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PUTTING MODELS AND TECHNIQUES IN CONTEXT

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> Mental health care exerts an influence on the basis of its claim to scientific status, but that claim is false. What it actually does is induct people into understanding life in certain ways that are artifacts of the cultures of healing.
>
> —Robert Fancher

At first glance, this chapter may seem out of place. Why would a book with a focus on the common factors—the "Heart and Soul" of psychotherapy—include a chapter on factors as specific as models and techniques? Any confusion is entirely understandable. For many years, *common* (e.g., the therapeutic relationship) and *specific* (e.g., therapeutic models and techniques) have been the primary and traditional categories used for understanding psychotherapy research. In recent decades, the distinction has also been the major organizing scheme used by practitioners and researchers, many of whom feel compelled to represent their work either as primarily based on technique (e.g., empirically supported treatments; Chambless & Hollon, 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995) or based on common relationship factors (e.g., empirically supported relationships; Norcross, 2002). However, the common versus specific divide emphasizes a fundamental misunderstanding, namely, that the treatment model and the common factors are separate and distinct. In point of fact, the therapeutic factors identified and discussed in this volume are intricately interwoven with the theoretical orientation of the therapist and the treatment provided (Wampold, 2007).

Historically, there have been varied and often contradictory definitions for models. Some view them as specific to predicting change in therapy, whereas others consider them highly abstract formulations with applicability to all human behavior (Matarazzo & Garner, 1992; Poznanski & McLennan, 1995). The first therapy models were simply extensions of psychological theories. Early models of treatment were not merely a collection of techniques to be used with people in therapy but reflected an overarching worldview. Most were rational, quasiphilosophical formulations about individual development and personality that contained implicit assumptions and values about life, mental health, and mental illness.

In this chapter, a *model* is defined as a collection of beliefs or a unifying theory about what is needed to bring about change with a particular client in a particular treatment context. Models generally operate based on a set of core principles (Castonguay & Beutler, 2006; Goldfried, 1980) that lead to or include specific therapeutic *techniques*, defined here as actions that are local extensions of the beliefs or theory. Orlinsky, Grawe, and Parks (1994) summarized that "the particular techniques or methods employed by therapists can be thought of as tactical interventions made to implement heuristic goals. These [techniques and goals] vary according to the treatment model being followed" (p. 306). Models and techniques are, therefore, related but not identical, but one assumes that therapists implement techniques that originate from some sort of model. In other words, however implicit, all therapists operate according to certain beliefs or assumptions about what facilitates positive outcomes. Often, these models are aligned with a theoretical orientation.

In contrast to the contemporary focus on specificity, the earliest theories and techniques were thought to be universally applicable. Much of the early history of psychoanalysis involved Freud's efforts to establish that all mental disorders had libidinal causes; his theories were sufficiently expansive that they could explain cultural practices, history, and art (Makari, 2008). Skinner's theory of radical behaviorism not only served as the impetus for behavioral treatment but also as the inspiration for a utopian vision of a society based on the widespread application of behavioral principles (Skinner, 1948). Rogers's (1961) client-centered theory, on the other hand, served as a vision of society based on individual freedom and self-determination as well as underpinning a method of psychotherapy. Accordingly, these initial psychotherapy approaches were used widely to treat all distress, regardless of the disorder, cultural context, and client history. Of course, there was mutual antipathy between various approaches and even within approaches, as the proponents of a particular brand of psychotherapy believed fervently that theirs was the only legitimate approach and all others were misguided (Miller, Duncan, & Hubble, 1997)!

Although the proponents of various approaches fought bitter battles, a few scientists and theoreticians who approached psychotherapy as a contextual phenomenon suggested that the commonalities among the various psychotherapies were more important than the differences (Frank & Frank, 1991; Rosenzweig, 1936). Over the years, a number of common factors models have been proposed. The typical strategy has been to present a list of categorized components believed to account for the benefits of psychotherapy (cf. Garfield, 1995; Grencavage & Norcross, 1990; Hubble, Duncan, & Miller, 1999b; Imel & Wampold, 2008; Lambert, 1992; Lambert & Ogles, 2004).

It is unfortunate that the various categorization schemes, although providing a compelling argument that the common factors were the essence of therapeutic success, served to reinforce the mistaken impression that psychotherapy was primarily a technical endeavor. In place of a grand organizing theory applied to everyone seeking treatment or a specific treatment applied to a specific disorder, effective therapy was now a matter of mixing in the appropriate amounts of client strengths and resources, therapeutic relationship, hope and expectancy, and therapeutic techniques. However, as the authors of chapter 1 of this volume point out, such a conceptualization ignores that the common factors are embedded in the context of the delivery of specific treatments.

In this chapter, emphasis is placed on how the various therapeutic factors are organized around treatment. Without a treatment, the factors, like techniques, are simply ingredients; with a treatment, they form a coherent and viable package of what is known as psychotherapy. To explain the relationship between treatment models and other therapeutic factors, we now turn to a metaframework that has been termed the *contextual model*.

