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COMMON FACTORS ACROSS THEORIES OF MARRIAGE AND FAMILY THERAPY: A MODIFIED DELPHI STUDY

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The Delphi methodology was used to explore common factors across theories of marriage and family therapy (MFT). Leading clinicians and researchers from the American Family Therapy Academy and select faculty members from MFT training programs accredited by the Commission on Accreditation for Marriage and Family Therapy Education were asked to achieve consensus regarding common factors. Respondents were asked to report on commonalities across the various MFT theories, as well as what they personally considered to be the core ingredients of change. A final profile of items was created from the responses. Qualitative interviews were conducted with selected panelists to clarify discrepancies as well as to add meaning to the data. Implications for the training and practice of MFTs as well as direction for future research are discussed.

Since the time of Freud, the field of psychotherapy has expanded at a rapid rate. It is estimated that there are now more than 200 therapy models and 400 techniques associated with these models (Karasu, 1986; Miller, Duncan, & Hubble, 1997). Since the 1960s, the number of psychotherapy approaches, and their respective techniques, have grown by approximately 600% (Garfield & Bergin, 1994). Yet, this rapid proliferation of therapy models is not only a sign of rapid growth, but also a reflection of the splintered nature of the psychotherapy field as a whole. The field of marriage and family therapy (MFT) has not escaped growth or theoretical fragmentation. Since its early years, MFT has been comprised of a group of distinct, competing theories, each built largely around the ideas and personalities of charismatic theoreticians and gifted clinicians (Sprenkle, Blow, & Dickey, 1999).

While on the one hand, a multiplicity of theoretical ideas leaves the clinician with a wealth of options to choose from in working with clients, on the other hand it may lead to clinicians choosing approaches based on intuitive appeal rather than documented evidence; clinicians "blindly" practicing a diffuse form of treatment based on an eclectic selection of what feels best; a lack of theoretical rigor as a field contributing to the marginalization of the field; or it may produce a high level of theoretical confusion for novice clinicians. One answer to the multiplicity of therapy approaches is to identify common factors across approaches. Common factors are those dimensions of the treatment setting (therapist, therapy, client) that are not specific to any particular technique or theory (Lambert & Bergin, 1994). In recent years, common factors have become a prevalent component of the literature of the field of psychotherapy as a whole (Garfield, 1992; Garfield & Bergin, 1994; Lambert, 1992; Lambert & Bergin, 1994). The importance of

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these factors in change is corroborated by a large body of research that details their significance in all types of psychotherapy (Asay & Lambert, 1999).

However, in spite of their purported importance, these common factors have not gained the prominent stature they deserve in the psychotherapy field (Asay & Lambert, 1999; Hubble, Duncan, & Miller, 1999). Similarly, in MFT, the subject of common factors has not dominated the thinking and practices of researchers, clinicians, and theoreticians (Sprenkle et al., 1999; Wampler, 1997). It is only in more recent years that work has been done on this subject (Duncan, Solovey, & Rusk, 1992; Hubble et al., 1999; Miller et al., 1997; Sprenkle et al., 1999). Wampler (1997, p. 10) concluded that, "Outcome research in marriage and family therapy has largely ignored the research literature on common factors underlying effective psychotherapy."

This study represents a first attempt in the MFT field to identify commonalities across MFT theories. This study, by using the Delphi methodology, pools together the viewpoints of experts in the MFT field and establishes what they view to be common factors. Norcross (1999, p. xviii) states that "The aim of common factors is to determine the core ingredients that different therapies share, with the eventual goal of creating more parsimonious and efficacious treatments based on those commonalities." Building on this, the aim of this study is to identify core ingredients of MFT theories with the goal of constructing parsimonious and efficacious MFT treatments.

BACKGROUND

After 40 years of research, studies clearly support the idea that people who undergo psychotherapy treatment are better off than those who do not (Lambert & Bergin, 1994; Smith, Glass, & Miller, 1980). In an overview of psychotherapy outcome research, meta-analyses, and scholarly reviews of the last 40 years, Hubble et al. (1999, p. 2) report that psychotherapy has been shown to work and that "Regarding at least its general efficacy, few believe that therapy need be put to the test any longer." However, although it is well substantiated that therapy works, there is no clear indication as to exactly which therapy approach is most efficacious (Miller et al., 1997). The bulk of studies indicate that there are no meaningful differences among therapy models (Lambert & Bergin, 1994). Luborsky, Singer, and Luborsky (1975) refer to this finding as the "dodo-bird verdict," which is taken from the children's book, *Alice's Adventures in Wonderland* (Carroll, 1992, p. 34), which proclaims that, "Everyone has won and so all must have prizes."

Given that the dodo-bird verdict is true for psychotherapy in general, there is little reason to believe that models of MFT fare any better. This was confirmed in the most thorough meta-analysis of outcome research in the MFT field to date, which confirms that no theory of MFT is superior to any other theory of MFT (Shadish, Ragsdale, Glaser, & Montgomery, 1995).

Lambert (1992) proposed a four-factor model of change related to common elements among theories. He arrived at this model from his extensive and diverse reviews of empirical studies of psychotherapy outcome research, and he estimated the weighted percentages for each factor in the model. Miller et al. (1997) later modified this model. In Lambert's model, common factors were a separate component of the four-factor model. However, Miller et al. (1997) include all four factors under the overarching umbrella of "the common factors." The modified common-factors model is comprised of: Client/extratherapeutic factors; relationship factors; technique/model factors; and expectancy, placebo, and hope factors.

