# Resolving the Common Factors Debate: Training and Practice Development after the Collapse of the Medical Model Paradigm.

**Abstract:** The debate between specific factors/evidence-based techniques adherents and common factors proponents has stalled out with neither side able to fully declare victory. This dilemma can be resolved by examining the literature on the effects of therapist experience and training on outcomes; multiple reviews show that therapists fail to improve client outcomes via experience or training. The lack of these effects demonstrate that techniques lack inherent power and that psychotherapy's privileged knowledge fails to enhance therapeutic results. Social constructionism and cultural anthropology provide a good explanation for these disturbing findings. Abandoning the traditional strategies of technique development and replacing them with a focus on client fit, development of rituals, and cultivation of therapist charisma is one way to respond to the paradigm shift. Specific strategies that can be derived from this shift have the potential to meaningfully enhance psychotherapeutic outcomes and to allow therapists to profit from training and experience.

**Keywords:** Psychotherapy, Social Constructionism, Psychotherapy Training, Psychotherapy Experience, Therapist Charisma

The psychotherapy world is divided by a debate about how psychotherapy works and how it should be developed. On the one side are the adherents for the status quo: the medical model. These theoreticians and practitioners believe that psychotherapy works like medicine and that the way forward is to develop more accurate methods of diagnosis and to find specific, evidence-based treatments that address each diagnosis. On the other side is a smaller group of thinkers who argue that the outcome research findings refute the basic assumptions underlying the medical model. They believe that psychotherapeutic techniques lack inherent power and that change is essentially due to the common factors that underlie all models of psychotherapy.

These two groups have a core disagreement about the meaning of one of psychotherapy's most important research findings: the Dodo Bird theory. This theory refers to the provocative research finding that all schools of therapy—in spite of their differing techniques and underlying theories—create positive, *and equivalent*, outcomes in psychotherapy.

> 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)

The Dodo bird debate is essentially a discussion about whether there are any specific factors in psychotherapy. Researchers long ago divided the sources of the effectiveness of psychotherapy

between common factors—most often portrayed as a therapeutic alliance with a wise and caring therapist—and 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 positive effect sizes? 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; they are simply functional therapeutic 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. As a result, there has been a strong push-back against endorsing the Dodo bird argument. The primary counter argument is simple: there are literally hundreds of studies that have found one technique superior to another, at least in certain circumstances. In addition, there are dozens of metanalytic dismembering studies—studies that attempt to determine statistically the factors responsible for the effectiveness of psychotherapy. These studies allocate a certain percentage of the variance of the effectiveness to, for example, client factors, therapist factors, and the specific factors connected to the inherent power of techniques. These estimates of the variance due to specific factors range from a low estimate of 5% (Groth-marnat, Roberts & Beutler, 2001)) to a more commonly cited number of 15% (Lambert & Ogles, 2004).

The Dodo bird adherents respond with several counter-arguments: first, the metanalyses have consistently failed to find that any therapeutic approach is superior to another and second, many of the studies finding superiority have either flawed research design or have been biased by allegiance factors. Using such arguments, the Dodo bird advocates reduce the specific factors percentage in the dismembering studies down to an insignificant number (Wampold & Imel, 2015a).

This debate rages on with no clear resolution. Miller, Hubble, Chow, & Seidel (2013) provide this estimate of the probability of victory by one side or the other.

> …the hope that with the right research design or line of investigation, a clear victor will come forth is—to put it bluntly—akin to an alchemist's optimism. After 50 years, and a massive expenditure of time, effort, and money, had one side or the other been right, lead would have been transformed into empirical gold long ago… Few have been sufficiently swayed to give up their claims or view of the evidence. (pp. 89-90)

This stalemate has resulted in the field attempting to synthesize the two viewpoints with statements such as "common factors are very important—probably more important than specific factors—but we still believe that it is valuable to study, master and employ powerful psychotherapeutic techniques." And, in spite of the common factors critiques, the field as a whole continues to embrace the concept

that psychotherapeutic techniques have inherent power; a simple glance at the program of the annual American Psychological Association convention finds hundreds of workshops based on learning or applying psychotherapeutic techniques.

Fortunately, there is another perspective—one that leaves behind the Dodo bird metanalyses and the dismembering studies—that is capable of resolving the dilemma. More specifically, the studies on the effects of therapist experience and therapist training on outcomes shed new light on the stalemate. The connections are simple and logical. More experienced therapists know more techniques than the inexperienced; moreover, they have practiced them more assiduously. If techniques have inherent power, then there will be an experience effect on outcomes. Training effects are even more clear. The untrained do not know psychotherapeutic techniques and the trained know a significant number. Similarly, the lightly trained know and have practiced fewer techniques than the relatively highly trained. If techniques have inherent power, the more highly trained professionals will achieve better therapeutic outcomes.

Measuring the effects of therapist experience on outcomes is rather easy; psychology has performed hundreds of treatment outcome studies which have also included measurements of therapist experience. Christensen and Jacobson (1994) summarize the results of these early metanalytic studies.

