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ORIGINAL PAPER

Determining What is Common: A Theoretical Account of Common Factors in Psychotherapy through the Lens of Self-Determination Theory

Franziska Baier-Mosch[1] · **Gerald Marc Weiher**[2] · **Schahryar Kananian**[3]

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Abstract
The common factors hypothesis as an explanation for the equivalent therapy outcome paradox has stimulated numerous empirical and theoretical studies. However, the existing common factors models (e.g., the contextual model) have hardly succeeded in convincingly linking the quite different common factors and at the same time considering their different conceptualization as technique (e.g., exposure) or process (e.g., expectations). We attempt to overcome these limitations by showing how common factors can be explained and linked against the background of the well-known self-determination theory (SDT). In particular, we will show how common factors can be integrated in the context of SDT concepts of basic psychological needs satisfaction (autonomy, relatedness and competence) and integration of experiences and extrinsic regulations into a unified sense of self. We will argue that repeatedly proposed common factors (e.g., awareness/insight, emotion/behavior regulation, positive expectations/hope, social belonging) can be understood as processes of either autonomy, competence or relatedness need satisfaction and autonomous regulation that lead to positive patient outcomes. Furthermore, we will show how common factors that are techniques rather than change processes (e.g., alliance building) can trigger the common change processes that reflect basic need satisfaction and autonomous regulation.

Keywords Self-determination theory · Common factors · Psychotherapy integration · Osmotic regulation · Autonomy · Competence · Social belonging

The equivalent outcome paradox ("Dodo bird verdict") describes the observation that "all therapies produce equivalent or similar therapeutic outcomes" (Lampropoulos, 2000, p. 416; Rosenzweig, 1936), which is mostly supported by empirical research (Cuijpers et al., 2019, 2021; Marcus et al., 2014). Common factors, that cut across different kinds of psychotherapy and are inherent to all therapy schools, have been proposed as the most parsimonious explanation for the equivalent outcome paradox (Lambert & Ogles, 2014; Rosenzweig, 1936). Long lists of such factors have been assembled (e.g., Grencavage & Norcross, 1990); however, these factors are often grouped into purely heuristically derived categories (e.g., support, learning, action; Lambert & Ogles, 2004), inconsistently conceptualized at different levels of abstraction (e.g., technique-level, change process-level, therapist-level; Finsrud et al., 2022; Lampropoulos, 2000) and exhibit considerable construct and definitional overlap with each other (Finsrud et al., 2022). Furthermore, researchers have faced several challenges in

Franziska Baier-Mosch and Gerald Marc Weiher share first authorship.

✉ Franziska Baier-Mosch
Baier@psych.uni-frankfurt.de

Gerald Marc Weiher
weiher@psych.uni-frankfurt.de

Schahryar Kananian
kananian@psych.uni-frankfurt.de

[1] DIPF| Leibniz Institute for Research and Information in Education, Frankfurt am Main, Germany

[2] Institute of Psychology, Department of Educational Psychology, Goethe University Frankfurt, Frankfurt am Main, Germany

[3] Institute of Psychology, Department of Clinical Psychology, Goethe University Frankfurt, Frankfurt am Main, Germany

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explaining the effects of common factors within a coherent yet differentiated theoretical framework that can also relate to specific psychopathology (Finsrud et al., 2022; Lambert & Ogles, 2014). Existing common factor models, such as the contextual model (Wampold & Budge, 2012) or Frank's (1963) model, offer valuable opportunities to better integrate the common factors, but face several of the difficulties described above. An extension of this prior work therefore appears necessary. An advanced theoretical understanding of common factors may promote common factors as a valuable avenue for psychotherapy integration, which is a current need in psychotherapy research (Hofmann et al., 2022). In addition, a more consistent conceptualization of common factors as techniques or change processes and a sound theoretical basis will promote the systematic teaching and application of common techniques, which is a current need in therapist training (Anderson & Perlman, 2020; Bailey & Ogles, 2019).

We argue that it may be worthwhile to examine self-determination theory (SDT; Deci & Ryan, 2000), an internationally recognized framework of human motivation and personality with a strong empirical evidence base (Ryan et al., 2022), as a unified common factor theory of psychopathology, treatment, and change (Ryan & Deci, 2017). SDT seems well-suited for our purpose because it has already been used to explain health-related and therapeutic outcomes (Ryan & Deci, 2008) and individual SDT-concepts have already been linked to prominent common factor models (e.g., Zuroff & Koestner, 2023). In general, SDT, with its sparing use of only three basic needs, its empirically supported focus on the need for autonomy and associated self-regulatory abilities, and its theory of organismic integration (which other motivation theories do not have in this combination), is well suited to explain both psychopathology (Ryan et al., 2016) and concrete pathways to behavior change and well-being (Ryan et al., 2021). Our work shows how the wide variety of common factors can be theoretically integrated based on SDT to explain general and specific patient outcomes and how this approach may overcome some of the limitations of previous common factor models.

Building our Way to a Common Factors Theory

To integrate common factors based on SDT we will distinguish between *common processes* and *common techniques*, develop a rationale for which common factors should be considered, and develop an understanding of what is missing in current models.

Differentiating Common Factors into Common Processes and Common Techniques

Common factors can be defined as shared factors of specific therapies (Barth et al., 2014). Such shared factors can be either factors that are specific to a certain approach but are also present in other approaches without being theoretically defined in these approaches or factors that are not specific to any approach (e.g., empathy; Barth et al., 2014). Examples of well-investigated common factors are therapeutic alliance, empathy, and therapy expectations (Cuijpers et al., 2019). Common factors can be contrasted with unique factors, that is, theory-based psychotherapeutic techniques of a specific school of psychotherapy that are unique to this school and that are *not* present in any other approach (e.g., homework assignment in CBT; Barth et al., 2014; Tschacher et al., 2014).