Client/Extratherapeutic Factors

Client/extratherapeutic factors are ingredients in the life and environment of the client that contribute to change. They act separately in the life of the client, independent of his or her' participation in therapy. Lambert (1992), in his review of empirical outcome research data, attributes 40% of improvement in clients to these factors. These factors include client characteristics, such as inner strengths, religious faith, goal directedness, personal agency, and motivation, as well as things outside of the control of the client, such as fortuitous events, social support, and winning the lottery. Miller et al. (1997, pp. 25–26) state that, "The research literature makes it clear *that the client is actually the single, most potent contributor to outcome in psychotherapy.*" [Italics in original]

Relationship Factors

Relationship factors are relationship-mediated variables that occur between therapist and client(s) in the therapy room. These factors include variables, such as warmth, respect, genuineness, and empathy. Relationship factors have been shown to be the most important therapist related contributing factor to change in clients (Bachelor & Horvath, 1999; Beck & Jones, 1973). Lambert (1992) estimates from his reviews of empirical data that relational factors account for 30% of change in therapy.

Model/Technique Factors

Model/technique factors are those factors that are unique to specific theories of therapy. Lambert (1992) attributes 15% of therapeutic change to these factors. Model/technique factors refer to the theory-specific methods and processes that therapists use to intervene in the lives of their clients. Models and techniques in and of themselves have been shown to have little influence on the outcome of treatment (Ogles, Anderson, & Lunnen, 1999; Shadish et al., 1995).

Placebo, Hope, and Expectancy Factors

Placebo, hope, and expectancy factors reflect changes that occur simply because the client is in treatment of some kind. Hubble et al. (1999, pp. 9–10) suggest that, "This class of therapeutic factors refers to the portion of improvement deriving from clients' knowledge of being treated and assessment of the credibility of the therapy's rationale and related techniques." Lambert (1992) attributes 15% of improvement in therapy to these factors.

Unique Common Factors Found in MFT

Sprenkle et al. (1999) suggest five common factors that are unique to MFT: Relational conceptualization, the expanded direct treatment system, the expanded therapeutic alliance, behavioral, cognitive, and affective common factors, and the privileging of clients' experiences. The first three are unique to MFT in that they are not emphasized in individual therapies. Behavioral, cognitive, and affective factors are only unique to MFT to the extent that they operate through relational conceptualization, the expanded direct treatment system, and the expanded therapeutic alliance.

Relational conceptualization. Traditionally, MFTs translate human problems into relational terms. MFTs attempt to keep the whole system (or systems) in view when relating to any individual client, subsystem of a family, or presenting problem, regardless of the number of people present in the therapy room.

The expanded direct treatment system. The direct treatment system is made up of the people who are physically present in treatment, whereas the indirect treatment system is made up of persons or entities outside of treatment who may affect therapy in important ways (Sprenkle et al. 1999).

The expanded therapeutic alliance in MFT. When a therapist works with more than one person, the therapeutic alliance is expanded to include more people. In MFT, the therapist forms an alliance with each member of the family, with subsystems in the family, and with the family as a whole (Pinsof, 1995; Sprenkle et al., 1999).

Behavioral, cognitive, and affective common factors in MFT. Behavioral regulation occurs in MFT when therapists facilitate change in clients through, for example, changing interactional patterns, modifying boundaries, changing family structures, and helping clients to learn new skills. Cognitive mastery occurs in MFT when therapists, for instance, help clients to gain insight about interactional processes within themselves, the family, between the family and other systems, and across generations (Wampler, 1997). An example of affective regulation or experiencing is when therapists facilitate the emotional connections that clients make with themselves, the therapist, and (most importantly) with each other.

Privileging of clients experiences. Many postmodern approaches to therapy emphasize the privileging of clients' experiences (Miller et al., 1997). This characteristic of postmodern thought appears to have influenced most MFT approaches.

METHODOLOGY

The Delphi Method

In recent years, studies in the MFT field have utilized the Delphi technique to obtain expert group consensus on a variety of topics (Fish & Piercy, 1987; White & Russell, 1995). The exploratory nature of this method has allowed these studies to poll the opinions of experts in the MFT field on topics of interest. In the Delphi method, data are collected by a series of questionnaires that are sent to a group of experts, referred to as panelists, until there is a consensus of opinion about the topic, which may only occur after the questionnaires have been mailed to participants on several occasions (Fish & Busby, 1996).

In the first phase of a Delphi study (DQI), participants brainstorm about the subject in an open-ended process and provide creative responses to open-ended questions. In the second phase, the research team edits the information provided by DQI for clarity, eliminates redundancy in the responses, and categorizes the responses if necessary. The second questionnaire (DQII) is created from these responses and is returned to the panelists. This phase includes a ranking scale (usually a 7-point Likert scale) that allows participants to evaluate each item.

The third phase in a Delphi study typically deals with the disagreement encountered by differing views that arise in DQII. In this study, only two survey rounds were completed because of the exploratory nature of the study, and because we wished to eliminate panelist dropout caused by fatigue. However, in place of a third round of questionnaires, qualitative interviews were conducted with six panelists (Linstone & Turoff, 1975).

Panel Selection

Panel selection is a critical component of the Delphi method. The panelists' knowledge of the subject matter at hand is the most significant assurance of a quality outcome, and so participants are chosen because of their expertise related to the subject (Fish & Busby, 1996).