> These studies address the overall effects of psychotherapy, but often code such factors as therapist experience and relate these factors to outcome. Across 47 studies of psychotherapy outcome. Smith, Glass, and Miller (1980) found no relationship (r = 00) between years of therapist expenence and therapy outcome. In a later meta-analysis of 143 studies, Shapiro and Shapiro (1982) also found no relationship between the two. Finally, a meta-analysis of 108 well-designed psychotherapy studies with children and adolescents (Weisz, Weiss, Alicke, & Klotz, 1987) found no overall difference in effectiveness between professional therapists, graduate-student therapists, and paraprofessional therapists. These meta-analyses of psychotherapy research suggest a substantial effect of psychotherapy compared with control conditions. Effect sizes range from .68 to .93 Yet none of the seven reviews described found evidence that professional training or therapist expenence enhanced outcome. (p. 9)

This lack of a therapist experience effect was both provocative and anti-common sense; virtually every therapist feels that their effectiveness has been enhanced by their experience. Not surprisingly, the finding resulted in a series of efforts attempting to repudiate the research. The best counterargument comes from a metanalysis done by Stein and Lambert (1995) who found: "It is concluded that a variety of outcome sources are associated with modest effect sizes favoring more trained therapists. In many outpatient settings, therapist with more training tend to suffer fewer therapy dropouts than less trained therapists (p. 182)." In a 2013 review article on experience effects, Hill and Knox summarize two other studies that provide some supporting evidence. One found small effect sizes for experience but no effects for therapist age while another study found a small effect for therapist age but none for experience.

It is significant, however, that these findings about experience effects were quickly challenged. For example, the same Michael Lambert, writing nine years after his original review summarized the experience findings as, "…overall, the meta-analytic reviews of psychotherapy that have provided correlational data find little evidence for a relationship between experience and outcome (Lambert & Ogles, 2004, p. 169)." Hill and Knox, in the same vein, summarized the more recent findings.

> 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. (2013, p. 797)

There is another area in the outcome literature that has important implications for the experience effect: metanalyses comparing the outcomes of paraprofessionals with licensed therapists. Paraprofessionals are mental health counselors that work in clinical programs but lack an advanced degree. Some have nonclinical college degrees, others have attended a few workshops, and some have learned on-the-job. In sum, they have almost no clinical training and their level of experience ranges from almost none to modest.

The paraprofessional outcome literature has also been quite provocative, primarily because several of the metanalyses showed that the paraprofessionals achieved better results than the licensed professionals. Following are two quotes summarizing almost 200 studies of the therapy outcomes of professionals versus paraprofessionals.

> The outcome and adequacy of design in 42 studies comparing the effectiveness of professional and paraprofessional helpers are reviewed. Although studies have been limited to examining helpers functioning in narrowly defined clinical roles with specific client populations, it is argued that the findings are consistent and provocative. Paraprofessionals achieve clinical outcomes equal to or significantly better than those obtained by professionals. (Durlak, 1979, p. 80)

> A meta-analysis of child and adolescent psychotherapy outcome research tested previous findings using a new sample of 150 outcome studies and weighted least squares methods. The overall mean effect of therapy was positive and highly significant. …. Paraprofessionals produced larger overall treatment effects than professional therapists or students, but professionals produced larger effects than paraprofessionals in treating overcontrolled problems (e.g., anxiety and depression). (Weisz, J. R., Weiss, B., Han, S. S., Granger, D. A., & Morton, T., 1995, p. 450)

This finding that paraprofessionals achieved better results than trained and experienced professionals was so challenging that a number of subsequent reviewers speculated that it might be an artifact of poor research design. However, Miller, Hubble, and Chow (2018) argue that the evidence supporting a decrease in outcomes over time and experience might be a valid finding.

> The evidence shows individual therapists do not get better with time and experience (Wampold & Brown, 2005, Chow et al., 2015). Worse, instead of improving, effectiveness plateaus early, then steadily declines (Miller & Hubble, 2011). In the largest study of professional development to date, Goldberg and colleagues (2016b) documented a diminution in performance, not unlike a slow leak from an inflated balloon. Importantly, the deterioration was unrelated to several factors often advanced as moderating variables, including client severity, number of sessions, early termination, caseload size, or various therapist factors (e.g., age, gender, theoretical orientation). (p. 2)

Finally, there are only a handful of studies that directly compare outcomes with therapists with no experience against experienced therapists. The most famous of these studies is from Strupp and Hadley (1976) which showed that untrained college professors were capable of achieving equivalent positive outcomes in comparison to experienced, licensed therapists. Significantly, that study was recently replicated when Anderson, Crowley, Himawan, Holmberg & Uhlin (2016) compared the outcomes of advanced clinical psychology graduate students with graduate students in non-helping fields (e.g., history or biology); they also found that both groups achieved equivalent positive results with normal neurotics.

The preponderance of the evidence in this review supports the finding that there is no solid support for the common-sense idea that more experienced therapists achieve better outcomes. The early metanalyses that found no relationship between experience and outcome were partly rebuked by Stein and Lambert's (1995) conclusion that there is a small positive effect size from experience and by a few small and inconsistent studies noting reduced dropout rates and better results from older therapists. But the most important study in this area was rebuked by one of the co-authors and the rest of the findings were overwhelmed by more recent and better designed studies finding no effects. The paraprofessional studies completely refuted the value of experience and mildly reinforced the idea that therapists might get worse as their careers continue. Finally, the two studies comparing therapists with no experience against experienced professionals were convincing in their own right. An appropriate summary of this evidence comes from Wampold and Imel (2015b, p. 2) when they argue: "Therapists do not get better with time or experience. That is, over the course of the professional careers, on average, it appears that therapists do not improve, if by improvement we mean 'achieve better outcomes'."

