A Constructionist Extension of the Contextual Model: Ritual, Charisma, and Client Fit

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Abstract: The contextual model school and the medical model adherents have been engaged in a spirited debate about how psychotherapy actually works. While the medical model continues to dominate the field, the contextual model theorists have presented an analysis of the literature that refutes many of the assumptions underlying the medical model. More specifically their findings of no effects from training and experience and their ability to sustain the Dodo bird hypothesis argues against specific factors in psychotherapy, suggests interventions are rituals not techniques, and disputes the value of psychotherapy's privileged knowledge on client outcomes. As a result, they have advanced new models of psychotherapy—the contextual model, feedback informed therapy (FIT), and deliberate practice--which align with the research results. Unfortunately, they have failed to offer an explanatory hypothesis for their provocative results. This paper uses a cross-profession analysis and a Berger-Luckmann perspective on mental health models to argue the constructionism is the best explanatory model for their results. Hypothesizing that psychotherapy primarily operates in constructed reality permits and mandates extensions of both the contextual theory and deliberate practice; more specifically, pragmatic recommendations are offered in the area of ease of change, creating and carrying out therapeutic rituals, and deliberate practice and FIT. The material in this article is adapted from my recent book: *Practicing Psychotherapy in Constructed Reality: Ritual, Charisma and Enhanced Client Outcomes*.

Key Words: Psychotherapy, Theories of Psychotherapy, Therapeutic Rituals, Therapist Training, Constructionism, Deliberate Practice, FIT.

There is a new movement afoot in the psychotherapy universe, a movement which questions the fundamental assumptions that underlie all the schools of psychotherapy. Perhaps best embodied by two seminal works, *The Heart And Soul Of Change*: *Delivering What Works In Therapy* (Duncan, Miller, Wampold & Hubble, 2010) and *The Great Psychotherapy Debate* (Wampold & Imel, 2015), this movement is best defined as a debate between the contextual model group and the medical model adherents. Put more directly, the medical model group argues that the best way forward is to seek evidence-based treatments which will provide the most effective intervention for each specific diagnosis; this is a technique-centered strategy. In contrast, the contextual model group believes in the primacy of the relationship and the development of the

therapist; moreover, many of its thought leaders specifically argue that techniques have no inherent power.

In a pragmatic sense, this debate is far from over; the medical model has a firm grip on the worldview of most psychotherapists and it will take a great deal of evidence and work to alter its influence. However, the contextual model group has highlighted a number of issues that—at least from a logical point of view—appear to refute the basic assumptions of the medical model. Contextual model theorists have responded to this "victory" in a variety of ways including presenting a new model for how psychotherapy works (Wampold, 2017), focusing attention on developing the therapist instead of developing techniques (Miller, Hubble & Chow, 2017), and seeing all interventions as rituals (Anderson, Lunnen & Ogles, 2010). The purpose of this paper is twofold: 1) demonstrate how the provocative findings of the contextual research analysis are best explained by constructionism and 2) speculate on how the new contextual model recommendations for training and practice can be modified and extended from a constructionist perspective.

In order to address these issues, a brief summary of the contextual model research is required. This article does not intend to rehash the full debate between the medical model and the contextual model approaches. However, because many psychotherapists are not familiar with the debate, and it is vital to understand its essence if we are going to extend the contextual model, we are going to begin by summarizing the major points. What follows is not intended to be a miniature literature review; readers interested in that are referred to the two titles above. Rather the salient points of the debate are briefly presented—and illustrated with representative quotes from leading review articles—so that readers can grasp the flavor of the debate.

Let's begin in the area of training effects, especially because the lack of training effects is one of the major findings that supports the contextual model side of the debate. Training effects are common and robust in most professions and, of course, we hope to find the same in psychotherapy. Unfortunately, however, this is not the case. Hill and Knox (2013), in a review article on training, find a variety of outcomes; some showed small effects for the benefits of training, a couple showed a negative effect from training, and most showed no significant effects. This pattern of results is found when researching a factor that has small, negligible, or no effects; this is a far cry from the training effects seen in most professions. Here is their summary statement about the effects of training.

> The results of these studies certainly do not provide direct evidence for the effectiveness of training; in fact, they call into question the very necessity of this training. … No differences were found, however, between trained experienced therapists and friendly college professors or lay helpers, nor between clinical psychology graduate students and graduate students in nonhelping professions who were equally matched in terms of facilitative levels. (p. 799)

In a separate review article focusing on psychology graduate students and the effects of their training on outcomes, Malouff (2012) noted that, "There appears to be no evidence to suggest that coursework and research completion, which make up a great deal of required psychology training, have any value to future psychotherapy clients of the students (p. 31)." And his evaluation of training programs as a whole concluded, "Overall, research findings provide little support for the idea that typical professional training of psychologists leads to better outcomes for their psychotherapy clients (p. 29)."

This lack of training effects is one of the provocative and peculiar findings in the outcome literature analysis. It is certainly does not arise from a dearth of effort; we have literally thousands of books and articles designed to contribute to our professional knowledge and we have a myriad of trained, motivated, and competent professionals and academics who work unceasingly in the area. The sum of their efforts is what might be termed psychotherapy's privileged knowledge—the knowledge that characterizes the profession, the knowledge that must be mastered to succeed at the profession. If all this effort has failed to establish potent privileged knowledge, there must be something different about the field of psychotherapy—something that precludes establishing the robust knowledge base belonging to fields such as chemistry or engineering.

The second major area with provocative negative findings is the question of whether experience enhances effectiveness in psychotherapy. This is also an area where we should find robust effect sizes; experienced surgeons get better outcomes than beginners, tennis players with years of experience beat players with weeks of experience; in virtually every field the experienced best the inexperienced. However, in psychotherapy, this experience factor is notably absent.

It is rather easy to test this assumption; psychology has performed hundreds upon hundreds of treatment outcome studies which have also included measurements of therapist experience. The data, whether bundled together in large meta-analyses or taken individually, have consistently failed to find a relationship between experience and outcome. For example, Lambert & Ogles state (2004):

> …overall, the meta-analytic reviews of psychotherapy that have provided correlational data find little evidence for a relationship between experience and outcome (p. 169).