In choosing panelists for this study, the following criteria were considered: Exposure to a wide variety of family therapy theories, depth of clinical experience, experience in the field of MFT, specifically, and an advanced degree in MFT or a closely related field. Ninety-five panelists were invited to participate from the member list of the American Family Therapy Academy (AFTA), a list of the faculty members of Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) training programs, and a pool of candidates thought to be suitable by the research team because of their extensive clinical experience, theoretical knowledge, or recommendation by another panelist.

Procedures

A letter of invitation was sent to the 95 invitees along with a demographics form and DQI, which included two questions. The first question assessed the panelists' views regarding common change processes within MFT theories, whereas the second question assessed their personal views of change. The two questions were: What factors or variables that promote positive change in the lives of clients are important components of most theories of Marriage and Family Therapy?; what are the most important factors that bring about change in families?

Fifty of the 95 surveys were returned. Of these, seven declined to participate, one was unable to be reached (address unknown), one contained missing information, and one was deemed to unsuitable (clear inexperience in the MFT field), leaving 40 panelists and an initial response rate of 42%.

The DQII phase was a 333-item Likert-scale questionnaire that was created from the responses of the 40 panelists on DQI. Every nonoverlapping response of every panelist on DQI was included in DQII. Responses were edited for clarity and redundancy, and every effort was made to retain the wording and meaning of the original items. The responses were grouped into four categories to organize the large amount of data: Client/extratherapeutic factors, relationship factors, model/technique factors, and placebo/expectancy factors. Two doctoral students read the responses independently to ensure that they were accurate, clear, and nonredundant. Two members of the research team achieved consensus in assigning the items to the most appropriate categories.

The DQII questionnaire was then sent to the 40-member panel together with a cover letter. The panelists were asked to rate each item in relation to the question asked on a 7-point Likert scale. A total of 88% of DQII questionnaires were returned. Items in DQII that received a median 6.00 and an interquartile range 1.50 were selected for the final profile (Fish & Busby, 1997). The median and interquartile range are set at these levels to ensure that the items included in the final profile were those items thought to be most important by the majority of the panelists. A median score of 6.00 and above indicates that the majority of respondents ranked the item as important or very important. An interquartile range of 1.50 or less indicates a high degree of consensus among the panelists as to the inclusion of a response.

Six of the panelists participated in qualitative interviews. They were selected in an effort to balance gender perspectives (the split ended up not being equal with four men, two women), their background in the MFT field, as well as their willingness to participate in the interviews. These interviews were conducted to clarify discrepancies in the data, to further explore the meaning of results, to address differences of opinions among panelists, and to flush out deeper meanings behind panelists' responses. Five 30-min interviews were conducted by the same interviewer by telephone and were recorded and transcribed. The sixth interview was conducted by e-mail. All of the interviewees were asked similar questions related to discrepant views in the data.

RESULTS AND DISCUSSION

A total of 35 panelists completed both rounds of the Delphi study. The average age of participants was 52 years (range 28–72 years). The panel included 22 men and 13 women. All of the panelists had advanced degrees: 74% had PhDs, and 26% had master's degrees. In terms of specialty, 37% of the panelists earned their highest degree in MFT; 20% earned it in clinical psychology; 9% in social work; 11% in counseling psychology; 6% in family studies; and 17% specialized in other areas. The panelists had an average of 22 years of experience in the MFT field (range 4–39 years). The percentage of couples/families being seen by the panelists in their clinical work ranged from 0% to 100%, with a median of 60%. Thirty-seven percent of the panelists did primarily academic work, 26% did primarily clinical work, and 37% did both academic and clinical work about equally. Although we attempted to ensure that the final panel included a balance of academicians and clinicians, it included more academics.

Panelists were requested to rank the top three theories that they adhered to in their work. Of the first choices, 32% of the panelists chose integrative therapy; 16% chose solution-focused therapy; 11% chose structural therapy; 6% chose strategic therapy; 6% chose Bowenian therapy; 6% chose internal family systems; and 3% chose other theories. The theoretical orientations of the panelists as a whole do not appear to reflect traditional models of family therapy, such as structural, strategic, and Bowenian, although those who selected integrative would no doubt utilize these traditional forms in some way in their work. It is possible that the field as a whole has moved away from the pure practice of one model of MFT, and the sample may be reflective of this trend.

The 80 items that made the final profile were organized into the four categories that were advocated by Miller et al. (1997). The items were further broken down into subcategories: Client/extratherapeutic factors (inner strengths of client; personal agency); relationship factors (factors inherent in relationship; relationship factors attributable to client(s); and relationship factors attributable to therapist); model/technique factors (therapist conceptualization; therapist involvement and proficiency; cognitive strategies; and behavioral strategies); and placebo, hope, and expectancy factors (placebo, hope, and expectancy factors linked to therapist; placebo, hope, and expectancy factors linked to client; placebo, hope, and expectancy factors in the therapy process). Summaries from the qualitative interviews are included in the discussion to clarify the results in areas of discrepancy.