THE CONTEXTUAL MODEL

The contextual model of psychotherapy (Frank & Frank, 1991; Wampold, 2001) is a superordinate or metamodel of psychotherapy. The contextual view holds that psychotherapy orientations (and other forms of healing) are equivalent in their effectiveness because of factors shared by all, in particular: (a) a healing setting; (b) a rationale, myth, or conceptual framework that provides an explanation for the client's presenting complaint and a method for resolving them; (c) an emotionally charged, confiding relationship with a helping person; and (d) a ritual or procedure that requires involvement of both the healer and client to bring about the "cure" or resolution.

In contrast to the traditional theoretical models described above, which propose that change is due either to specific technical operations or various common factors, the contextual model proposes that therapeutic 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. Rather, the key is that there must be (a) a set of techniques or rituals that are consistent with shared cultural beliefs, (b) a theory that is understood and accepted by the client, and (c) a treatment that is implemented in a way that promotes a positive outcome.

As just one example, consider the treatment of depression and anxiety. Many different psychotherapeutic approaches exist. In cognitive therapy, for example, specific interventions such as identifying and altering automatic thoughts and core belief structures are believed to be responsible for change. At the same time, however, numerous other approaches based on entirely different and sometimes contradictory rationales (e.g., interpersonal therapy, process experiential therapy, short-term dynamic therapy) have been tested and proven effective (Wampold, 2007). Finally, many of the specific actions of different therapies can be explained through the mechanisms championed by rival therapies. A prominent example is the technique of psychoanalytic interpretation that when explained by Wachtel (1997) is nearly identical to behavioral exposure techniques. It is clear that the truth of any model and associated strategies is not critical to success. Rather, each merely offers an opportunity for engagement of the client and therapist in a process that promises to be helpful.

Figure 5.1 uses Orlinsky and Howard's (1986) generic model of psychotherapy to illustrate the relationship between the contextual model and traditional psychotherapy models, principles, and techniques. The rectangular shapes represent the four components of the contextual model. Treatment models and techniques are contained within the circular shapes. The more abstract aspects of psychotherapy models—including the healing setting or culture, the myth or rationale, and psychotherapy orientations—are found at the top of the diagram. Principles and processes are in the center, illustrating links between theory and technique as well as interconnections among theories that share principles. Rituals, or the procedures and techniques associated with specific models, are located at the bottom of the figure.

In the material that follows, each component of the contextual model is explored and connected to the delivery of specific treatments. As we see it, the various components of the model can be discussed separately but are held together by common principles that link these factors into a cohesive treatment (Wampold, 2007) that works best under specific cultural circumstances, problems, and shared beliefs. A metaphor for this dynamic connection among the various components of common factors is the three-legged stool. As used by Miller, Duncan, and Hubble (2005), the treatment methods and the emotional bond serve as two of the three supporting ingredients of a helping relationship; the third leg is agreement between client and therapist on the goals, meaning, or purpose of the therapy. Holding the legs in place is the seat or
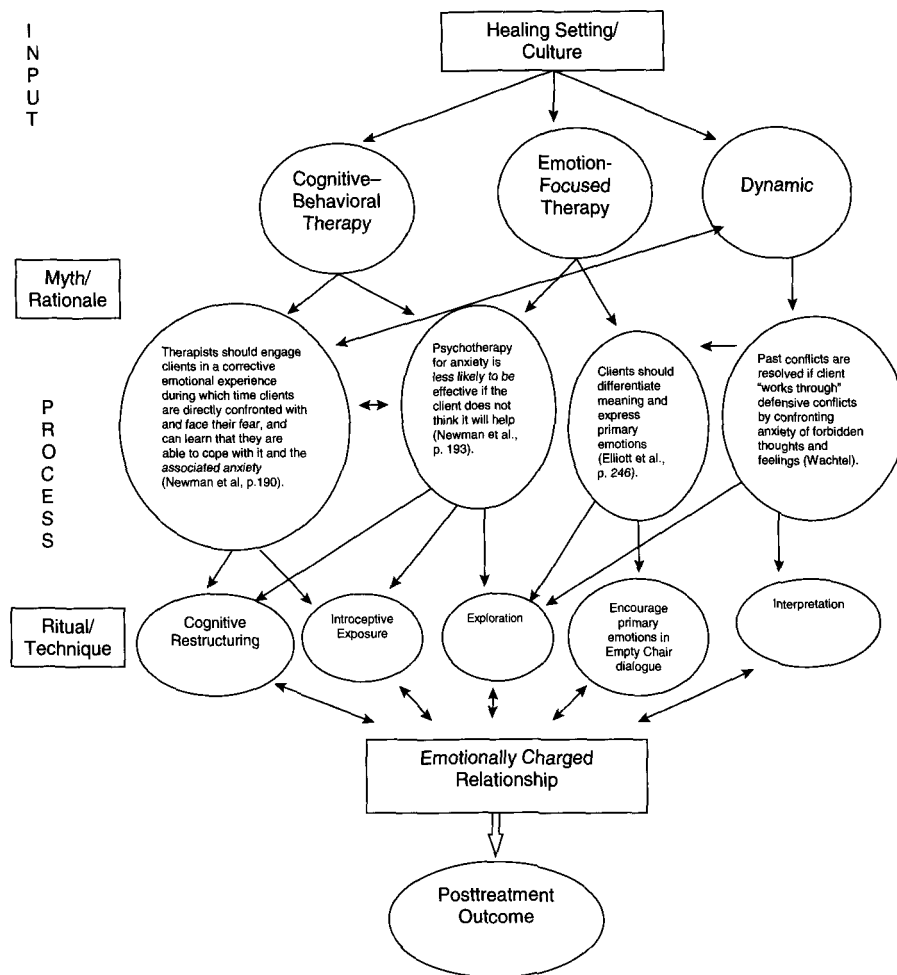
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Cognitive–Behavioral Therapy

