Motivational Interviewing as a Framework for Common Factors Approach in Psychotherapy[*]

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Abstract

Along with reaching saturation in the field of psychotherapy modalities which currently includes more than 400 models that are proven to be effective, common factors approach has started to become one of the hot topics of the psychotherapy debate in the last ten years. While there is a growing literature taking a common factors proponent stance, there are also criticisms including the common factors approach being speculative and not having a scientific ground. In this conceptual paper, first we will outline the common factors approach and motivational interviewing framework. Then, we will discuss the overlapping between common factors perspective and motivational interviewing framework and propose motivational interviewing as an evidence-based research tool and empirically based theoretical framework for the common factors research and theory. Finally, we will discuss the implications and limitations of taking such a stance.

Keywords: Common Factors, Motivational Interviewing, Psychotherapy

Psikoterapide Ortak Faktörler Yaklaşımı İçin Bir Çerçeve Olarak Motivasyonel Görüşme

Özet

Etkinliği kanıtlanan psikoterapi modellerinin sayısının 400'e ulaşmasıyla birlikte, psikoterapide ortak faktörler yaklaşımı son on yıldır araştırmalarda önemli bir yer edinmeye başladı. Bir yandan ortak faktörler yaklaşımını destekleyen araştırmalar artarken diğer yandan bu yaklaşımı spekülatif olmakla ve bilimsel temele dayanmamakla eleştiren yayınlar ortaya konmaktadır. Bu kavramsal çalışmada, öncelikle ortak faktörler yaklaşımı ve motivasyonel görüşme çerçevesinin ana hatlarını çizecek, ardından ortak faktörler yaklaşımı ve motivasyonel görüşme çerçevesi arasındaki benzerlikleri tartışacak ve motivasyonel görüşme çerçevesinin ortak

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faktörler yaklaşımı araştırmaları için kanıt-temelli bir araştırma aracı ve teorik çerçeve olduğunu öne süreceğiz. Sonuçta bu yaklaşımın çıkarımları ve eksiklerini tartışacağız.

Anahtar Kelimeler: Ortak Faktörler, Motivasyonel Görüşme, Psikoterapi

Introduction

According to the most recent literature, there are more than 400 psychotherapy modalities that are proven to be effective (Karimi, 2015). As the psychotherapy field reaches saturation in terms of the variety of the modalities that are proven to be effective, more and more researchers have been stating that it might be the common elements cutting across the treatment modalities, rather than the model-specific ones, that are responsible for the effectiveness of psychotherapy and highlighting the need for research exploring these common factors, rather than focusing on modifying, diversifying, and specifying of the modalities.

Even though growing evidence supports the common factors perspective, there are also criticisms against the common factors approach revolving theoretical and practical issues. The theoretical level criticisms are based on the argument that the common factors perspective is tautological, not-falsifiable, and thus not scientific (Laska, Gurman, & Wampold, 2014). It is further argued that contrary to the evidence-based researchers, the common factors proponents are using inductive and inferential approaches (Baker & McFall, 2014) and it is based on repudiation of scientific practice as it is based on meta-analyses findings rather than scientific experimentation (Asnaai & Foa, 2014). Moreover, it is argued that even though common factors perspective seems appealing for students, researchers, clinicians, and educators as it premises a basic foundational framework and a symbiosis of the post-modern values, it oversimplifies the complex and multileveled nature of the psychotherapeutic change mechanisms (Sexton, Ridley, and Kleiner, 2004).

This paper is an attempt to contribute to the common factors approach discussion from a conceptual viewpoint. First, we will provide a broad outline the common factors approach and motivational interviewing framework. Then, we will discuss the overlapping between these two frameworks and propose that motivational interviewing might serve as an evidence-based, theoretical ground for common factors research. Finally, we will discuss the implications and limitations of using motivational interviewing framework to explore the common factors of effective psychotherapy practices.

Common Factors Perspective

The common factors perspective in psychotherapy may be broadly defined as an approach stating that the commonalities rather than differences among the psychotherapy practices are responsible for the effectiveness of the psychotherapy (Karam, Blow, Sprenkle, & Davis, 2014). Although the suggested common factors including the quality of relationship among the therapists and clients, therapeutic techniques, and client-related factors are as old as the psychotherapy practice itself, the discussion of common factors in the psychotherapy research literature is relatively new.

Common factors perspective is rooted in the Rosenzweig (1936) study asserting a Dodo Bird Verdict among psychotherapy modalities. With a reference to the Dodo Bird from the Alice in Wonderland ("All won, all must have prizes"), for the first time in psychotherapy literature, Rosenzweig (1936) argues that the effectiveness of psychotherapy modalities is due to the common factors across models, rather than the specifics. Later on, Jerome Frank (1961) argues that not only in psychotherapy but also in all forms of therapeutic contexts including medical and traditional healing practices, there are four components of effective practice: a healing context: a rationale or a myth providing an explanation for the problem and a method for the solution, a meaningful relationship with the healer, and a ritual or a procedure the client and the healer actively participate.