The second area of research that bears directly on the question of the inherent power of techniques consists of the studies on the relationship between training and outcomes. Clearly training includes instruction, practice, and supervision in psychotherapeutic techniques. The more training, the more techniques learned, the more opportunities to practice the techniques, and the more opportunities to receive meaningful feedback from supervision and input from advanced psychotherapists. It stands to reason, therefore, that this edge in techniques would translate into better outcomes.

The first training finding is the inability of doctoral-level therapists to achieve better outcomes than masters-level therapists. Doctoral-level psychotherapists receive approximately six years of training, supervision and clinical experience and masters-level practitioner receive approximately half that. To

put this into perspective, this difference in training is roughly equal to comparing the expertise of a nurse practitioner or a physician's assistant to the boarded medical doctor who supervises them.

Beutler et al (2004) in a review of training and experience variables and outcomes notes that this masters/doctoral differentiation in effectiveness is a relatively unresearched area. He found one study that demonstrated that psychologists get better outcomes than psychiatrists and another study that found that therapists with a MSW outperform those with a doctoral degree. He concludes that the extant research is insufficient to demonstrate a meaningful link between years of training and outcomes.

There are quite a few studies that support the concept that trainees can learn skills that "should" lead to better outcomes. For example, Hill and Knox (2013), in their review of the training literature, cite studies showing that trainees can be trained to administer manualized treatments, that they can improve various skills such as listening, exploring therapeutic issues, and empathy, and that training reduces trainee anxiety.

In addition, supervision has been evaluated from various angles including whether it increases measures of alliance, decreases trainee anxiety, and enhances the development of specific skills. There have only been a few studies connecting supervision to outcomes. Miller, Hubbard, and Chow (2018) review these studies.

> Nevertheless, after reviewing research spanning a century, Watkins (2011) writes: "We do not seem any more able to say now (as opposed to 30-years ago) that psychotherapy supervision contributes to patient outcome" (p. 235). Using a large, five-year naturalistic dataset consisting of 6521 clients, seen by 175 therapists, who were supervised by 23 supervisors, Rousmaniere, Swift, Wagner, Whipple and Berzins (2016) confirmed and extended Watkins's conclusions Once more, supervision was found not to be a significant contributor to client outcome. (p. 2)

The paraprofessional studies described above are not only important for determining the experience effect, they are also highly relevant to the training/outcome question. Given that paraprofessionals have almost no training, and they achieve outcomes that are equivalent to or superior to trained therapists, they provide strong evidence that training fails to enhance outcomes. The importance of the paraprofessional data is, of course, amplified by the hundreds of studies in that database.

Finally, there are only two studies that are pure examples of no training versus professional training. As we already know, these two studies—Strupp and Hadley (1976) and Anderson et al (2016)—found equivalent positive outcomes and no effects from training. In a somewhat related study, Nyman, Nafziger & Smith (2010) compared the results of new graduate students, pre-doctoral interns, and licensed, doctoral-level practitioners in a university counseling center and found all achieved equivalent positive outcomes. They summarized their results as follows.

> Clients in this study displayed improvements in psychological functioning that were independent of the training level of the counselor. … (C)lients … experienced

> moderate symptom relief over six sessions regardless of whether they were seen by a licensed doctoral-level counselor, a pre-doctoral intern, or a practicum student.
>
> It may be that researchers are loathe to face the possibility that the extensive efforts involved in educating graduate students to become licensed professionals results in no observable differences in client outcome. …. (W)e urge the field to squarely face the possibility that supervised novice counselors may be as effective as experienced counselors … (p. 207 -8)

Putting all these studies together, we can conclude that training is reasonably effective at teaching techniques and skills and at reducing trainee anxiety. However, when we look at whether training directly effects outcomes, we get a different picture. Doctoral-level professionals—who get almost twice as much training—do not achieve better outcomes than masters-level professionals. The two studies on completely untrained counselors show that they achieve the same outcomes as trained professionals. And the hundreds of studies with paraprofessionals shows their almost complete lack of training fails to diminish their effectiveness with actual clients. Results like these have led different reviewers to bemoan the absence of evidence for the effectiveness of training on outcomes. For example, Malouff (2012) in his review of training in psychology graduate programs 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).

Returning to our Dodo bird controversy: it is clear that the research fails to find any significant evidence of training or experience effects in psychotherapy. While it is impossible to "prove" that there are no effects at all, it is fair to state that the preponderance of evidence argues that there are either no effects from training and experience or that the effect sizes are so small that they are clinically insignificant. As a result, the Dodo Bird finding is confirmed and it is appropriate to conclude that psychotherapy techniques lack inherent power. Put another way: psychotherapeutic interventions are rituals driven by beliefs and expectancies.

"But that's not all", as the late-night commercials so often promise. The lack of experience and training effects also have implications for the usefulness of psychotherapy's privileged knowledge. Privileged knowledge, as used here, refers to the idea that each profession is characterized by its unique privileged knowledge—the knowledge that is owned by the profession, the knowledge that must be mastered to succeed at the profession. In psychotherapy, this knowledge includes psychotherapy techniques but also consists of everything related to mental health—concepts like diagnosis, prognosis, etiology, and pathology. This privileged knowledge—psychotherapy's collective wisdom—is applied to virtually every client case. Western psychology is not simply a compilation of techniques, it is an entire way of visualizing health versus pathology.