On a conceptual level, two categories of common factors need to be differentiated: shared techniques (Barth et al., 2014) and shared processes (Grencavage & Norcross, 1990). According to this definition, a technique or psychological intervention is an "*action* on the part of a psychotherapist to deal with the issues and problems of a client" (APA, 2023, dictionary, Intervention). As some techniques refer to broader processes or settings (e.g., role playing, hypnosis) others refer to more detailed descriptions of single therapeutic (verbal) actions such as using evocative language (Gumz et al., 2015). In contrast, processes are "responsible for the change" (Kazdin, 2007) and are induced by the treatment or the techniques (Murphy et al., 2009). One example would be gaining insight.

Although common factors have been proposed on both the technique- and process-level (Finsrud et al., 2022), defining them on the process level has been far more prominent (e.g., Grencavage & Norcross, 1990). However, based on empirical findings from studies that investigated the effectiveness of specific psychotherapies by including non-directive supportive treatment (NDST) as a control for common factors (Cuijpers et al., 2012) understanding common factors on both levels is plausible. NDST has been considered a full treatment itself (e.g., for depression) that only includes techniques common to all kinds of psychotherapy (Cuijpers et al., 2012; Markowitz, 2022), such as active listening, encouragement and support, promoting reflection, and helping the patient to express emotions (Cuijpers et al., 2012). Cuijpers et al. (2012) and Cuijpers et al. (2021) showed that NDST had substantial positive effects on patient outcomes (depression) and was superior to no-treatment control conditions. Thus, it seems plausible to understand common factors not only as common change processes (Tschacher et al., 2014) but also as common techniques, namely concrete actions of the psychotherapist.

Which Common Factors Need to be Integrated into a Common Factors Theory?

A common factors theory faces the challenge of integrating many common factors in a meaningful way (Elkins, 2022; Finsrud et al., 2022). From a pragmatic viewpoint, it seems important to include common factors for which there is empirical evidence (Bailey & Ogles, 2019), that have already been integrated into common factors models (Wampold & Budge, 2012), that have proven effective in NDST (a common factors treatment; Cuijpers et al., 2012) and/or that most researchers agree upon (Bailey & Ogles, 2019).

The most agreed-upon common factors are related to the therapeutic relationship which involves "the feelings and attitudes that the therapist and the client have toward one another" (Norcross & Lambert, 2018, p. 304). An effective therapeutic relationship is closely related to the therapist and their interpersonal skills and behaviors such as genuineness, empathy, positive regard, warmth, and respect (Elliott et al., 2018; Norcross & Lambert, 2018). The therapeutic alliance is traditionally defined as the most important therapeutic relationship variable (Cuijpers et al., 2019; Laska et al., 2014), focusing not only on the emotional bond between therapist and patient but also on the working bond that includes consensus about therapeutic goals and tasks (Flückiger et al., 2018; Tschacher et al., 2014). It is thought to have a positive impact on patient engagement and active participation (Wampold & Budge, 2012) which in turn are seen as common factors (Lambert & Ogles, 2004; Tschacher et al., 2014). Furthermore, actions of the therapist to establish and maintain a good therapeutic alliance are considered common factors like structuring and adapting the therapeutic process, based on client feedback (Horvath et al., 2011; Lambert & Ogles, 2004).

Patients' positive expectations are another agreed-upon common factor (Cuijpers et al., 2019; Finsrud et al., 2022) and can either be triggered by a rational/explanation for the patient's disorder or the healing setting (Frank, 1963; Frank & Frank, 1991). Positive expectations do not only include a patient's expectations with respect to therapy outcomes and receiving help but also expectations in terms of own personal effectiveness, (cognitive) mastery and self-efficacy (Frank, 1971; Tschacher et al., 2014).

In addition, common factors that are related to patient learning have been identified (Frank & Frank, 1991; Lambert & Ogles, 2004). In psychotherapy, the patient either learns new behaviors, to regulate emotions, restructure cognitions (corrective experiences) or becomes aware of their disorder and gains new insights (Lambert & Ogles, 2004; Tschacher et al., 2014). This can, for example, be achieved through exposure (Stricker, 2010) in which the client confronts the feared situation, object, or thought in person or in imagination (Bailey & Ogles, 2019). Some type of exposure, whether emotional, cognitive or behavioral, seems to be inherent in any type of psychotherapy (Bailey & Ogles, 2019; Brown, 2015).

Important Existing Common Factors Models

The two most prominent common factors models are Frank's framework (Frank, 1963; Frank & Frank, 1991) and the contextual model (Wampold & Budge, 2012; Wampold & Imel, 2015). Frank's model and the contextual model both include many of the common factors described above, that is, a particular type of relationship, an explanation that triggers positive expectations and a procedure that requires active participation and leads to insight/learning (Frank, 1971) and healthy actions (Wampold & Budge, 2012). Frank and Frank (1991) suggest that these common factors make therapy effective because they address demoralization, a common psychopathology of all patients that seek out psychotherapy. Wampold and Budge (2012) similarly argue that the benefits of the real relationship are at the level of patients' general well-being rather than at the level of specific symptoms (p. 611).

Wampold and Budge (2012) agree with Frank and Frank (1991) about emphasizing the therapeutic relationship and a theory-derived rationale and treatment (that induce positive expectations) as common central features of psychotherapy. Both Wampold and Budge (2012) and Frank and Frank (1991) agree on the necessity of prescribed treatment (activity) because of its functional role throughout the therapeutic process (e.g., inducing any kind of learning or healthy action) and not so much because of its specific content. In contrast to Frank and Frank (1991), Wampold and Budge (2012) more strongly emphasize "being connected to another human being" (p. 608) and incorporate an evolutionary human need perspective, implying that psychotherapy is effective because "humans have evolved to respond to psychotherapy" (p. 603).