Orlinsky and Howard (1987) proposes a "generic model of psychotherapy" consisted of five main processes: (a) therapeutic contract consisted of the mutual agreement between the therapists and the clients on the dynamics of the therapeutic relationship including logistical details like site, schedule, fee, duration; treatment goals of the clients, and treatment methods the therapist use; (b) therapeutic operations that is consisted of the cyclical work between the therapists and the clients including the elements of client input or problem statement, therapist reaction or interventions, and the co-operation among the participants; (c) therapeutic bond including the elements of team-work and rapport; (d) participants' self-relatedness suggesting the level of openness/defensiveness of the clients and the therapists, and (e) in-session impacts consisted of the outcomes attained during the psychotherapy session, like emotional relief or gaining insight. The authors argue that the generic model of psychotherapy not only provides a meta-perspective, but also the highlights common elements of effective psychotherapy practice.

Based on extensive reviews of psychotherapy outcome research, Lambert (1992, Lambert & Barley, 2002) proposes a taxonomy of effective therapy practice which is often considered as the basis of the common factors perspective. The taxonomy is consisted of four

factors: Extratherapeutic/client factors including clients' resources, psychological functioning, and life events (40%); interpersonal relationship between therapists and clients (30%); hope, expectancy, and placebo (15%); and model or technique (15%). In the similar vein, Grencavage and Norcross (1990) identify five categories of common factors: Client characteristics, therapist qualities, change processes, treatment structure, and therapeutic relationship. They further state that most of the treatment outcome is due to the therapeutic alliance (56%) followed by catharsis opportunities (38%), practice of new behaviors (32%), expectancies of the clients (26%), therapist qualities (24%), and the rationale providing a roadmap for the change processes (24%).

Miller, Duncan, and Hubble (1997) embraces and enhances the taxonomy of common factors proposed by Lambert (1992) and highlights the biggest role of client factors during the psychotherapy process. The authors further argue that the psychotherapy process should include a formal client feedback in psychotherapy process (Duncan, Miller, & Sparks, 2004). Wampold (2001) conducts a detailed meta-analysis and argues that 70% of the outcomes of psychotherapy were due to common factors and only 8% were due to model specific elements. Later on, Wampold (2015) proposes a contextual model which is composed of three common pathways: Forming a real relationship, fostering expectations, and enacting healthy behaviors.

Davis and Piercy (2007a, b) proposes a stages-based perspective to common factors across treatment modalities. They state that at the earlier stages of psychotherapy, the factors common across models are therapists' search and conceptualization of a dysfunction, therapists' allegiance to a model and being perceived as a credible agent by the clients, the fit of the therapists' models to the clients' expectations, therapists' providing a safe and healing environment, clients' readiness for change and taking responsibility for their actions. At the second stage that is characterized as intervention, the commonalities across models include slowing down the process, helping clients to step outside of their meaning frameworks, highlighting client's responsibility for change, as well as building and maintaining therapeutic alliance. At the outcome stage the common elements across models include softening negative experiences and creating a space for the other by means of acceptance.

Overall, the current state of discussion regarding the common factors can be grouped into six categories: Client specific factors, therapist specific factors, therapeutic relationship, expectancy/hope of clients, techniques/interventions, and allegiance of therapists.

Client Specific Factors

Proposed by Lambert (1992) as the largest portion of variance in outcome and embraced and enhanced by the proponents of common factors perspective. Miller, Duncan,

and Hubble (1997) point out that psychotherapy practice and research dismiss the clients' potential for change and situate the clients to an "incompetent" position. They argue that:

> *"In the clinical literature, clients have long been portrayed as the "unactualized," message bearers of family dysfunction, manufacturers of resistance, and in most therapeutic traditions, targets for the presumably all-important technical intervention. Indeed, it seems that once people decide to enter treatment they suddenly become something less than they were before. They cease knowing their own mind, are disconnected from their feelings, certainly have "something" wrong with them that requires fixing, and, of course, will do their devilish best to resist the therapist's efforts to help them. It is curious that the very profession that makes helping a virtue has also made a cult out of client incompetence" (p.24).*

The extratherapeutic factors encompass all the factors external to the treatment process that are influencing the outcomes. The proponents of common factors perspective highlight that the client specific variables like developmental status, strengths and the risks, resources and challenges, psychological functioning, social support system, readiness for change, and even the external life events have significant effect on the treatment outcomes (Bohart & Tallman, 1999; Duncan, Miller, Hubble, 1997; Duncan, Miller, Sparks, 2004; Hubble, Duncan, and Miller, 1999).

Wampold (2001) argues that more than 80% of variance in psychotherapy outcome is explained by extratherapeutic factors. Bohart and Tallman (1999) state that the individuals are more resilient than most of the professionals in the mental health field are thinking of and they can change without receiving psychotherapy. Prochaska (1999) states that people can find solutions without receiving psychotherapy service and proposes the transtheoretical model of change with DiClemente (Prochaska & DiClemente, 1983) offering a psychotherapist- facilitated self-change process for the clients. In the similar vein, the results of a study exploring the clients' experience of what was helpful in the psychotherapy process reveal that for the clients the most helping aspects of psychotherapy process are feeling understood, being supported while experiencing difficult times, being encouraged when they try new behaviors, and receiving advice when they need (Levitt, Butler, & Hill, 2006).

Sprenkle, Davis, and Lebow (2009) highlight the "match" between the client needs and therapeutic interventions. They state that when the clients are considered as autonomous human beings who know what works best for them, then, depending on the needs and desires of the clients, the therapists may utilize the client-appropriated interventions. The research shows that when people start therapy they usually have an idea about what they need and what works best for them (Philips, Wennberg, & Werbart, 2007).

