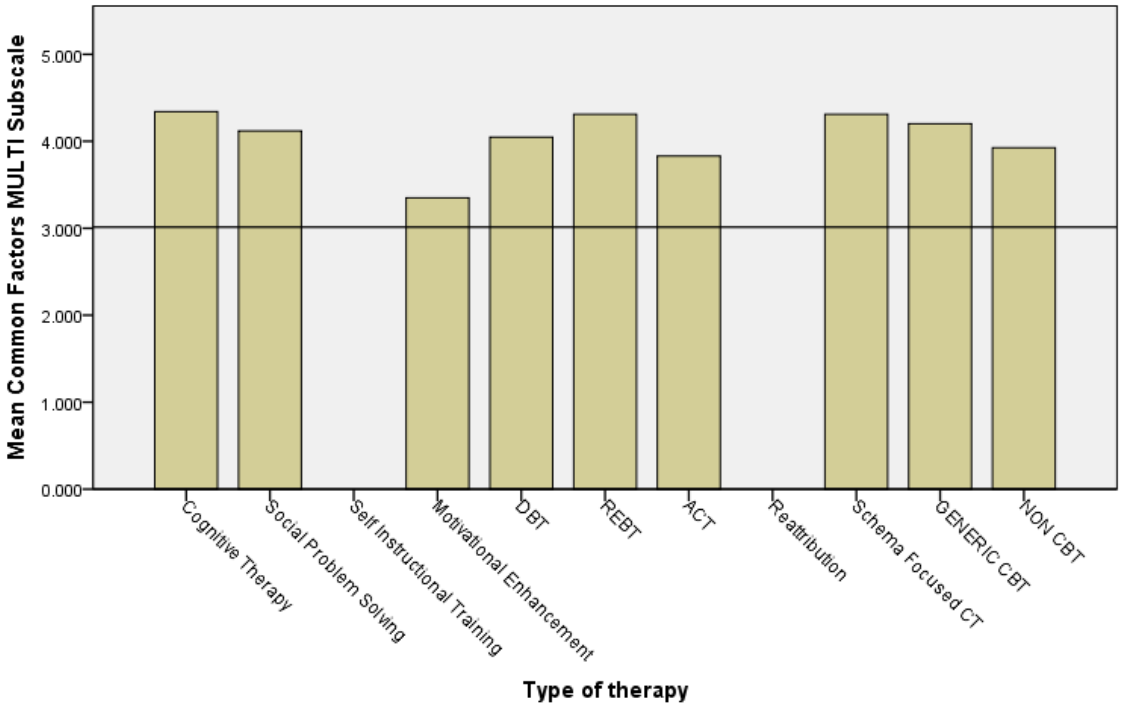
Furthermore, finally, Generic cognitive behavioral therapy demonstrated common factors between *a lot of the session* and *most of the session.* Figure 1 shows that all the cognitive base therapies greatly surpassed the rating of three, but CT, ME, REBT, SFT, and Generic CBT had significant differences. On CF scores, the therapies that had significant differences, CT, ME, REBT, SFC, and Generic CBT, all surpassed the MULTI's Likert rating of three. The therapies that had significant findings had high ratings of CF scores.

Table 3
Estimates of Fixed Effects Of Common Factors

Parameter	Estimate	Std. Error	df	t	Sig.	95% Confidence Interval Lower Bound	Upper Bound
Intercept	**3.929**	**0.068**	**1758.121**	**57.778**	**.000**	**3.796**	**4.063**
Cognitive Therapy	**4.336**	**0.073**	**1760.506**	**5.576**	**.000**	**0.264**	**0.550**
Social Problem Solving	4.908	0.100	1789.997	1.792	0.073	-0.017	0.376
Motivational Enhancement	**3.339**	**0.094**	**1761.513**	**-6.283**	**.000**	**-0.774**	**-0.407**
Dialectal Behavioral Therapy	4.048	0.086	1761.529	1.391	0.164	-0.049	0.287
REBT	**4.431**	**0.077**	**1760.663**	**4.929**	**.000**	**0.230**	**0.533**
ACT	3.852	0.092	1783.575	-0.835	0.404	-0.258	0.104
Schema Focus CT	**4.303**	**0.100**	**1752.746**	**3.752**	**.000**	**0.178**	**0.570**
Generic CBT	**4.203**	**0.073**	**1760.454**	**3.756**	**.000**	**0.131**	**0.417**
[Treatment type=11]	0b	0	.	.	.	.	.

a. Dependent Variable: Common Factors MULTI Subscale. B. This parameter is set to zero because it is redundant.