Emotion-Focused Therapy

Dynamic

Myth/
Rationale

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Therapists should engage clients in a corrective emotional experience during which time clients are directly confronted with and face their fear, and can learn that they are able to cope with it and the *associated anxiety* (Newman et al, p.190).

Psychotherapy for anxiety is less likely to be effective if the client does not think it will help (Newman et al., p. 193).

Clients should differentiate meaning and express primary emotions (Elliott et al., p. 246).

Past conflicts are resolved if client "works through" defensive conflicts by confronting anxiety of forbidden thoughts and feelings (Wachtel).

Ritual/
Technique

Cognitive Restructuring

Introceptive Exposure

Exploration

Encourage primary emotions in Empty Chair dialogue

Interpretation

Emotionally Charged Relationship

Posttreatment Outcome

Figure 5.1. Examples of models and techniques in context from the contextual and generic models of psychotherapy. Rectangular boxes are the four factors from Frank and Frank's (1991) contextual model. Circular shapes represent specific examples of various models and techniques (i.e., myths and rituals), which are on a continuum *of high (orientations) to low (specific techniques) levels of abstraction. Treatment* principles (intermediate circular shapes) link orientations and techniques. Newman *et al. = Newman, Stiles, Janeck, and Woody (2006); Elliott et al. = Elliott, Watson,* Goldman, and Greenberg (2004); Wachtel = Wachtel (1997).

degree to which the three legs fit with the culture, worldview, circumstances, and preferences of the client (i.e., the client's theory of change; see Duncan & Miller, 2000).

The model described in Figure 5.1 is similar in that common factors are interdependent. When there are shifts within these treatment components (i.e., culture, myth or rationale, ritual or technique, relationship) or

the connecting principles, the entire treatment must be brought into balance for the treatment to remain sustainable. In Miller et al.'s (2005) stool analogy, adjustments in the legs or seat of the stool have the potential to make "the stool uncomfortable or toppl[e] it completely" (p. 87). For the sake of parsimony, we review the components of this comprehensive model separately.

Healing Setting or Culture

The first element of the contextual model refers to everything from the architecture of a clinic to the number and nature of the forms used to initiate services. Whether conducted in a shaman's hut or a Western hospital, the setting in which a treatment occurs imbues the process with power and prestige while simultaneously reminding the participants of the predominant cultural beliefs regarding effective care. That said, seeing the cultural influences in one's core beliefs is not easy, making it difficult (if not impossible) to clearly perceive the role of this critical factor in the operation of psychotherapy models.

To be persuasive, any intervention must first be meaningfully linked with shared communal beliefs (Wampold, 2007). As Frank and Frank (1998) noted, "The power of any therapeutic rationale to persuade is influenced by the culture from which it derives. In devout cultures, religious rationales may have the greatest therapeutic power. In our secular society, such power derives from science" (p. 590). In short, models must possess a rationale that strikes at the heart of what it means to be a person within a particular place and time.

The implications for treatment are clear. Clinicians not only need to be aware of the many meaningful cultural myths available but also should be open to altering techniques, style, and approach to achieve a better fit with the client. As Fischer, Jome, and Atkinson (1998) argued, therapists should use

> cultural (and individual) knowledge to be flexible—that is, to consider the role of culture (broadly construed)—in negotiating the structure of the relationship, the way that they and their clients communicate about that relationship and about the clients' experience (the worldview), the course of action and experience they anticipate (expectations for change), and the steps they and their clients take to help clients reach their goals (intervention). (p. 603)

Myth or Rationale

Following setting and culture in the contextual model is myth or rationale. In the practice of psychotherapy, this aspect is most easy linked to theoretical orientation or therapeutic school. As can be seen in Figure 5.1, therapeutic theories or rationales serve an important function, acting as the "central station" between (a) the culture in which psychotherapy is embedded and (b) the

principles of treatment and associated therapeutic techniques. The close relationship between these parts makes clear, as Wampold, Imel, Bhati, and Johnson-Jennings (2007) noted, that