Overall, the proponents of common factors perspective argue that there is a need for a paradigm shift in the field of psychotherapy towards a person-centered approach (Rogers, 1957) in which the clients are considered as active, resilient, competent, creative, and autonomous agents who can realize their own-change process rather than the passive recipients of therapeutic interventions and interpretations about their very own realities.

Therapist Specific Factors

Therapist specific factors are introduced by Wampold and Brown (2005) as the owner of 8-9% of variance in psychotherapy outcomes. In a more recent meta-analysis on therapist effects based on 45 studies, Baldwin and Imel (2013) reports that 5% of the variability in outcomes was explained by differences among therapists which translates into almost 15% of variance when the effect size is considered.

Because the therapist is the deliverer of the treatment, the sole effects of the therapists are not easy to be distinguished from technique/intervention related factors (Duncan, Solovey, & Rusk, 1992). However, despite this difficulty, Hubble, Duncan, and Miller (1999) argue that "everybody knows but at the same time is on the building to acknowledge or explore that some therapists are more effective than others." (p.38). Research shows that despite the standardization movements, the therapist effects on the treatment outcomes cannot be eliminated (Beutler et al., 2004; Okiishi et al., 2006). However, still there is no solid picture regarding personal characteristics and actions of effective psychotherapists (Beutler et al., 2004).

The research reveals conflicting results regarding the effectiveness of the therapists. There are research supporting the uniformity of therapist effectiveness hypothesis suggesting that the demographic characteristics including age, gender, race, and ethnicity as well as experience and orientation of the therapists are not associated with treatment outcomes (Beutler et al., 2004; Okiishi et al., 2006; Stolk & Perlesz, 1990; Wampold & Brown, 2005). Wampold and Brown (2005) finds that the clinicians who are good at treating depression are also good at treating anxiety. Similarly, in a more recent study exploring universality of therapist effectiveness, Nissen-Lie et al. (2016) finds that therapists' effectiveness in one domain is positively correlated with their effectiveness in another.

There are also research suggesting the hypothesis there are nuances of effectiveness of the therapists. Based on a study including 6,960 patients treated by 696 therapists, Kraus et al. (2011) finds that therapists who are skillful in treating individuals with particular problems may not be that skillful in treating individuals having different set of problems. Similarly, it has been found that some therapists are better in the treatment of racial/ethnic

minority individuals than the non-minority clients (Hayes, Owen, & Bieschke, 2015). However, at a deeper level focusing on what the therapists are actually doing in the psychotherapy process, the research shows a more coherent picture. There seems to be a significant correlation between the interpersonal skills of the therapists and treatment outcomes of the clients (Anderson et al., 2016; Moyers et al., 2016).

It has been repeatedly found that the clients' perceived support (Gellatly et al., 2007; Titov et al., 2009), warmth (Farber & Doolin, 2011; Thomas, Werner-Wilson, & Murphy, 2005), friendliness and positivity (Lebow, Kelly, Kobloch-Fedders, & Moss, 2006), empathy (Elliott, Bohart, Watson, & Greenberg, 2011), congruence (Klein, Michels, Kolden, & Chisolm-Stockard, 2001), and unconditional positive regard (Farber & Lane, 2001) from their therapists are significantly associated with positive psychotherapy outcomes.

The research on the qualities and actions of highly effective therapists are also showing surprising results. Miller, Duncan, & Hubble (2008) asserts that highly effective therapists, whom they call as "supershrinks" with a reference to the Ricks (1974) study, engage in deliberate practice. Deliberate practice is defined as "individualized training activities especially designed ... to improve specific aspects of individual performance through repetition and successive refinement (Ericsson & Lehmann, 1996). In a recent study exploring the role of deliberate practice of therapists on treatment outcomes, based on the data from 17 therapists treating 1,632 clients, Chow et al. (2015) finds that the time spent on deliberate practice including receiving supervision and attending to professional trainings, is a significant predictor of clients' positive psychotherapy outcomes.

Moreover, it has been found that perceived directiveness (Kamo & Longabaugh, 2005) of the therapists is significantly associated with negative psychotherapy outcomes. In an exemplary summary of research on what does not work in psychotherapy, Norcross (2002) lists "seven caveats" that should be avoided: Confrontation (Miller, Wilboume, & Hettema, 2003), negative processes (i.e. hostile, blaming, critical, rejecting behaviors and attitudes, listed in Lambert & Barley, 2002), assumptions (Miller, Duncan, Sorrell, & Brown, 2005), therapist centricity (Orlinsky, Ronnestad, & Willutzki, 2004), rigidity (Ackerman & Hilsentoth, 2001), not addressing the alliance ruptures (Safran, Murran, Samstag, & Stephens, 2002), and not-responding to the needs of the clients (Norcross, Koochet, & Gaiofalo, 2006).

Blow, Sprenkle, and Davis (2007) argue that being a competent therapist is a common factor of effective relational psychotherapy practice, as the therapeutic change is either initiated or influenced by the therapist. Fife, Whiting, Bradford, and Davis (2013) proposes a meta-model of therapy effectiveness in a therapeutic pyramid shape which rises above the

therapist's way of being. The cultural competency of the relational therapist is found to be an important factor in determining the quality of the relational psychotherapy outcomes (Breuk et al. 2006). Also, D'Aniello, Nguyen, and Piercy (2016) highlights the role of being culturally sensitive as opposed to doing cultural sensitivity in effective psychotherapy practice.