Figure 1. Bar Chart Representation of The Use of Common Factor Interventions By Recoding Therapy Type



The next subscale that was loaded was psychodynamic interventions. Here only two therapeutic interventions demonstrated significant results. Table 4 demonstrates that out of all the interventions, social problem solving, and schema-focused cognitive therapy had significant differences. Figure 2 provides a visual representation of these differences; the raters had a high level of agreement that social problem solving and schema-focused cognitive demonstrated psychodynamic interventions *several times a session*. Figure 2 provides a visual representation of the findings. The two therapies that were significantly different, SPS and SFT, barely passed the MULTI's Likert rating of three. All of the other therapies' fellow below the Likert score of three.

Table 4.
Estimates of Fixed Effects for Psychodynamic interventions

Parameter	Estimate	Std. Error	df	t	Sig.	95% Confidence Interval Lower Bound	Upper Bound
Intercept	2.551	0.089	1734.061	28.724	.000	2.377	2.726
Cognitive Therapy	2.417	0.095	1736.609	-1.393	0.164	-0.320	0.054
Social Problem Solving	**3.036**	**0.129**	**1767.873**	**3.77**	**.000**	**0.233**	**0.738**
Motivational Enhancement	2.14	0.123	1734.694	-3.343	0.001	-0.652	-0.170
Dialectical Behavioral Therapy	2.421	0.112	1737.99	0.895	0.371	-0.119	0.320
Rational Emotive Behavioral Therapy	2.551	0.101	1736.945	-0.002	0.998	-0.198	0.197
Acceptance Commitment Therapy	2.563	0.120	1760.754	0.096	0.923	-0.224	0.247
Schema Focused CT	**3.047**	**0.129**	**1728.577**	**3.855**	**.000**	**0.244**	**0.749**
Generic CBT	2.53	0.095	1736.806	-0.221	0.825	-0.208	0.166
Treatment Type = 11]	0b	0	.	.	.	.	.

a. Dependent Variable: Psychodynamic MULTI Subscale. b. This parameter is set to zero because it is redundant.

Finally, person-centered interventions were loaded and run. As seen in table 5, Beck's CT, ME, REBT, and generic CT all had significant differences. Figure 3 provides a visual representation of the results. The therapies that were significantly different

passed the MULTI's Likert scale of three. The only exception was ME, falling below the Likert score of three. The raters had a high level of agreement that Beck's cognitive therapy demonstrated person-centered interventions between *several times a session* and *a lot of the session*. Motivational enhancement demonstrated person-centered interventions *several times a session*. Rational emotive behavioral therapy demonstrated person-centered interventions *several times a session*. Furthermore, generic cognitive behavioral therapy demonstrated person-centered interventions *several times a session*.

