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EMPIRICALLY SUPPORTED TREATMENTS: THE DECONSTRUCTION OF A MYTH

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Summary

This article summarizes recent findings from analyses and meta-analyses of psychotherapy research that show that so-called empirically supported treatments (ESTs) are no more effective than are traditional psychotherapies. In addition, the findings show that specific modalities and techniques have little, if anything at all, to do with therapeutic benefits and that client improvement and therapeutic outcome are instead the result of other factors in the therapeutic situation such as the alliance, the therapist, the relationship, and other contextual factors. The article shows how these findings deconstruct the whole notion of ESTs and make the current debate about them meaningless. Finally, the article discusses implications of the findings and urges humanistic psychologists and other proponents of traditional psychotherapies to shift the debate away from modalities and techniques and to focus on the factors that are actually responsible for therapeutic benefits.

Keywords: *psychotherapy; treatment; empirical; evidence; contextual*

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I am not being overly dramatic when I say that our profession is currently engaged in a debate whose outcome may very well determine the future of psychotherapy in America. The debate is about "evidence-based practice" (EBP) and the use of "empirically supported treatments" (ESTs) versus what I will refer to in this article as "traditional psychotherapies." Lists of ESTs are dominated by short-term, technique-focused treatments such as behavioral and cognitive behavioral therapy (CBT). "Traditional psychotherapies," as I use the term here, refers to therapies that are generally longer-term, more complex, and less technique focused, such as humanistic, psychodynamic, and systems approaches.

The reason this debate is so important is that it is not simply about which therapeutic approach is "better" or which might be more effective with a particular client or disorder. Our profession has debated these kinds of issues for years, and if that were all the debate were about, there would be no reason for concern. This debate, however, is different, and the outcome has enormous implications for the future of psychotherapy. *Let me put it bluntly: The debate is about the complete eradication of all therapeutic approaches that do not meet the so-called "scientific" standards set up by proponents of ESTs.* Although not every clinician who uses ESTs endorses such an extreme goal, the more ardent supporters of ESTs believe that all "unscientific" psychotherapies should be abolished and replaced with approaches that are deemed to be "empirically supported." Indeed, some proponents of ESTs (Lohr, Fowler, & Lilienfeld, 2002) have gone so far as to suggest that the American Psychological Association (APA) and other psychology associations should enforce the use of ESTs and "impose stiff sanctions, including expulsion if necessary" (p. 8) against clinicians who do not comply.

So far, APA has refused to take such an extreme position. It is unsettling, however, that APA (2002) now specifically requires, as part of its official accreditation criteria, that psychology programs provide training in ESTs. Clearly, training programs seeking initial or renewed accreditation will view this as an endorsement of ESTs by APA, and most will do whatever is necessary to make sure their students receive such training. As this article will show, there is no scientific basis for this requirement, and APA has clearly gone beyond the evidence to burden programs with this questionable requirement. On the other side of the coin, in 2005, under the leadership of Ronald F. Levant as APA president, the APA Council of Representatives approved the policy statement of the APA Presidential Task Force on Evidence-Based Practice (2006), which

represented a more moderate position on the use of ESTs. (This is discussed later in this article.) Nevertheless, APA remains a "house divided"—especially at the division and at individual member levels—over the issue of EBP and the use of ESTs in psychotherapy.

POLITICS AND ELITIST ATTITUDES CLOUD THE SCIENTIFIC ISSUES

Despite all the talk about scientific versus unscientific treatments, this debate is not simply about science. If it were, those of us who support traditional psychotherapies would have nothing to worry about because since the late 1970s and early 1980s, the research has clearly shown that psychotherapy, including traditional approaches, is robustly effective (Bergin & Lambert, 1978; Grissom, 1996; Lambert & Bergin, 1994; Lipsey & Wilson, 1993; Seligman, 1995; Smith, & Glass, 1977; Smith, Glass, & Miller, 1980; Wampold, 2001). In light of this well-established scientific fact, one has to wonder why ardent proponents of ESTs are so critical of traditional psychotherapies and want to replace them with ESTs. The answer, no doubt, is that this debate is not only about science but also about politics, economics, the medical model, managed care, and getting a piece of the health insurance pie. These political and economic matters cloud the scientific issues and ultimately may have more to do with the outcome of the debate than the scientific findings. Thus, it would be naïve for those of us who support traditional psychotherapies to assume that all we have to do is demonstrate the scientific validity of our approaches and the debate would be over. In fact, we have already done that, and it has had no detectable effect on the debate. The truth is, if we want to win this debate, we must be politically sophisticated as well as scientifically grounded.

Levant (2004), the former president of APA mentioned above, described the attitudes one often encounters when trying to discuss ESTs with ardent supporters. Levant said,

> Empirically-validated treatments is a difficult topic for a practitioner to discuss with clinical scientists. In my attempts to discuss this informally, I have found that some clinical scientists immediately assume that I am anti-science, and others emit a guffaw, asking incredulously: "What, are you for empirically *unsupported* treatments?" McFall (1991, p. 76) reflects this perspective when he divides the world of clinical psychology into "scientific and pseudoscientific clinical psychology," and rhetorically asks "what is the