> to be effective [the therapeutic rationale] must lie within the expected cultural frame in which the healing practice is most often conducted, should be proximal to the client's currently held explanation or expectation, and should not create dissonance with the attitudes and values of the client that would cause the client to reject the explanation outright. (p. 125)

The idea that client perceptions are critical to successful psychotherapy, Duncan and Miller (2000) pointed out, "has a rich, although somewhat ignored theoretical heritage" (p. 174; see also Duncan & Moynihan, 1994; Duncan, Solovey, & Rusk, 1992; Hubble, Miller, & Duncan, 1999a). As early as 1955, for example, psychiatrist Paul Hoch (1955) observed that "there are some patients who would like to submit to a psychotherapeutic procedure whose theoretical foundations are in agreement with their own ideas about psychic functioning" (p. 322). Others have hypothesized that problems in treatment were often the result of the "two parties . . . applying models that are out of phase with one another" (Brickman et al., 1982, p. 375).

Once again, the implications for psychotherapy are clear: The rationale for treatment should be selected and carefully tailored to the culture, worldview, circumstances, and preferences of the client (Hubble et al., 1999a). "Ideally," Frank and Frank (1991) argued, "therapists should select for each patient the therapy that accords, or can be brought to accord, with the patient's personal characteristics and view of the problem" (p. xv). Consistent with the history of the profession, the currency of particular explanations wax and wane as culture evolves and changes. To be sure, the notion that the "truth" of a particular treatment rationale is unimportant may be unsettling to some (Grawe, 2004). And yet, Duncan and Miller (2000) pointed out that key to finding what works for the individual client is found in this very indeterminacy.

Ritual or Technique

The third component of the contextual model needs little introduction. Ritual or technique is the means by which a given cultural myth or therapeutic rationale is enacted. Where myth or rationale explains why, ritual or technique shows how. In the field of psychotherapy, practice and research have long been dominated by therapeutic technique. At the same time, it may be said, paraphrasing Winston Churchill, that never has a subject that contributes so little to outcome received so much professional attention and approbation.

As reviewed elsewhere in this volume, no differences in effectiveness have been found among treatment approaches intended to be therapeutic. The same body of evidence has also failed to find any connection between the techniques of a specific model and outcome (Ahn & Wampold, 2001). When combined with research showing that structurally equivalent sham treatments (e.g., placebo; technically inert comparison conditions designed to closely resemble real treatments) reliably produce effects as large as bona fide therapies (Baskin, Tierney, Minami, & Wampold, 2003), the conclusion is inescapable. 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 (Kirsch, 2005). This is discussed further later in this chapter. At this point, suffice it to say that techniques work, in large part, if not completely, through the activation and operation of placebo, hope, and expectancy.

The saga of present-centered therapy is illustrative. As Wampold (2007) effectively described, the approach currently known as present-centered therapy (PCT) began its journey to empirically supported status as a lowly control group technique. Researchers testing the efficacy of cognitive–behavioral treatments (CBT) for posttraumatic stress disorder (PTSD) needed a comparison condition that contained curative factors shared by all treatment approaches (e.g., warm empathic relationship) while excluding those believed unique to CBT (e.g., exposure). This control treatment, described as *supportive counseling*, contained no treatment rationale and no therapeutic actions. Moreover, to rule out any possibility of exposure, even covert in nature, clients were not allowed to talk about the traumatic events that had precipitated treatment!

Needless to say, PCT was found to be less effective than CBT. However, when a manual containing a rationale and condition-specific treatment actions was added later to facilitate standardization in training and delivery, few differences in efficacy were found between PCT and CBT in the treatment of PTSD (McDonagh et al., 2005). In fact, significantly fewer clients dropped out of PCT than CBT. Thus, when PCT was made to resemble a bona fide treatment, it was not only as effective as but also more acceptable than CBT. Although recent findings were more favorable to CBT over PCT (Schnurr et al., 2007), the malleability of PCT illustrates our point. Specifically, the effect of a treatment likely depends on the extent to which the treatment matches shared social constructions about what it means to be remoralized within the culture in which it is practiced.

While discussing the qualities of effective rituals and techniques, we should also mention the impact of researcher or therapist allegiance on treatment outcome. Briefly, *allegiance* is the degree to which a practitioner delivering or a researcher investigating a treatment believes a particular therapy to be efficacious (Wampold, 1997). Considerable evidence now exists that belief in

or commitment to a particular method of treatment has a significant influence on treatment outcome (Dush, Hirt, & Shroeder, 1983; Hoag & Burlingame, 1997; Luborsky et al., 1999, 2002; Paley & Shapiro, 2002; Robinson, Berman, & Neimeyer, 1990; D. A. Shapiro & Shapiro, 1982; Smith, Glass, & Miller, 1980). Indeed, allegiance effects appear to be greater than the effects produced by comparisons of treatments—as much as 3 times greater when the most liberal estimates are used (Wampold, 2001). As Frank and Frank (1991) observed, "A therapist who is convinced by personal experience of the validity of a particular method may be powerfully effective in persuading patients they too will benefit" (p. 161).