And in a 2013 review article Hill and Knox summarize the same material by citing two seminal studies.

> Two recent analyses of very large numbers of therapists perhaps provide the most definitive evidence about therapist experience. Wampold and Brown (2005) found no effects for therapist experience level (years of practice) when they analyzed the outcomes of 6,146 clients seen by 581 therapists in a managed care setting (all

> therapists were postdegree). Similarly, Okiishi et al. (2006) found no effects of therapist experience level (pre-internship, internship, post internship) on the speed of client improvement in their study of more than 5,000 clients seen by 71 therapists at a university counseling center" (p. 797).

This finding again verges on the remarkable. "Practice makes perfect" is, of course, a cliché but a cliché that is based in reality. This finding again suggests that psychotherapy differs markedly from other professions that have a typical relationship to experience. It also suggests that psychotherapists must be doing something during practice that blocks their ability to learn from experience.

The third and final research finding is the so-called "Dodo bird" effect, the finding that different schools of therapy achieve equivalent positive results.

> The conclusion of most, but not all, of these reviews is similar to that drawn by Luborsky, Singer, and Luborsky (1975) who suggested a verdict similar to that of the Dodo bird in Alice in Wonderland: "Everyone has won and all must have prizes."…. However, meta-analytic methods have now been extensively applied to large groups of comparative studies, and these reviews generally offer similar conclusions, that is, little or no difference between therapies (Lambert & Ogles, 2004, p. 161).

This finding is robust and frequently replicated. It has stood up against a variety of critiques. However, of the three arguments marshalled by the contextual model group, the Dodo bird effect is the most debatable. This is due, of course, to the fact that there are literally hundreds of studies that have found one technique superior to another, at least in certain circumstances. In response, the Dodo bird defenders cite metanalyses and research design flaws to account for the seeming superiority.

The Dodo bird debate is essentially a discussion about whether there are any specific factors in psychotherapy. As we are all aware, the effects of psychotherapy are divided between common factors—most often portrayed as a relationship with a wise and caring therapist—and the specific factors—the innately powerful techniques and ideas developed by each different psychotherapy system. When the Dodo bird conclusion is accepted—and each school is seen as achieving equivalent, positive results--it implicitly destroys the argument for specific factors. This is due to the obviously irrational idea that every school has "coincidentally" developed specific factors that account for an equivalent amount of the variance in outcome. In other words, given that each school has very different theories and very different interventions, can we possibly believe that they would generate the exact same size positive effects? Clearly, that's highly unlikely. That, in turn, leads us to conclude that therapy is nothing but common factors; the differing interventions, therefore, are simply therapeutic rituals. The rituals must be

convincing and believable but, in truth, their form and structure are unimportant–mere empty vehicles powered by expectations.

Accepting such a stance—that psychotherapeutic interventions are placebos/rituals—makes psychotherapy "unscientific," feels counter-intuitive, and reduces the status of the profession. It's easy to see how the debate over the validity of the Dodo bird finding rages on; the entire reputation of our profession is at stake. It seems unlikely that the debate will be settled by simply looking at the outcome research. As long as one side can say "meta-analyses and poor research design" and the other can say "but many studies show superiority" we will fail to reach a consensual decision.

Fortunately, there are three other arguments that support the Dodo bird theory; collectively they have the capacity to resolve this debate. The first argument is the "absence of failure" finding. It appears that virtually every system of therapy—and there are over 400 of them (Arkowitz & Lilienfeld, 2012)—generates positive, measurable results. This bias to the positive is well illustrated by the problems discovered when researchers attempted to create a placebo psychotherapy—an approach that appears to be therapeutic but which fails to generate client improvements (Wampold, 2010). Unfortunately, actual ineffective approaches were quickly recognized by the research subjects as placebo/false therapy. When these placebos were made more credible, they generated the same positive results as the "active" intervention. The following quote from Wampold (2010) summarizes this sense that everything credible works.

> Clinical trials comparing two treatments should be discontinued. Much money has been spent on clinical trials, with the same result: "Both treatments were more effective than no treatment, but there were no differences in outcomes between the two treatments." (Wampold, 2010, Kindle Locations 2089-2092).

The second argument supporting the Dodo bird finding is the no training effect finding. If Dodo bird is false, and specific factors do contribute to psychotherapy outcomes, then techniques and knowledge of systems have inherent power. Put another way, knowing techniques—since they are inherently powerful—gives the knower an edge over the ignorant. However, since there are no training effects, neither knowledge of systems nor knowledge of specific techniques creates superiority. Hence, the Dodo bird finding is confirmed and the specific factors theory is unsupported. The third argument is the no experience finding. Experienced therapists know more systems and techniques than the inexperienced and have practiced them more assiduously. However, since there are no experience effects, we can conclude—again—that techniques and systems have no inherent power.

In sum, the Dodo bird finding was already credible simply by analyzing the outcome research. When we include the three arguments of everything works and no training and experience effects, it is clear that the Dodo bird finding is simply a better explanation than the specific factors theory. Something unusual is going on in psychotherapy. The simple explanation is that

our vaunted therapeutic procedures are actually rituals—rituals powered by client and therapist beliefs and expectancies. This is an old discussion in psychotherapy; one form it has taken is the conceptualization of psychotherapists as "placebologists" (Lambert & Ogles, 2004). Therapy works but not because of the inherent power of techniques. Instead, it appears that it works because of common factors: the therapeutic relationship/alliance and the associated power of rituals, beliefs and expectancies.

Let's ground this abstract argument by offering concrete examples. Imagine that two different cultures believe that spirit possession is the primary explanation for mental health problems. In the first culture, there are real spirits and the possession really does cause the mental health symptoms. Exorcists, after much experimentation, have developed a number of effective techniques that tend to drive the spirits out. Many other techniques have failed to remove the spirits. Study of the spirits has led to theories that predict additional techniques that might work. While most of these also fail, the ones that work tend to improve outcomes and there is a sense that the field is evolving. Trained exorcists best the untrained because they are using proven and inherently powerful techniques. In addition, more experienced exorcists best less experienced as they become more proficient with the techniques and master more of them.