> alternative [to scientific clinical psychology]? *Unscientific* clinical psychology." (See also Lilienfeld, Lohr, & Morier, 2001)
>
> There are, thus, some ardent clinical scientists . . . who appear to subscribe to scientistic faith, and believe that the superiority of scientific approach is so marked that other approaches should be excluded. Since this is a matter of faith rather than reason, arguments would seem to be pointless. . . . Punctuating these interactions from the practitioner perspective, the controversy seems to stem from the attempts of some clinical scientists to dominate the discourse on acceptable practice, and impose very narrow views of both science and practice. (p. 219)

Unfortunately, the elitist attitudes that Levant describes are part of the political realities of this debate. The history of psychology is rife with examples of those who were so sure of their own "scientific" views that they marginalized those who disagreed with them. Freud started it by banishing such luminaries as Carl Jung and Alfred Adler from his inner circle. John Watson (Watson & Raynor, 1920) continued the trend in the early 1900s by touting the "scientific" basis of behaviorism and publicly taunting psychoanalysts (after he had psychologically abused "Little Albert"). Today, such elitist attitudes characterize those who, in the name of "science," would eliminate all therapeutic approaches except their own. Although we must be tolerant, as William James put it, toward those who themselves are tolerant, we must challenge colleagues who insist that they have a monopoly on therapeutic truth and who would, if they had their way, eliminate all therapeutic modalities except those they deem to be "empirically supported." It's also important that we monitor our own motives and remember that this debate is not about our own egos or even, ultimately, about our own professional futures. Something much larger is at stake. *This debate is about the future of psychotherapy as a healing art and about the thousands of clients, present and future, who desperately need the kind of therapeutic experience that traditional psychotherapies provide* (for information on the benefits of longer-term therapy, see Elkins, in press; Miller, 1994, 1996a, 1996b, 1996c; Seligman, 1995). The stakes in this debate could not be higher. It is a debate we cannot afford to lose.

EMPIRICALLY SUPPORTED TREATMENTS: A BRIEF HISTORY

In the late 1970s, psychology began to put "all of the eggs in the 'technique basket'" (Bergin, 1997, p. 83). In the 1980s, managed care

companies and the health insurance industry in general put pressure on psychology to demonstrate that it could do both efficient and effective psychotherapy. In keeping with their medical model assumptions, the companies wanted psychology to identify specific treatments that were scientifically proven to be effective for specific disorders. In 1993, responding to the pressure and wanting to ensure that psychologists got a piece of the health insurance pie, Division 12 of APA, Society of Clinical Psychology, formed a task force to identify effective therapies and publicize these to psychologists, health insurance companies, and the public. The task force created a list of treatments that they referred to as "well-established" and "probably efficacious" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 3). In time, the terminology was changed to "empirically validated treatments" and later to ESTs. The general term EBP is also widely used to designate therapeutic approaches that use ESTs. The Division 12 list of ESTs was dominated by short-term behavioral and cognitive-behavioral treatments. Traditional psychotherapies, which tend to be longer-term, more complex, and less technique focused, did not make the list. By creating and publishing their list of ESTs, the Division 12 task force joined with managed care and health insurance companies in taking psychotherapy down a road that many of us in humanistic psychology feared would be the end of psychotherapy as we had known it. When the task force made it clear that ESTs must be administered using manualized instructions, we were even more disturbed. Then, when the task force urged APA to make adherence to ESTs a major criterion for accreditation and even for approving continuing education sponsors, some of us were about ready to throw in the towel. Then, when it was rumored that clinicians who failed to use ESTs would be vulnerable to charges of professional incompetence and unethical practice and could be sued by clients for not meeting "standard of care" requirements, we became nauseous and fell into existential despair. Finally, when some proponents of ESTs, apparently getting into the spirit of things a bit too much, went so far as to say that APA should enforce the use of ESTs and sanction or expel those who refused to comply, many of us concluded the apocalypse was here and the end of the world was at hand. Those of us with weak ego strength and paranoid tendencies were haunted by visions of being lined up against clinic walls or in university commons and shot for having humanistic or existential inclinations. The more reality-oriented ones among us envisioned a managed care world where technician-like

therapists, manuals in hand, would administer ESTs to treat depression, panic, phobias, generalized anxiety disorder, and other emotional problems using the short-term formats demanded by managed care and enforced by its checklist-using clerks. A few humanistic clinicians, perhaps panicked about their economic futures, began offering workshops on short-term therapy, trying to show that we, too, could fit into the new managed care world. Others, believing in the basic scientific soundness of humanistic therapies, criticized traditional research methods and called, with little success, for the inclusion of qualitative approaches in determining what treatments would be deemed empirically supported.

Fortunately, when Division 12's list of ESTs was made public, there was "an attendant landslide of criticism from practitioners and researchers who found the project to be scientifically questionable as well as overzealous in its assertions" (Lambert & Barley, 2002, p. 17). Division 32, Humanistic Psychology, along with other APA divisions, voiced strong concerns about the direction of the Division 12 task force and succeeded in getting individuals on the committee who were able to moderate, at least to a degree, some of the committee's more extreme goals. Division 32 formed a task force of its own (Task Force for the Development of Guidelines for the Provision of Humanistic Psychosocial Services, 1997) to establish humanistic guidelines and to offer an alternative to those proposed by the Division 12 task force. Division 17, Counseling Psychology, also got into the act and issued principles that challenged Division 12's methods for determining empirically supported approaches (Wampold, Lichtenberg, & Wachler, 2002). Division 29, Psychotherapy, also established a task force (Task Force on Empirically-Supported Therapy Relationships) to identify and publish the scientific evidence showing that the therapeutic relationship is a major determinant of therapeutic outcome, thus counterbalancing Division 12's emphasis on ESTs with what the Division 29 task force called ESRs, i.e., empirically supported relationships (for comprehensive presentations of the work of the Division 29 task force, see Norcross, 2001, 2002).