In sum, techniques are a necessary component of effective care. 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.

Emotionally Charged, Confiding Relationship

An emotionally charged, confiding relationship is the fourth and final component of the contextual model. Although little debate exists regarding the overall importance of the therapeutic relationship, there is considerable difference of opinion regarding its potency and place. Advocates of particular treatment approaches emphasize the specific ingredients of their chosen method, arguing that the relationship is necessary but not sufficient to bring about change. Barlow (2004), for example—although acknowledging the "strengths of traditional psychotherapy, including the importance of therapeutic alliance, the induction of positive expectancy of change, and remoralization"—argued that effective psychological treatments must contain "specific psychological procedures targeted at the psychopathology at hand" (p. 873). Others have disagreed sharply, downplaying the role of techniques and citing the primacy of the relationship in successful therapy. Thus, Jordan (2002) contended, treatment "is not based on a sophisticated set of techniques, but depends largely on an attitude of mutual respect and inquiry . . . brought to a therapy relationship" (p. 237). In each instance, the therapeutic relationship and treatment techniques are treated as separate, independent factors contributing to the outcome of psychotherapy.

The contextual model, by contrast, emphasizes the coordinated and synchronized interaction of technique and relationship factors (see Figure 5.1). In short, the two are inextricably linked, are mutually dependent, and must be delivered in a coordinated fashion with each other (Butler & Strupp, 1986; Duncan & Moynihan, 1994; Gelso & Hayes, 1998; Hatcher & Barends, 2006). Conceptualized in this way, there can be no alliance without a treatment.

Equally true, any technique is only as effective as its delivery through the context of the client–therapist relationship. Frank and Frank (1991) put it this way, "The success of all methods . . . depends on the patients' conviction that the therapist cares about them *and* [italics added] is competent to help" (p. 154).

PLACEBOS: CULTURAL SYMBOLS THAT CREATE POWERFUL EXPECTATIONS

We have made allusions throughout this chapter to the role that hope and expectancy play in successful psychotherapy, a subject taken up in more detail here. We argue that many of the benefits of treatment occur via the installation of hope and changed expectations. We also argue that the primary means for inspiring hope; changing expectations; and facilitating belief in the therapist, treatment, and relationship is the therapeutic myth or rationale provided to or developed in conjunction with the client.

A brief review of placebos in medicine reveals the power of expectations. Modern medicine was established as a scientific endeavor, in part, by demonstrating that the administration of a substance or the application of a procedure had benefits over and above an inert substance or method; that is, the treatment was superior to a placebo (A. K. Shapiro & Shapiro, 1997a; Wampold, Minami, Tierney, Baskin, & Bhati, 2005). As a consequence, placebo effects were deemed unimportant. Occurring as they did in the psyche rather than in the soma, placebos were not considered real phenomena worthy of serious study (A. K. Shapiro & Shapiro, 1997b; Wampold, Imel, & Minami, 2007). As the name implies, the randomized, double-blind, placebo-controlled design was designed and widely adopted to eliminate the influence of positive expectations or other psychological mediators of outcome (e.g., a caring relationship with the practitioner)—the very ingredients research indicates are critical to successful psychotherapy.

Recent investigations establishing physiological as well as subjective psychological effects of placebos have led to renewed interest in the phenomenon. Data indicate, for example, that placebo analgesics increase natural opioids in the brain (Price, Finniss, & Benedetti, 2008). Physiological responses to placebos have been detected in other medical disorders as well. For example, people with Parkinson's disease who receive a placebo with the suggestion that motor performance will improve indeed show a marked improvement. A number of studies have demonstrated that the low levels of dopamine, which is hypothesized to be related to the motor deficits, increases in those exhibiting a placebo response (Price et al., 2008). Studies are underway to explicate placebo mechanisms in hypertension, gastrointestinal diseases, and asthma (Benedetti, Czajkowski, Kitt, Stefanek, & Sternberg, 2002).

Many models have been proposed for understanding placebo effects (Guess, Kleinman, Kusek, & Engel, 2002; Harrington, 2008; Price et al., 2008), some of which are particularly informative when psychotherapy models and associated techniques are considered among many shared therapeutic factors. Some of the models suggest that the placebo response is embedded in culture (Brody, 1997; Morris, 1997). According to these models, a treatment has symbolic value. Pills, syringes, stethoscopes, and white coats are the symbols of modern medicine and as such they can be powerful placebos without much adornment (for a discussion of placebo effects and psychiatric drugs, see chap. 7, this volume). Psychotherapy, accepted by many, may have healing power simply because of its cultural status as a healing practice. Two research results support this contention. Frank noticed several decades ago that psychotherapy clients improve greatly from the time they make an appointment to the time they present for the first session (Frank & Frank, 1991), underscoring the notion that even the expectation of psychotherapy is in and of itself potent. Furthermore, the form of psychotherapy, without any particular active ingredients, is moderately effective. "Placebo" psychotherapies in which there is no rationale or therapeutic actions produces effects about half as large as a treatment intended to be therapeutic (Wampold, 2001).