Limitations of the Presented Common Factors Approaches

A limitation of existing common factors models concerns the question of whether common factors can address specific symptoms or whether they must be motivated through their effect on a shared state like the patients' demoralization. According to Frank and Frank (1991), common factors make therapy effective because they address demoralization. This implies that common factors cannot (exclusively) address specific symptoms. This limits the scope of a common factors theory considering that "a small proportion of patients seek treatment for specific symptoms without being

otherwise demoralized" (Frank & Frank, 1991, p. 36). In our opinion, there is no reason why a common factor like exposure (Bailey & Ogles, 2019) should not be able to exclusively address specific symptoms in patients that are not demoralized. For example, patients with specific phobic disorders, do not seem to be demoralized, that is, to be in a situation of acute crisis (Grassi et al., 2020); yet they respond well to a common technique like exposure (Klein et al., 1983). Therefore, a common factor theory should include a theory of common *and* specific psychopathology.

Another limitation concerns the assumption that a specific treatment with a rationale for the patient's psychological disorder is necessary. According to Frank (1963), a theory-prescribed treatment seems necessary to remoralize the patient, but not so much because it is effective in its theoretically assumed way but because it functions to create positive expectations in the patient by providing an explanation for the disorder. Wampold and Budge (2012) take a more radical formulation and claim that a treatment or therapeutic task, including an explanation, derived from a *specific theory* is "absolutely necessary" (p. 614). However, this assumption seems disputable as NDST, that only includes active listening, encouragement, support, and reflection, is effective (Cuijpers et al., 2012). Common factors like "active listening" can be understood as common *techniques* used by the therapist that may be sufficient to evoke common change processes like positive expectations without providing a clear rationale for the patient's disorder.

Another related limitation concerns the ambiguity regarding the conceptual level on which the existing models define common factors. Frank often uses the term common "features" to describe the factors that all kinds of psychotherapy share without clearly naming them either "techniques" or "change processes" (Frank, 1971; Frank & Frank, 1991). In Wampold's writing, the conceptual nature of the described constructs sometimes seems ambiguous, too. For example, the "creation of expectations through explanation and some form of treatment" is described as one of three pathways within the contextual model without conceptually distinguishing between therapist's actions (i.e., the explanation) and the change processes (i.e., the expectations) that these actions evoke.

Another limitation concerns the contextual model. Wampold and Budge (2012) point to the importance of basic, evolved human needs such as the need for social connectedness in understanding the causes of psychopathology and the effectiveness of psychotherapy. However, this needs perspective only seems to be clearly specified for the real relationship pathway but not for the expectation and healthy action pathway. With respect to therapy expectations, Wampold and Budge (2012) only state that "there is some speculation that response to placebos by way of expectancy is an evolved characteristic" (p. 616) without clearly taking a human needs perspective.

Extending Previous Common Factors Models by Means of SDT

Our SDT-based approach to common factors integration builds on some of the core ideas of the described common factor models. It embraces Wampold and Budge's (2012) evolved human needs perspective and elaborates it using SDT (Deci & Ryan, 2000). Furthermore, our approach considers the numerous common factors proposed in the literature and offers a unifying theoretical basis for them. In contrast to previous common factor models, we seek to develop a common factors theory that is a theory not only of common psychopathology or demoralization but also a theory of *specific* psychopathology. Moreover, we will argue and show how general and specific psychopathology can be addressed through common techniques and techniques unique to a particular therapeutic approach via common change processes. Accordingly, the SDT-based approach presented here makes a fruitful distinction between common techniques and common change processes.

SDT as a Common Factors Theory

Understanding Important Concepts of SDT

To understand how SDT can be used as a theory to integrate common factors, it is important to be familiar with the basic concepts of SDT, for which there is strong meta-analytical evidence (Ryan et al., 2022).

The Organismic Dialectic and Basic Psychological Needs

SDT postulates that humans have evolved to be growth-oriented organisms (Deci & Ryan, 2000). They are naturally inclined toward integration of their experiences and extrinsic regulations into a unified sense of self, the engagement of interesting activities (intrinsic motivation) and the integration of themselves into social structures (integrative tendencies; Deci & Ryan, 2000). SDT further proposes that these tendencies for integration require ongoing nutriments and supports of basic psychological human needs (Deci & Ryan, 2000). If these nutriments are supplied by the (social) environment or constructed by the individual from inner resources and the basic needs are satisfied, humans will function effectively and experience well-being and vitality (Deci & Ryan, 2000). Therefore, basic need satisfaction can also be the aim of integrative tendencies (Ryan & Deci, 2017) but does not have to be (Deci & Ryan, 2000). The

basic needs are the need for *autonomy*, *competence*, and *relatedness* (Deci & Ryan, 2000).

Autonomy plays the most important role for adaptive functioning in SDT (Ryan & Deci, 2017). At a phenomenological level, the need for autonomy refers to the necessity of experiencing a sense of volition and integrity (Deci & Ryan, 2000, p. 253; Ryan et al., 2016; p. 386). Autonomy at a structural level is the tendency of humans toward self-regulation of action and coherence (Deci & Ryan, 2000, p. 253; Ryan et al., 2016; p. 386). When autonomous, an individual's actions are self-organized regarding their inner and outer circumstances instead of being prompted by nonintegrated inner processes or environmental pressures (Deci & Ryan, 2000, p. 254). Autonomous actions are informed by an individuals' permanent values and are congruent with their sense of self (Ryan et al., 2016). According to SDT, the attentional state of *awareness* facilitates this autonomous self-regulation of actions and is foundational to autonomy (Deci et al., 2015; Ryan et al., 2021). In a state of awareness, people are more receptive to internal and external experiences, which helps them to focus on self-endorsed values (Elphinstone et al., 2021). This makes them better able to select behaviors that are aligned with their values and to align their responses "to the pressures the world" with their personal values (integration; Elphinstone et al., 2021; Ryan et al., 2021). This fosters more autonomous motivation (Elphinstone et al., 2021).