While the second culture also believes in spirit possession, in this instance the spirits are not real; rather, they are shamanic constructs. In this world, the exorcists also use techniques to banish the "spirits;" significantly, all the different techniques work as long as the client believes in them. The exorcists become attached to the interventions they have developed and argue about whether their interventions—e.g., painting someone blue versus sprinkling them with holy water--are superior to the competing exorcists' interventions. In most cases the exorcism succeeds in that the client reports feeling the spirit leave her body and, as a result, the mental health symptoms remit. Both exorcist and client believe that the spirits are real and the interventions have inherent power. Partly because everything works and partly because the interventions seem logical by that culture's standards, the question of whether the spirits are constructs or real and whether their interventions are rituals or techniques never seems to arise.

We can use these imaginary cultures to understand the outcome research results. The first culture has big training effects because they have something to teach new exorcists. The first culture exorcists tend to get better with experience because they are paying attention to factors which directly affect outcomes and because they can contrast failure with success and learn from the difference. While having a good relationship with their clients helps facilitate the outcomes, the power of the techniques makes the real difference; hence, relationship is secondary.

Conversely, the second world exorcists would not show a training effect; when everything works, beginners match the well-trained. It is difficult to learn from experience in the second world because the exorcists are focusing on the wrong factors. They should focus on how persuasive they are and how well the rituals fit the clients; instead they are focusing on the

"techniques"–the constructed rituals. The exorcist/client relationship is much more important; when techniques lack inherent power, the relationship becomes definitive.

Returning to our abstract thinking, the research results imply that psychotherapeutic reality is much more similar to the second world than the first. The main difference between the two, of course, is the actual reality of the spirits. The secondary difference is the reality of the symptoms. While it's true that the symptoms in both worlds are equally painful—and in that sense they are equally real--in the second world they arise secondary to a misconstrual. Symptoms arising from misconstruals are more malleable and fluid than symptoms arising from "real" malevolent spirits.

The two worlds example illustrates the way that rituals—powered by expectancies and beliefs—are primarily effective on misconstruals and constructed symptoms. While we all understand the power of placebo, how many believe that a broken leg will heal well if we limit our intervention to a ritual when the leg also needs the techniques of being reset and casted? Problems in the material world are solved with techniques with inherent power; problems in a constructed world—problems that live in the dimension of beliefs, assumptions and expectancies—are amenable to ritual solutions.

Finally, there is the question of the contrast of exorcist knowledge between the two worlds. In the first world, the knowledge fits the reality; the exorcists think there are real spirits and they know what techniques work with them. Actions in the second world are built on misunderstandings and misconstruals. The interventions continue to work even if they achieve their results through mechanisms that the second world exorcists fail to understand. The final question arises: how much could the outcomes of the second world be improved if the exorcists understood the nature of their reality?

Constructionism

While the contextual model research analysis is logical and cohesive, it is very difficult to accept on a gut level. I feel that my training helped me; I certainly believe that I am a better therapist because of my years of experience; and I know that the many books, classes, and workshops I have taken that embody psychotherapy's privileged knowledge expanded and refined all of my capacities as a therapist. Asserting the opposite feels untrue. Especially given these incongruent feelings, I need to understand the "why" behind the research results.

We can begin that quest for understanding with a 1979 study performed by Strupp and Hadley comparing the effectiveness of college professors with licensed, experienced clinicians when doing therapy with normal neurotics. Surprisingly, the professors and the clinicians were equally effective. The results of this study, while suggestive and provocative, were not considered definitive primarily because of the small sample size. Now that the contextual model analysis

has been completed, however, it can be argued that Strupp and Hadley were prescient and that all of the eventual conclusions of the research analysis were presaged in their study.

That is a significant accomplishment in itself; however, more important for current attempts to create a new psychotherapy paradigm is that the study points toward the *reason* for the provocative findings. To understand how, one needs to imagine rerunning the study from the standpoint of a cross-profession analysis. More specifically, suppose the study was altered so that this time we are comparing professors with cardiologists and the task is to install a pacemaker. Without literally conducting the experiment, we already know the result. If this were a sporting event, it would be scored cardiologists--100 and professors – 0. The reason we know the outcome without running the experiment is because we recognize that cardiology is a profession that has privileged knowledge. Lots of professions have established privileged knowledge—e.g., engineering, auto mechanics, chemistry. And in other professions—e.g., psychotherapy, sales, leadership and education—the establishment of privileged knowledge is in doubt.

Fields with established privileged knowledge are never concerned with comparing the outcomes of trained versus untrained professionals; it is always clear that the untrained, as in the cardiology example above, are essentially incompetent in terms of accomplishing basic tasks. No one would imagine that an untrained mechanic could rebuild an engine or that an untrained soils engineer could specify the foundation requirements for a new house.

Conversely, in fields without established privileged knowledge, we can easily imagine that an untrained manager who is promoted to lead a corporate division could do a fine job. A big responsibility of university professors is teaching and yet we fail to require any training in the area; in the same manner, many realtors are successful without any formal instruction in sales. In sum, a pragmatic test of privileged knowledge in any profession is whether it is possible to work in that profession without training. By this test, sales, leadership and education lack potent privileged knowledge and auto mechanics, engineering and metallurgy have privileged knowledge. By these criteria, the Strupp study shows that psychotherapy lacks privileged knowledge; training is not required for psychotherapists to be effective.

Look at the fields with privileged knowledge; isn't it clear that they all operate in the material world? Conversely, the fields without privileged knowledge all operate in the social, psychological, and interactional world. Postmodernism has a term for these differences. The ones without privileged knowledge function in constructed reality; the ones that have privileged knowledge function in the material world.

The concepts of constructed reality and social constructionism have become increasingly popular in psychology over the past forty years. At this point it is safe to say that there are numerous psychological systems that are either largely constructionist or exhibit constructionist influences. In that sense, constructionism and constructionist explanations are hardly new. However, stating

that psychotherapy operates in constructed reality--that constructionism is the leading explanation for the impotence of privileged knowledge and the lack of inherent power in techniques—that is new.

We're going to define the form of constructionism used in this article via a series of significant quotations. The first, from Burger and Luckmann's seminal work, *The Social Construction of Reality* (1966), argues that different cultures actually create different realities.