Figure 2. Bar Chart Represention Of Psychodynamic Interventions by Therapy Type

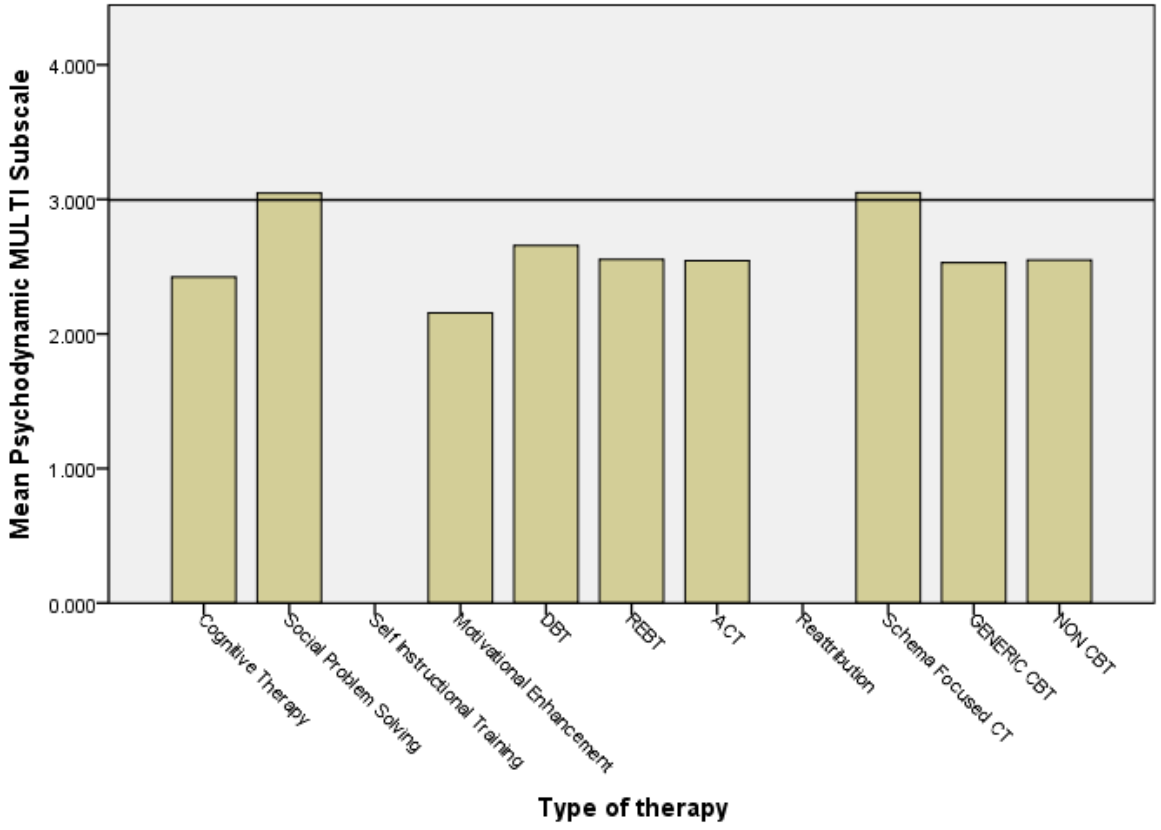


Table. 5

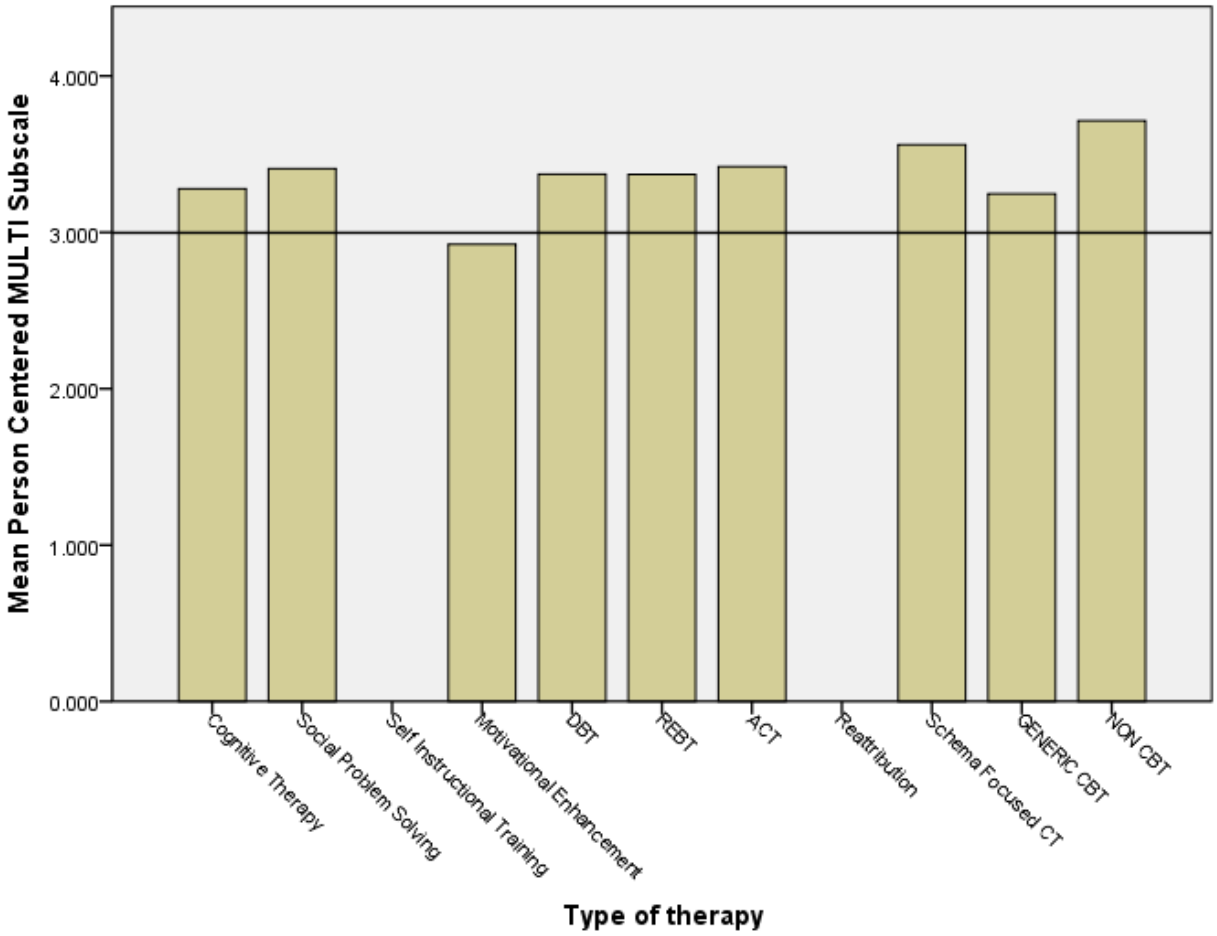
Estimates of Fixed Effects of Person-Centered Interventions