Client/Extratherapeutic Factors

This category addressed the question: "How did the panelists view the role of client/extratherapeutic factors in MFT?" Table 1 summarizes the items for this category that made the final profile. When the panelists looked at MFT theories as a whole, they believed that the client's motivation was important. The

TABLE 1
Client/Extratherapeutic Factors that Made the Final Profile

Subcategory	Median*	Interquartile range**
Inner strengths of client		
Client motivation[a]	6.39	1.25
Client motivation[b]	6.75	0.91
Client's recognition of support/resources/strengths[b]	6.33	1.50
Personal agency		
An increase in the ability/willingness of individual family members to assume responsibility for their own contributions to relationship problems[b]	6.69	0.92
An increase in the ability of couple/family members to regulate their own internal and external reactions to provocations from others[b]	6.30	1.50
Clients shift from efforts to change others to efforts to change themselves[b]	6.50	1.25
Clients actively engaged in the process of change[b]	6.66	1.00
Each family member learning to change his or her part in overall patterns[b]	6.21	1.50
The willingness of clients to try new behaviors[b]	6.07	1.23

[a] Response to question 1, which assessed the panelists' views regarding common change processes within MFT theories.
[b] Response to question 2, which assessed the panelists' personal views of change.
*A median score 6.00 indicates the majority of respondents ranked item as important/very important.
** An IQR 1.50 indicates a high degree of consensus among the panel as to the inclusion of a response.

panelists also personally believed client motivation to be an important part of the change processes in families.

Looking at MFT theories as a whole, panelists did not emphasize items related to personal agency. However, the personal views of panelists placed an emphasis on the self-agency of clients. This discrepancy may be reflective of newer MFT theories, which focus more overtly on the strengths and resources of clients. Blow and Piercy (1997) suggest that most therapists help clients to access their personal agency, which then provides the impetus for change.

It is interesting that, when panelists looked at MFT theories as a whole, they emphasized the importance of therapist factors over client factors. The therapist was seen as an expert, playing out a director role in therapy. However, when panelists reflected on their personal views of change, more emphasis was placed on the characteristics that clients bring to the therapy room. This trend was also reflected in the relationship-factors category in which the panelists personally viewed the therapist as less of a director and more as a relational being.

Several client/extratherapeutic factors to which the literature referred did not make the final profile for either question. For example, Sprenkle et al. (1999) refer to nonstatic characteristics of clients (e.g., family cohesion, family expressed emotion) as important factors in MFT research. However, these factors were not viewed by the panelists as vital to change. Further, although there is convincing research evidence for the importance of client/extratherapeutic variables, such as social support, panelists did not endorse these items.

TABLE 2
Relationship Factors that Made the Final Profile

Subcategory	Median*	Interquartile range**
Factors inherent in relationship		
The alliance between the therapist and client[a]	6.75	1.12
The quality of the therapist–client (therapeutic) relationship[a]	6.59	1.25
A cooperative relationship between therapist and client(s)[a]	6.50	1.12
The alliance between therapist and client[b]	6.83	0.83
The strength of the therapeutic relationship[b]	6.71	0.85
Therapist/client collaboration[b]	6.44	0.88
Relationship factors attributable to client		
A client's trust in the therapist[a]	6.62	0.95
A client's belief in the therapist[a]	6.25	1.50
A client's trust in the therapist[b]	6.76	0.84
A client's belief in the therapist[b]	6.08	1.50
Relationship factors attributable to therapist		
A client feels heard by the therapist[a]	7.00	1.34
Therapist empathy[a]	6.50	1.45
Respect shown by therapist to clients[a]	6.53	1.15
Clients feeling understood and respected[b]	6.50	1.25
Clients feeling accepted by therapist[b]	6.54	1.28
Clients feeling respected by therapist[b]	6.63	1.45
Clients feeling heard by the therapist[b]	6.90	0.90
Therapist supporting clients[b]	6.58	1.16
Therapist empathy[b]	6.85	1.33
Therapist self-awareness[b]	6.63	1.12
Ethical integrity of the therapist[b]	7.00	0.71
Presence of the therapist with clients[b]	6.50	1.36
Therapist caring[b]	6.54	1.22
Therapist validation of the client as competent[b]	6.53	1.12
Therapist warmth[b]	6.38	1.42
Authenticity of the therapist[b]	6.81	0.90
A caring but not overly responsible therapist[b]	6.66	1.00

[a] Response to question 1, which assessed the panelists' views regarding common change processes within MFT theories
[b] Response to question 2, which assessed the panelists' personal views of change.
* A median score 6.00 indicates the majority of respondents ranked item as important/very important.
** An IQR 1.50 indicates a high degree of consensus among the panel as to the inclusion of a response.

Three items on DQII that were directly related to client/extratherapeutic factors—good fortune, improvement in social support, and external life factors—were far from making the final profile.

Although Lambert (1992) attributes 40% of change in therapy to client/extratherapeutic factors, and psychotherapy research in general places a high emphasis on these factors, they were not emphasized by the panelists personally nor seen as important across MFT theories. It is possible that DQII items were not the best examples of these factors. However, this does not explain why some items in DQII related to this group of factors did not make the final profile. It is possible that the MFT field underemphasizes these factors.

Relationship Factors

This category addresses the question: "Do panelists view the therapeutic relationship as an important component of change in MFT?" Table 2 summarizes the items for this category that made the final profile. It is evident that the panelists viewed the therapeutic relationship as a very important part of the MFT therapy process, both when they looked at MFT theories and when they reflected on their personal views of change. However, a difference between the ways that the panelists responded to the two questions was that, although panelists personally viewed collaboration between therapist and clients as an important change factor, they did not believe that this was emphasized in most MFT theories.

Factors inherent in relationship. In question one, the item related to therapist/client collaboration had an Interquartile Range (IQR) of 2.59, which indicated a high level of disagreement by panelists. The difference in responses to question one and question two may be attributable to the influence of postmodernism on the practices of MFT clinicians. Although the theories as a whole may not reflect a postmodern trend, the current practice of family therapy may well reflect this trend.