Competence is the need to experience mastery or self-efficacy and to make a meaningful impact on one's environment (Deci & Ryan, 2000). It is the tendency to seek optimal challenges and to develop skills (Deci & Ryan, 2000). The need for relatedness refers to the experience of warmth, reciprocal care, and belongingness (Ryan et al., 2016). It is the need to feel connected with others (Ryan & Deci, 2000) and to experience "a sense of being integral to social organizations" (Ryan & Deci, 2017; p.11).

Basic Needs and Goal-Directed Intentional Behavior (Motivation)

The existence of the three basic needs can explain why some kinds of goal pursuit are associated with greater well-being than others. Goal pursuit is associated with greater well-being if the content of the goals consists of intrinsic aspirations (e.g., personal growth and not extrinsic aspirations like attaining fame) and if the process by which goals are pursued is autonomous/self-determined and not controlled (Deci & Ryan, 2000). This is because basic needs are more likely to be satisfied when pursuing goals in this way (Deci & Ryan, 2000, pp. 247–248). The most extreme kind of controlled behavior is external regulation as one type of extrinsic motivation (regulatory style). In external regulation, a person's behavior is controlled by external contingencies such as tangible rewards (Deci & Ryan, 2000). In contrast, the prototype of autonomous activity is intrinsically motivated behavior (Deci & Ryan, 2000). Intrinsically motivated behaviors are activities that individuals engage in naturally "when they feel free to follow their inner interests" (Deci & Ryan, 2000, p. 234). Besides controlled and autonomous behaviors that involve regulatory processes, there are also states in which people lack any intention to act. In such states of amotivation, people are not able to regulate themselves. This may occur when they lack a sense of efficacy or control with respect to a desired outcome (Deci & Ryan, 2000, p.237).

The Internalization of Extrinsic Regulations

SDT argues that individuals seek to transform external regulations (like socially sanctioned requests) into personally endorsed values so that they can be autonomous by enacting them (Deci & Ryan, 2000). This internalization process is aimed at building a coherent sense of self and becoming more intrapsychically and socially integrated. When this process functions well, the individual will identify with the importance of social regulations and accept them as their own, which is called *integration* (fullest form of internalization; Deci & Ryan, 2000). However, when the internalization process is impeded, external regulations may remain external or only be partially internalized (Deci & Ryan, 2000). In this latter case, introjects or unintegrated identifications are formed which are not fully self-determined (Deci & Ryan, 2000). By introjects, Ryan and Deci (2008) mean "partial internalizations" that manifest as intrapersonal pressures and rewards and result in individuals experiencing no real choice. Hence, in introjected motivation the individual's behavior is controlled by contingent consequences that are administered by the individual to themselves and not by others. In identification, the individual has come to accept the value of a behavior and more fully accepts it as their own. Although the behavior is more autonomous, it is still extrinsically motivated (somewhat controlled) as it is still instrumental and not simply conducted out of mere enjoyment (Deci & Ryan, 2000).

Lack of Life Satisfaction, Ill-Being and Their Causes

According to SDT, a persistent lack of basic need satisfaction or even a thwarting of basic needs (i.e. the active frustration of basic needs, such as rejection) in the person's immediate situation or developmental history leads to a lack of integration and growth and thus to a diminished experience of mental health and to ill-being (Deci & Ryan, 2000; Ryan et al., 2016). People who are thwarted of their basic

needs can withdraw from others, behave antisocially, compartmentalize rather than integrate psychological structures and display controlled motivation or even amotivation (Deci & Ryan, 2000, p. 237). They may develop need substitutes or compensatory motives (e.g., strong focus on extrinsic values like money; Deci & Ryan, 2000; Ryan & Deci, 2017). Social environments that impede satisfaction of the need for autonomy promote controlled motivation whereas environments that also undermine satisfaction of the needs for competence and relatedness promote amotivation (Deci & Ryan, 2000, p. 251). A state of need deprivation or lack of well-being can exacerbate the thwarting of needs and thus increase the experience of ill-being (Deci & Ryan, 2000). A lack of basic need satisfaction or need thwarting in everyday context has not only external (e.g., social environment like family) but also internal reasons like inter-individual differences in regulatory styles and biological vulnerabilities (Deci & Ryan, 2000, p. 232).

Specific Psychopathology and Their Etiology

Developmental need thwarting (in interaction with genetic and biological factors) can lead to autonomy disturbances, that is, the disruption of integrated self-regulation (Ryan et al., 2016; Ryan & Deci, 2017). Ryan et al. (2016) argue that autonomy disturbances are central to different kinds of psychopathology. Autonomy can be disrupted in different ways, and the impairments in competence and relatedness experience can vary (Ryan & Deci, 2017).

In *internally controlling pathologies* (e.g., depression, eating disorders, obsessive pathologies), the individual's motivation to act is highly controlled (Ryan et al., 2016). These pathologies are characterized by regulation through introjects (Ryan et al., 2016). Social norms and values have been only partially internalized (they are not part of the integrated self) and exert ongoing pressure on the individual (Ryan & Deci, 2017). Parental thwarting of autonomy and relatedness are central factors in these disorders (Ryan et al., 2016).