Parameter	Estimate	Std Error	df	t	Sig.	95% Confidence Interval Lower Bound	Upper Bound
Intercept	3.709	0.082	1762.29	45.356	.000	3.548	3.869
Cognitive Therapy	**3.277**	**0.088**	**1764.534**	**-4.921**	**.000**	**-0.605**	**-0.260**
Social Problem Solving	3.408	0.120	1797.247	-2.512	0.012	-0.536	-0.066
Motivational Enhancement	**2.909**	**0.113**	**1763.072**	**-7.105**	**.000**	**-1.021**	**-0.579**
DBT	3.373	0.103	1766.352	-3.258	0.001	-0.539	-0.134
REBT	**3.368**	**0.093**	**1765.323**	**-3.666**	**.000**	**-0.524**	**-0.159**
ACT	3.431	0.111	1788.151	-2.495	0.013	-0.496	-0.059
Schema Focused CT	3.557	0.120	1755.636	-1.262	0.207	-0.388	0.084
Generic CBT	**3.245**	**0.088**	**1764.645**	**-5.287**	**.000**	**-0.636**	**-0.291**
Treatment Type = 11]	0b	0	.	.	.	.	.

. Dependent Variable: Person-Centered MULTI Subscale.

. This parameter is set to zero because it is redundant.

Figure 3. Bar Chart Representation of Person-Center Interventions by Recording Therapy Type



Chapter 4: Discussion

This study found that common factors' interventions were indeed highly rated and agreed upon among the cognitive-based therapies. When comparing the ratings and the MULTI's other subscales that were looked at in this study, Common factors had the highest, psychodynamic scores were low and agreed upon with only two therapies, and person-centered was in the middle. Indeed, the MULTI provided findings that are significant when assessing the extent that common factors are found in cognitive therapies. Among the therapies that were rated high on CF were CT, ME, REBT, and GCBT. As seen in Figure 1 , the students perceived CF within those tapes. When compared to PC and PD interventions, PC had ratings that ranged in the middle and PD scores were rated the lowest. PD had few significant differences across the theoretical orientations (SPS and SFCT). While PC had significant differences across Beck's CT, ME, REBT, and generic CBT.