Overall, as the common factors proponents suggest that despite the conflicting research findings with regard to the association between the therapists' demographic qualities and clients' therapy outcomes, there seems to be a coherent picture of the therapist actions helping clients to achieve positive psychotherapy outcomes: Therapists highlighting the factors including empathy, positive regard, congruence, warmth, friendliness, support, and deliberate practice as well as refraining from confrontation, negative processes, not checking preconceived assumptions, centricity, ignoring the ruptures, and not responding the needs of the clients.

Therapeutic Alliance

The term working alliance was defined by Bordin (1979) as the agreement on the tasks and the goals of the treatment process and having a personal bond between the therapist and the clients. Lambert (1992) reports the second highest (after client factors) percentage of variance in psychotherapy outcomes to the quality of relationship between the therapists and the clients. The studies and meta-analyses consistently reveal that higher therapeutic alliance is positively associated with successful treatment outcomes (Duncan, Miller, Sparks; 2004; Horvath & Bedi, 2002; Messer & Wampold, 2002).

A study exploring the role of working at alliance among the clients with depression symptoms in which the researchers test the alliance and outcome scores at the 5th, 10th, and 15th sessions review outcome is explained by the working alliance in the range of 19-32% at the 5th, and in the range of 36-57% at the 15th sessions (Gaston, Marmar, Gallagher, & Thompson, 1991). Similarly, various studies exploring the role of early working alliance on the treatment outcomes suggest that higher early working alliance is significantly correlated with positive psychotherapy outcomes (Martin, Garske, & Davis, 2000; Zuroff & Blatt, 2006). Also, weaker early alliances are significantly correlated with early-terminations (Sharf, Primavera, & Diener, 2010). In a similar vein, experimental studies and meta-analyses show that therapists detecting the ruptures in the working alliances and repairing the ruptures by means of collaborative negotiation is significantly related to positive psychotherapy outcomes (Safran, Muran, & Eubanks-Carter, 2011; Samstag, Muran, & Safran, 2004).

Several components of working alliance are explored, including goal consensus (Mackrill, 2011; Schnur & Montgomery, 2010) and collaboration (Creed & Kendall, 2005;

Schnur & Montgomery, 2010). Tyron and Winogard (2002) states in a meta-analysis exploring the role of working alliance that 89% of the studies report significantly positive association between therapist-client collaboration and treatment outcomes. Also, Friedlander, Escudero, and Heatherington (2006) report that even when the family members have high individual working alliances with their therapists, when the alliances among the family members are low, there is a high likelihood of early termination.

Overall, as the proponents of common factors perspective highlight that there seems to be a significant relationship between the quality of the therapeutic alliance and the treatment outcomes. The agreement between the therapists and the clients on the goals and tasks of the therapeutic process, having a personal bond with the therapists and other family members, therapists' being mindful about the essentiality of alliance building and maintaining, and collaborating with the clients from the start to the end of the psychotherapy process are crucial for getting positive treatment outcomes.

Hope/Expectancy of the Clients

Lambert (1992) attributes 15% of variance in psychotherapy outcomes to expectancy, hope, or placebo factors. The research on the effects of placebos support the hypothesis that there is a strong correlation between the clients' expectancy and treatment outcomes (Kirsch et al., 2002; Wampold, Minami, Tierney, Baskin, & Bhati, 2005; Wampold, 2015).

Sprenkle & Blow (2004b) highlight that especially at the beginning of all psychotherapies, instilling hope is considered as the essential component of therapeutic modalities and they call for further attention of the researchers regarding the association between clients' expectancy and treatment outcomes.

Therapeutic Techniques and Interventions

The therapeutic interventions are considered to be contributing 15% of the variance in Psychotherapy outcomes (Lambert, 1992). Miller et al. (1997) refers to the common technical procedures as "... asking particular questions, listening and reflecting, dispensing reassurance, confronting, providing information, offering special explanations (i.e. reframes, interpretations), making suggestions, self-disclosing, or assigning tasks to be done within or outside the therapy session." (p.29).

A formulation of techniques was offered by Prochaska, DiClemente, and Norcross (Prochaska, DiClemente, and Norcross, 1992) for effective psychotherapy practice. Based on the research findings suggesting no difference between the self-changers and treatment-receivers in terms of treatment of addictions (Pederson & Lefcoe, 1976), the authors conducted extensive studies exploring the dynamics of change, and proposed a

Transtheoretical Model of Change transacting across models. The authors proposed that there are 10 processes of change which are consciousness raising, self-liberation, social liberation, self-reevaluation, environmental reevaluation, counterconditioning, stimulus control, reinforcement management, dramatic relief, and helping relationships that can be grouped into five stages of change: pre-contemplation, contemplation, action, maintenance, and relapse (Prochaska & DiClemente, 1982). The authors describe the stages in terms of change mechanisms as follows:

> *"Pre-contemplators tend to be defensive and avoid changing their thinking and behavior, they would use the change processes significantly less than subjects in other stages. Because contemplators are seriously thinking about changing their smoking behavior, they would use consciousness raising the most to gather further information about their smoking. Because self-reevaluation appears to be a process that bridges contemplation and action, self-reevaluation would be used most in the contemplation and action stages. Because subjects in the action stage are most committed to making behavioral changes, they would use self-liberation, counter-conditioning, stimulus control, and reinforcement management the most. No clear predictions had emerged from previous research on which processes would be emphasized during the maintenance and relapse stages." (Prochaska & DiClemente, 1986).*

The stage specific intervention focused model proposed by Prochaska, DiClemente, and Norcross (Prochaska & DiClemente, 1982; Prochaska, DiClemente, and Norcross, 1992), not only found to be very effective in the treatment of the problems that are considered to be "most difficult to treat" (O'Brien, Childress, Ehrman, & Robbins, 1998), but also inspired various evidence based interventions including Motivational Interviewing (Miller & Rollnick, 1991, 2014).