In many ways, cultural symbols create expectations, leading some to argue that placebos act through expectations (Kirsch, 1997, 2005; Price et al., 2008). Expectations can be created by the context in which the treatment is administered. As an example, consider a series of ingenious experiments by Benedetti and colleagues. In the studies, the researchers administered an analgesic in open and hidden formats (Benedetti et al., 2003; Price et al., 2008). It is not surprising that when people were aware a drug was being administered, it was experienced as more effective. Accumulating evidence corroborates that the degree to which expectations are induced, the larger the effects that follow (Montgomery & Kirsch, 1997; Nitschke et al., 2006; Price et al., 2008).

Typically, expectations are created in a verbal context; in practice, the clinicians' explanations to the client are powerful. Thomas (1987) demonstrated that simple verbal explanations can result in the reduction of certain symptoms. In the study, people suffering from problems such as pain, cough, or tiredness were assigned either to a placebo treatment or a no treatment condition (e.g., some inert treatment or no treatment at all) and a positive versus negative consultation context (e.g., "You will soon be well" or "I am not sure this treatment will help"). Results indicated no differences in outcome between the placebo treatment and no treatment but a significant difference between the positive and negative explanations.

A comprehensive review of available psychotherapy research has found that therapist explanations influence clients' experience of and benefit from psychotherapy (Greenberg, Constantino, & Bruce, 2006). The same body of

evidence shows that clients' pretreatment expectations regarding both the process and outcome of psychotherapy interact in significant ways with engagement, retention, and outcome (Arnkoff, Glass, & Shapiro, 2002; Constantino & DeGeorge, 2008; Greenberg et al., 2006). In their succinct and clinically oriented summary of both areas of research, Constantino and DeGeorge (2008) observed that although expectancy "has been traditionally undervalued across all psychotherapy orientations," the strength of the data makes clear that therapists should "heed the expectancy literature and, if they have not already, incorporate expectancy-based strategies into their clinical repertoires." That not only includes, the authors go on to say, "explicitly assess[ing] patients' expectations at the treatment's launch . . . [but also] . . . work to change their patients' expectations . . . and/or, if appropriate, alter the nature of treatment to better meet patients' expectations" (pp. 2–3).

IMPLICATIONS FOR RESEARCH AND PRACTICE

In this chapter, we have provided support for a contextual model of psychotherapy, not just as an appealing alternative to any theoretical orientation but more broadly as a superordinate explanation for the effectiveness of therapy that incorporates the importance of theoretical orientations (myths) and their related principles and techniques (rituals). Discussion was purposefully limited to models and techniques. Other chapters in the book provide additional evidence for the importance of other therapeutic factors along with expanding philosophical and theoretical musings about the central ingredients for psychotherapy. With the conceptual framework squarely in place, one might reasonably ask what the implications of this model are for research and practice.

Implications for Research

Understanding the importance of explanation and therapeutic action as a central therapeutic factor has implications for the study of psychotherapy. Clinical trials in psychotherapy often use a type of control condition that involves an interaction with an empathic healer but contains no treatment, at least not a treatment that a clinician would deem legitimate. The therapists in these comparison conditions might be allowed to respond empathically but prevented from offering explanation for the client's distress or suggesting actions to overcome that distress; these conditions lack the myth and ritual components of the contextual model. These control conditions—often called *alternative treatment, supportive counseling,* and *common factor controls*—therefore lack

one of the most important ingredients of successful psychotherapy, regardless of school or theoretical orientation (Wampold, 2001; Wampold, Imel, Bhati, & Johnson-Jennings, 2007). Moreover, in such conditions, the therapeutic relationship is itself artificially constrained, lacking essential qualities such as agreement on the tasks and goals of therapy. Is it any surprise really that treatments intended to be therapeutic are more effective than such controls (Baskin et al., 2003; Wampold, 2001)? With shocking frequency, the superiority of a treatment over such a control condition is (inappropriately) cited as evidence for the importance of the specific ingredients of the investigated approach (e.g., Stevens, Hynan, & Allen, 2000).

A more productive research program could be fashioned by using what is known about the delivery of effective treatments. Much variability in outcomes, for example, is attributable to the therapist who provides a treatment (Wampold, 2006). As discussed in this chapter, it may well be that these super therapists select treatments that are compatible with clients' attitudes, values, and cultural context (Miller, Hubble, & Duncan, 2007). There is in fact a modest, although somewhat ambiguous, literature on client preferences for treatment that appears to indicate that providing the preferred treatment results in increased engagement and stronger alliances (Arnkoff et al., 2002; Elkin et al., 1999; Iacoviello et al., 2007; Leykin et al., 2007; Lyddon, 1989). This is a perspective that is compatible with the idea of client-directed services (Bohart & Tallman, 1999; Duncan et al., 1992; Duncan, Miller, & Sparks, 2004). Clearly, further research is needed in this area.