The findings are consistent with the CF research. When examining different theories of psychotherapy, the therapies that work present these CF's. The fact that students could perceive CF interventions in cognitive based therapies, adds more evidence to their presence. The practical implications of this study provide evidence cognitive therapies that were highly perceived by the students that they were seeing the CF's. When it also comes to psychotherapy integration, PC interventions were highly rated and perceived than PD interventions. This means that the students were witnessing the therapists also utilizing PC interventions within Beck's CT, ME, REBT, and generic CT. PD interventions rated low across the cognitive therapies. With only SPS therapy and SF therapy having significant differences but rated low on the MULTI's Likert

scores. SF therapy focuses on affective change methods, the therapeutic relationship, and limited reparenting (helping the client find early childhood experiences that can resolve the damaging experiences that led to maladaptive schemas) more than general CT (Prochaska & Norcross, 2018). While SPS therapies are psychological treatments that help teach clients to effectively manage the negative effects of stressful events in life (Society of Clinical Psychology AP Division 12, 2016). This could explain why these therapies stood out to students when rating them. Clearly, PC interventions were perceived more than PD. PC interventions might be able to integrate with CT approaches. The findings of this study provide a look into how well CT and PC therapies could integrate. If cognitive therapists were perceived utilize PC approaches, this does provide some interesting points to consider in terms of integration.

The findings of this study raise further problems. Could CF be a confounding variable? CF was indeed perceived most of the time within these cognitive therapies. Given the significant findings, perhaps more attention should be given to CF within psychotherapy research. This also calls into question the uniqueness of a specific theoretical orientation. CF may be found within other types of therapy. CBTs are some of the best empirically studied therapies. CF may have the power to funnel effective empirically-based treatments. This study examined the extent that students perceived the CFs within cognitive therapies. They were highly perceived by the students. What does this say about the skilled therapist? Could it be that CT and REBT therapists are some of the most skilled within the CF approach? Future directions to look at is the extent that CFs are found with other therapy systems. As they could reveal the common language found within strong ESTs.

References

American Psychological Association (2013). Recognition of Psychotherapy Effectiveness. *Psychotherapy, 50 (1,)* 102–109.

American Psychological Association, Presidential Task Force on Evidence-Based Practice (2006). Evidence-based practice in psychology. *American Psychologist*, 61(4), 271–285. https://doi.org/10.1037/0003-066X.61.4.271

American Psychological Association. (2010, January 25). Psychodynamic psychotherapy brings lasting benefits through self-knowledge [Press release]. http://www.apa.org/news/press/releases/2010/01/psychodynamic-therapy

Aveline, M. (2001). Innovative contemporary psychotherapies. *Advances in Psychiatric Treatment*, 7(4), 241-242. doi:10.1192/apt.7.4.241

Beck, A. T., Rush, A., Shaw, B., & Emery, G. (1979). *Cognitive therapy of depression*. New York, NY: Guilford Press.

Beitman, B. D., Goldfried, M. R., & Norcross, J. C. (1989). The movement toward integrating the psychotherapies: an overview. *The American Journal Of Psychiatry*, 146(2), 138–147. https://doi.org/10.1176/ajp.146.2.138

Browne, J., Cather, C., & Mueser, K. (2021). Common Factors in Psychotherapy. *Oxford Research Encyclopedia of Psychology*. https://doi.org/10.1093/acrefore/9780190236557.013.79

Castelnuovo, G. (2010). Empirically supported treatments in psychotherapy: towards an evidence-based or evidence-biased psychology in clinical settings? *Frontiers in Psychology*, 1, 27. https://doi.org/10.3389/fpsyg.2010.00027

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: controversies and evidence. *Annual Review Of Psychology* 52, 685–716. https://doi.org/10.1146/annurev.psych.52.1.685

Chambless, D. L., & Hollon, S.D. (1998). Defining Empirically Supported Therapies. *Journal of Consulting and Clinical Psychology.* 66(1), 7-18.