The general outcry from researchers and clinicians, along with the actions of Division 32, Division 17, Division 29, and other APA divisions, had an effect. Indeed, those efforts may have saved psychotherapy, at least for the time being, from being redefined as a short-term, manualized, technique-dominated enterprise. To date, neither Division 12 nor APA has mandated the exclusive use

of ESTs, and, to my knowledge, no clinicians have been shot, sued, sanctioned, kicked out of APA, or charged with professional incompetence or unethical conduct for refusing to follow the official list of ESTs. In fact, as noted earlier, when clinician Levant was president of APA in 2005, he commissioned a task force on evidence-based practice in psychology (EBPP). The APA Presidential Task Force on Evidence-Based Practice (2006), as the committee was called, issued a policy statement on EBPP that was approved by the APA Council of Representatives. The report of the task force, which was published in the *American Psychologist* (APA Presidential Task Force on Evidence-Based Practice, 2006), makes it clear that EBPP is a broader concept than ESTs, giving psychologists greater leeway in using clinical expertise to determine which treatments are best for a particular client and how, considering all research evidence, to adapt treatments to individual situations. The task force defined EBPP as follows: "*Evidence-based practice in psychology* (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences." (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273). This definition, which represents APA's current position on EBP, is clearly a more moderate posture than the extreme position taken by the original task force of Division 12. Thus, a battle was won, at least in part, for those of us who believed in the effectiveness of traditional psychotherapies and who did not endorse the exclusive use of ESTs.

WHY TRADITIONAL PSYCHOTHERAPIES ARE IN DANGER

We must not, however, think the conflict is over. Although we may have won a battle, we are still in grave danger of losing the war. Many psychologists believe the Division 12 task force was right to advocate the use of ESTs. Many graduate training programs, internship sites, and mental health clinics endorse the use of ESTs. Managed care and the health insurance industry in general, along with governmental agencies and research centers, still believe that ESTs are the only way to go. Many professors and clinical supervisors in graduate training programs tell students that competent treatment can only be delivered by using ESTs. Perhaps most disturbing of all, as noted earlier, APA (2002), in *Guidelines and Principles for Accreditation of Programs in*

Professional Psychology, prescribed competencies in ESTs. The guidelines specifically mention that students should receive such training in programs (p. 9), practicum experiences (p. 10), and internships (p. 17). As Wampold (2001) said,

> Although there is no scientific evidence that training should place emphasis on ESTs, the Guidelines and Principles of Accreditation prescribe competencies in ESTs. For example, the Guidelines and Principles for internship sites states that "all interns (should) demonstrate an intermediate to advanced knowledge of professional skills, abilities, proficiencies, competencies, and knowledge in the area of theories and methods of . . . effective interventions (*including empirically supported treatments*)." (p. 230)

In this milieu, psychology students who are interested in traditional psychotherapies are at a woeful disadvantage. When professors and clinical supervisors tell students that certain approaches, such as CBT, are "empirically based" and that others are merely "theoretical and speculative," it becomes difficult for students to remain committed to therapies not endorsed by their mentors. Because today's psychology students will be the clinicians of tomorrow, there is reason to believe that psychotherapy will be increasingly dominated by therapists who practice CBT and other such "empirically based" approaches. If this occurs, the extreme goals of the Division 12 task force will be realized after all, through an influx of thousands of new clinicians who are committed to ESTs and who, in time, will replace those of us who are practicing today.

Meanwhile, those of us who are committed to traditional psychotherapies look for effective ways to respond to students and others who ask about the scientific bases of our approaches. As this article will show, some scholars among us are able to reframe the issue and provide very clear and convincing answers. Most of us, however, tend to respond in one or more of the following ways. First, because we, too, respect science, we sometimes say that our therapeutic approach, although perhaps not scientifically proven, is nevertheless supported by softer forms of "clinical evidence" and many years of "clinical experience." Second, we may launch into a short lecture about the limitations of traditional research methods, implying that if qualitative methods were used, our approach undoubtedly would do well. Third, if we happen to practice from the person-centered approach, we may dust off some of the old research by Carl Rogers and his associates that showed

the scientific validity of his "necessary and sufficient" conditions of psychotherapy. (Of course, this does not do much for those of us who practice from existential, psychodynamic, and systems approaches.) Fourth, as a last resort, we may respond that our therapeutic approach is merely "untested," implying that if we ever get around to testing it, it will surely prove to be just as scientific as those that are said to be empirically based.