This knowledge has been accumulated via a great deal of work; the field of psychotherapy rests on literally hundreds of thousands of books, articles, and experimental studies designed to contribute to

our professional knowledge. Moreover, we have a myriad of trained, motivated, and competent professionals and academics who work unceasingly in the area. Unfortunately for this effort, the lack of experience and training effects suggest that initiation into this knowledge base fails to contribute to enhanced clinical outcomes.

The arguments for this startling statement are identical to the ones above about the lack of inherent power in techniques. Experienced clinicians have mastered psychotherapy's privileged knowledge and use it on a daily basis. They have not only applied it but they have systematically refined it as their experience shows what aspects of the privileged knowledge are most useful and important. These strategies should lead to better outcomes. Somehow, they do not.

Similarly, all of the training in psychotherapy is training in privileged knowledge. Graduate students typically feel that the accumulation of this knowledge helps them understand the clients and contributes to case conceptualizations. These feelings are certainly real; however, it appears that these feelings of usefulness and empowerment are not endorsed by the ability to achieve superior results. Shockingly, graduate students need to accept that what they are learning in their training program is irrelevant in terms of enhancing outcomes.

In sum, taking the training and experience findings seriously requires us to not only renounce our belief in specific factors and the inherent power of techniques, it also requires us to recognize the impotence of psychotherapy's privileged knowledge. Of course, it is profoundly destabilizing to assert that everything based on our privileged knowledge is unrelated to outcomes; put another way, the vast majority of our books, research, workshops, and training programs don't contribute to making clients better. Yet it is impossible to deny that these are the implications of the no training, no experience effects.

## Explaining the Provocative Findings

Frankly, it's not that easy to understand why psychotherapeutic techniques lack inherent power, why therapists don't get better with experience, and why all the efforts of thousands of bright people have failed to create a privileged knowledge that facilitates outcomes. To begin to answer these questions, it's useful to examine mental health paradigms from a cross-cultural perspective.

Berger and Luckmann, in their classic work, *The Social Construction of Reality (1966)*, make the compelling point that different cultures inhabit different realities.

> It is an ethnological commonplace that the ways of becoming and being human are as numerous as man's (sic) 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)

They go on to point out that human suffering occurs in every culture and, therefore, every culture develops a mental health paradigm that explains the reason for the suffering and prescribes the

requisite procedures to resolve the problem. These paradigms vary widely and include concepts such as spirit possession, witchcraft, evil eye, and deficits in spiritual substances such as mana or chi. Berger and Luckmann also argue that the individuals in each culture experience differing symptoms of their suffering that match the cultural paradigm; one would have symptoms corresponding to possession in a culture that believed in malevolent spirits and, in a different culture, one might have symptoms that fit with a mana deficit model. In sum, Burger and Luckmann believed in the suffering but argued that the explanations, the exact form of the symptoms and the curative procedures were constructed.

Western psychotherapy certainly concurs—at least for the paradigms used in other cultures. Because we do not believe that spirit possession or mana deficits are "real," we see other cultures mental health models as constructions. We agree that these constructed models help individuals resolve mental health symptoms but we would argue that they function via the power of rituals, placebo, expectations and beliefs. Berger and Luckmann moved beyond this agreement and argued that the bulk of the western mental health model is as constructed as the other cultures.

It's been half a century since Berger and Luckmann advanced these arguments, and in the ensuing period, social constructionism and post modernism have thoroughly pervaded western intellectual thought. Their ideas, which appeared so radical, are now accepted fairly widely. Except, of course, when it comes to this argument about whether western psychotherapy is as constructed as previous mental health models. The counter argument is usually short and simple: since the western mental health paradigm is based on science, it supersedes the previous models. The corollary is that this quality of "science-based" and "evidence-based" implies that it addresses processes that apply to "human nature" and, hence, are valid cross-culturally.

Before proceeding it is important to spend moment defining our terms. We are using western mental health and western psychotherapy interchangeably. Virtually all psychotherapists recognize that the field includes some physical factors that influence mental health like drug use, brain tumors, head injuries, and illnesses. Psychotropic medications also play a significant role in the western mental health model. For purposes of this paper, however, we are referring to psychotherapeutic interventions and the privileged knowledge of psychotherapy; our discussion is not intended to be generally applicable to the physical correlates of mental illness nor to medications.

This attempt to take refuge in the "western psychotherapy is scientific" argument is very difficult to sustain. The first confrontation comes from cross-cultural psychology and anthropology; experts in those fields are united in the sentiment that the western approach is constructed and it is inappropriate to impose one culture's beliefs on another. For example, Lawson-Te (1993) comments.

> 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)

In addition to this cross-cultural critique, there have been a stream of western therapists arguing—from within the field—that our psychotherapeutic concepts and models are constructed. For example, here is a constructionist critique of the alleged scientific, reality-based claims by one of our most well-known psychotherapists, Irving Yalom.

> 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)

And no one can forget that the most intellectually rigorous refutation of defining psychotherapy as "scientific" came from the behavioral school. They pointed out that the scientific method is dependent on satisfying certain conditions including consensual agreement on basic terms such as "what is being measured/studied." For example, given the field can't arrive at the same definition for almost all of the key concepts in psychotherapy, including emotions, cognitions, mind and self, it becomes impossible to employ science in an undefined space. Moreover, it is difficult or impossible for independent observers to measure psychological variables and get the same results when it has been well documented that the relationship between the researcher and the subject is so important that is significantly biases each measurement. Their famous solution—limit psychology to studying behaviors—while intellectually and scientifically pure, was discarded long ago as failing to include so much of the scope of being human.