In the 1990s, postmodern theories, such as solution-focused therapy, narrative therapy, and collaborative language systems have become very popular and have even been referred to as the third wave of psychotherapy theories (O'Hanlon, 1994). These theories have attempted to move therapists out of the expert role into a collaborative relationship with clients. These theories have, no doubt, influenced the ways in which the older, more established MFT theories are practiced, as well as the ways in which MFT theories are taught, the ways in which conference themes are selected, and on the literature that is published in the field. The interviewees all concurred that postmodern thinking has had a significant effect on the practice of MFT.

Relationship factors attributable to the client. This category addresses the question: "How important to change in MFT are relationship factors that can be attributed to the client?" The responses to both questions one and two included the same two relationship factors attributable to the client. The way the client views the therapist was seen by the panelists as an important factor in the building process of the therapeutic relationship. Specifically, the client needs to be able to trust and believe in the therapist with whom he or she is working for there to be a successful therapeutic relationship (Bachelor & Horvath, 1999). This may especially be of concern for people who experienced severe childhood trauma or who were court ordered for therapy services. These results support the view of Bachelor and Horvath (1999), who suggest that healing ideally takes place through the process of client trust in the therapeutic relationship. It was encouraging that the belief and trust that clients have in the therapist were seen to be important relational factors, given their clear importance in the literature.

It is surprising that more relational factors that were attributable to the client did not make the final profile. Research has made it clear that the quality of the client's participation in the therapeutic relationship is, by far, the single most important determinant of positive outcome (Orlinsky, Grawe, & Parks, 1994). The lack of emphasis on client relational factors may be a reflection of the culture of MFT, which in the past has emphasized more of what the therapist brings to therapy. Even though the postmodern trends of the last decade have influenced the MFT field, the field may still see the therapist as more important to change than the client.

Relationship factors attributable to the therapist. This category addresses the question: "How important to change in MFT are relationship factors that can be attributed to the therapist?" The panelists' responses to question one included three items that were related to relational factors attributable to the

therapist. These three items were also a part of the list of items from question two. However, question two had 11 more relational items than did question one. These 11 additional relationship factors attributable to the therapist de-emphasize therapist expertise and accentuate the creation of a quality therapeutic relationship where the client is valued.

The panelists reported that the therapist should ideally be able to listen to clients or at least help them to feel heard. The panelists believed that one of the crucial roles of the therapist is to provide a context of warmth and safety in which therapy can take place. It was also important for the therapist to portray him- or herself in an authentic and ethical light. Bachelor and Horvath (1999, p. 162) state that "On the part of the therapist, establishing a climate of trust and safety through responsiveness; attentive listening; and the communication of understanding, liking, and respect are generally important characteristics of a quality relationship." These were the exact items that panelists endorsed when looking at change from their personal perspectives.

One of the panelists commented on the history of the therapeutic relationship in MFT:

> "I think traditionally, that the therapist–client relationship has been way underemphasized in MFT, and it is still underemphasized, even by a lot of the newer theories. Harlene Anderson, probably of any of the postmodern people emphasizes it the most—in a very Rogerian way. However, I think that the field is coming around, slowly to what Rogers was on to or to what Virginia Satir was talking about years ago."

It appears from the results that when panelists separated their personal views from the theories, they were able to identify more with relationship factors in therapy. Possibly, in practice, these panelists experienced the reality of therapy differently from what they read in family therapy books. It appears that panelists personally saw the relationship in MFT as important, but they do not see it as a factor that is emphasized enough in the MFT theories themselves. An interviewee stated:

> "When I look at MFT theories, I feel that relationship factors are assumed in the theories. It is assumed that because there is a therapist doing therapy, that the relationship is important. The relationship is not something that is overtly taught or spoken about in the theories, but it is an important part of them."

The ethical integrity and the authenticity of the therapist made the final profile when respondents answered question two, but it did not when they responded to question one. It is unclear why this occurred. One of the interviewees suggested that:

> "Possibly the ethical integrity of the therapist got blurred early on with the deception of early strategic therapy, where it was promoted that it was OK to deceive clients if your intentions were good."

Model/Technique Factors

Thirty-six items related to model/technique factors made the final profile. This was, by far, the largest category of items. This is not at all surprising given the technique-focused nature of much of the work done by MFTs in the past. Table 3 summarizes the items from this category.

Therapist conceptualization. This category addresses the question: "How important to change in MFT is the therapist's conceptualization of problems in relational ways?" Sprenkle et al. (1999) posit that a major difference between MFT theories and the field of individual psychotherapy is that the therapist conceptualizes problems in relational ways. When panelists viewed MFT theories as a whole, they endorsed relational conceptualization as an important component of MFT theories. However, it is interesting that no responses to question two fit into this category. Those interviewed attributed this to various reasons. One interviewee believed that:

> "Relational conceptualization of problems may diminish in importance once clinicians actually do the work in the therapy room, largely because clinicians do not always have time to reflect on the theory driven nature of their work."