Similarly, in an extensive study exploring the common factors across emotion-focused couples therapy, cognitive behavioral couple therapy, and internal family systems therapy by means of qualitative analyses of the interviews with model developers, previous students, and clients, Davis and Piercy (2007a, b) report that the common techniques cutting across the models include slowing down the process, helping the client to stand meta to themselves, and encouraging personal responsibility. The authors argue that despite the different sets of techniques specific to the models, encouraging the clients to feel responsible in their thoughts, feelings, and actions seem to be common across all the therapy modalities (Davis & Piercy, 2007a, b).

Overall, it seems like the core techniques/interventions of an effective psychotherapy practice can be summarized with three basic helping skills: helping the clients to reflect on the problem, to gain awareness about their personal, biological, social, and relational roles, and to

encourage them to make the change they want for their lives through the basic counseling skills including reflective listening, asking questions inviting for further clarification, and encouraging personal responsibility to take action for the desired behaviors.

Allegiance of the Therapists

Proposed by Frank (1961) as a rationale or a myth as one of the components of effective healing practices and embraced and enhanced primarily by the proponents of common factors perspective. The term allegiance is defined as the belief of the therapists in the treatment method as an effective way to help clients to change (Luborsky, Singer, and Luborsky (1975). The meta-analyses exploring the role of the clinician allegiance on the treatment outcomes show significantly positive associations (Luborsky, 1999; Luborsky et al., 2002).

In a recent meta-meta-analysis including twenty-nine publications from thirty studies exploring the allegiance and outcome relationship, Munder, Brutsch, Leonhart, and Barth (2013) found that there is a "substantial and robust" association between therapist allegiance and client psychotherapy outcomes. The authors also explored the moderator effects, and found no difference across treatment formats, age groups, and presenting-problems of the clients. Similarly, in a recent meta-analysis including findings of a total of 240 randomized controlled trials, Dragioti, Dimoliatis, Fountoulakis, and Evangelou (2015) confirmed that there is a strong effect of researcher/ clinician allegiance on the treatment outcomes. The authors further argued that allegiance effect is stronger when the primary investigators of the studies are the founders, developers, or supervisors of the "preferred" treatment modalities.

Leykin and DeRubeis (2009) mention that allegiance creates a significant bias favoring the "preferred" treatments among the evidence based clinical research studies. They suggest that the allegiance bias can be eliminated by strengthening the research designs by means of including research teams favoring each of the treatment conditions. They argue that the allegiance bias can be balanced out by methodological modifications as well. In a recent study, Wampold (2015) highlights the methodological issues related to allegiance, including the fact that in most evidence based clinical trials, therapist and clients both know that they are in the control (aka less-preferred) groups which may be affecting the performance of the therapists as well as the expectancy of the clients.

Overall, as the proponents of common factors perspective highlight, it seems like regardless of the therapeutic modality, there is a positive association between the allegiance of the therapists and the treatment outcomes of the clients. Because the term allegiance also refers to the therapists' attributed meaning to their therapeutic performance and the attempts

to eliminate the allegiance effect would be unethical. As Wampold (2001) suggests, the best way to handle it would simply accepting allegiance effect and exploring the ways in which it can be utilized within the therapeutic process.

Motivational Interviewing

Defined as a client centered and goal oriented therapeutic style aiming to facilitate behavioral change through the exploration of ambivalence (Miller & Rollnick, 1991), motivational interviewing (MI) has gained great success and popularity in the evidence-based research area, in the treatment of a variety of psychopathological problems such as alcohol and substance use disorders (Carroll et al., 2006), eating disorders (Macdonald, Hibbs, Corfield, & Treasure, 2012), depression (Anderson, 2007), school underachievement (Stewart-Donaldson, 2012), and health coaching (Linden, Butterworth, & Prochaska, 2010) in a short period of time.

The goal of motivational interviewing is to help the clients to feel an intrinsic desire to make a change (Miller & Rollnick, 2013, 2002). Using motivational interviewing, the clinicians encourage the clients to come up with their own solutions to their problems. As mentioned above, even though motivational interviewing was developed as a "brief opportunistic intervention" to be used along with other modalities, owing to the research evidence supporting the effectiveness of motivational interviewing, it has been used as a stand-alone intervention, and has been developing into a theory (Miller & Rose, 2009).

Motivational Interviewing Elements

Motivational Interviewing is composed of three major elements (spirit, principles, and micro skills) and four processes (engaging, focusing, evoking, and planning) (Miller & Rollnick, 1991, 2013). In the following section, the elements and processes of motivational interviewing will be discussed in detail.