> It is an ethnological commonplace that the ways of becoming and being human are as numerous as man's cultures. Humanness is socio-culturally variable. … While it is possible to say that man has a nature, it is more significant to say that man constructs his own nature, or more simply, that man produces himself. (p. 49)

Not surprisingly given that the different cultures operate in different realities, when it comes to mental health, there are wide variations between cultures. The following quote highlights the problems with imposing one culture's definitions on another.

> Psychology... has created the mass abnormalization of Maori people by virtue of the fact that Maori people have been... recipients of English defined labels and treatments... Clinical psychology is a form of social control... and offers no more "truth" about the realities of Maori people's lives than a regular reading of the horoscope page in the local newspaper. (Lawson-Te, 1993)

Drilling down further, the constructs we use in western mental health can also be criticized from within our own culture. For example, examine the following quote from famous psychotherapist, Irving Yalom, arguing that all of our vaunted psychotherapeutic systems are invented.

> The superego, the id, the ego; the archetypes, the idealized and the actual selves, the pride system; the self system and the dissociated system, the masculine protest; parent, child, and adult ego states-none of these really exists. They are all fictions, all psychological constructs created for semantic convenience, and they justify their existence only by virtue of their explanatory power….. . (Yalom & Leszcz, 2008, Kindle Locations 4852-4867)

With this quote, Yalom deconstructs our psychotherapeutic concepts—part of our privileged knowledge—from the standpoint of his therapeutic experiences. After a long career focusing on how therapy actually works, Yalom has concluded that everything we tell clients is made up; however, it is still useful in that it makes our rituals believable ("explanatory power"). Like the exorcists in the second world, we are making up rituals and, like them, our rituals must be credible. To make them credible, we are required to use concepts accepted by the culture.

These three quotes will define our simple, generic version of constructionism. Different cultures create different realities; mental health models are constructed inside each culture and the imposition of a foreign mental health model is perceived as a violation; and the competing and divergent mental health beliefs—even a seen from within the culture—reveals that they are invented.

Our fourth constructionist principle—that reality can be divided into constructed and material reality—is more problematic. Many constructionist thinkers have critiqued such a differentiation as naïve, simplistic, and inappropriate. The following quote from Burr (2018) is representative of these objections.

> Both symbolic interactionism and social constructionism regard language as fundamental to our constructions of reality. The now classic paper, "Death and furniture… (Edwards, Ashmore, & Potter, 1995), convincingly made the point that, as soon as the material world enters discourse, it becomes transformed, and it is impossible for us to think about or encounter it in some hypothetical "objective" state. And there is arguably little or nothing in human experience that could be said to lie outside of discourse. Through my window I see a garden wall, but as soon as I begin to interrogate just what this "is," I become caught up in an infinite regress of language, cultural meanings, and features of the human condition. It is only a wall by virtue of its capacity to retain or keep out the desired or the unwanted—human concerns. It is a wall only by virtue of the builder's skill, rendering it more than a pile of rubble by common cultural criteria. …. It is allowed to be a wall through the operation of countless social and cultural norms and expectations. (p.371)

This cogent argument exposes the fallacy of a simple division of the world into material and constructed realities. While granting Burr's basic premise, it can still be important to divide knowledge into two categories: knowledge that is true across cultures (material) and knowledge that is culturally relativistic (constructed). As we have shown above, professions that primarily operate in the material world have very strong training effects, effective privileged knowledge, the ability to improve outcomes from experience, and use techniques with inherent power instead of rituals. Professions that operate in constructed reality fail these tests. So even when Burr's arguments are seen as valid on one level, from a second, and more pragmatic perspective, we are going to continue using concepts such as material reality and constructed reality.

This is particularly important as we take up the question of whether our culture 1 & 2 metaphor is a useful description of the current state of psychotherapy. To answer that question, we are required to make a brief detour into the arena of cultural anthropology. While constructionism in the last few decades has primarily been derived from thinkers in the area of language, discourse, philosophy, and power relationships (Gergen, 2009; Burr, 2003), much of the early development of constructionism was influenced by the cultural anthropology perspective embodied in the

Berger and Luckmann book. Put simply, they argued that different cultures had different mental health models and that all of them—including our own—were constructed.

The medical model agreed that other cultures—with their concepts of spirit possession or witchcraft and the evil eye—were indeed constructed; however, they argued that western mental health was based on science, research and evidence-based practices. Hence, it was not constructed but instead reflected material reality and had cross-cultural validity. The contextual model research, of course, has destroyed this scientific argument. This in turn revalidates Berger and Luckmann's argument that the mental health models of all cultures—including our own—are constructed. Put another way--without really intending to do so--the contextual model research analysis, and its rejection of the scientific/medical model, when joined with the cross-profession analysis and the default anthropological assumptions about mental health, provides major support for the argument that psychotherapy operates in constructed reality.

If we grant that the culture 1 & 2 metaphor usefully outlines material versus constructed reality, three basic concepts arise that are predictive of enhanced therapeutic outcomes: discernment, client fit, and therapist charisma. Discernment refers to the ability to understand whether we are operating in constructed or material reality. This apparently simple task is made challenging by several factors. First, one of the key characteristics of constructed reality is that it appears to be material reality when viewed from inside the culture and when it is endorsed by all other cultural members (Berger & Luckmann, 1966). Second, even when an individual is successful at deconstruction and deprogramming, continued vigilance is necessary to avoid slipping back into the standard, socially-endorsed perspective. For example, Brach (2012) compares regressing to the accepted cultural perspective to reentering a familiar trance state. Meehan & Guilfoyle (2015) caution that even therapists trained in the poststructural tradition can readopt modernist perspectives and I (Bacon, 2018) argue that Kahneman's (2013) System 1 & 2 perspective can be used to explain how quickly the deconstructive (constructionist) efforts of System 2 can be overwhelmed by the simplistic, black and white thinking of System 1–a System 1 imbued with the culturally normative view of reality. In our culture 2 metaphor, even if an exorcist realizes the spirits are invented and the interventions with the clients are rituals, simply being surrounded by clients and other exorcists who believe they are literally real tends to seduce one back into the standard view.