Although such responses may be persuasive to the "choir," they are not very convincing to graduate students and others who are already wavering in their commitment to "theoretical and speculative" approaches in favor of those that are said to be scientific and empirically based. Perhaps these arguments had some merit in the 1990s when we were forced to debate managed care and the Division 12 task force about which modalities and techniques were "empirically supported." Today, however, I believe these arguments are inadequate and misguided. The problem with all the arguments is that they are based on the assumption that we should be able to scientifically demonstrate that our particular modality and techniques produce client improvement and successful therapeutic outcome. As I will show in this article, this assumption is problematic, not only because it focuses on the wrong factors in psychotherapy (i.e., modalities and techniques) but also because, from a political and strategic perspective, if we continue to fight the war for traditional psychotherapy on the battleground this assumption created, we will lose. Admittedly, in the 1990s this was the battleground staked out by managed care and the Division 12 task force, and we had little choice but to fight on their turf and according to their terms. Indeed, some of our colleagues did an excellent job of presenting the research evidence for humanistic therapies and of making the case for alternative research approaches in determining the effectiveness of treatments (e.g., Cain & Seeman, 2002; Elliott, 2002; Elliott, Greenberg, & Litaer, 2003; Task Force for the Development of Practice Recommendations for the Provision of Humanistic Psychosocial Services, 2004). But today things are different, and we must shift the debate to a new venue, one created by recent analyses and meta-analyses of the research on therapeutic effectiveness that show what is actually responsible for client improvement and therapeutic outcome (hint: It is *not* modalities and techniques). By shifting the scientific debate to this new venue, we will not only deconstruct the myth of ESTs but also demonstrate the

scientific validity of our own "theoretical and speculative" approaches to psychotherapy.

DECONSTRUCTING ESTs: THE SCIENTIFIC EVIDENCE

One of the remarkable things about science is that it cuts both ways. For example, if a group insists that science and science alone should decide which psychotherapies are effective, that group then has a logical obligation to accept whatever science reveals. In that regard, science has now shown in a clear and convincing way that although psychotherapy is highly effective, no therapeutic modality is any more effective than any other therapeutic modality and no therapeutic techniques are any more effective than any other therapeutic techniques. Instead, therapeutic effectiveness is the result of certain other factors in the therapeutic situation that are common to all therapeutic systems. As I will show, these findings deconstruct, in a devastating way, the whole notion of ESTs. The scientific evidence for these statements is summarized below.

In a landmark study, Bruce Wampold (2001), a psychologist, mathematician, and statistician at the University of Wisconsin, reviewed decades of research and conducted analyses and meta-analyses of thousands of studies in an effort to clarify the determinants of therapeutic effectiveness. Wampold reported his findings in journal articles (e.g., Ahn & Wampold, 2001; Messer & Wampold, 2000; Waehler & Wampold, 2000; Wampold, 1997; Wampold et al., 1997) and also in his book, *The Great Psychotherapy Debate: Models, Methods, and Findings* (Wampold, 2001). Although other scholars, including Rosenzweig (1936), Luborsky, Singer, and Luborsky (1975), Goldfried (1980), Frank and Frank (1991), Castonguay (1993), Grencavage and Norcross (1990), Orlinsky, Grave, and Parks (1994), Hubble, Duncan, and Miller (1999), and Norcross (2001, 2002), have come to similar conclusions, I will focus on Wampold's book because, in my opinion, it is the most comprehensive, detailed, and balanced presentation of the scientific evidence relative to the issues addressed in this article.

The debate referred to in the title of Wampold's (2001) book is the debate over *why* and *how* psychotherapy works. *That* therapy works is no longer a question in the research literature. As noted earlier, since the late 1970s and early 1980s, we have known that psychotherapy is highly effective. But *why* psychotherapy works and *how* it works are questions over which there is still much debate.

As Wampold pointed out, there are two sides to this debate. One side, the *medical model*, says that therapy works because of "specific ingredients" (i.e., specific techniques). Thus, for example, proponents of the medical model would say that CBT alleviates clinical depression because of the "specific ingredients" in CBT, meaning the techniques such as challenging negative thoughts that are hypothesized to be maintaining the depression. Thus, the medical model supports the search for specific psychotherapy techniques that will cure specific mental disorders, in much the same way that medical researchers search for specific medications that will cure specific physical illnesses. For obvious reasons, ESTs are the "superstars" of the medical model in psychotherapy.

The other side of the debate, which Wampold called the *contextual model*, argues that it is *not* techniques that are responsible for therapeutic benefits but certain other factors in the therapeutic situation that are common to all therapeutic systems. Wampold (2001) named this the contextual model "because it emphasizes the contextual factors of the psychotherapy endeavor" (p. 23). Among these "contextual factors" are the alliance, the therapist, the relationship, client expectations, the presence of a plausible rationale and set of procedures, allegiance of the therapist and client to the rationale and procedures, and so forth.

To determine which side of the debate—the medical model or the contextual model—was supported by the scientific evidence, Wampold conducted elaborate analyses and meta-analyses of decades of research on therapeutic effectiveness. The results were clear and unambiguous. The scientific evidence showed that the contextual model is correct and that the medical model is wrong. In other words, the evidence showed that it is not techniques that are responsible for therapeutic outcome but certain other factors in the therapeutic situation that are common to all therapeutic systems. The following is a summary of Wampold's major findings:

First, psychotherapy is highly effective. After reviewing the meta-analyses of psychotherapy research that had been conducted since the late 1970s, Wampold (2001) concluded that psychotherapy is robustly effective. He wrote,

> From the various meta-analyses conducted over the years, the effect size related to absolute efficacy appears to fall within the range of .75 to .85. A reasonable and defensible point estimate for the efficacy of psychotherapy would be .80, a value used in this book. This effect would be classified as a large effect in the social

> sciences, which means that the average client receiving therapy would be better off than 79% of untreated clients. . . . Simply stated, *psychotherapy is remarkably efficacious*. (pp. 70-71)

This finding was neither new nor controversial. Previous reviews and meta-analyses had made it clear that psychotherapy is highly effective (e.g., Bergin & Lambert, 1978; Grissom, 1996; Lambert & Bergin, 1994; Lipsey & Wilson, 1993; Smith et al., 1980; Smith & Glass, 1977).