Externalizing pathologies (e.g., antisocial personality, conduct disorders) are characterized by the relative absence of self-regulation, internalization, emotion regulation, and capacities for relatedness (Ryan et al., 2016; Ryan & Deci, 2017). In these pathologies, attachment to caregivers and the readiness to internalize their values/social norms has not taken place (Ryan et al., 2016).

Disorders associated with *fragmented self-functioning* (e.g., borderline personality, dissociative identity disorders) are characterized by serious disturbances of the self with little integrated functioning and capacities for internalization (Ryan et al., 2016). Individuals may lack internal regulatory processes to modulate emotions like anxiety or they show impulsivity (Ryan et al., 2016). They may further lack a stable identity and capacities for reflective awareness (Ryan et al., 2016). In these disorders, active intrusive thwarting of autonomy and relatedness needs throughout development plays an important role (Ryan et al., 2016).

Other severe mental illnesses characterized by fragmented self-functioning, such as schizophrenia (Hamm et al., 2017), may not be the result of developmental need thwarting, but are still associated with a lack of need satisfaction and autonomy dysfunction (Ryan & Deci, 2017; Thai et al., 2024). For example, Breitborde et al. (2012) showed that individuals with first-episode psychosis reported lower levels of need satisfaction than individuals without psychosis, and that the need for relatedness was most frequently associated with well-being in individuals with first-episode psychosis.

Understanding Common Processes of Change in Psychotherapy through SDT

We now show how the described SDT-concepts can be used to coherently organize and integrate the common factors (see Fig. 1). According to SDT, the described lack of well-being and the specific psychological disorders (also severe mental illness like schizophrenia) can be improved by basic psychological need satisfaction in psychotherapy and by increasing the patient's (self-regulatory) skill to satisfy these needs in their natural environments (Breitborde et al., 2012; Ryan et al., 2016). Therefore, at least according to our SDT-based reasoning here, different types of psychotherapy may be equally effective because they all provide the patient with experiences of autonomy, competence, and relatedness and increases their self-regulatory skills to achieve and maintain need-satisfaction and integration of experiences into a unified self. When patients become aware of their basic needs and these are satisfied in the immediate (therapeutic) situation and in the long term in their everyday contexts, they no longer have to direct their energy towards need substitutes (e.g. extrinsic life goals) and show controlled motivational orientations that they had developed in the past due to basic need thwarting (Ryan & Deci, 2008). Empirical research has shown that basic psychological need satisfaction (i.e. autonomy, competence, relatedness) is related to positive therapy outcomes (e.g., Quitasol et al., 2018; Zuroff et al., 2007).

We argue that the various common processes proposed in the common factors literature reflect all instances of basic need satisfaction and increased self-regulatory skills as defined by SDT and may therefore be effective. In particular, we refer to the following common factors: the patient gaining awareness and insight (McAleavey & Castonguay, 2014), the patient learning to (self)-regulate their emotions,

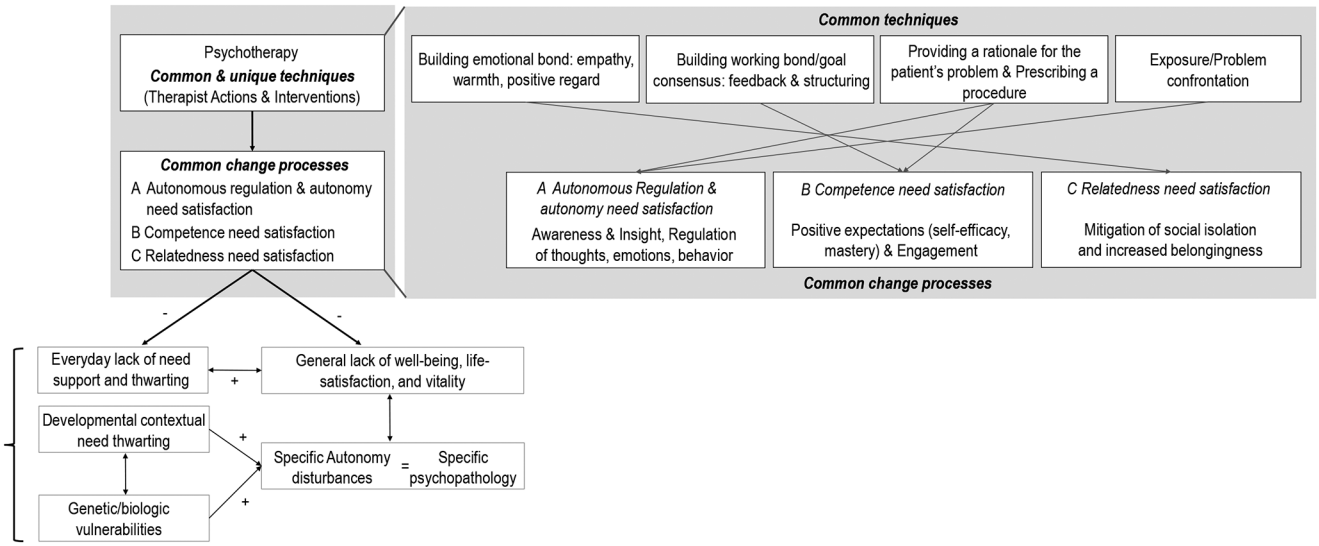

Fig. 1 Common Factors Model of Psychopathology, Change, and Treatment Based on Self-Determination Theory (SDT). Note. Only the SDT processes that are primarily or most strongly addressed by the common techniques are shown; the relationships between the common change processes are also not shown (e.g. increased autonomous regulation leads to higher satisfaction of competence and relationship needs)

behavior, and thoughts (Lambert & Ogles, 2004), the patient having positive and self-efficacy expectations (Frank & Frank, 1991), and the patient experiencing the mitigation of their social isolation (Frank & Frank, 1991; Wampold & Budge, 2012). From the SDT perspective, these common factors each reflect a process of increased *basic need satisfaction* and *self-regulation* leading to higher well-being.