When discernment is sustained, psychotherapists enjoy all the benefits of practicing in constructed reality. Essentially those benefits are fluidity and malleability. Material reality is solid and hard to change; constructed reality—because it is essentially invented—is mobile, ephemeral, and permeable. When psychopathology is seen a constructed, therapists have more access to creativity, optimism, and a sense that change is possible (Held, 2007, p33-4). This is communicated to clients both implicitly and explicitly. Returning to our metaphor, when the exorcist knows that there are no spirits, it is relatively easy to see the client's issues as changeable and to cultivate a positive prognosis. Examples from western psychology might

include letting go of the concept that personality disorders are fixed and immobile or rejecting the idea that sobriety must be life-long for all substance abusers. For a profession dedicated to facilitating change, seeing all mental health issues as fluid and ephemeral has an enormous benefit.

One of the key signs that discernment is present is that the therapist has the capacity to see all interventions as rituals. This awareness is well articulated by contextual model advocates, Anderson, Lunnen and Ogles (2010), in the following quote.

> … (T)herapeutic change occurs because there is a single theory or rationale that is acceptable or believable to both the healer and client. The specifics of the theory and techniques are for all points and purposes irrelevant…..
>
> As long as a treatment makes sense to, is accepted by, and fosters the active engagement of the client, the particular treatment approach used is unimportant. In other words, therapeutic techniques are placebo delivery devices. …(Moreover), suffice it to say that techniques work, in large part, if not completely, through the activation and operation of placebo, hope, and expectancy. ….Fortunately, the evidence indicates that therapists need not spend any time searching for the right treatment for a particular disorder. Instead, the "best" methods are those (a) intended or believed to be therapeutic; (b) delivered with a cogent rationale; and, above all, (c) acceptable to the client. (Kindle Locations 3864-3990)

In this thoughtful and well-organized statement, Anderson et al present the basic concepts behind interventions as rituals versus techniques. Rituals differ from techniques in that they require belief and they promote hopes and expectations; they are flexible and fluid as opposed to defined and carefully sequential; and—while they need to have a cogent rationale, they need not be based on coherent theory. Returning to culture 2: given that there are no real spirits, anything that convinces the client that the "spirit" can be banished, is functional and effective.

In the next quote, Anderson et al appear to reverse their position and endorse the importance of being trained in techniques and schools of therapy.

> One might think the contextual model would lead to downplaying the necessity of training in techniques. However, training in the specific techniques (or rituals) and a given orientation (or myth) is important for the cultural belief systems of both the healer and client. As indicated throughout the chapter, models and techniques are important and necessary ingredients of successful therapies. That said, having an understanding of the importance of the myth and ritual within any given social context may enhance effective practice. (Kindle Locations 4120-4128).

This quote is highly similar to the Yalom quote from the last section in that both emphasize the importance of therapists being familiar with psychological concepts, techniques, and systems so that they might match client beliefs when they structure rituals. Constructionism also sees this familiarity as vital, however, it diverges from the contextual model in terms of taking the findings on the impotence of psychotherapy's privileged knowledge more seriously.

More specifically, the absence of a training effect argues that beginning therapists have sufficient mastery over these concepts prior to formal training. If we return to the Strupp study, we can easily imagine that the college professors were competent at saying things like, "I think your childhood experiences helped create your anxiety disorder," or "The way to break through your depression is to discover who you are and be that authentic self." These kinds of explanations are sufficient to activate belief in the power of the healing ritual; the detailed exploration of the therapeutic myths taught in graduate schools and workshops does not result in enhanced outcomes.

In addition, while specific training in most interventions is probably not necessary—at least in any extended way—any training in "techniques" needs to come with a requisite caution: it is easy to lose discernment and become confused about constructed and material reality. We can see that Anderson et al included words like "myth" and "ritual" in their training recommendations. However, unless the trainer provides a strong emphasis on these constructionist ideas, it is possible or even likely that the trainee will leave the training believing in the inherent power of techniques and will adopt some kind of alignment with the misconstruals of the medical model.

This points to one of the weaknesses of the contextual model: the inability to accept the full implications of the no training effect/impotent privileged model finding. And, in truth, it is rather difficult to accept the shocking conclusion that our privileged knowledge—since it adds nothing to outcomes—can be effectively ignored.

While that is difficult in itself, constructionism goes even further and argues that our privileged knowledge is often part of the problem not part of the solution. Narrative therapy offers a particularly scathing critique of extant privileged knowledge when it argues (Madigan, 2012) that mental health authority figures use concepts such as diagnoses, prognoses, and psychological systems to sustain power relationships and to disenfranchise clients and liminal peoples. Going even further than that critique, constructionists can argue that privileged knowledge serves to reify reality (Bacon, 2018); each definition, idea, and psychological system serves to limit the creativity and fluidity of therapist and client. Yes, we need extant psychological concepts for explanatory purposes and to pace the client's understanding of how change operates; but it is vital to avoid simultaneously limiting mobility and ephemerality as practitioners offer their therapeutic rationales. In culture 2, the discerning exorcist continues to pace the client by promising the malevolent spirit will be removed, but the same therapist must remain aware that this is about removing suffering not removing spirits.

Client Fit and Therapist Charisma

Client fit is already familiar to every psychotherapist and is implicitly or explicitly endorsed by virtually every psychotherapeutic system. That said, idealized client fit is limited in every modernist psychotherapy because when interventions are seen as inherently powerful—as exemplified by the culture 1 metaphor--by definition there is more focus on the diagnosis and the technique than on the client and the relationship. Whenever the first thought is "what's wrong and what evidence-based intervention is required," the relationship will always be secondary. Even Roger's client centered therapy, with its emphases on reflection and active listening, suffered from this issue. When every client is required to work in the same mode, the clients who would be better served by a more directive intervention like CBT end up with their needs being deemphasized.

The contextual model, however, with its clarity that interventions are rituals, is much better positioned to be responsive to client fit. Specifically, Scott Miller and his colleagues attempted to master the client fit goal by developing a new approach to collecting client information called Feedback Informed Treatment (FIT) (Miller, Hubble, Chow & Seidel, 2015). FIT requires the administration and scoring of two brief feedback instruments obtained during the therapy session itself. The first instrument, completed at the beginning of each session, assesses progress outside of therapy and the second, gathered at the end of each session, assesses the quality of the session. Early studies found that this kind of feedback enhanced outcomes (Duncan, Miller, Wampold & Hubble, 2010) although later and larger studies found that such feedback alone failed to improve effectiveness over time.