As the expectancy research cited earlier indicates, therapist explanations influence clients' experience of and benefit from psychotherapy. Clients may have some preconceived notions about psychotherapy, but the effective therapist creates positive expectations for an alternative approach. An old literature on therapy induction (i.e., a pretreatment session to explain how psychotherapy works) seems to indicate that it improved outcomes (Frank & Frank, 1991). There is also some research to indicate that clients prefer treatments delivered by credible therapists; that is, preference follows credibility (Goates-Jones & Hill, 2008). Therapist credibility is the extent to which the therapist can don the mantel of socially shared expectations for a healer who provides the client solutions to problems that fit within a broadly accepted cultural change narrative. Again, an examination of how effective therapists both accommodate and influence client expectations in the delivery of treatment is critically needed.

Clients drop out of treatment for many reasons, but one good candidate reason is that they find the treatment rationale and actions unacceptable. In clinical trials, therapists have less latitude to modify treatments, and this suggests that if clients do not find the treatment agreeable, they drop out of treatment. In general, dropout rates in clinical trials are quite high (Wampold,

2007; Westen, Novotny, & Thompson-Brenner, 2004). For example, in a trial of CBT for PTSD, an empirically supported treatment, the dropout rate was approximately 40% (McDonagh et al., 2005). Research could be productively focused on whether effective therapists are flexible in their approach so that when resistance to the treatment is expressed, the therapist alters the treatment or uses a different treatment altogether.

Implications for Practice

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. 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.

Lambert and colleagues (Lambert, Hansen, & Finch, 2001; Lambert, Harmon, Slade, Whipple, & Hawkins, 2005) have shown that therapists often are poor judges of therapy process and outcome. To aid in monitoring therapy process and outcome, researchers have designed a number of measures and systems to help therapists be aware of these important aspects of psychotherapy (Duncan et al., 2004; Hannan et al., 2005; Lambert et al., 2001; Miller et al., 2005; for a full discussion, see chap. 8, this volume). Feedback systems of this sort may assist therapists in becoming more flexible in their styles and encourage earlier referrals when there is a mismatch. Although the most effective therapists may naturally monitor process and outcome, it is clear that providing such information to therapists generally increases the quality of services (Anker, Duncan, & Sparks, 2009; Lambert et al., 2001; Miller et al., 2005).

Additional tools may be needed to assist practitioners to integrate facets of the healing setting. Working within the cultural context of the healing setting requires therapists to be empathically attuned to the client's cultural experiences, beliefs, and values. Both the client's and the therapist's cultural identities are likely to be a significant influence on how the healing myth is

negotiated and ritualized. Failing to be aware of cultural differences may enhance the likelihood of stereotype beliefs and inappropriate therapist behaviors. As Sue and Lam (2002) noted, conforming to "politically correct" behaviors with diverse groups alone suggests that the "intrinsic appropriateness of the behavior" (p. 416) may be lost. Therapists who primarily are driven by appearing socially desirable, without internalized cultural beliefs, may unknowingly inject needless tension in the therapeutic relationship and thus damage the persuasiveness of the myth and ritual.

In conclusion, one should keep in mind the following points:

- The complex interplay of a therapeutic orientation (myth), including its specific techniques (ritual), within the context of a healing setting and relationship provide the needed ingredients for successful psychotherapy.
- Whether specific ingredients are highly idiosyncratic or aligned with one of the dominant therapeutic orientations does not matter. The cogency of the rationale for the treatment and its acceptance by the client are the critical aspects of a successful treatment.
- Effective therapists and therapy provide a culturally acceptable rationale for change that leads to altered expectations and enhanced well-being.
- As future research and practice continue to evolve, the contextual model will provide a coherent metatheory for ongoing exploration.
- In the final analysis, the beauty of a treatment, or the efficacy established in a clinical trial, is not important; the important issue is whether for a particular client, the treatment as delivered by the therapist is successful. This success can only be established by monitoring the outcomes for this particular client.

QUESTIONS FROM THE EDITORS

1. *You make clear in this chapter that specific factors associated with treatments are not responsible for treatment outcome. If the therapist knows that his or her treatment is a myth, then how can the therapist generate belief (e.g., allegiance) sufficient to create a credible treatment? That is, if he or she knows that the explanation is not true, how does he or she convince the client that it is true?*

Awareness that contemporary healing practices are infused with the culture's mythology does not necessarily diminish one's ability to participate in and use them in treatment. Therapists who gain an appreciation for the myths

of treatment are perhaps similar to the film critic who becomes savvy to the many devices that filmmakers use to entice the typical moviegoer into the narrative. Certainly, one can become jaded and cynical as a result of this knowledge, but many film critics seem to believe that their participation in film is enhanced by their knowledge and expertise. 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!