Second, no therapeutic approach is any more effective than any other therapeutic approach. Although it may be surprising to some, this finding is in line with other reviews and meta-analyses that show that no particular therapy has proven itself to be more effective than any other therapy (e.g., Bergin & Lambert, 1978; Lambert & Barley, 2002; Lambert & Bergin, 1994; Luborsky et al., 1975; Orlinsky et al., 1994; Rachman & Wilson, 1980; Robinson, Berman, & Neimeyer, 1990; Seligman, 1995; Shapiro & Shapirio, 1982).

In specific regard to this article and the debate about ESTs, this finding means that so-called "empirically supported" psychotherapies such as CBT are no more effective than traditional psychotherapies. Also, when coupled with the fact that psychotherapy is highly effective, the finding means that all therapeutic approaches, including traditional psychotherapies, are effective, and equally so. In more strident moments, I have wanted to ask my colleagues on the other side of this debate, "What part of 'equal' do you not understand?" By continuing to insist that so-called "empirically supported" approaches are more effective than other approaches, they are apparently taking the position that their approaches are "more equal" than others! Wampold's research makes it clear, however, that no therapeutic approach is any more effective than any other therapeutic approach. And in regard to the question of which therapies are "empirically supported," the answer is that they are all "empirically supported" because the evidence shows that they are all effective, and equally so. Thus, in that sense, traditional psychotherapies are just as "empirically supported" as CBT and other such approaches whose proponents try to exercise a monopoly on that designation.

Third, no therapeutic techniques are any more effective than any other therapeutic techniques. This finding agrees with other studies (e.g., Gloaguen, Cottraux, Cuchert, & Blackburn, 1998; Lipsey & Wilson, 1993; Shadish, Navarro, Matt, & Phillips, 2000) that

show no significant differences in the effectiveness of techniques from various therapeutic approaches. To make sure his findings were correct on this point, Wampold took the additional step of analyzing the research that specifically focused on the efficacy of techniques. He found no evidence for "specificity," meaning he found no evidence to support the view that specific techniques are responsible for therapeutic outcome. As Wampold (2001) put it,

> In this chapter, research designed particularly to detect the presence of specificity were reviewed. The results of studies using component designs, placebo control groups, mediating constructs, and moderating constructs consistently failed to find evidence for specificity. (pp. 147-148)

Near the end of his book, Wampold reiterated this finding and admonished clinicians to have humility about their techniques. He said,

> The evidence in this book has shown that specific ingredients are not active in and of themselves. Therapists need to realize that the specific ingredients are necessary but active only in the sense that they are a component of the healing context. Slavish adherence to a theoretical protocol and maniacal promotion of a single theoretical approach are utterly in opposition to science. Therapists need to have a healthy sense of humility with regard to the techniques they use. (p. 217)

In a more recent book on EBP, Wampold (2005) contributed a chapter titled "Do Therapies Designated as ESTs for Specific Disorders Produce Outcomes Superior to Non-EST Therapies? Not a Scintilla of Evidence to Support ESTs as More Effective Than Other Treatments." According to my old Merriam-Webster dictionary, the word *scintilla* is a noun meaning "spark" or "trace" (Webster's, 1965, p. 771). Thus, Wampold was saying that there is not a spark or trace of scientific evidence to support ESTs as more effective than other treatments!

In specific regard to this article and the debate about ESTs, Wampold's findings mean that so-called "empirically supported" techniques are no more effective than the techniques of traditional psychotherapies. Going even further, Wampold's findings show that techniques, in and of themselves, are not responsible for therapeutic outcome. These scientific findings are a devastating blow to ESTs, which are based on the medical model assumption that specific techniques are responsible for therapeutic healing. As Wampold (2001) said,

> The evidence presented in this book has undermined the scientific basis of the medical model of psychotherapy, thus destroying the foundation on which ESTs are built. (p. 214)

Fourth, therapeutic effectiveness is the result of certain factors in the therapeutic situation that are common to all therapeutic systems. Wampold (2001) referred to these as "contextual factors" and showed that these factors, rather than modalities and techniques, are responsible for client improvement and therapeutic outcome.

In specific regard to this article and the debate about ESTs, this finding means that the debate about which modalities and techniques are "empirically supported" is meaningless. Simply put, if contextual factors, instead of modalities and techniques, are responsible for therapeutic benefits, then it is pointless to talk about which modalities and techniques are "empirically supported" because modalities and techniques are not responsible for therapeutic outcome anyway! This finding also means that proponents of traditional psychotherapies have no scientific obligation to prove that their modalities and techniques are "empirically supported" because, again, modalities and techniques are not responsible for therapeutic outcome anyway! Instead, we should focus our scientific efforts on the factors in psychotherapy that are actually responsible for therapeutic benefits.

THE PLACE OF THEORY AND TECHNIQUES IN THE CONTEXTUAL MODEL

One might conclude from what has been said that theories and techniques have nothing to do with therapeutic outcome. In one sense, this is true because Wampold's research shows that theories and techniques, *in and of themselves*, have very little, if anything at all, to do with therapeutic benefits. On the other hand, although they have no *inherent* power to heal, theories and techniques *do* contribute to therapeutic outcome by providing a credible rationale and set of procedures that serve as a vehicle for the therapeutic work and by expressing, and serving as a conduit for, other factors in the therapeutic situation known to be responsible for outcome. In other words, in their role and function as contextual factors found in all therapeutic systems, theories and techniques *do* contribute to therapeutic outcome.