The final argument arises out of the research results themselves. The scientific paradigm works well in terms of generating privileged knowledge and techniques with inherent power in virtually every field that operates in fundamental reality; for example, no one can practice as an engineer or metallurgist without training in the professional knowledge bases and mastery of essential techniques. Contrast those fields with ones that operate primarily in constructed reality—e.g., leadership, sales, and education. These professions have had great difficulty establishing privileged knowledge even though they allegedly employ the scientific method. Any sophisticated cultural member can practice in those fields without special training. Finally, the fields where the scientific paradigm functions well have cross-cultural applicability—antibiotics work across all cultures—whereas the nonscientific fields lack that generalizability—knowing how to lead or how to sell something works in one culture but would need to be significantly different in another culture.

Do the research findings plus the additional arguments listed in this section "prove" that the Berger/Luckmann argument is true? Social science traditions are very hesitant to make such claims. However, it is certainly reasonable to state that the scientific theory lacks any compelling evidence and that it is highly likely that the western mental health model is as constructed as other culture's mental health model.

Before using this conclusion to explain the research findings, it is important to explore the privileged knowledge finding in more detail. Examine the concept: "regular, restful sleep is conducive to positive mental health outcomes." Certainly, this principle appears to be part of psychotherapy's privileged

knowledge and virtually no one can doubt its truth and usefulness. Here's the problem: the word, "privileged," means that it is special knowledge owned by the profession of psychotherapy. However, when trainees come to graduate school, they already know this principle. Hence, while it is true and useful, it isn't privileged; rather, it's common knowledge. Imagine other familiar examples, "appropriate socializing is good for most people;" "getting a dog often reduces depression;" and "some ability to handle conflict enhances self-esteem."

This analysis leaves psychotherapy in the unenviable position of concluding that the portion of our knowledge that is effective is primarily common knowledge and the privileged portion of our knowledge fails to enhance outcomes. While it is difficult to discern the exact dividing line between privileged knowledge and common knowledge in psychotherapy, the fact that psychotherapy's knowledge base fails to enhance outcomes strongly suggests that very little of our privileged knowledge is useful.

There is a corollary to this privileged knowledge finding that applies to the techniques finding. Many of our primary approaches to psychotherapy are common knowledge in the culture. More specifically, it seems likely that Strupp's professors would have said things like, "it's a good idea to talk about highly charged memories from the past;" or, "you can learn to control your feelings of shyness by using your rational mind;" or, "you'll feel better about your life if you can use your feelings to guide you as you attempt to discern your authentic path." These concepts are widely disseminated across western culture and it appears that many graduate students, paraprofessionals, and coaches already have a functional grasp of these ideas before they receive any training.

In sum, most of western psychotherapy is constructed although the bulk of its practitioners and clients believe it is scientific and evidence-based. The primary construction of the western model is, of course, the idea that therapy works like medicine and that mental illness—psychopathology--is like having a disease. Our privileged knowledge fails to enhance outcomes because most of it consists of intellectual elaborations on constructed material. We fail to learn from experience because we are focusing on the wrong things—techniques and elaborations on psychopathology—and miss the appropriate focus on beliefs, expectations, and client fit.

Beyond, the "western model is scientific" argument, there is a second problem with accepting constructionism as an explanation for the provocative research findings: it simply "feels" wrong. Social constructionism has an easy explanation for this. One of the chief characteristics of social constructionism is that when other members of the culture endorse the validity of a construction, it feels as real as a solid object like a table. For examples, in cultures that have the construct, "romantic love," the existence and relevance of love is as significant as the fact that copper conducts electricity. In this sense, therapists have the feeling—like exorcists—that the intervention that occurred in the room is responsible for client improvement and that psychotherapy works like medicine. It is very challenging to repudiate these beliefs.

The final difficulty in terms of rejecting the "it feels wrong" response to the provocative research findings is contained in the famous Upton Sinclair quote: "It is difficult to get a man to understand something when his salary depends on his not understanding it." The research findings require mental

health professionals to agree that all of their studies, supervision, workshops and readings have failed to enhance outcomes. It is a rare person who is happy to hear that their "expertise" primarily consists of misconstruals.

## The 55%

Before proceeding to pragmatic suggestions for training and practice, it is important to explore the implications of the research findings for the therapeutic milieu. Psychotherapy has a stable, positive effect size of .8 which can be operationalized as treated clients are better off than 80% of a waiting list control group (Wampold & Imel, 2015a). When framed as percent improved, which is a different statistic, one can estimate that approximately 55% of clients improve in psychotherapy and 45% are either unchanged, become worse or drop out (Miller, 2015; Miller, 2019).

The research shows that it is ridiculously easy to achieve this 55% result. Beginners can accomplish it, paraprofessionals can accomplish it, and non-therapists can accomplish it. Moreover, every system invented and practiced also achieves this 55% level of success (c.f., Wampold, 2010, Kindle Locations 2089-2092). In this sense, the 55% might characterized as the "readily adaptable" group.

This group changes so easily that one could argue that they are able to evolve simply "on request." Essentially, they can resolve their issues whenever they are approached by a reasonably credible therapist with a reasonably credible rationale. This ease of change has a number of implications for psychotherapy. First, it virtually guarantees that any new psychotherapy system will work and help people; this ease of change group of clients validates every new approach. This explains the success of classic systems like psychodynamic psychotherapy but also explains more unusual systems like primal scream and EMDR.