Spirit. Since the introduction of the motivational interviewing framework, Miller and Rollnick (1991, 2008, 2011, 2013) have always been arguing that the spirit of the motivational interviewing is the fundamental aspect of it, and neither of the "motivational techniques" can be considered as components of motivational interviewing without the "larger mindset and heartset" of the motivational interviewing spirit (Miller & Rollnick, 2013, p.5). In the first edition of the book, the authors present three components of motivational interviewing spirit: Collaboration, evocation, and autonomy (Miller & Rollnick, 1991). Starting from the third edition, they add one more component: Compassion.

The *collaboration* component of the motivational interviewing spirit is defined as the "cooperative partnership between the patient and clinician" (Miller & Rollnick, 2013, p.20).

The authors highlight the role of exploration instead of exhortation, supporting the clients rather than persuading or arguing with them, and having an attitude of conducting change instead of coercion. They say that "instead of an uneven power relationship in which the expert clinician directs the passive patient in what to do, there is an active collaborative conversation and joint decision-making process" (Miller & Rollnick, 2013, p:20). *Evocation* is the second component of the motivational interviewing spirit. It is defined as clinician's active attempts to motivate the client's to use their own resources for change. Rooted in the strengths focused understanding, the authors highlight that they see the clients as individuals who already have the resources to be able to make a change in their own lives and they do not need "expert-opinions" about their inner realities to be able to make a change. The authors say that "a patient may not be motivated to do what [the clinicians] want him or her to, but each person has personal goals, values, aspirations, and dreams.' (Miller & Rollnick, 2013, p:20). Thus, in motivational interviewing the clinician instill motivation for the clients to make change. *Autonomy*, as stated in the first edition of Motivational Interviewing, is the third component. Along with collaboration and evocation, honoring autonomy is defined as acknowledging the other individual's' freedom of choice and expressing unconditional positive regard towards them as human beings. The clinicians may give advice or provide information, but, by spirit, they should always highlight that it is the clients who are responsible for making a change they want for their lives. The authors point out the research suggesting that people generally respond which reactions when they are try to be coerced (i.e. Karno & Longabaugh, 2005a). They assert that "Directly acknowledging a person's freedom of choice typically diminishes defensiveness and can facilitate change" (Miller & Rollnick, 2013, p:20). The last component Miller and Rollnick (2013) considered within the spirit of motivational interviewing is compassion. They define compassion as "actively promoting the others welfare, to give priority to others needs". They argue that they choose to include compassion because motivational interviewing implemented without compassion, but it doesn't necessarily help the clients to change. Miller and Rollnick (2013) say that "the spirit of compassion is to have your heart in the right place so that the trust you engender will be deserved."

In the first version of Motivational Interviewing, in order to make the components of the motivational interviewing spirit clearer, Miller and Rollnick (1991) also provides a comparison chart. Collaboration component is presented as the "mirror-image" of confrontation in which the clinicans expose the clients to an aspect of the clients that they are not ready to accept. The contrasting component of evocation is presented as education in

which instead of drawing out change, the clients are educated for the change. The mirror image of honoring autonomy is presented as authority in which the clinicians take an expert role in their interactions with the clients and tell them what to do.

Principles. Motivational interviewing is practiced based on five main clinical principles: Expressing Empathy, Developing Discrepancy, Avoiding Argumentation, Rolling with Resistance, and Supporting Self-Efficacy.

Expressing Empathy. Miller and Rollnick (1995) propose that the main principle of motivational interviewing is rooted in Rogerian conceptualization of empathy. They state that expressing empathy through reflective listening techniques and accepting attitude is the most essential and characterizing component of motivational interviewing. The empathic clinicians are described as the ones who accept their clients as they are, and show deep understanding of the clients' perspectives. The principle of expressing empathy is rooted in the spirit of accepting all kinds of feelings the clients may or may not be experiencing, including desiring or resisting to change, or feeling ambivalent to make a change.

Developing Discrepancy. Based on Festinger's (1957) conceptualization of "cognitive dissonance", Miller and Rollnick (1995) argues that the second principle of motivational interviewing is to help the clients to identify and amplify the inconsistencies of thoughts, feelings, attitudes, or behaviors between current behaviors and future goals. The principle of developing discrepancy is rooted in helping the clients to become aware of the discrepancy between the current and desired states. The authors state that when the clients develop awareness, they start to consider change.

Avoiding Argumentation. Miller and Rollnick (1995) state that the third principle of motivational interviewing is avoiding argumentation with the clients. The authors state that direct confrontation elicits defensive and reactive responses in clients rather than enhancing the clients' motivation to make a change. Increased amount of defensive responses of the clients are considered as the signals of decreased motivation to change. Based on this principle, the therapists avoid arguing with their clients.

Rolling with Resistance. Rolling with resistance is considered as the "hallmark" of motivational interviewing (Miller and Rollnick, 2002) that is defined as acknowledging the perspectives of the clients, providing new information, and leaving the decision to make a change to the client. Rather than confronting or challenging the clients, the therapists roll with the resistance of their clients. The authors highlight that in motivational interviewing the clients are considered as people who are capable of finding solutions themselves and they are responsible for creating a change in their lives.

Supporting Autonomy. The last principle of motivational interviewing is supporting the autonomy of the clients. Rooted in Bandura's conceptualization of self-efficacy (Bandura, 1977), it is stated that the clients' confidence in their abilities to make a change is essential in creating a change (Miller & Rollnick, 1995). The authors state that when the clients hope that they can change, it is a lot more likely for them to do so. Therapists conveying hope for the clients to make a change is an essential principle of motivational interviewing.