> However, feedback systems have not been shown to lead to the development of clinical expertise for individual therapists (Miller et al., 2013; Tracey et al., 2014). That is, although therapists who receive feedback about particular clients can alter the treatment for those particular clients, receiving the feedback does not appear to reliably generalize to other cases or improve therapists' overall clinical skills. (Rousmaniere, Goodyear, Miller & Wampold, 2017, p. 6)

Constructionism offers a useful explanation both for the early successes and for the eventual disappointing results. Anything that helps a therapist focus on client fit should enhance outcomes and it appears that this is exactly what the early results revealed. The explanation for why these improvements failed to sustain themselves is contained in the explanation for why experience fails to predict better outcomes.

While Miller (Duncan, Miller, Wampold & Hubble, 2010), has argued that therapists do poorly when it comes to ongoing assessment of client improvement, it is clear that most therapists have at least some idea of which clients are improving and which are not. To profit from experience, therefore, they should prioritize behaviors associated with improvement and avoid behaviors

associated with client degradation. Constructionism argues that this common sense strategy fails because the therapists are so bemused by their focus on techniques and systems that their ability to see what works, and adjust strategies accordingly, is overwhelmed by their attention to distractors.

Using this argument, isn't it reasonable to assume that this same process occurs with FIT-trained therapists. They are directed to pay attention to FIT but they are not taught the basics of constructionism, discernment, and the fact that prioritizing privileged knowledge can do more harm than good. Over time, directing attention to techniques, systems, and diagnoses creates a kind of fog of confusion and distraction. In sum, if FIT were complemented by including constructionist ideas, it would have good prospects of sustaining its early promise.

Anderson et al offer an additional contextual model approach to client fit; this approach emphasizes the need to master many different treatments.

> Contrary to the claims of critics of common factor models, therapists need to be able to deliver many different kinds of treatments. To ensure a good fit with the individual consumer of psychological services, therapists need to carefully monitor client acceptance of and agreement with the treatment and agreement about the tasks and goals of therapy (i.e., the alliance). Resistance to the treatment provided is viewed as a function of the type of treatment delivered or the manner in which it is delivered rather than the result of a "resistant" client; that is, it is the therapist's responsibility to address resistance to treatment, and it is not the fault of the client. (Kindle Locations 4120-4128)

This contextual model recommendation is significantly different than the standard recommendation that therapists either learn one method in depth or perhaps blend several approaches together into an eclectic style. Constructionism not only agrees with Anderson et al here, but—as discussed above—the concept that most therapists come to training "prequalified" in terms of standard therapeutic systems, adds pragmatic credibility to the Anderson recommendation.

In addition, constructionism is an especially useful stance when it comes to minimizing client resistance. Resistance implies an argument between client and therapist about the nature of reality; given that constructionism reduces or eliminates a therapist's attachment to any particular form of reality, these types of arguments are necessarily diminished. More specifically, if one imagines being an exorcist in culture 2, and being aware that there are no real spirits and that all interventions are rituals, where else can one stand except in the essential needs and path of the client? Constructionist Harlene Anderson has called this state "not knowing" (Guilfoyle, 2003); she believes that "not-knowing" is a foundational aspect of every postmodern therapy.

The third factor arising from our culture 1 & 2 metaphor is therapist charisma; it seems clear that the more connected and persuasive the therapist, the more the client will find the ritual compelling and healing. Similar to the almost universal endorsement of client fit, some form of therapist charisma is recommended by most schools of therapy; indeed, it is implicit in the common factors basic principle, "a relationship with a wise and caring therapist." The contextual model recommends its own version of therapist charisma; more specifically, Wampold (2017, p. 56-7) derives a set of therapist factors from the empirical literature associated with enhanced outcomes. This include persuasiveness, verbal fluency, interpersonal skills, alliance-bond capacity, hopefulness and emotional expressiveness.

Scott Miller takes a more provocative stance when he argues that "…far more important than what the therapist is doing is who the therapist is." (Duncan, Miller, Wampold, & Hubble, 2010, Kindle Locations 385-386). With this quote Miller makes the radical shift in emphasis from a focus on developing systems and techniques to a concentration on developing the therapist. This is a clear break from both the medical model and modernist psychotherapies.

In order to accomplish this therapist development, the contextual school created a training model based on Ericsson's model of deliberate practice. (Rousmaniere, Goodyear, Miller and Wampold, 2017). While the deliberate practice model can be enhanced by other factors such as outcome measurements and ongoing feedback, its central concentration is on identifying therapist weak points and focusing efforts specifically on remediating those weak points; this is accomplished through a clear identification of learning objectives, guidance from a coach, immediate and ongoing feedback, and ongoing successive refinement (Miller, Hubbard, & Chow, 2017).

Weak points are identified by, for example, examining cases that show lack of progress, practicing higher order skills via demanding therapeutic vignettes, and receiving advanced supervision. Weaknesses are remediated via tools such as solo practice, video review, analyzing relevant case material, reading journals, learning specific models of psychotherapy, receiving clinical supervision, and viewing video of master therapists with the aim of developing specific skills (Miller, Hubble, Chow, & Seidel, 2015, p. 121).

These strategies are straight forward and logical as long as we are operating in material reality and analyzing, for example, the expertise of a basketball player. If the weakness is the left-hand dribble, drills can easily be designed to remediate this issue. Conversely, determining weak points in psychotherapy—where the pathology is constructed, the client's identity and current functioning is constructed, and virtually every intervention works, can be relatively difficult. Moreover, if the remediation practices described above are examined from a constructionist perspective, it's clear that a number of them come from modernist models of psychotherapy and include implicit assumptions about techniques having inherent power (e.g., analyzing case material, learning models of psychotherapy, reading journals, and developing skills). Not only

are such remediation practices at odds with the contextual model research analysis, they are also highly likely to reinforce the concept that psychotherapy operates in material reality.