For many therapists, adherence to their practices seems to be based on both literal and historical sense. Therapists may believe just as stridently that only the client's narrative construction is true in its own right. With regard to the latter, narrative truth is no less real than the physical and historical reality, such as in the prior discussion of placebo effects. Part of the delight in thinking contextually about psychotherapy can be the discovery of how our healing rituals are linked to myth, which no doubt can be a lifelong journey and occupational benefit. Knowledge of how psychological treatments are grounded in myth and how those myths translate into real-world change should actually serve to enhance the beliefs of the proponents of various psychotherapies.

2. *If therapy works in the way you describe, how can or should the field distinguish between therapists, religious ministers, and native healers? Put another way, is the professional psychotherapist (regardless of degree, training, or licensure) a mere player in a historical context—in our particular case, an epiphenomenon of Western, Enlightenment-based cultures?*

We believe that psychotherapy is indeed an epiphenomenon of Western, Enlightenment-based cultures. Tracing the evolution of the need for and current role of psychotherapy and psychotherapists would require significantly more space than is allotted here, however. Suffice it to say, we can imagine a time in the future when, as in the past, clinicians delivering psychotherapy as presently practiced would not be necessary. The "secular priesthood" (London, 1986) has a place in our time because the culture creates a place for it. And as soon as the culture does not have a place for it, it will be replaced.

It is also clear that religious ministers and native healers are connected with therapists whether the "professionals" like it or not. Even if one ignores

the obvious connection between psychotherapy and religious healing through the myth, ritual, setting, and relationship of the contextual model, it is obvious to astute observers that religious ministers and native healers capitalize on many of the techniques and beliefs that are effectively used by therapists (or is it the other way around?). Perhaps the difference lies in the fact that therapists, for the most part, form a society-sanctioned profession with associated rules of operation, laws to govern practice, and guidelines for handling problems. In addition, psychotherapists typically adhere to the scientific model of evidence, whereas religious ministers and native healers may have a different standard and source of evidence demonstrating effective practice.

3. *As a follow-up, are all treatments provided by psychotherapists legitimate? Are some therapies simply too "crazy" to be used by psychotherapists? If so, how does one discriminate between legitimate and illegitimate psychotherapies?*

According to the model described in this chapter, a therapy would be defined as too alien only when it fails to include a belief that is meaningfully linked to larger cultural beliefs. Specifically, the belief has to not only be meaningful but also, as stated in the body of the chapter, acceptable and helpful to the client. Obviously, treatments that do not engage the client, however well intentioned, will only serve to diminish hope.

Discriminating therapies that are legitimate from those that are not is a more difficult task. New therapies must be allowed to flourish if psychotherapy is allowed to keep pace with social evolutionary changes within society. A natural evolutionary course will take place in which inert treatments, those that fail to make meaningful connections to core contextual beliefs held by the client patient and his or her community, will naturally drop out of use. Similarly, therapies that are not effective will likely fall out of use naturally because the rationale behind the treatment is not believable to clients. Consider the bounty of remedies that are no longer used in therapy: primal scream, nude marathon and encounter group therapies, Orgone therapy, transactional analysis, prolonged bathing, nasal surgery, and even tooth extractions for treatment of psychosis (Scull, 2005). Such treatments were used in the United States in the 20th century but are now viewed as quaint, out of date, simplistic, and even torturous.

Given the large number of therapies that have been introduced in the past 20 to 30 years, legitimate concerns have been raised about ethical practice. It seems that these judgments could be made through a consensus from committees of distinguished therapists and researchers. We believe that such monitoring would be best if cautious and limited to excluding therapies that are suspect, ethically questionable, or not likely to be effective. Monitoring does not guarantee discontinuation of treatments that harm. For instance, the example of repeated, drastic surgery and tooth removal (Scull, 2005) was based on a stated rationale of benevolence (i.e., certain limbs, organs, etc., must be

removed because of pockets of infection believed to be causing insanity). Although some professionals publicly voiced concerns, those who could have halted this practice believed the theory of focal infection. The prominence of those who voiced support for radical surgeries illustrates the power of the rationale behind any treatment and the inherent problems with oversight and monitoring myths. Even so, such examples give us reason to hope that future oversight will be more reflective of the context in which these myths arise.

It seems reasonable (from the current place and time) that therapies whose myth does not appear believable could be required to be submitted for empirical study and support. Asking that a handful of therapies be submitted to a clinical trial to demonstrate empirical support (i.e., equivalent effectiveness with other therapies) seems to us a more parsimonious solution to the problem of illegitimate treatments. Such a solution would seem both practically and scientifically more reasonable than asking that all treatments undergo clinical trials to demonstrate that they are just as effective as almost all other forms of therapy (see the overview of this research in this chapter). This solution would free practitioners to engage in treatment development. It would also free scientists to study legitimately framed research issues (e.g., search for active ingredients common to all therapies). As a field, psychotherapy will be in much better position to distinguish legitimate from illegitimate treatments once our research advances enough to determine how common factors are used as active ingredients in circumstances and contexts.

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