Second, this ease of change group is responsible for the general sense among psychotherapists that they are personally successful. The average therapist is virtually guaranteed to be effective with the 55%; moreover, their personal effectiveness quotient appears even higher when we think through how many of the 45% present themselves as poor therapy candidates. Put another way, experienced therapists recognize that a certain percentage of their referrals are unsuited for psychotherapy; when these people are eliminated, many therapists have the understandable feeling that they are successful with 70% or 75% of their "real" clients.

While these numbers are helpful for therapist self-esteem, the downside is that they make therapists complacent and disguise the fact that there are no training or experience effects and that psychotherapy is stuck with outcomes that have failed to improve for at least forty years (Miller, Hubble & Chow, 2020). Most importantly, there is an implication that the medical model is working and that the system or systems that one is using are the cause of the improvement. When what I do actually works, why make radical changes? It's easy to imagine an identical argument being proposed by the shamanic healers who use exorcisms….

The second contribution of the ease of change group has to do with understanding and feeling the fluidity implicit in constructed reality. Accepting that most clients change easily—*with virtually any rationale*—suggests that psychopathology and its solutions and resolutions exist in such a malleable psychological space that they can be changed by a word, an idea, or a feeling. In this sense, it can be useful to picture psychotherapeutic reality as so constructed that it operates in an almost "magical" realm where dilemmas are created by enchantments and resolved by white sorcerers. From this perspective, one might argue that some of the shamanic metaphors better describe the feeling of the constructed reality of psychotherapy than the medical model's scientific metaphors.

Finally, this understanding of the 55% gives another level of understanding of the lack of training and experience findings. Doing therapy with the 55% is so easy that it can be compared to learning to open a jar; given the ease of mastering "jar opening," one should not be surprised that beginners are as good as experts and that jar opening doesn't improve after 10 years of practice. It even explains Miller's argument that outcomes decrease slightly over experience; one can become somewhat bored or burned out when using repetitive and predictable protocols.

Exploring the implications of the ease of change of the 55% inevitably leads us to examine the 45% who fail to benefit from therapy. The first implication is that the only way to improve therapeutic outcomes is to succeed with the 45%; the 55% are already in the bag for most therapists. Common sense argues that the 45% are composed of clients who are hyperstabile—or prone to decline--because they have more negative personal and life factors; for example, they are more traumatized, have fewer resources, have current disabilities, use dysfunctional social strategies, etc. In addition, it can be assumed that the 45% have ways of resisting and defeating the typical strategies that work with the 55%. We already know, from the arguments above, that the primary therapeutic protocols are widely distributed in western culture. Given, therefore, that the 45% have encountered most, if not all, of these approaches, part of their successful hyperstability is due to the fact that they are well-defended against common approaches. This suggests that success with this group requires doing "something different."

## Fluidity and Deconstructing Underlying Assumptions

A constructionist therapist is always poised to "do something different" because, by definition, they understand that standard ways of operating—instead of being "evidence-based," or "best practices"--are, in fact, constructions that are no better or worse than any other constructions. Achieving this level of fluidity—seeing psychotherapeutic reality and psychopathology as essentially malleable—requires most therapists to analyze and release underlying assumptions; more specifically, it requires a radical deconstruction of the misconstruals that characterize the medical model.

This necessary deconstruction begins with the direct implications of the research. For example, we should stop developing psychological systems that simply achieve the same outcomes as extant systems. We should stop offering and attending workshops that imply that learning new techniques will enhance outcomes. We should stop claiming that our ability to specialize in a certain area enhances outcomes. We should be very suspicious of the underlying assumptions of the disease model particularly

in terms of accepting the implications of diagnoses, prognoses, and client characteristics. And we should reject the concept that our experience level has made us more competent.

Of course, there is no chance that the field as a whole will respond like this; however, it is incumbent on a practitioner who wishes to benefit from a constructionist worldview to divest themselves of unhelpful and misleading assumptions. And this takes some work. If we were awakened exorcists training new exorcists, we wouldn't be satisfied simply telling them that the spirits are constructs and the exorcisms are rituals. The spirit possession model is deeply rooted in that culture and has threads running everywhere. The student exorcists would need to recognize these threads and root them out. Similarly, practicing constructionism effectively requires practicing deconstructionism comprehensively.

A constructionist therapist needs to cringe inwardly when they hear about the 5 love languages, or parent skills training, or that DBT is <u>the</u> treatment for borderlines. One needs to cringe not because these approaches are ineffective—remember that the research clearly documents that every credible approach works—but because they each have a way to influence one—or even bewitch one—into seeing the medical model as real and not as constructed. Moreover, understanding why there can't possibly be five love languages, or why the "skills" taught to parents don't make them more effective, or why the DBT model isn't the best way to treat borderlines are major contributions to enhancing a personal understanding of fluidity.

The Jerome Frank model (Frank & Frank, 1993) explaining how psychotherapy works is very useful when it comes to operationalizing this understanding of fluidity. Frank's model attempts to place western psychotherapy in the context of cross-cultural healing. More specifically, he suggested that healers ameliorate human suffering by offering an *explanation* for the suffering and then prescribing an *action or procedure* designed to rectify the problem. The process is facilitated if the culture sees the healer as *high status* and if the relationship between healer and sufferer is marked by *wisdom* and *caring*.