Microskills. Motivational interviewing is a brief intervention in which the spirit and principles described above are practiced through a variety of "microskills" including open ended questions, affirmations, reflections, and summarizing (abbreviated as OARS) that are "borrowed from person-centered counseling" (Arkowitz, Miller, & Rollnick, 2015). It is asserted that while the OARS skills are primarily used in the early stages of therapy process. At the following stages, OARS shifts into an EARS form in which E is abbreviated for Elaboration (Arkowitz, Miller, & Rollnick, 2015).

The open-ended questions serve the therapists to engage with the clients, and to build trust with them. They also serve as the ground builders for the therapy process in which the therapists can use other techniques. Affirmations can be implemented in the forms of appreciation and acknowledgement, such as "I appreciate your hard work" which conveys the strength based approach of motivational interviewing. Reflections are considered as challenging skills to practice, because even though mirroring what the clients say may sound easy, there is a risk of dismissing the client's perspective and telling the clients what they "actually" feel. Summarizing consists of reflecting a whole to the clients with the purpose of drawing a whole picture of what the clients presented so far.

Four Processes. Miller and Rollnick (2011) proposes that motivational interviewing is composed of four processes: Engaging, focusing, evoking, and planning. Engaging process refers to the first stage of the treatment that in which the therapeutic alliance between the therapist and the clinicians are built. The OARS skills mentioned above are critically important in that stage. Besides the essentiality of implementing OARS skills, the therapists are also encouraged to refrain from behaviors of persuasion and confrontation that are considered to be non-adherent to motivational interviewing. At the second stage, the therapists and the clients focus on the treatment goals. They work together in order to identify the goals and the direction of the treatment process. At the third stage, the therapists specifically focus on evoking the motivation of the clients to make a change in the context of the pre-determined treatment goals. At this stage, the three kinds of specific skills are expected from the therapists to be used: Recognizing, eliciting, and responding to change talk.

In terms of recognizing, the therapists pay specific attention to the change related content the clients use, which is grouped as desire, ability, reasons, and need for change. Along with identifying the change talk content, the therapists are also expected to elicit them by means of using OARS skills. When the change talk is heard, the therapists are expected to respond to them with EARS skills in order to amplify the change talk while decreasing the sustain talk which is defined as the talk content not favoring change. Finally, at the last stage, which actually is a recursive process, the therapist and the clients work together on developing and implementing a strategic plan of change. Overall, motivational interviewing framework offers a minimalistic change directed approach in which basic counseling skills are used strategically to recognize, elicit, and amplify the clients' motivation for change.

Discussion

In the light of the literature review outlined above, we propose that the common factors perspective and the motivational interviewing framework share many common components. These common elements can not only expand our understanding of the common factors perspective and motivational interviewing theory, but also can help us to have more grained and nuanced understanding about how psychotherapy helps people to change.

The person-centered focus of the common factors perspective proponents highlighting that the clients are capable of knowing their self-knowledge (Miller, Duncan, & Hubble, 1997), are more resilient than their conceptualizations in the therapy-models (Bohart & Tallman, 1999), are able to help themselves effectively (Norcross, 2006; Prochaska, 1999), are equally emphasized by the motivational interviewing model developers. Miller and Rollnick (1991) mentions that motivational interviewing is deeply rooted in *person-centered psychotherapy*. Clients are considered as the active agents of their own processes and their state of mind (and heart) are well respected with understanding and compassion. The clinicians may give advice, provide information, use thea variety of techniques but always highlight that it is the clients who are responsible for making a change they want for their lives.

The common factors perspective and motivational interviewing share the similar approach to the *therapist factors*. The common factors proponents highlight findings from various therapist factors including the positive influence of interpersonal skills (Anderson et al., 2016; Moyers et al., 2016), warmth (Farber & Doolin, 2011), empathy (Elliott, Bohart, Watson, & Greenberg, 2011), congruence (Klein, Michels, Kolden, & Chisolm-Stockard, 2001), and unconditional positive regard (Farber & Lane, 2002). Similarly, motivational

interviewing is rooted in the necessary and sufficient (Rogers, 1957) therapist qualities including empathy, unconditional positive regard, and congruence.

Therapeutic alliance is considered as one of the strongest common factors of effective psychotherapy practice that is highly researched (Duncan, Miller, Sparks; 2004; Horvath & Symonds,1991; Horvath & Bedi, 2002; Messer & Wampold, 2002). Similar to the common factors proponents, Miller & Rollnick (1991) stresses the role of collaboration in the realm of motivational interviewing spirit, as well as in terms of principles while expressing empathy, rolling with resistance, and supporting autonomy at the same time. Also, as the rationale of the model developers in having the word choice of "interviewing" over therapy that is discussed above implies, the collaboration is the heart of motivational interviewing framework, as does the common factors perspective.

The common factors proponents argue that *hope and expectancy* are the common elements of effective psychotherapy practices (Hubble, Duncan, & Miller, 1999; Sprenkle & Blow, 2004b). The proponents of motivational interviewing refer to various research findings showing the significant relationship between client hope and expectancy, and therapy outcomes. Similar to the proponents of common factors approach, Miller and Rollnick (1991) highlights the role of "motivation" not only in the realm of evocation factor of the spirit or the developing discrepancy factor of the principles, but also in the title of the model itself. Motivational Interviewing is all about instilling hope, motivating the clients to make the change they desired for, as does the proponents of common factors perspective.