(A) Awareness/Insight and Regulation of Thoughts, Emotions, and Behavior may Reflect Autonomous Regulation, Integration and Autonomy Need Satisfaction

According to SDT, the development of (autonomous) self-regulatory processes plays an important role for growth and well-being (Deci & Ryan, 2000). In autonomous self-regulation, an individual's actions are informed by the individuals' values and preferences and are congruent with their sense of self (Ryan et al., 2016). Through internalization/integration, external regulations (like social pressures) can be transformed into personally endorsed values so that they become autonomously regulated (Deci & Ryan, 2000). According to SDT, psychotherapy promotes the patient's autonomous self-regulation of their actions by helping them to understand their experiences and take responsibility for new behaviors (Ryan & Deci, 2008). For example, in emotion regulation, the patient learns to better control, express and validate their emotions (Brown, 2015; Tschacher et al., 2014). According to SDT, better (i.e. more autonomous) emotion regulation means emotional integration. In emotional internalization/integration, the patient has differentiated awareness of their emotional states and has "the capacity to use this sensitivity and awareness in the volitional regulation of action" (Ryan et al., 2016, p. 407). In other words, emotions, when "openly received" and accessed by the self, provide crucial information that guides the individual in setting goals and adjusting them toward the fulfillment of their basic psychological needs (Ryan et al., 2016, p. 407). Emotional integration is characterized by emotions neither controlling the individual (being overwhelmed by affect) nor the individual controlling (e.g., ignoring, suppressing) their emotions (Ryan et al., 2016). The same logic can be applied to thought regulation and controlling thoughts: when thoughts are "openly received" and accessed by the self in psychotherapy, they provide important information to set self-endorsed goals that align with basic need satisfaction, reflecting autonomous regulation. It becomes clear that SDT offers a thorough explanation why the common factors of better emotion, thought, and behavior regulation are important common change processes: they reflect increased autonomous regulation and autonomy need satisfaction.

From the above reasoning it also becomes clear that the common factor insight/awareness supports the described autonomous self-regulation of emotions, thoughts and behavior. In a state of awareness people have better access to internal and external (social) environments, their emotions, introjects, and suppressed experiences which facilitates integration of the latter so that they become more aligned with endorsed values and motivation becomes more autonomous (Elphinstone et al., 2021; Ryan & Deci, 2008). The common factors literature has also described initial awareness, on which insight (the forming of new connections/a new understanding; Connolly Gibbons et al., 2007) relies,

as condition through which the individual "recognizes his external and internal environment" (Trevisi et al., 2012; p. 236; Martin, 1997). Furthermore, it has been stated that insight may be particularly helpful if it is followed by practice and regular implementation of the new behaviors that have been acquired through insight (McAleavey & Castonguay, 2014). This is in line with the SDT idea that awareness can support more autonomous self-regulation as a "new" way of regulating that leads to higher well-being (Deci et al., 2015). Thus, SDT offers a thorough explanation why insights/awareness are important common change processes: they facilitate autonomous self-regulation and reflect autonomy need satisfaction.

(B) Increased Positive Expectations, Hope, and Self-efficacy may Reflect Competence Need Satisfaction

The induction of positive expectations in the patient as a common process in psychotherapy has been a major focus of other common factor models (e.g., Wampold & Budge, 2012; Frank & Frank, 1991). For example, Frank and Frank (1991) focused on patient's (positive) expectation of help and hope for improvement that are inspired in any kind of psychotherapy (through the healing setting, a rationale, a treatment). They also focused on a sense of self-efficacy, mastery and capability that psychotherapy promotes (Frank & Frank, 1991). Hope and general self-efficacy are very similar constructs: they both emphasize "expectancies of achieving good outcomes in life, and a general attitude that desired outcomes (i.e., goals) are likely to be achieved" (Zhou & Kam, 2016, p. 544). The concepts of hope and self-efficacy, that can be subsumed under positive expectations (Zhou & Kam, 2016), closely align with the conceptualization of competence experiences in SDT. According to SDT, competence is the need to experience mastery and effectiveness (self-efficacy) and in this way to make a meaningful impact on one's environment (Deci & Ryan, 2000). Therefore, perceived competence is what has been labeled self-efficacy in Bandura's social learning theory (Deci & Ryan, 2000). However, it is important to mention that Deci and Ryan (2000) have defined competence as an evolved basic human need and argued that the experience of competence itself contributes to well-being and does not only contribute to well-being through the outcomes it might yield. Overall, SDT can well explain why increasing competence/self-efficacy experiences is directly associated with well-being.

(C) Mitigation of Social Isolation or Increased Belongingness may Reflect Relatedness Need Satisfaction

Wampold and Budge (2012) argued that belongingness is a basic evolved human need and that a common process in therapy is the elicitation of feelings of belongingness in the patient through the therapeutic relationship. Satisfying a basic need for belongingness closely aligns with relatedness-need-satisfaction in SDT (Zuroff & Koestner, 2023). According to Ryan et al. (2016), the need for relatedness refers to the experience of warmth, reciprocal care, and belongingness. Deci and Ryan (2000) argue that this need must be satisfied for optimal human functioning and well-being. Frank and Frank (1991) have also highlighted that all kinds of psychotherapies are effective because they help the patient overcome their feelings of alienation from other people although they have not explicitly denoted that people have a basic psychological need for social belonging. Overall, SDT can well explain the relevance of the proposed common factor creating belongingness for therapy effectiveness by referring to the need for relatedness (Ryan & Deci, 2017; Zuroff & Koestner, 2023).