Another interviewee hypothesized that "Postmodern thought may have had a huge impact on the relational conceptualization of problems." Marital and family therapy was built on the foundation of general systems theory (GST), and the field in general has been characterized by the relational conceptualization of

TABLE 3
Model/Technique Factors that Made the Final Profile

Subcategory	Median*	Interquartile range**
Therapist conceptualization		
Therapist understanding a couple/family in interactional terms[a]	6.50	1.46
Systemic assessment and conceptualization by the therapist[a]	6.04	1.50
The idea that individuals are interconnected and that problems can be maintained by the system rather than the "craziness" of one individual[a]	6.42	0.78
Therapist involvement and proficiency		
Therapist supports change in client(s)[a]	6.56	0.95
Therapist reinforces change in client(s)[a]	6.53	0.95
Therapist's ability to conduct session in an able and responsible manner[a]	6.70	0.95
Intervention(s) by the therapist[a]	6.19	1.40
Joining[a]	7.00	0.67
Therapist providing leadership in the therapy process[b]	6.40	1.33
Therapist recognition of couple/family strengths[b]	6.85	1.25
Therapist's ability to instill positive expectations in clients[b]	6.60	1.28
Therapist competence and knowledge about specific client problems[b]	6.08	1.45
Therapist confidence[b]	6.52	0.94
Therapist curiosity[b]	6.46	1.25
Joining[b]	7.00	1.00
Cognitive strategies		
Therapist has a theory of how change occurs[a]	6.45	1.50
Reframing of the problem[a]	6.19	1.40
Consideration of alternative ways of viewing problems[a]	6.27	1.41
Clarification of issues[a]	6.16	1.48
Introduction of new "information" (e.g. new ideas, behaviors, meanings, feelings)[a]	6.35	1.43
Change in the couple/family members' perceptions of the problem[b]	6.20	1.50

problems. However, postmodern theories challenge the very core on which MFT stands in that they do not emphasize relational issues in the same way as GST. Schwartz (1999, p. 263) states the following with regards to narrative therapy:

> One of the most revolutionary aspects of this new narrative phase of family therapy is that the family has become off-limits as a focus for factors that cause or maintain problems. Considering that much of family therapy's history until the nineties was spent trying to identify and change such factors, that is a big shift.

Another interviewee reported that the relational conceptualization of problems was an integral and distinctive part of her clinical work: "Conceptualizing problems in relational ways is a big part of the work that I do. It is what makes me distinct in my practice where I work with psychiatrists, psychologists, and social workers."

Previous First Next

TABLE 3 (continued)
Model/Technique Factors that Made the Final Profile

Subcategory	Median*	Interquartile range**
Clients able to broaden their perspectives and open themselves up to new possibilities[b]	6.18	1.45
Therapist having a theory and practice of change[b]	6.54	1.40
Acknowledgment of difference (can be new meaning, idea, behavior, or feeling)[b]	6.09	1.50
Behavioral strategies		
Clients are empowered to make competent choices[a]	6.11	1.31
The development of constructive communication patterns among couple/family members[a]	6.25	1.27
The alteration of communication patterns to change the process of communication[a]	6.39	1.25
Clients take action to do something different[a]	6.36	1.06
Achieving a healthy balance between separateness and connectedness[a]	6.12	1.33
Change in couple/family members actions[b]	6.66	1.28
Clients take action to do something different[b]	6.53	1.00
Building on the strengths of the client[b]	6.72	1.00
A willingness to listen, understand, and respectfully respond to the point of view of others[b]	6.63	1.16
A change in interaction patterns[b]	6.55	1.30
A change in communication patterns[b]	6.46	1.20
Practice of new behaviors[b]	6.07	1.47

[a] Response to question 1, which assessed the panelists' views regarding common change processes within MFT theories
[b] Response to question 2, which assessed the panelists' personal views of change.
* A median score 6.00 indicates the majority of respondents ranked item as important/very important.
** An IQR 1.50 indicates a high degree of consensus among the panel as to the inclusion of a response.

Therapist involvement and proficiency. This category addresses the question: "How important to change in MFT is the involvement and proficiency of the therapist?" In responses to question one, the therapist was seen to be directive, reinforcing changes in clients, and supporting this change. These factors appear to be linked to the abilities of the therapist to intervene successfully in the lives of clients. This is congruent with Garfield's (1992) views of the therapist as a reinforcer of change. It appears the panelists believed that therapists play the role of directors of change from the standpoint of MFT theories. In the responses to question two, panelists emphasized qualities of the therapist, such as confidence, curiosity, and leadership. Joining was overwhelmingly endorsed by participants as a common factor across theories of MFT, as well as a common factor from the personal views of change represented by the panelists.

Cognitive strategies. This category addresses the question: "How important are cognitive strategies to change in MFT?" The panelists saw some cognitive strategies as important components of MFT theories, as well as important in their own personal views of change. The answers of the panelists to both questions one and two suggest that these cognitive components are important. Although panelists give different answers to both questions, the responses are similar in that they involve techniques that help clients to view problems in different ways. This is consistent with Garfield's (1992) view of reattributional techniques. One of the participants in the qualitative interviews stated:

> I think that a critical factor to change is a cognitive one. I believe that therapy happens and that people change when they can identify and remove constraints, and that they believe that constraints can indeed be removed so that they can do other things. So I think that reframing, and finding a collaborative framing of the problem so that the therapist and client are on the same page is a critical ingredient in any kind of therapy.

Behavioral strategies. This category addresses the question: "How important are behavioral strategies to change in MFT?" The panelists in their responses to both questions all overwhelmingly endorsed items related to behavioral change factors. Garfield (1992) views reinforcement, information and skills training, and desensitization as common factors across individual therapies. Similarly these are important factors in MFT theories. However, MFT theories are unique in that they provide a context where the therapist can work directly with, for example, the communication patterns of a family in the teaching of skills, the rehearsing of skills, reinforcement of change, and in providing specific feedback to all members of the family.