The common factors perspective proponents suggest that the basic *counseling techniques* like asking particular questions, providing information, and reframing are used in all models of psychotherapy (Miller et al., 1997). Similarly, in motivational interviewing the basic techniques of open ended questions, affirmations, reflective listening, and summarizing are presented as the microskills of motivational interviewing and the *tools* to convey the goal of the motivational interviewing which is instilling hope, motivating the client to change (Miller & Rollnick, 1991). In both approaches, psychotherapy is considered as a process helping the clients to slow down their psychological processing, to see the problem they are experiencing from a meta-perspective, and to encourage personal responsibility for change (Davis & Piercy, 2007a, b). Also, Norcross (1999) points out that confrontation (Miller, Wilboume, & Hettema, 2003) and negative processes including critical and blaming behaviors (Lambert & Barley, 2002) are the attitudes that need to be avoided by therapists. Along with the common factors perspective proponents, confrontation and persuasion are considered as the two-main motivational interviewing inconsistent behaviors (Moyers et al., 2014).

Even though, it is not mentioned in the original framework of motivational interviewing (Miller & Rollnick, 1991) or basic outline of common factors approach (Lambert, 1992), thanks to the evidence based research emphasizing the standardization of the treatment delivery, a group of researchers developed various assessment tools including Motivational Interviewing Treatment Integrity Scale (MITI 4.2.1., Moyers et al., 2016) and Motivational Interviewing Skills Code (MISC; Miller, Moyers, Ernst, & Amrhein, 2008) in order to assess the adherence and competence of the therapists in using Motivational Interviewing. The researchers highlighted that the therapists' use of motivational interviewing at a competent and proficient level is significantly associated with better treatment outcomes (Moyers et al., 2005; Westra, Arkowitz, & Dozois, 2009), as discussed by the proponents of the common factors perspective highlighting the role of treatment myth or rationale (Frank, 1961) or therapeutic contract (Orlinsky & Howard, 1987).

Conclusion

Given criticisms of lack of a theoretical framework, operational definitions, and research support for the common factors perspective, we believe motivational interviewing can provide a solid theoretical ground, standardized definitions, and evidence base, as the spirit, principles, and techniques highlighted in motivational interviewing provide an elegant theory-practice ground for the common factors perspective. Considering motivational interviewing a framework for common factors perspective promises to be a valuable contribution to the common factors perspective and motivational interviewing that may, in turn, lead to major changes in therapeutic structures, educational programs, research practices, mental health policies, and potentially, in our conceptualization of psychotherapy.

With regard to the therapeutic structures, highlighting the value of common factors can change the delivery of psychological treatments. As the common factors proponents suggest and motivational interviewing research literature demonstrates, the psychological treatments might shift to the person-centered focused approaches from the therapist/techniques-focused ones. Through SBIRT which uses motivational interviewing as an empirical and theoretical framework, this paradigm shift has already began among various mental health professionals including medical residents, nurses, and counselors working specifically on the treatment of substance use problems (Madras, 2009). It is hoped that the person-centered spirit of the motivational interviewing as a framework for the common factors perspective might influence more mental health professionals providing treatments for other types of psychological problems.

Another help of adopting such a perspective is that, thanks to the use of motivational interviewing framework as a research tool to explore the common factors of effective psychotherapy practices, the effective factors can be identified and consolidated, while less-effective factors can be eliminated (Kraemer, Wilson, Fairborn, & Agras, 2002). Also, through the research and training, the focus on the elements of psychotherapy can shift. For instance, as illustrated in common factors approach and motivational interviewing framework, the therapeutic interventions and techniques are the *tools* to convey the spirit – of motivating people to change, not the goals. Thus, in clinical practice the focus might evolve into the more effective elements –like therapeutic alliance, or client motivation.

In the educational settings, more attention can be directed towards common factors (Blow & Sprenkle, 2001), so that more therapists can be trained along with the guidelines drawn through the common factors research and thus the quality of the clinical practice can be improved. Given the substance use problems focus of motivational interviewing, the factors specific to the treatment of substance use and other problems might be identified through further research and practice, and the trainings can be tailored accordingly. The supervision and education system can highlight the person-of-the-therapist as the meta-model (Fife, Whiting, Bradford, & Davis, 2014; Aponte et al., 2009; Norcross, 2002) which in turn change the educational system of psychotherapy training from a technique oriented to a therapist characteristics oriented one. Furthermore, along with the changes in clinical practice and psychotherapy training programs, the research practices can shift focus from uniqueness of the models to the commonalities of the models, so that the research results may be more beneficial for the clients, therapists, helping professions, and mental health in general (Laurenceau, Hayes, & Feldman, 2007).

Despite these implications, considering motivational interviewing as "the" framework for the common factors approach might be false and misleading. It might be false and misleading, as motivational interviewing is developed as a technique to motivate clients having substance use problems. Even though, the individuals with substance use issues are as human as the other individuals having other types of problems, with the current literature, we do not know to what extent motivational interviewing is applicable for individuals having different types of problems. In short, currently we do not have scientific evidence to suggest that motivational interviewing is "the" framework for common factors approach. More research is needed to identify the similarities and divergences between these approaches.

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