Common Change Processes and Different Types of Psychopathologies

We have argued that based on SDT, different processes of need thwarting in development lead to different kinds of autonomy disturbances (Ryan et al., 2016; Ryan & Deci, 2017) and that some mental illnesses are at least associated with a lack of need satisfaction and autonomy dysfunction (e.g., schizophrenia; Ryan & Deci, 2017). Therefore, given these differences in psychopathology, the described common change processes that reflect autonomous regulation and/or basic need satisfaction (e.g., self-efficacy/competence, mitigation of social isolation/relatedness) may be of different importance to different kinds of psychopathology. Relatedness need satisfaction may for example be more important to depression that is caused by loss of love or attachment (Ryan et al., 2016). Furthermore, depending on the specific way in which autonomy is disturbed, the pathway to internalization and integration (behavior, emotion regulation) must be differently shaped in psychotherapy. For example, in disorders that are characterized by introjects (e.g., obsessive-compulsive disorder), these internally controlling states (have-to, musts) should be reduced to achieve higher self-integration and autonomy (Ryan et al., 2016). In contrast, in some kinds of externalizing disorders (e.g., conduct disorders), a higher degree of the internalization of social norms and a higher capacity to generally regulate one's behavior seems crucial (Ryan et al., 2016). In severe mental illnesses such as schizophrenia, which are associated with self-fragmentation, initially addressing the need for relatedness in pre-therapy and in therapy (Breitborde et al., 2012; Prouty, 2001) can provide a basis for self-integration and reduction of dissociation (Prouty, 2001).

Common and Unique Techniques That Trigger Common Processes

We have described how common factors in psychotherapy that are understood to be common change processes can be integrated with the help of SDT. Now, we use SDT to describe how common and unique techniques may trigger these common change processes.

Linking Common Techniques to Common Change Processes Based on SDT

Common factors that align with the definition of techniques are building a therapeutic alliance through the expression of empathy and the provision of structure and collecting feedback, providing a rationale for the patient's problem, and exposure/problem confrontation. We argue that these common techniques increase patient well-being by triggering the common change processes described above, which all represent processes of basic need satisfaction and/or autonomous regulation according to SDT.

First, we will analyze the common factor of building a *therapeutic alliance* and the concrete therapist actions that are associated with it. Therapist actions that are associated with creating an emotional bond are the therapist's expression of empathy, warmth, positive regard, and genuine interest and support (Elliott et al., 2018; Norcross & Lambert, 2018). According to SDT, by showing empathy and giving genuine support, the therapist increases the patient's sense of relatedness (Ryan et al., 2016). Therefore, these therapist actions seem to address the common change processes mitigation of social isolation and increasing belongingness that reflect basic relatedness need satisfaction according to SDT. Zuroff and Koestner (2023) also suggested that the emotional bond component of the therapeutic alliance is a common factor associated with the satisfaction of relationship needs.

In contrast to the emotional bond, the working bond (e.g., reaching goal consensus) is associated with therapist actions such as collecting and providing feedback and structuring (Cuijpers et al., 2019; Norcross & Lambert, 2018). Ryan and Deci (2008) link feedback and structure to the satisfaction of the patient's need for competence. They argue that the provision of feedback and structuring therapeutic activities bring direction to the therapeutic work and thereby enhance the patient's sense of competence. Frank (1971) has also emphasized that providing a structure and objective measures of progress (feedback) leads to success and mastery experiences in the patient. Based on SDT, direct and indirect effects on patient outcomes are plausible. Satisfying the need for competence through the therapeutic alliance (i.e., structure, feedback) leads to higher patient engagement with the therapy (Ryan & Deci, 2008). Moreover, it directly increases well-being, as the satisfaction of the need for competence in and of itself is a contributor to well-being (Deci & Ryan, 2000).

Providing a rationale and prescribing a procedure presents another important common technique. According to Frank and Frank (1991), the provision of a rationale that provides a plausible explanation for the patient's symptoms gives the patient the feeling that they understand their problem (Frank & Frank, 1991). Consequently, they gain control over their problems and their symptoms as understanding them increases the potential of changing them as well (Frank, 1963). The patient's active participation according to this rationale leads to success and mastery experiences (Frank & Frank, 1991). Wampold and Budge (2012) also argue that the explanation evokes the positive expectation in the patient that the therapy will help them in solving their problem. According to SDT, the rationale and the prescribed procedure would address both, competence (efficacy) and autonomy needs satisfaction (Zuroff & Koestner, 2023) and in this way free the patient from a state of amotivation that is characterized by either a lack of sense of efficacy or a lack of sense of control (Deci & Ryan, 2000). The patient becomes willing and able to self-regulate their behavior again (Deci & Ryan, 2000). Providing a meaningful rationale and prescribing a procedure is hence competence but also autonomy-supportive (Ryan et al., 2016).

Exposure/Problem confrontation is another important common technique (Bailey & Ogles, 2019). It refers to "the client confronting in person or in imagination the feared situation, person, object, or thought" (Bailey & Ogles, 2019, p.9) in safe circumstances (Foa, 2006). The client comes to recognize that their fears are not realistic (Foa, 2006). In the context of SDT, exposure can be understood to trigger common change processes like awareness and insight more generally and emotion regulation more specifically which represent ways of autonomy need-satisfaction and/or integration (Roth et al., 2019). Healthy emotion regulation contains the access to emotions (awareness), exploring them, and accepting both positive and negative emotions through self-reflection (Ryan et al., 2016). This helps the individual to make informed choices in terms of volitionally expressing or withholding emotions (integration/self-regulation; Roth et al., 2019). In exposure, controlled emotion regulation like avoidance should be given up (emotions are fully brought to awareness) and replaced by integrated emotion regulation that includes flexible and volitional expression of emotions (Rauch et al., 2012; Roth et al., 2019). Therefore, exposure is primarily an autonomy-supportive strategy if specific features of supporting the patient's volitional emotional engagement are included (Roth et al., 2019).