Cook, S. C., Schwartz, A. C., & Kaslow, N. J. (2017). Evidence-Based Psychotherapy: Advantages and Challenges. *Neurotherapeutics: the journal of the American Society for Experimental Neurotherapeutics*, 14(3), 537–545. https://doi.org/10.1007/s13311-017-0549-4

Cuijpers, P., Reijnders, M., Huibers, M.J.H. (2019). The Role of Common Factors in Psychotherapy Outcomes. *Annual Review of Clinical Psychology,* (15), 207-231. https://doi-org.jerome.stjohns.edu/10.1146/annurev-clinpsy-050718-095424

David, D., Cristea, I., & Hofmann, S. G. (2018). Why Cognitive Behavioral Therapy Is the Current Gold Standard of Psychotherapy. *Frontiers in psychiatry*, *9*, 4. https://doi.org/10.3389/fpsyt.2018.00004

Desai N. G. (2006). Evidence-based practices in mental health: Distant dream or emerging reality*? Indian journal of psychiatry*, 48(1), 1–3. https://doi.org/10.4103/0019-5545.31611

Ellis, A. (1964). Thoughts on theory versus outcome in psychotherapy. *Psychotherapy: Theory, Research & Practice, 1(2)*, 83-87. doi:10.1037/h0088576

Goldfried, M. R. (2019). Obtaining consensus in psychotherapy: What holds us back? *American Psychologist*, 74(4), 484–496. https://doi.org/10.1037/amp0000365

Frank, J. D., & Frank, J. B. (1961). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Johns Hopkins University Press.

Hofmann, S. G., Asnaani, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The Efficacy of Cognitive Behavioral Therapy: A Review of Meta-analyses. *Cognitive therapy and research*, 36(5), 427–440. https://doi.org/10.1007/s10608-012-9476-1

Institute of Medicine (US) Committee on Quality of Health Care in America. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academies Press (US).

Kirschenbaum, H., & Jourdan, A. (2005). The Current Status of Carl Rogers and the Person-Centered Approach. Psychotherapy, 42(1), 37-51. http://dx.doi.org.jerome.stjohns.edu/10.1037/0033-3204.42.1.37

Lambert, M. J. (2005). Early response in psychotherapy: further evidence for the importance of common factors rather than "placebo effects". *Journal of clinical psychology*, 61(7), 855–869. https://doi.org/10.1002/jclp.20130

Lilienfeld, S. O. (2012). Are All Psychotherapies Created Equal? *Scientific American Mind*, 23, (4), 68-69. doi:10.1038/scientificamericanmind0912-68

Okamoto, A., Dattilio, F. M., Dobson, K. S., & Kazantzis, N. (2019). The therapeutic relationship in cognitive–behavioral therapy: Essential features and common challenges. *Practice Innovations, 4(2)*, 112-123. http://dx.doi.org.jerome.stjohns.edu/10.1037/pri0000088

Prochaska, J. O., & Norcross, J.C. (2018) *Systems of Psychotherapy, A Transtheoretical Analysis* (8th Ed.). Oxford University Press.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. American Journal of Orthopsychiatry, 6(3), 412-415.

Sackett, D. L., Rosenberg, W. M., Gray, J. A., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: what it is and what it isn't. *BMJ (Clinical research ed.)*, 312(7023), 71–72. https://doi.org/10.1136/bmj.312.7023.71

Sox, H. C., Jr, & Woolf, S. H. (1993). Evidence-based practice guidelines from the US Preventive Services Task Force. Journal of the American Medical Association, 269(20), 2678.

Society of Clinical Psychology AP Division 12. (2016). Psychological Treatments. https://div12.org/treatments/

Society of Clinical Child & Adolescent APA Psychology Division 53. (2020). Evidence Based Therapies. https://effectivechildtherapy.org/therapies/

Southam-Gerow, M.A. & Prinstein, M.J. (2014). Evidence Base Updates: The Evolution of the Evaluation of Psychological Treatments for Children and Adolescents, *Journal of Clinical Child & Adolescent Psychology*, 43(1), 1-6, doi:10.1080/15374416.2013.855128

Tolin, D. F., McKay, D., Forman, E. M., Klonsky, E. D., & Thombs, B. D. (2015). Empirically supported treatment: Recommendations for a new model. *Clinical Psychology: Science and Practice, 22(4),* 317–338. https://doi.org/10.1037/h0101729

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, 14(3), 270-277. http://dx.doi.org.jerome.stjohns.edu:81/10.1002/wps.20238

Wampold, B.E., & Imel, Z.E. (2015). *The Great Psychotherapy Debate: The Evidence for What Makes Psychotherapy Work* (2nd ed.). Routledge. https://doi.org/10.4324/9780203582015

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