That said, as long as the supervisors are individuals like Yalom—with his clear constructionist insights—or Anderson, Lunnen and Ogles—with their understanding that interventions are "placebo delivery devices"—then the deliberate practice strategies will almost certainly bear fruit. Unfortunately, the contextual model fails to distinguish between modernist supervisors and contextual/constructionist ones; hence, it is possible that deliberate practice might yield the normal fruits of supervision: no effects on outcomes (Duncan, Miller, Wampold & Hubble, 2010).

Constructionism offers a different approach to developing therapist charisma. From a developmental perspective, the primary task of the emerging human—from a postmodern point of view—is the acceptance and incorporation of the prevailing cultural reality (Berger and Luckmann, 1966). This is primarily accomplished via every interaction with cultural members; the quality and nuances of the interactions mutually reinforce the shared social reality and affirm our place in it. In addition to these standard encounters, however, there are certain key individuals—seen as charismatic and powerful—who are granted special authority to define constructed reality and our role in it. Given the malleability of reality, such individuals--mentors, teachers, leaders--have strong powers; they can alter our perceptions, frames, identities or prospects with a word or a gesture. Ideally a therapist strives to be seen as having this kind of "charisma" by her clients.

The difference between constructionist charisma and modernist positive therapist characteristics is the feeling of the fluidity of reality. When psychotherapy is seen as occurring in the material world, with techniques with inherent power, pathologies that are real and solid, and systems of therapy that define prognoses, then the power of charisma is necessarily limited. Conversely, when the world is understood as essentially fluid and malleable, the power of a suggestion, or being persuasive, or being charismatic is multiplied. Even if only the therapist—not the client--sees reality as constructed, flexible and mobile, the confidence that therapist actions and ideas have power are implicitly communicated to the client.

Pro-charisma statements such as these can give rise to a great deal of discomfort. First, it should be understood that cultivating charisma is not simply cultivating the authoritarian ability to order the reality of another. Yes, communicating a sense of personal power and wisdom is vital, but we all remember that the therapeutic relationship is equally characterized by compassion, caring, and the ability to listen—particularly the ability to discern the client's ultimate concern. Each therapist has their own way to cultivate charisma and it can be just as impactful on a client to feel that the therapist is especially humble, caring and connected as it is to feel that they are confident and know life's secrets.

Postmodern therapies—such as narrative therapy and collaborative therapy—have been particularly critical of concepts like therapist charisma because they tend to equate hierarchical client therapist relationships with modernism and expertise run amuck (Guilfoyle, 2003). Narrative therapy (Madigan, 2012) is particularly adamant that hierarchy in therapy often leads to the exploitation of liminal groups as authority figures manipulate ideas to sustain extant power relationships.

While space precludes a full discussion of this important topic, a few key points can be offered. First, the "not-knowing" aspect of constructed reality requires a prioritization of client fit and eliminates the narcissistic sense that I have an obligation/right to impose my "validated" truth on the confused client. Second, this paper is about enhancing therapeutic outcomes; adopting a traditional medical model/expert stance will limit outcomes to the extant standard. Third, as Guilfoyle (2003) notes, power differentials are structurally present in all therapeutic relationships; he believes that it is more effective to work with them consciously as opposed to believing that they can be eliminated by simplistic strategies such as framing insights as possible suggestions. In sum, understanding that psychotherapy operates in constructed reality does not guarantee that there will be no client exploitation, but it is far safer than the concept of "cultivating charisma" might be in modernist therapies.

This conclusion leads to the question of whether charisma can be consciously cultivated beyond the general recommendations contained in Wampold's list presented above. Other professions offer guidance here in that a number of them recommend or even require such cultivation. For example, in the area of military leadership, a general is seen as an inadequate leader unless he has had combat experience, especially combat experience where he was particularly heroic, resolute, or skilled. Similarly, certain types of religious leaders—primarily mystics--are expected to have personal spiritual experiences to support their underlying credibility and test pilots have to demonstrate the "right stuff" to be fully respected by their peers. Psychotherapists have never had similar requirements given our ability to rely on the power of techniques; with the rise of constructionism and the awareness that our interventions are rituals, the cultivation of charisma-enhancing experiences can become an important part of professional development.

Perhaps even more fruitful, however, is the concept of cultivating charisma inside the room. Returning to our culture 2 metaphor: imagine that you are one of the few exorcists who know that the spirits aren't real and that all the interventions are actually rituals. Wouldn't the sense that you have access to hidden knowledge effect your feelings of depth and confidence? Certainly, you would need to guard against transforming this "I'm a knower" into some form of narcissism, but if it were handled well it could confer on you something like the enthusiasm and confidence sometimes seen in therapists who have developed new systems of therapy. When they avoid the pitfalls of arrogance, their sort of numinous confidence has allowed them to achieve results well above the norm.

Finally, charisma is always intertwined with authenticity; when therapists believe in what they are doing—the so-called "alignment factor"--they achieve better outcomes (Wampold & Imel, 2015). Achieving this kind of alignment/authenticity can offer challenges when the therapist is aware that pathology and rituals are constructed. How can the constructionist therapist have the same level of belief and commitment to an intervention or a case conceptualization as, for example, a therapist who is psychodynamic?

Anderson et al (2010) were asked this same question and responded as follows.