Thus, Wampold would support cognitive-behavioral therapists who explain to clients that their depression is due to negative thoughts and then proceed to show the client how to change those thoughts using the "specific ingredients" of CBT, meaning the specific techniques designed for thought modification. In the same way, Wampold would support psychoanalysts who tell their clients that their depression is due to unconscious conflicts and that through analytic techniques they can uncover those conflicts and alleviate their depression. However, unlike the clinicians using these approaches (probably), Wampold does not believe that the theories and techniques, in and of themselves, are responsible for alleviating the depression. Instead, he believes other factors in the therapeutic situation are responsible for the therapeutic benefits. Thus, paradoxically, one can say that theories and techniques have nothing to do with therapeutic benefits, and, in the same breath, one can also say that theories and techniques *do* contribute to therapeutic benefits. The key to this apparent conundrum is to understand that although theories and techniques are not effective in and of themselves, they are effective in the sense that they provide a credible rationale and set of procedures for the therapeutic work and they serve as expressions of, and conduits for, other factors in the therapeutic situation that are known to contribute to outcome, such as the alliance, the therapist, the relationship, and so forth.

FACTORS RESPONSIBLE FOR THERAPEUTIC BENEFITS

More than 70 years ago, Rosenzweig (1936) wrote an article titled "Some Implicit Common Factors in Diverse Methods of Psychotherapy: 'At Last the Dodo Said, "Everyone has won and all must have prizes."'" Rosenzweig was the first to suggest that all therapies are effective because of certain factors that are common to all therapeutic approaches. (The reference to the dodo is from *Alice in Wonderland*, where the dodo bird, after watching a race, decided that everyone had won, the point being that every therapy "wins" or is as effective as any other therapy. Since the publication of Rosenzweig's article in 1936, the idea that therapeutic effectiveness is because of common factors has been referred to as the "dodo bird effect").

In 1991, Frank and Frank published *Persuasion and Healing: A Comparative Study of Psychotherapy*. In the tradition of Rosenzweig, the authors took the position that therapeutic effectiveness is due to factors common to all therapeutic systems. Wampold (2001), who based his "contextual model" on Frank and Frank's thesis and list of four major "common factors," said,

> The contextual model explains the benefits of psychotherapy by postulating that the "aim of psychotherapy is to help people feel and function better by encouraging appropriate modifications in their assumptive worlds, thereby transforming the meaning of their experiences to more favorable ones" (Frank & Frank, 1991, p. 30). The components common to all therapies include (a) an emotionally charged confiding relationship with a helping person; (b) a healing setting that involves the client's expectations that the professional helper will assist him or her; (c) a rationale, conceptual scheme, or myth that provides a plausible, although not necessarily true, explanation of the client's symptoms and how the client can overcome his or her demoralization; and (d) a ritual or procedure that requires the active participation of both client and therapist and is based on the rationale underlying the therapy. (pp. 204-205; for more information on the four factors, see Wampold, 2001, pp. 24-26)

The four factors above provide a basic framework for the contextual model. The four factors can be broken down further into more specific "common factors" such as the alliance, the therapist, the relationship, client expectations, and so forth. Taken together, these are the elusive "healing factors" in psychotherapy. It is ironic that the factors that were almost completely ignored by proponents of ESTs and the medical model have now been identified as the effective ingredients in psychotherapy! To adapt a sacred quotation, "The stone that the builders rejected has now become the cornerstone."

How much influence do contextual factors have on therapeutic outcome? Perhaps the best known "pie chart" for contributions to outcome is that of Lambert (1992, p. 97), who partitioned the variability in improvement of psychotherapy clients into four parts. He attributed 40% to extratherapeutic change, 15% to expectancy (placebo effects), 15% to techniques, and 30% to common factors. However, as Wampold (2001) pointed out, these percentages are somewhat arbitrary. Lambert (1992) did not use meta-analytic techniques to arrive at the percentages and admitted that "no statistical procedures were used to derive the percentages" and that they appeared "somewhat more precise than

perhaps is warranted" (p. 98). Nevertheless, even using Lambert's questionable percentages, if one combines his expectancy or placebo effects (15%) with his common factors (30%), this means that contextual factors (expectancy plus common factors) account for 45% of the variance versus only 15% for techniques. In other words, even in Lambert's schema, contextual factors account for 3 times as much of the variance as do techniques!

Using sophisticated meta-analytic techniques, Wampold (2001) derived percentages of variability due to specific contextual factors. Summarizing these, Wampold said,

> Placebo treatments, which contain some but not all common factors, account for 4% of the variability in outcomes. . . . One prominent common factor studied is the working alliance; the proportion of variability in outcomes due to this one factor is substantial (about 5%). Moreover, allegiance, another common factor, accounts for up to 10% of the variability in outcomes. Finally, the variance due to therapists within treatments accounts for somewhere between 6 and 9% of the variance in outcomes. (p. 206)

Perhaps more striking is Wampold's (2001) estimate of the variance attributable to common factors in the effects of psychotherapy. He said, ". . . at least 70% of the psychotherapeutic effects are general effects (i.e., effects due to common factors)." He went on to say that specific effects, i.e., techniques, "account for at most 8% of the variance. . . ." (p. 207). In regard to variability of outcomes, Wampold noted that although previous work had suggested that specific ingredients are responsible for 1% of the variability, that figure failed to take into account therapist effects. Wampold's own analysis suggested that techniques, *in and of themselves,* may very well account for none of the variance! Wampold stated his conclusion as follows:

> Lest there be any ambiguity about the profound contrast between general and specific effects, it must be noted that the 1% of the variability in outcomes due to specific ingredients is likely a gross upper bound. . . . Clearly, the preponderance of the benefits of psychotherapy are due to factors incidental to the particular theoretical approach administered and dwarf the effects due to theoretically derived techniques. (p. 209)

To put it simply, techniques have little, if anything at all, to do with therapeutic outcome, whereas contextual factors have powerful effects on therapeutic outcome.