Using our spirit-possession metaphor, we can imagine the benefits that accrue to the awakened healer who knows that the spirits are constructs and the exorcisms are rituals. First, they are free to change the explanation—the type of spirit—from one that is powerful and severely malevolent to one that is relatively benign. They are free to alter the prescribed action—the exorcism—from one that has rigid, defined rules to one that is expressly crafted to fit the needs and expectations of the client. A simple example of how one might alter the explanation in our culture could involve a new client who states that their previous therapist diagnosed them as borderline; they have read about the diagnosis and, while they agree with certain characteristics, they are simultaneously frightened and depressed. The constructionist therapist, after assessing the situation carefully, might respond that the client has multiple parts or ego states; however, only one of these parts merits a borderline diagnosis. Furthermore, they might add, the prognosis for "borderline in one ego state only" is much better than a classic borderline diagnosis.

Clients typically arrive in therapy with formal or informal explanations for their presenting problems. Of course, most standard therapists implicitly or explicitly review these explanations; while they sometimes leave them intact, they will often replace them with a psychodynamic explanation or a cognitive one, or

whatever seems appropriate. The constructionist therapist, who understands that privileged knowledge fails to enhance outcomes and who recognizes the malleability of psychotherapeutic reality, has much more freedom, much more room for creativity with the explanations. For example, a client might present stating that her OCD problems have returned. Every time she encounters anything connected to religion—e.g., a church, a priest, or a religious term in conversation—she is compelled to perform a ritual consisting of touching a surface in a certain numeric pattern. She also reported that she had just started a relationship with a new boyfriend, who she likes but who she suspects is somewhat narcissistic, and she says that she is a "very spiritual" person although she doesn't attend church. The constructionist therapist might explain that these urges, while resembling OCD, could also be a higher power reaching out to her. Instead of touching and counting, she could respond to each spiritual prompt with two kinds of prayers: one that her new boyfriend would gain inner peace and release his narcissistic strategies and an alternative prayer for all men who suffer from narcissism. The client returned reporting that this new strategy felt empowering to her; she was now welcoming the spiritual prompts and the prayers felt as if they were expanding her spiritual consciousness. Over the ensuing four weeks, she reported that she had become more assertive inside the relationship and that the boyfriend had responded positively to her feedback.

The obvious objection to this freewheeling redefinition of the presenting problem is that it isn't "true." rather, it is simply an invention—or even a conceit--of the therapist. Constructionism has already destroyed the concept that the definitions of western psychotherapy are true, yet there remains some validity in the critique; the therapist is not free to invent "just anything;" the explanation must somehow be validated by the beliefs and the life circumstances of the client. In the case of the OCD client, her beliefs and life circumstances were highly supportive of the new explanation. In the case of the imaginary borderline with only one borderline "part," the explanation would prove unhelpful unless the therapist could make the case that it fit naturally with the client's current situation.

Determining this "fit" requires the constructionist to pay much more attention to both client beliefs and life situation than the standard therapist. This makes the constructionist more client-centered. It also encourages the constructionist therapist to assess their own level of persuasiveness and charisma; the more charismatic, the more the improved explanation feels real and accurate to the client. In sum, while there are obvious benefits with replacing a problematic, standard explanation/diagnosis/prognosis with something easier or more meaningful, the successful execution of this strategy requires a higher level of client-centeredness and therapist charisma. But that should come fairly naturally for the constructionist; when psychotherapy's privileged knowledge is deconstructed, all that is left to lean on are the client's beliefs and life circumstances.

Another meaningful contribution of constructionism is the concept that the symptoms are also constructed. They are constructed along two dimensions: culturally and transactionally. Cultural construction of symptoms has been mentioned above and simply implies that the symptoms will correspond to what the culture believes mental health symptoms "ought to look like." Symptoms as a transaction have been explored by various psychological systems, especially systems theory (e.g., Alexander & Parsons, 1982). When the practitioner is aware that the symptoms are fully constructed—and are not the expression of an internal "disease"--they become much more focused on exploring the

transactions. This is an extension of the client-centered/client fit nature of constructionist psychotherapy. And, while many practitioners already attempt to look at secondary gains and the meaning of symptom transactions, the constructionist has a significant edge in this department. Once again, when privileged knowledge is abandoned, the state of the client—their beliefs and behaviors—gains proportionally in importance and emphasis. Especially with the 45%, who require "something different"—the ability to fully explore the transactional nature of symptoms opens new possibilities and can often offer new insights into the profound hyperstability.

At this moment in western culture, social constructionist ideas are relatively common in psychotherapy; they are somewhat present in many psychological systems and certain approaches—particularly personal construct therapy, narrative therapy, and collaborative therapy—are appropriately described as constructionist psychotherapies. What do the research findings add that is not already available with these extant approaches? First, while these systems are appropriately labeled as constructionist in that they are theoretically based on constructionist concepts, their interventions are as technique-oriented as standard psychotherapies. For example, Personal Construct Therapy (Neimeyer, 2007) recommends laddering—a technique for eliciting superordinate constructs—and mirroring—a technique to facilitate self-exploration. Narrative Therapy (Madigan, 2012) recommends re-authoring and the externalization techniques. And Collaborative Therapy argues for "not knowing" and sharing the inner thoughts of the therapist with the client (Anderson, 2003). Moreover, collaborative therapy and narrative therapy teach that the therapist/client relationship should always be nonhierarchical—a formal technique.

Once again, it's not that these interventions are unhelpful—as usual, everything works with the 55%--it's that teaching that techniques have inherent power binds the therapist to the assumptions of the medical model. When a constructionist therapy system unabashedly endorses techniques, it implicitly renounces its constructionist foundations.