Affective experiencing. This category addresses the question: "How important is affective experiencing to change in MFT?" No items related to affective experiencing were included in the final profile for either question. In fact, items related to affect were far from making the final profile. Sprenkle et al (1999) see the therapy done by MFTs as an ideal context in which emotional connection can occur. The lack of emphasis on emotions may be attributed to the fact that very few members on the panel adhered to theories that privilege emotions. One of the interviewees strongly spoke about the omission of affective experiencing in the following way:

> I think that people who have been attracted to the MFT field, by and large, are not people who are comfortable with emotion. It is interesting for example to trace the struggles that Virginia Satir had with the field—that is sort of a reflection of what I think is still a prevailing attitude about emotion.

Another interviewee concurred. "I am biased because I like emotion. I see it to be key, but I don't know that the field itself makes that tie. I personally think it is a common factor, but it is not reflected in the literature." Another interviewee however played down the importance of emotions in the practice of MFT and did not see it as an integral component of change. Still another interviewee suggested that, although many MFT practitioners may not openly acknowledge the role of affect in their therapy or ask overtly recognizable questions related to emotion, in reality, it might be inextricably linked to their work in subtle ways.

Historical factors. Historical factors or family-of-origin factors in the life of clients are important components of many theories of MFT. However, no historical factors made the final profile when respondents looked at MFT theories as a whole or when they reflected on their personal perspectives. Those interviewed addressed this issue in different ways. One interviewee spoke of historical factors as clearly not a common factor found in MFT theories but, rather, as one option to look at in initiating change. Another interviewee stated that MFTs are not adequately equipped to deal with historical data from the lives of clients, and so they underplay these issues. Another interviewee reported on the influence that managed care and HMOs have had on the practice of MFT and how these external influences on the field may have a direct impact on the nature of the work carried by MFTs. Although MFTs may value historical factors, they may ignore them because of these constraints. Another interviewee made the point that many models use history in therapy, but they use it in very different ways and for different purposes.

TABLE 4
Placebo, Hope, and Expectancy Factors that Made the Final Profile

Subcategory	Median*	Interquartile range**
Placebo, hope, and expectancy factors linked to therapist		
Therapist displays an expectation of change[a]	6.25	1.50
Therapist's conviction that the approach to treatment is useful[a]	6.70	0.85
The therapist's belief that change is possible[a]	7.00	0.88
Placebo, hope, and expectancy factors linked to client		
Client views the therapist as a competent individual[a]	6.32	1.25
Belief in the value of therapy (expectancy)[a]	6.05	1.48
Client's views of the therapist as a competent individual[b]	6.50	1.12
Placebo, hope, and expectancy factors in the therapy process		
Safety in the therapeutic environment[b]	6.88	1.00
Hope[b]	6.63	1.12

[a] Response to question 1, which assessed the panelists' views regarding common change processes within MFT theories
[b] Response to question 2, which assessed the panelists' personal views of change.
* A median score 6.00 indicates the majority of respondents ranked item as important/very important.
** An IQR 1.50 indicates a high degree of consensus among the panel as to the inclusion of a response.

Placebo, Hope, and Expectancy

Table 4 summarizes the items from this category that made the final profile.

Placebo, hope, and expectancy factors linked to the therapist. This category addresses the question: "How important in MFT are placebo, hope, and expectancy factors that are linked to the therapist?" It appears from the responses of the panelists that a therapist's confidence and expectations are an important component of MFT theories. It is clear that what the therapist expects to happen in therapy influences the way that he or she does therapy, as well as the experiences of clients in therapy. This is in line with existing research, which shows that the therapist's attitude towards treatment, and his or her belief that the clients will improve, is an important factor related to change (Snyder, Michael, & Cheavens, 1999).

Placebo, hope, and expectancy factors linked to the client. This category addresses the question: "How important in MFT are placebo, hope, and expectancy factors that are linked to the client?" The client's view of the therapist as an expert who is competent was seen by the panel as an important factor. Although there is no empirical support in the MFT literature for this assertion, the panelists overwhelmingly endorsed this factor.

Placebo, hope, and expectancy factors occurring in the therapy process. This category addresses the question: "How important in MFT are placebo, hope, and expectancy factors that occur in the therapy process?" Safety and hope were included as important factors in responses to question two, but they were omitted from question one. Respondents to question one were split as to whether or not hope was an important factor in MFT theories. Approximately one-half of the participants reported that hope was important or very important, but the other half stated that it was not important. Those who participated in the interviews overwhelmingly saw hope as an integral, although understated, component of MFT theories.

STRENGTHS OF THE STUDY

This study provides direction for the MFT field in the area of common factors. The main strength of the study is the make up of the Delphi panel itself, which was comprised of a panel of leading experts in the MFT field. Academicians and clinicians were relatively equally represented in the panel. The panelists who participated in the study adhered to a variety of theoretical orientations, and one-third of these participants referred to their theoretical orientation as integrative. The panel was highly educated with the majority of participants having PhDs. Another strength of the study is the utilization of mixed methods.

LIMITATIONS OF THE STUDY

A weakness of any Delphi study is that the viewpoints of individual panelists are often lost in the quest for consensus (Linstone & Turoff, 1975). The panelists were predominantly Caucasian and a concern is that this study largely reflects the viewpoints of the white middle class. The final sample was skewed with regards to gender, given that two-thirds of the sample were men. The sample was also skewed toward an older, more experienced population. The sample was also skewed in the direction of academically oriented people. Although many of the academicians in the sample reported that they were active in private practice, 64% of the panelists were involved in an academic setting. The sample was also skewed in the direction of integrative theory as a first choice of panelists and away from more traditional approaches to MFT.

The Delphi methodology provides merely the opinions of participants. The results of this study represent the subjective viewpoints of this particular group of panelists regarding the common factors that may be operative in MFT. It offers no outcome data regarding the extent to which these common factors actually contribute to therapeutic outcome (although the psychotherapy literature suggests that they may be at the heart of change).