IMPLICATIONS AND RECOMMENDATIONS

The findings summarized in this article not only undermine the foundations of ESTs and the medical model that created them, they also have other important implications. These implications, along with some recommendations, are presented below.

First, humanistic psychologists and other proponents of traditional psychotherapies should shift the debate about ESTs and EBP to a new battleground. The old battleground was based on the assumption that we should be able to prove the scientific validity of modalities and techniques. The "rules of engagement" called for efficacy studies under controlled conditions where a particular modality or technique was compared to another modality or technique (or to a placebo group) in an effort to prove its efficacy. The findings presented in this article make it clear that this old battleground is now obsolete. The scientific debate, whether some recognize it or not, has shifted to a new venue. The new venue is based on the assumption, supported by the findings summarized in this article, that therapeutic benefits are not due to modalities and techniques but due to certain "contextual factors" common to all therapeutic systems. I would urge humanistic psychologists and other proponents of traditional psychotherapies to recognize that the debate has shifted to this new venue. If we do this, we can win the scientific debate because the evidence clearly shows that (a) all psychotherapies are effective, and equally so; (b) modalities and techniques (including ESTs) have little or nothing to do with therapeutic outcome; and (c) contextual factors, not modalities and techniques, are responsible for therapeutic effectiveness. These findings deconstruct the whole medical model notion of ESTs and provide scientific support for traditional psychotherapies.

Second, researchers and clinicians associated with humanistic psychology and other traditional psychotherapies should reduce efforts to prove that particular modalities and techniques are more efficacious than others and focus instead on understanding the factors that are actually responsible for therapeutic outcome. Much work needs to be done to understand contextual factors and exactly how they contribute to therapeutic effectiveness. Bohart and Tallman (1999; Tallman & Bohart, 1999) have provided an excellent example of what is needed. Their work has focused on the client as a "common factor" in therapy and as active agent in the healing process, a perspective that challenges the medical model view that

the client is the passive recipient of "treatments." Rennie's (1990, 1994, 1997) work also demonstrates how the client is active in therapy and exercises control of the therapeutic process. Once we throw off the shackles of medical model thinking and begin to focus on the factors that are actually responsible for therapeutic healing, we will radically "revision" psychotherapy. This is an exciting opportunity for researchers and clinicians who wish to make substantive contributions to our understanding of therapeutic healing.

Third, researchers and clinicians associated with humanistic psychology should focus increased attention on humanistic therapies to identify "additional benefits" these therapies may provide in addition to the alleviation of emotional problems. ESTs and EBP, in accord with the medical model that created them, focus almost entirely on the elimination of symptoms and disorders. Humanistic therapies, by contrast, purportedly provide clients with additional benefits that go beyond the alleviation of symptoms and problems. It would be relatively simple to design a research project that asks, "What, if anything, does existential psychotherapy (for example) offer clients that CBT (for example) does not?" These additional benefits, if indeed they exist, may not be reimbursable by health insurance companies, but their identification and publication would show what humanistic therapies can offer clients, as contrasted to the offerings of technique-dominated ESTs, which appear, on the surface at least, to be quite barren. To conduct such a research project, one could generate a list of possible additional benefits of psychotherapy and ask clients from two therapies (e.g., existential therapy and CBT) to indicate which, if any, additional benefits they received from their respective therapeutic experiences. Likert-type scales could be used so clients could indicate to what degree each of these additional benefits was part of their therapeutic experience and to what degree they considered each benefit important. (By providing this outline, I am hoping that some graduate student will be inspired to take this on as a dissertation project!)

Fourth, training programs in clinical and counseling psychology should include a strong focus on the contextual factors so that students do not spend an undue amount of time learning modalities and techniques to the neglect of cultivating skills, attitudes, and values associated with the factors actually responsible for therapeutic effectiveness. Unfortunately, most graduate training

programs focus generous amounts of time on modalities and techniques and relatively little time on helping students develop the qualities and skills associated with contextual factors. Based on the evidence presented in this article, programs that put all their eggs in the modality and technique basket are shortchanging their students' education. Such programs, it could be said, are "majoring in minors and minoring in majors." In regard to the focus of training, the research already provides considerable guidance. For example, Orlinsky et al. (1994) reviewed more than 2,000 studies and identified several therapist-related variables that consistently have been shown to contribute to therapeutic outcome. Based on this research, Lambert and Barley (2002) published the following list:

> Therapist credibility, skill, empathic understanding, and affirmation of the patient, along with the ability to engage with the patient, to focus on the patient's problems, and to direct the patient's attention to the patient's affective experience, were highly related to successful treatment. (p. 22)