Moreover, none of these systems overtly recognizes the inability of psychotherapy's privileged knowledge to enhance outcomes. Without overtly teaching this shocking conclusion it is difficult for the narrative therapist or the constructivist therapist to fully embrace the actual level of fluidity implicit in constructed reality. In sum, while extant constructionist psychotherapies are certainly based on constructionist ideas and principles, in practice, their endorsements of the assumptions underlying the medical model reduce their creativity and limit their impact. To achieve their full potential, they need to integrate the full implications of the research results and be more serious about supporting a deconstruction practice.

This leads us back to the particular characteristics of the 45%: they need something different and unexpected in order to move in a positive direction. An example of the scope of this "differentness" is revealed via what has been called the "kill the Buddha" tradition. This particular example is attributed to Dogen Zenji.

> When asked why he practiced zen, the student said, "Because I intend to become a Buddha."
>
> His teacher picked up a brick and started polishing it. The student asked "What are

you doing?" The teacher replied, "I am trying to make a mirror."

"How can you make a mirror by polishing a brick?"

"How can you become Buddha by doing zazen? If you understand sitting Zen, you will know that Zen is not about sitting or lying down. If you want to learn sitting Buddha, know that sitting Buddha is without any fixed form. Do not use discrimination in the non-abiding dharma. If you practice sitting as Buddha, you must kill Buddha. If you are attached to the sitting form, you are not yet mastering the essential principle."

The student heard this admonition and felt as if he had tasted sweet nectar.

While this story comes from hundreds of years ago, it has a striking set of parallels to the research results. It points out that practices—sitting zazen—are rituals that are easily confused with techniques. It emphasizes the tendency of practitioners to confuse what is constructed with what is real. We can safely assume that the students of this teacher were formally familiar with constructionist concepts—such concepts are literally present in so many aspects of the Buddhist teachings. In spite of the fact that the teacher knew of this familiarity, he still presented his "polish the brick" metaphor; this suggests that even a good theoretical understanding of constructionism is difficult to sustain in real life. In a similar fashion, even with formal knowledge of the research results, psychotherapists need to be on guard in terms of the seductions of the medical model.

The story also suggests that real wisdom—of a higher order—accrues to the one that can tell the difference between what is constructed and what is not. The average therapist has the wisdom that arises from being an accomplished and experienced member of the culture. Understanding the constructed nature of psychotherapy creates an uncommon wisdom—a type of wisdom that our "kill the Buddha" story implies is rare and valuable.

This potential for higher order wisdom has direct implications for the effort to be successful with the 45%. We are already aware that the 45% are not significantly moved by the wisdom of the average therapist; moreover, they are likely to have preestablished defenses against standard approaches. Given that "constructionist wisdom" has the potential to be higher order wisdom, and, more importantly, given that one of the ideal qualities of the constructionist therapist is to create explanations and interventions that are unconventional and explicitly designed for the individual client, it is reasonable to expect that the accomplished constructionist has a chance of achieving successful outcomes with a certain portion of the 45%.

It is also reasonable to imagine that the 45% would be responsive to a more caring therapist; part of their hyperstability is almost certainly due to excessive fear, and the therapist who can imbue the relationship with a greater sense of safety has an edge. The average therapist sets a high bar in terms of caring and, unfortunately, there is nothing that arises directly out of constructionism that enhances caring. The one factor that is relevant, however, is the amount of energy expended by the constructionist with their client-centered focus on beliefs and expectations. From the therapist perspective, this focus literally consists of doing a careful client assessment; from the client's perspective, however, it not only signifies a sense that they and their beliefs are important, it can also be experienced as a co-creation of the explanation and the healing procedure. The deeper the focus on the

client, the more the constructionist therapist can embrace “what is” instead of “what I expect,” the easier it is for the client to experience the interaction as caring and compassionate.

## Summary

Given the research results, there are no credible arguments supporting the concept of specific factors, or the inherent power of techniques, or the efficacy of psychotherapy’s privileged knowledge. While most of the field will have a hard time accepting these points, it should be logically recognized that specific factors are a “dead man walking” sort of idea--only sustained by the difficulties and discomfort inherent in any meaningful paradigm shift.

The primary implication of the research findings for training and practice is that we must shift the image of the idealized therapist from an expert on mental illness, diagnosis and techniques to an expert on the fluidity of reality who has a special ability to fit interventions to client needs. The first step in achieving this fluidity is to recognize just how easy it is to change for most people. The second step is thoughtful deconstruction of the implicit assumptions of the medical model and the resulting enhancement of freedom and creativity. The third step is the profound prioritization of client beliefs and life circumstances; this results in a client-centered stance that is so profound that it can be experienced as a flattening of the therapeutic hierarchy and a commitment to co-creation of explanations/healing procedures.

The research results have destroyed the extant psychotherapeutic paradigm. Fortunately, this deconstruction has opened new avenues that have the potential to advance the field. This paper includes a variety of speculations on how the implications of the paradigm shift might affect pragmatic psychotherapeutic practice. While it can be hoped that these ideas will be useful in advancing the field, they should be simultaneously conceptualized as invitations to enter into dialog. We need our most creative thinkers to begin to ask the question, “how should psychotherapy evolve now that we can reject the medical model explanation?” This paradigm shift has put the psychotherapy field back into a potentially creative space reminiscent of the times of our revered early thinkers like Freud, Jung and Adler. The doors are open wide; there is ample space for a spirited dialog about new directions.

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