> However, just because a therapist might have an awareness of treatment as myth does not reduce the therapist into a detached and cynical critic who is playing a charade. As noted throughout, effective therapy requires emotional investment and commitment to some shared cultural values. That is, the therapist who cannot summon a passionate commitment to his or her core beliefs will ultimately fail to engage the patient in an emotionally charged relationship. The therapist's own emotion and commitment serve to weave treatment myth, treatment principles, and ritual into a powerful and persuasive communication that, in turn, enhances the therapeutic relationship (see Figure 5.1). Knowledge that these values are culturally dependent need not be a forbidden fruit that bans the therapist from participation in his or her own culture, nor from conducting good psychotherapy! (Kindle Locations 4164-4170)

In addition to these references to shared cultural myths and therapist core beliefs, there are also the supporting factors of client beliefs and the client's "ultimate concern." While many modernist therapists derive their sense of engagement and authenticity from their beliefs in diagnoses and evidence-based practices, humanistic/existential therapists have always connected authentic practice to discerning and following the client's "truth" (Yalom, 2008). As long as practice is essentially congruent with the client's ultimate concern, therapists feel justified in terms of adjusting the specific ways they frame an issue; in this sense, therapists often use intermediate goals in place of ultimate goals. For example, in certain cases in family therapy, therapists will support overt expressions of anger as intermediate goals, while in the back of their mind, their ultimate goal might be family cohesion. Similarly, presenting a rationale to a child differs from presenting a more mature version of the same rationale to an adult yet the therapist can feel equally authentic as long as the rationales participate in the ultimate concern. Every intermediate goal might seem inauthentic when taken out of context; every child-like explanation might leave out the nuances required for an adult rationale; but both intermediate and childlike rationales can still evoke powerful levels of belief and commitment in the therapist.

Practicing in constructed reality always requires the therapist to align all case conceptualizations and interventions with client fit and with the client's ultimate concern. The extra effort to accomplish this alignment has the capacity to make the constructionist psychotherapist's belief in their interventions superior to a modernist psychotherapist who falsely believes that their system

or technique has inherent power. Moreover, this question is addressed in the section on developing therapist charisma because the client, implicitly or explicitly feeling the therapist's deference to the ultimate concern, responds with the sense that it's all about him; the therapist is not walking down a modernist, theoretical pathway that forces him to fit into predetermined categories and boxes. In the final judgment, this sense of "he sees me," contributes to the client's ability to perceive the therapist as a key individual.

Summary and Conclusions

Perhaps the best way to summarize the concepts in this paper is through the presentation of an imaginary lecture on Day 1 of a clinical psychology training program. Prior to receiving this lecture, the trainees have been exposed to the contextual model research analysis and the principles of constructionism.

> One of the major focuses of our program is cultivating the ability to structure and carry through many different types of ritual interventions with clients. These interventions will focus on various explanations for the client's problems and prescribe different healing rituals. You will have repeated exposure to rituals in common use in our culture. For example, you will study and practice interventions focusing on feelings and past traumas and you will become familiar with interventions that use the rational mind to regulate affect.
>
> Next, we will study some of the interventions and rituals used by supershrinks. We'll particularly focus on rituals where these gifted therapists show how they operate outside of normal parameters; some of these rituals will show a fluid understanding of pathology, others will show extraordinary creativity about the healing ritual, and still others will help you understand what's possible when a client has a particularly strong respect for his therapist.
>
> In addition, we will review interventions that use altered states—such as hypnosis or EMDR—as part of the ritual. As you will see, these kinds of rituals participate in a "magical" dimension of human experience which predisposes clients to be open to unlimited change. Part of constructionism requires exploring the unitary self versus multiple selves; the ability to visualize a client as a collection of ego states opens the door to a particularly fluid set of rituals. Finally, you will even be exposed to existential and spiritual rituals; while they are not for everyone, it is still important to be able to work with them.
>
> From more of a process point of view, we will examine how understanding constructionism affects therapeutic rituals in general. We'll pay particular

> attention to the tendency of the mind to move towards black and white thinking; there are forces in us, in our clients, and in the culture that act to confuse what is constructed with what is material. We will help you discern between the two.
>
> It's hard to let go of old assumptions. Some have of you will have trouble imaging that change is easy; others will have problems letting go of diagnoses; others will struggle with the difference between rituals and techniques; and still others will find it hard to accept the fluidity of the therapeutic milieu. Some therapists are uncomfortable when directive and authoritative; others find it difficult to cultivate a sense of "not-knowing."
>
> Most therapists have to find their own relationship to authenticity; it is challenging doing therapy when your client believes in techniques and you believe in rituals. In addition, the more one studies constructionism, the more important it becomes to find a solution to the so-called "relativity problem"—the sense that there is nowhere to stand when it's all made up. Finally, you will learn about the centrality of client factors in constructionism and the importance of being client-centered as you construct and co-construct rituals.
>
> No one can possibly be good at all of these types of rituals and paradigms and we will help you note your weak points so that you can improve in those areas. Similarly, we will help you focus on your strengths and learn how those strengths can enhance your charisma.

This imaginary lecture attempts to illustrate many of the principle discussed above. The students are required to discern between material and constructed reality and between techniques and rituals. Anderson et al's point about knowing many approaches is endorsed with the implicit assumption that the trainees already know more than they imagine. Deliberate practice strategies are highlighted via inviting the students to try many approaches and many processes, some of which are going to expose weak points.

The challenge of being authentic when operating in constructed reality is mentioned; in addition, the way that constructionism implicitly leads to existential questions is highlighted. Altered states are particularly aligned with constructionism (Gilligan, 2012), a perspective that we lacked space to explore in this article; as might be imagined, altered states are another approach to enhancing charisma.

Charisma is mentioned briefly and presented as an integral part of the training. Finally, the entire lecture is suffused with the concept that therapy is occurring in constructed reality; this is the foundational understanding that essentially opens the door to ease of change, therapist confidence, client fit and positive client prognosis.

This imaginary lecture points towards what might be seen as the most pressing set of questions that currently confront psychotherapy: can we develop a training model that has a measurable impact and can therapists learn from experience? One of Scott Miller's most frequent challenges to the profession is the idea that, yes, therapy works, but unfortunately its evolution has stalled and we are simply achieving the same results we did 50 years ago (Miller, Hubble, & Duncan, 2007). This paper has lauded the contextual model school for their groundbreaking research results, and has appreciated and supported most of their pragmatic attempts to improve outcome. But the basic argument here has been that these contextual model attempts need to integrate strong constructionist elements if they are going to succeed over the long haul.

That said, we should also understand that the dethroning of the medical model is not a minor achievement; it has shaken the foundational assumptions of psychotherapy to the core. Particularly when we integrate this achievement with a constructionist explanation, this significant set of reconceptualizations rises to the level of a paradigm shift as described by Thomas Kuhn in his well-known quote.

> Though the world does not change with a change of paradigm, the scientist afterward works in a different world... I am convinced that we must learn to make sense of statements that at least resemble these (1962, p. 120).

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