To show how important such training can be, even in regard to one therapist-related skill, one has to look only at the research by Lafferty, Beutler, and Crago (1991), who examined differences between less effective and more effective trainees. The findings showed that empathy was a differentiating variable between the two groups (i.e., less effective trainees had significantly lower levels of empathy than did more effective trainees). This led the researchers to say,

> The present study supports the significance of therapist empathy in effective psychotherapy. Clients of less effective therapists felt less understood by their therapists than did clients of more effective therapists. (p. 79)

Similarly, Burns and Nolen-Hoeksema (1992) examined the role of empathy in the treatment of depression by cognitive-behavioral therapists. The findings were clear: "The patients of therapists who were the warmest and the most empathic improved significantly more than the patients of the therapists with the lowest empathy ratings" (p. 447). As a result of this finding and wanting to be as effective as possible, the CBT clinic began asking patients to complete a form after every session indicating the level of their therapist's empathy.

The point is this: If one therapist-related variable such as empathy can have such a profound effect on therapeutic outcome, one can only wonder what the effect might be if training focused on an aggregate of therapist-related variables and other contextual factors known to contribute to therapeutic outcome. Clearly, if our goal is to turn out highly effective therapists, this is the area on which training should focus.

Fifth, training programs in clinical and counseling psychology should consider enlarging or changing the emphasis in their selection criteria. The major criterion for admission to many programs is the applicant's intellectual and academic ability, as measured by standardized tests. For decades, those of us who have taught in graduate training programs have observed that some students, with average or lower scores on standardized tests, nevertheless turned out to be highly effective psychotherapists. Conversely, some extremely bright students, as measured by standardized tests, turned out to be average (or even worse) psychotherapists. The findings summarized in this article may provide a clue to this puzzle. If contextual factors (e.g., the alliance, the therapist, the relationship, etc.) are responsible for therapeutic effectiveness, an applicant's intellectual and academic abilities may not be sufficient to guarantee success as a psychotherapist. Although a certain level of intellectual ability is obviously required for graduate training, it may be that personal characteristics, such as caring, warmth, and empathy, along with the ability to structure a therapeutic situation and create an intimate, healing environment, are more critical to success as a therapist than are intellectual and academic abilities. Programs might get better students—and better future clinicians—if selection criteria put less emphasis on standardized test scores and more emphasis on the personal and interpersonal skills and qualities of applicants.

Sixth, when evaluating current graduate students on their clinical abilities, training programs in clinical and counseling psychology should avoid focusing on theoretical and technical knowledge to the exclusion of the personal and interpersonal qualities and abilities of the student. The evidence summarized in this article suggests that it would be more helpful (and scientifically more defensible) to emphasize personal and interpersonal qualities and skills related to contextual factors. For example,

evaluators should ask, Is this student able to establish an effective working alliance with clients? Does the student exhibit the personal and interpersonal qualities and skills that we know are associated with the ability to form healing relationships? Does the student extend warmth, empathy, and respect to clients? Is the student able to structure and use the therapeutic situation to promote client improvement? It might even be worthwhile to ask, Do the clients of this student tend to get better? This is not to suggest that client improvement or lack of improvement should be the main criterion by which students are judged. Certainly, the kinds of clients a student works with, the level of experience and training of the student, the fact that practicum rotations can interfere with therapy, and other factors outside the student's control can affect therapeutic success. Nevertheless, if the clients of a student do indeed tend to get better, this suggests that the student may be doing something right (even if his or her theoretical and technical knowledge is not perfect), and this fact should receive appropriate consideration in the overall evaluation of the student.

CONCLUSION

Rollo May (1983) warned us about the American tendency to focus on techniques to the neglect of other, deeper dimensions of psychotherapy. As May knew, America is a frontier nation, and we want practical, simple solutions, even to complex problems. Above all, we want to "fix things." It is no accident that behaviorism has thrived in America and that CBT and other short-term, technique-dominated approaches are popular with American clinicians. In time, I suspect we will view psychology's current obsession with techniques and "quick fixes" as an historical expression of this cultural tendency gone wild in a time of economic fears brought on by managed care. In the meantime, we have a debate of historical proportions on our hands. I would urge humanistic psychologists and other proponents of traditional psychotherapies to embrace the scientific findings summarized in this article because they will help us to win the current debate. We should embrace these findings not only because they undermine so-called ESTs and EBP but also because they show that it is not modalities and techniques that heal the client but other factors in the therapeutic situation, most of which have to do with the deeply human experience of two persons reaching out to each other. One reaches out for help; the

other reaches out to give it. And although some of us may have to relinquish cherished beliefs that humanistic theories and techniques are more effective than other approaches, we should welcome the information that therapeutic healing, wherever it occurs, is largely due to such human factors as the strength of the alliance, the qualities of the therapist, and the nature of the therapeutic relationship. These findings are a powerful confirmation of what humanistic psychologists have maintained for years: It is not theories and techniques that heal the suffering client but the human dimensions of therapy and the "meetings" that occur between therapist and client as they work together. While writing this article, I often thought of Carl Rogers. His prescient insights always amaze me. If he were alive today, I suspect this "new" information about what heals in psychotherapy would cause him to smile. He was the first to discover, and raise to the level of theory, that what most clients need is simply a therapist in whom healer and human are seamlessly joined, one who knows how to create a healing context and a therapeutic relationship where empathy, respect, and genuineness are offered to the client, as one might extend one's hand to a friend who has fallen.

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