Linking Unique Techniques to Common Change Processes based on SDT

Besides the common techniques, there are techniques that are rather unique to a given therapeutic approach (Barth et al., 2014). We give two examples of such techniques and how they may trigger common change processes from the perspective of SDT.

A technique rather unique to CBT is *homework assignment* (McAleavey & Castonguay, 2015). Based on CBT, homework gives the patient the opportunity to practice the skills learned in therapy, generalize them to the real world, build behavioral and mental patterns that are sustainable and provides new opportunities for mastery (Blagys & Hilsenroth, 2002; McAleavey & Castonguay, 2015). Repeated practice and learning in different contexts to promote knowledge transfer play an important role in cognitive theory (Boswell, 2013). In psychodynamic treatment, *transference interpretation* is a rather unique technique (Barth et al., 2014; McAleavey & Castonguay, 2015). It aims to establish connections between past or present objects, internal conflicts, and the relationship to the therapist (Johansson et al., 2010). Psychoanalytic theory assumes that interpretation of transference increases the patient's insight that leads to better interpersonal functioning (Johansson et al., 2010).

Proponents of the common factors hypothesis would argue that these unique techniques work primarily (but not exclusively) through common pathways to achieve their positive outcomes. Thus, homework assignment would not conclusively work through knowledge generalization and sustainable learning and transference interpretation would not conclusively work through increasing interpersonal functioning. Using SDT as a theoretical foundation, those unique techniques may achieve their positive outcomes through the same common change processes that reflect basic need satisfaction and autonomous regulation that we have described. Homework assignment, for example, could increase well-being because the generalization and application of skills acquired in psychotherapy to real world situations leads to the experience of competence. In other words, the patient experiences that they have a meaningful impact on their environment. Thus, homework assignment promotes common processes like positive expectations and self-efficacy that reflect competence need-satisfaction. The patient experiences that they are competent to master their problem in the real world and thereby develop hope and positive expectations. In contrast to CBT, SDT places the emphasis on competence as psychological need that is central for human well-being. From an SDT-perspective, transference interpretations can enhance well-being because, for example, the awareness and insight they evoke enable the experience of autonomy. Being more in touch with one's inner states and understanding them makes it possible to achieve higher self-regulation in action and emotion. This may positively influence the patient's interpersonal functioning and their ability to satisfy their basic psychological needs in their everyday lives.

Discussion

By relying on SDT, we have shown an alternative way in which quite diverse common factors can be theoretically integrated and explained. We have tried to overcome limitations of previous common factor models like a lack of systematically explaining specific psychopathology within a common factors framework (Frank & Frank, 1991) and an unclear distinction between common techniques and common change processes (e.g., Frank, 1963). We have shown how different common techniques can be systematically linked to different common change processes, and we have given examples of how unique techniques can also be linked to certain common processes. Below we discuss the implications of our work.

Implications

Implications of our SDT-based approach for *researchers* are that hypotheses can be derived about how individual common factors should be associated with each other and with specific psychopathology beyond demoralization. Thus, our approach adds the research perspective to fruitfully link common factors among each other, e.g. structure and feedback (building the working bond; common techniques) with sense of mastery/expectations (common process of competence need satisfaction; Ryan & Deci, 2008) and with specific psychopathology (e.g., psychopathology in which competence need thwarting plays an important role). Our approach also addresses the current debate in psychotherapy research on possible ways to psychotherapy integration (Hofmann et al., 2022). The common factors traditionally represent an approach to psychotherapy integration. By expanding the scope of common factors to specific psychopathology in a more systematic way and linking quite different common factors theoretically, our SDT-based approach can further support common factors as a valuable approach for therapy integration.

Implications of our SDT-based approach for *practitioners* are that therapists can better select common techniques or focus on specific common change processes depending on whether they want to work more on autonomy/self-regulation, competence or relatedness need satisfaction in a particular therapeutic session. Such a finer selection of common factors seems difficult when the theory only

provides the information that all common factors primarily reduce demoralization and lead to positive expectations (see previous common factor models; Frank & Frank, 1991; Wampold & Budge, 2012). Furthermore, our approach has concrete implications for therapist training. A broader scope, namely more systematically linking common factors to specific psychopathology, and stronger theoretical foundation of the common factors may increase the common factors' status, their perceived importance and justify a common-factors curriculum (Anderson & Perlman, 2020; Bailey & Ogles, 2019). Common factors can be better communicated, learned and internalized if they are structured around a coherent, substantive and differentiated theory (Bailey & Ogles, 2019). A more systematic and clear separation between common techniques and common processes gives therapists in training more guidance about what are common techniques they can learn and practice (e.g., structuring and giving feedback) and what are change processes (e.g., experience of mastery/satisfaction of competence needs) that can be elicited by these or other more unique techniques (e.g., homework).

Conclusions

The aim of this paper was to provide an idea of how SDT, an internationally recognized and evidence-based theory, can be used as a differentiated common factors theory to overcome the existing limitations in the common factors literature. Of course, this idea needs to be further refined in future work so that its potential for practice (e.g., more systematic application and teaching of common factors) can be realized. We hope that our approach will inspire other researchers to utilize the potential of global existing theories and theories from related research areas to advance their own field of research as well.

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Declarations

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