SUMMARY

In this study, leading clinicians and researchers from AFTA and faculty members from COAMFTE-accredited MFT programs were asked to achieve consensus regarding common factors. Respondents were asked to report on commonalities across the various MFT theories, and they also were asked what they personally considered to be the core ingredients of change.

Regarding client/extratherapeutic factors, overall, respondents paid less attention to the role of clients in the change process than they did to the role of therapists. If Lambert's (1992) estimate is correct that 40% of the variance in outcome is caused by client characteristics, then perhaps this suggests that the field may not be paying sufficient attention to the clients' role in the change process. It is interesting that extratherapeutic variables (e.g., other significant events occurring in the clients' lives) did not make it into the final profiles from either the vantage points of MFT theories or the personal views of respondents. Perhaps therapists have an exaggerated sense of importance of what happens exclusively in the therapy room. Client motivation was considered to be important from both perspectives. However, client agency (clients taking responsibility for change) only achieved a high consensus from the respondents' personal perspectives.

Regarding relationship factors, they were clearly considered to be important from both perspectives. However, the respondents rated working collaboratively with clients more highly from a personal perspective than from their view of the MFT theories as a whole. Client belief and trust in the therapist was considered to be about equal from both perspectives. However, regarding relationship factors attributable to therapists, many more items were endorsed from the personal perspective. This seems to indicate (as was supported by the interview data) that the respondents believed that they have a more important role in establishing strong therapeutic relationships than they believe is emphasized in MFT theories as a whole. The importance of ethical integrity also made it into the final profile only from the personal perspective.

The personal perspective, then, placed greater emphasis on client agency, working collaboratively with clients, relationship factors attributable to therapists, and the importance of ethical integrity. Taken together,

these differences may suggest the influence of postmodern thought and/or a realization, on the part of respondents, that MFT theories as a whole have under emphasized these dimensions.

Regarding model/technique factors, more variables made it into the final profiles from both perspectives than any of the other three categories. This suggests that models and techniques are still given a great deal of salience. Somewhat surprisingly, thinking about problems in relational terms did not make it into the final profile from the personal perspective. Either the respondents take this thinking for granted, or perhaps this reflects Minuchin's (1998) concern that current theories do not pay sufficient attention to relational dynamics.

Both perspectives emphasized therapist activity, the importance of joining, and value of reattribution cognitive strategies. Both placed considerable emphasis on behavioral strategies. Affective techniques, however, did not make it into the final profile from either perspective. This may reflect an ongoing uncertainty in the field of family therapy about the role of feelings. Techniques related to history also did not make it into the final profiles, reflecting the respondents' beliefs that these techniques are not universal enough to be common factors among the MFT theories, nor are they sufficiently important to them personally. That affect and history did not make it into the final profiles does not mean that they are unimportant but, rather, that there was not sufficient consensus among the panelists for them to be included.

Regarding placebo, hope, and expectancy factors, respondents viewed variables linked to the therapist and variables linked to clients similarly from both perspectives. It is important that therapists and clients believe that change is possible and that clients believe that therapists are competent. However, regarding variables that are linked to the process of therapy generally, no variables made it into the final profile from the perspective of MFT theories as a whole.

RECOMMENDATIONS AND CONCLUSION

This study, along with the fairly robust finding from both psychotherapy and MFT research that shows that there is little or no differential effectiveness among various treatment models, has implications for how MFTs are trained. We believe that we need to move the focus of MFT culture away from the worship of cherished theory-specific models and the belief that it is the unique aspect of these theories that brings about change. Common factors should be given much more attention in the training of MFTs. The curricula of most COAMFTE training programs are heavily weighted toward the teaching of models in spite of the dearth of evidence that any model is superior to another. Certain common factors, such as helping to instill hope in clients, are rarely taught. Other common factors, such as those that reside within the client and extratherapeutic factors, tend to be underemphasized, whereas the therapist's role in the change process is given too much weight.

More research needs to be done on some of the variables that were highlighted in this investigation. The authors were able to find, for example, only one study on the implications of extratherapeutic variables in MFT. Nonetheless, the results of that investigation were quite telling and support the importance of these neglected variables. In a 2-year follow-up study of behavioral marital therapy, Jacobson, Schmaling, and Holtzworth-Munroe (1987) found that the only predictor of relapse was stressful external events in the lives of the clients. Neither the treatment the clients received nor attributes of the therapists had any predictive value. More research needs to be done on the role of expectancy and hope factors in MFT. Research on the therapeutic alliance, specifically in MFT, is in its infancy—especially if we look at ways in which family therapists establish relationships with different clients and subgroups within families. Given the somewhat surprising omission of affect from especially the personal views of the respondents, further research on the role of feelings in the change process is warranted. It may be that this dimension is underappreciated or underutilized.

In conclusion, the field of MFT runs the risk of being marginalized by mainstream psychotherapy (Shields, Wynne, McDaniel, & Gawinski, 1994). Much of the work that MFTs do overlaps with psychotherapy generally. The general psychotherapy field has paid much more attention to common factors. This study helps move the field in the direction of lesser marginalization by emphasizing that which unites

us internally as well as with our sister disciplines. The study is supportive of the integrative movement within psychotherapy in general, and marital and couple therapy in particular, which Lebow (1997, p. 1) has called a "quiet revolution." It is time that the field moves beyond being a coterie of competing religions and establishes a more ecumenical view concerning what really brings about change.

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